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INTERVIEW

Impacts of Gentrification on Health

An Interview with Shannon Whittaker, MPH

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Shannon Whittaker is a 4th year PhD student in Social and Behavioral Sciences at the Yale School of Public Health. Through a historical lens, her research evaluates how structural forms of racism, discrimination, and dispossession have evolved and how these systems of oppression affect communities of color. Her current research aims to identify pathways through which neighborhood change processes, such as gentrification, produce health disparities. Before Yale, she worked in healthcare advertising at Omnicom Group, as a production assistant at Atlantic Pictures, and as a health policy coordinator for the NYC Department of Health and Mental Hygiene. She holds a BA with honors in Community Health from Brown University and an MPH from the Brown University School of Public Health.

Tell us about your background and how you became interested in the kind of research that you do?

I became interested in this work in a really roundabout way. I was born in Brooklyn, New York, in Crown Heights, and my neighborhood at the time was majority Caribbean immigrants. When I was in middle school, we moved to Jamaica, Queens, and we would frequently go back to Brooklyn to visit family and friends. But every time we went back to Brooklyn, there were a lot of distinct changes that we saw in our neighborhood. The people that lived there before no longer lived there, some of whom were displaced or "forced" into lower income housing, and we realized that a lot of those residents (aka, our friends and family), had more health issues like diabetes or high blood pressure.

Because of that, I entered college pre-med but quickly changed paths when I realized that the things I was interested in studying, like health behaviors and health equity, were not aspects of medicine but instead public health. I remember taking a class in my Community Health program on place and health and that's where I was able to connect the dots between my changing neighborhood and the health outcomes of residents. I didn't really get into gentrification then because I feel like I didn't really know what it was or I couldn't put a name to what I experienced/witnessed but through the class I was able to find an incredible mentor at Brown. At the time, my mentor was conducting a lot of place-based intervention work in the context of neighborhoods and food access in Providence, Rhode Island. I really got my feet wet with doing on-the-ground research among marginalized communities, specifically low-income neighborhoods where residents had little-to-no access to healthy, affordable food because of where they lived and other structural inequities.

So that's what I did throughout my undergrad and my masters. A couple of years after graduating, I ended up at the New York City Department of Health as a health policy coordinator. My role was definitely more school focused, developing and implementing school-based wellness policies, but I had a lot of side projects within the department and the biggest one was a physical activity

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initiative involving a bike program for residents in East Harlem.

At that time, East Harlem was changing so drastically because of gentrification. You had residents who lived in the neighborhood since the 1960s/1970s feeling threatened because of new developments like the Whole Foods being built on 125th Street, and Citi Bike stations throughout their neighborhood. There were all these obvious signs of gentrification, yet city officials would deny that gentrification was happening because the population demographics remained the same. People were not getting displaced at that moment, but the residents knew what was happening and no one was listening to them.

I think that's where the gentrification bug got planted in my head and that's when I was able to again connect what I saw growing up to the work that I, we, were doing at that time. So, I left the department because I was just a coordinator and I only had an MPH and I was not able to enact a lot of change in that capacity. Then I applied for a PhD to study gentrification and how it relates to health.

Would you mind giving a definition of gentrification and how it interacts with displacement, or what gentrification-based displacement is and how that tends to work?

There are definitions that have stuck with me, that I often use and there are definitions that I've seen in papers that do not resonate. There's one definition that I actually came across maybe like two months ago. It's a definition by a grassroots organization called Just Cause/Causa Justa [1], and they say that gentrification is a profit driven racial and class reconfiguration of working-class communities of color that have suffered from a history of disinvestment and abandonment. I really love that definition because it considers history and that's something that I've been increasingly interested in in the context of place, but also in the context of public health which is largely absent from our curriculum.

So that's the definition that I've been currently using, but I think all the definitions that I relate to are ones that point to the fact that gentrification occurs in neighborhoods that have been historically disinvested from and abandoned because of structurally racist or discriminatory policies.

I've come to know and understand displacement to be a lot of different things outside of people being physically displaced. So, for example, in my dissertation, I'm assessing displacement in multiple forms. The first being residential displacement, which is debatably a known marker of gentrification where long term residents, usually people of color, are forcibly removed from gentrifying neighborhoods because they can no longer afford their rent or they don't have proper access to services.

Shannon Whittaker, MPH, Yale School of Public Health, New Haven, CT

But then you do have a subset of people who are able to stay in gentrifying neighborhoods and they experience displacement in different ways. For example, political displacement happens when long-term residents who are able to stay in gentrifying neighborhoods get outnumbered by newcomers who, you know, unjustly shift the balance of power towards the needs of those who gentrify, further overshadowing the needs of long-term residents. That also ties into cultural displacement, where cultural norms become replaced and removed from these neighborhoods because of new residents.

I have a broader question, but I think, while we're on this theme of history, I want to stick with that. I love what you say about the importance of history to public health. How does that history link into your questions about gentrification and displacement?

