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Linda M. Burton¹, Daniel T. Lichter²,
Regina S. Baker¹ and John M. Eason³

Abstract

Rural America is commonly viewed as a repository of virtuous and patriotic values, deeply rooted in a proud immigrant history of farmers and industrious working-class White ethnics from northern Europe. These views are not always consistent with the population and socioeconomic realities of rural terrains. Exceptions to these stereotypes are self-evident among large poor racial/ethnic minorities residing in rural ghettos in the “dirty” South and among poor Whites living in remote, mountainous areas of Appalachia. For these disadvantaged populations, sociocultural and economic isolation, a lack of quality education, too few jobs, and poor health have taken a human toll, generation after generation. Moreover, the past several decades have brought dramatic shifts in the spatial distribution and magnitude of poverty in these areas. And, America’s persistent racial inequalities have continued to fester as rural communities become home to urban-origin racial minority migrants and immigrants from Mexico and Latin America. As a result, the face of rural America has changed, quite literally. In this article, we address the primary question these changes pose: How will shifting inequalities anchored in poverty and race shape health disparities in a “new” rural America? Guided by fundamental cause theory, we explore the scope and sources of poverty and race inequalities in rural America, how patterns in these inequalities are transduced within families, and what these inequalities mean for the future of health disparities within and across rural U.S. terrains. Our goal is to review and interrogate the extant literature on this topic with the intent of offering recommendations for future research.

¹Duke University, Durham, NC, USA

²Cornell University, Ithaca, NY, USA

³Texas A&M University, College Station, TX, USA

Corresponding Author:

Linda M. Burton, James B. Duke Professor of Sociology and African American Studies, Sociology Department, Duke University, 255 Soc-Psy Bldg., Durham, NC 27708, USA.

Email: lburton@soc.duke.edu

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In this article, we interrogate the literature on poverty and race inequalities related family processes and health disparities in rural America. Our fundamental intent is to balance the usual metro-centric discourse on health inequities by placing the spotlight on rural residents and communities while also offering needed prescriptions for future research.

Our emphasis on inequalities and health in rural America is timely and important given that much of what we currently know about poverty, race relations, and health derives from studies based on national or urban samples. This urban-based knowledge is often translated into assessments of disease prevalence and treatment approaches for rural residents, as if their health needs are facsimiles of metropolitan experiences (Gamm & Hutchinson, 2008; Loue & Quill, 2001). Scholars have warned that our understanding of rural health does not recognize the unique and diverse health realities these populations face (Morton, 2003). This shortfall in perspective extends to rural health care systems that are sometimes ill-prepared to effectively address emergent patterns of health and morbidity that make up what some describe as a “new rural order” (Aday, Quill, & Reyes-Gibby, 2001; Brown & Swanson, 2003; Castle, 1995).

The new rural order is characterized by dramatic and rapid transformations in American rural life that are, in part, a consequence of growing economic interdependencies with urban centers (Brown & Schafft, 2011; Lichter & Brown, 2011). Recent rural trends reflect (a) the restructuring of rural economies represented by shifts away from stable, family-sustaining production jobs to low-wage service employment (Fitchen 1991; Smith & Tickamyer, 2011); (b) a recent rise in the migration of low-income urban racial/ethnic minorities and Hispanic and Latino immigrants to largely White small-town and pastoral communities (Foulkes & Newbold 2008; Hamilton et al., 2008; Kandel et al., 2011; Lichter, 2012); and (c) dramatic shifts in the spatial concentration of rural poverty (Lichter et al., 2008; Peters, 2012; Tickamyer & Duncan 1990). Taken together, these trends have (a) impacted labor markets and employment opportunities in ways that are redefining gender relations inside families (Mattingly & Smith, 2010); (b) been partner to a rise in single-parent households and multiple-partner fertility that exacerbate the prevalence and duration of poverty in the lives of children (Snyder & McLaughlin, 2004); (c) polarized race relations and heightened racial threat narratives in some communities in ways that directly impact stress and mental health (Burton, Garrett-Peters, & Eason, 2011; Keene, Padilla, & Geronimus, 2010); (d) increased pockets of “deep poverty” characterized by emerging rural ghettos and environmental “dumping grounds” (Eason, 2010; Lichter & Brown, 2011); and (e) profoundly segregated poor racial/ethnic minorities from poor as well as affluent Whites, further usurping the poor’s access to quality health care often associated with contiguous affluent neighborhoods (Jarosz & Lawson, 2002;

Lichter, Parisi, & Taquino, 2012). Variants of these circumstances have all been shown to be highly correlated with myriad health risks and disparities (Wolfe, Evans, & Seeman, 2012).