I think history is very important to my research because, as I mentioned above, I think the best definitions of gentrification consider this history of disinvestment. Ultimately, this history helps contextualize who is most at risk and what populations unequally carry the burden of urban change. This history, for me at least, highlights that Black and low-income communities are not only vulnerable to gentrification, but are also more likely to experience related adverse impacts caused by neighborhood change. Some really important work that has been instrumental in my thinking around the history of disinvestment is Dr. Mindy Fullilove's analysis on serial forced displacement [2].

My next question is a little more broad – could you talk about the concept of place and health

in public health, and then more specifically about the pathway from gentrification and displacement to negative health outcomes?

Generally, I mean, the places where we live, work, and play have a major influence on our health. The physical circumstances aka the built environment; the social context of place which extends to social networks and other measures of support; and the economic conditions of places pretty much dictate how we're able to achieve good health. For example, where we live dictates access to food, it dictates access to employment, quality schooling, etc. Also, we sometimes neglect to consider how symbolic representations of certain politically and economically disadvantaged places influence health among residents. Dr. Danya Keene's work on spatial stigma [3] does a great job at explaining some of these processes.

In the context of gentrification, the general dimensions that I just mentioned also hold true. As neighborhoods gentrify, these dimensions also change with implications for health. Focusing on gentrification-induced displacement, even though research/analysis makes it difficult to say that gentrification causes displacement, which then causes negative health outcomes…it does. I've experienced and witnessed it. Through the pathway of displacement (in its multiple forms), gentrification can remove people from social networks, negatively impact sense of community, reduce feelings of belongingness, increase the use of emergency and mental health services, etc. – all of which impact health and well-being. Not only that but environmental risks such as treatment plants and industrial facilities can also be displaced from gentrifying neighborhoods to surrounding resource-deprived communities. Even outside of the context of gentrification, there is a massive displacement, and health literature that showcases that displacement is related to a lot of negative health outcomes.

Also being a public health researcher, I'm curious what are the different methodologies you use? How do you go about even trying to answer these questions and investigate these associations?

I love qualitative research and I…kind of like quantitative analysis. Part of why I did a PhD program was to sharpen my quantitative skills and I think my dissertation combines both aspects quite well. I'm using concept mapping which is a mixed methods technique, where I get to collect qualitative data in group sessions and then use Concept Systems software to quantify that data to produce visual reports like point maps, pattern matches, go-zones, and cluster maps.

Studies that assess gentrification and health use both qualitative and quantitative techniques. I tend to gravitate to the qualitative studies because they're able to grasp resident perceptions of gentrification on the ground as it's happening as opposed to a census level analysis where it can take years for gentrification markers to show up as demographics change.

I think that's one of the challenges of gentrification research – it's very hard to measure gentrification because it looks and impacts populations differently. But techniques that aim to uncover the complexities and nuances of the process are impactful and necessary.

How much of focusing your research in New Haven is convenience and how much of that is New Haven as an actually interesting case study of gentrification?

The convenience is not the biggest factor for me. New Haven, historically and contemporarily, just presents a very interesting case study for this work. One, it's a smaller city. Typically, gentrification research is done in large cities like New York, San Francisco, and Portland, and New Haven is a mid-sized city with deeply embedded university ties. There's a lot of research that discusses the role of universities in gentrification and other processes of neighborhood change. Yale's one-sided relationship with New Haven (with Yale benefiting from the city) is something that needs to be unpacked, and I believe a lot of that will come up in my group sessions. Two, the history of New Haven, in terms of redlining and urban renewal, and the racialized patterns in housing affordability, housing stock, and household income we see today highlight the importance of doing this work here.

What do you see as potential outcomes of your research – both more immediate outcomes and what do you see at the broader scale as ways of dealing with health inequities related to gentrification?

The immediate outcomes are more community focused, for me. I think my job as a researcher is to work for and with the communities I live, work, and play in. The most immediate outcome for me would be to frame my research goals with what the community needs. That might mean giving what I've learned from my dissertation to community organizations and activists or working with them to present helpful deliverables. I'm a Robert Wood Johnson Health Policy Research Scholar, so I would love to use the tips and tricks I've learned in that capacity to help draft policy briefs and translate data into helpful and digestible information. An immediate outcome would be working with organizations to enact policy change in New Haven. That would be a job well done for me –

research that's not just being written and published in a journal, but more so research being used by community members who want it.

On a broader scale, I think the reparations piece of my dissertation will lay a strong foundation for my future place-based, health equity work. In the past couple of years, it feels like the word "reparations" has become a buzzword used by politicians to appeal to marginalized communities, but now we're seeing places like Evanston, Illinois, and Asheville, North Carolina, beginning to implement or just start talking about policies concerning reparations. I believe Evanston is the first city to distribute reparations – about $400,000 to Black households. I see this growing in the next couple of years, but I think more research needs to be done to examine how reparations can be used to advance health equity. While it is a smaller focus of my dissertation, I think it holds so much weight and importance.

Altogether, I just hope the work I do can further urban health research. Hopefully, all aspects of this work can lead to structural change.

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