Our discussion is grounded in a theoretical perspective that frames much of the current discourse on this topic—social conditions as fundamental causes of health disparities (Link & Phelan, 1995; Phelan, Link, & Tehranifar, 2010). This perspective postulates both a gradient effect and positive association between social conditions that produce inequalities in “money, knowledge, power, prestige, and beneficial social connections” (Link, Phelan, Miech, & Westin, 2008, p.73) and good health. The underlying premise is that health inequalities reflect variations in the status-patterned exposure and the stressors associated with inequalities that shape health disparities. Disparities are expressed at all levels along a continuum from micro biological processes to broader biological systems complicit in physical and cognitive functioning, disease risks, and ultimately mortality patterns (Wolfe, Evans, & Seeman, 2012). Health, good or bad, is a product, in part, of uneven exposure to unequal social conditions.

We begin our discussion with an overview of recent shifts in poverty and race inequalities in contemporary rural America and how they are absorbed and managed by families in ways such that social conditions impact levels of stress and other health risks. We acknowledge that rural health has a considerable disadvantage compared to urban health and that our goal is to consider how shifting inequalities alter rural health conditions for better or worse. We conclude with speculations about the impact of emergent inequalities and family processes on health disparities in the new rural order and offer suggestions for future research.

Rural America and Shifts in the Spatial Inequality of Poverty

Mapping Poverty and Inequality

The first decade of the new millennium has ushered in growing spatial inequality and concentrated poverty, which is characterized by the uneven geographic spread of historically disadvantaged populations into segregated and isolated communities in inner cities, aging suburban communities, and rural small towns (Grusky, Western, & Wimer, 2011; Lichter, Parisi, & Taquino, 2012; Lobao, Hooks, & Tickamyer, 2007). This new geography of “haves and have-nots” has been reinforced in the aftermath of the 2007–2009 “Great Recession.” The economic downturn and rising inequality have left a trail of personal misfortune and family upheaval across the United States, driven by their chief engineer, rising poverty rates (Jensen, McLaughlin, & Slack, 2003). Poverty rates increased nationally, spiking to 15.1% in 2010, and the number of poor Americans—46.2 million—reached an all-time high (DeNaves-Walt, Proctor, & Smith, 2011).

Much of the discourse on poverty and inequality has focused on big-city populations, which have been hit especially hard by slow job growth, high unemployment,

and the housing crisis. Indeed, the poverty rate reached nearly 20% in 2010 among the nation's metropolitan principal (or central) cities (DeNaves-Walt, Proctor, & Smith, 2011). And surprisingly, more of America's poor were living in economically disadvantaged neighborhoods despite unprecedented declines in concentrated poverty during the 1990s (Reardon & Bischoff, 2011). Since 2000, segments of the U.S. population residing in high-poverty urban neighborhoods (of over 40%) rose by one-third (Kneebone, Nadeau, & Berube, 2011). At the same time, America's upper income groups increasingly cordoned themselves off in gated communities, affluent neighborhoods (e.g., Plandome, Hewlett Neck on Long Island, or exurban developments in northern Virginia), downtown luxury condos, and exclusive resort communities (e.g., Aspen, Colorado) (Park & Pellow, 2011). This strategy of opportunity hoarding prevails as a leading indicator of growing socioeconomic inequality in America (Massey, 2007; Tilley, 1998).

High rates of poverty and growing class-based spatial segregation did not bypass America's rural landscapes (Weber et al., 2005). The poverty rate among rural Americans (i.e., living outside metropolitan areas)—16.5%—exceeded the nation's overall poverty rate in 2010. Today, the rural poor (7.9 million) comprise about 17% of America's poor population, yet they remain largely invisible to some social scientists, health researchers, and policy makers despite their presence in almost every geographic corridor in the United States. The rural poor are found in geographically isolated and economically depressed parts of Appalachia, the Delta, the Southern Black Belt, the Midwest and Great Plains, the Pacific Northwest, New England, the Alaskan panhandle, and American Indian Reservations in the upper Midwest and desert Southwest (Ulrich & Staley, 2011).

Indeed, the Great Recession has taken a large economic toll on many rural communities. Between 2000 and 2005–2009 alone, the number of nonmetro communities with poverty rates exceeding 30% increased from 1,125 to 1,666, or nearly 50% (Lichter, Parisi, & Taquino, 2012). Additionally, since the 1990s, the new Hispanic Diaspora—from traditional immigrant gateways to new destinations—has economically and racially transformed many small and often forgotten rural communities (Carr, Lichter, & Kefalas, 2012). As Fitchen (1991) and Naples (1994) aptly forecasted, rural communities have become points of destination for immigrants and for low-income urban minorities in search of housing and the “American Dream,” and through this process, racial tensions have continued to rise for some long-term White residents in these communities (Keene, Padilla, & Geronimus, 2010; Schafft, 2006).

Poverty in the New Rural America

Abrecht, Albrecht, and Albrecht (2000) have argued that increasing poverty and inequality, and the structural economic transformation of rural America, mirror the urban economic dislocations outlined by Wilson (1987) in *The Truly Disadvantaged*. Economic globalization, especially the movement of high-paying manufacturing jobs overseas, has preyed disproportionately on rural people and places. Industrial

restructuring, in particular, has reshaped the economic foundation of rural family life (Lichter & Graefe, 2011; Smith & Tickamyer, 2011) as many of the nation's small towns and rural communities have been left behind in the new economy. The "best and brightest" continue to leave economically depressed rural places for more education and better jobs in big-city labor markets (Carr & Kafalas, 2009). The result is that many declining small towns, especially in the upper Midwest, are aging rapidly, a result of chronic out-migration of young people and low fertility. Indeed, the number of nonmetro counties experiencing natural decrease—the excess of deaths over births—accelerated from 483 in 1990 to a record 985 in 2002 (Johnson, 2011). These counties have experienced the sapping of human capital for decades via the out-migration of young adults—a demographic fact that has reinforced economic declines and rising poverty in many small communities in America's rural heartlands.

Chronically poor communities lack good jobs that pay a living wage. Women are increasingly more likely to be employed than men and at significantly lower wages, local schools are underfunded, teachers are often inexperienced and underpaid, and access to health care providers and other social services is greatly limited (Albrecht, Albrecht, & Murguia, 2005). Thus, poverty remains the alpha and omega of many rural communities. The economic life course is re-created over generations in invisible and neglected communities across rural America. In fact, the Economic Research Service (U.S. Department of Agriculture [USDA]) has classified 340 rural counties as "persistently poor" because they experienced poverty rates exceeding 20% or more for at least three decades, a marker for generational turnover in families (Economic Research Service, 2012).

In recounting the pathways of poverty and inequality in rural America, we acknowledge that official poverty measures used in the existing literature do not fully capture the depth or severity of economic disadvantage or its implications for material hardship or hunger. Increasing shares of the rural poor live in "deep poverty," defined as less than one half the official poverty threshold. For a family of four, the income threshold defining deep poverty is only \$11,157 (DeNaves-Walt, Proctor, & Smith, 2011). Food insecurity in rural areas also increased rapidly during the 2007–2009 recession, affecting almost 15% of the population (Coleman-Jensen et al., 2011). Food insecurity is measured by tallying responses to questions such as, "We couldn't afford to eat balanced meals." The uptick in food insecurity occurred even as food stamp participation (through the USDA's Supplemental Nutrition Assistance Program, or SNAP) grew along with the rise in unemployment. More than one half of SNAP benefits go to persons in deep poverty (Tiehen, Jolliffe, & Gundersen, 2012), and 52% of households receiving SNAP benefits were food insecure (Coleman-Jensen et al., 2011).

Racial Inequalities in the New Rural Order

Our initial goal is to show how racial inequalities in the new rural order are shifting and ultimately shaping health disparities. In the new rural order, race, ethnicity, and

immigration in rural America perpetuate inequalities that are configuring health disparities through several interrelated pathways. The first concerns interdependence between urban and rural economies. Perhaps more than ever before, the lives of America's rural and urban people of all racial, ethnic, and cultural backgrounds are interconnected in fundamental ways (Lichter & Brown, 2011). Growing rural-urban interdependencies are driven by rapidly changing information technologies (e.g., the Internet), globalization, and devolution. As a case in point, the emergence of rural Hispanic enclaves reflects the globalization of low-wage farm workers, who have responded (with their feet) to the decisions of urban-based multinational corporations (e.g., big meat packers) and local government incentives (e.g., providing tax incentives or land to new employers) (Massey & Pren, 2012).

Another pathway highlights the demographic reality that some of America's most impoverished racial and ethnic minority populations live in geographically isolated rural areas and have done so for generations (Lichter, 2012; Summers, 1991). In this context, America may be entering a new period of growing spatial economic balkanization, which is inextricably linked to changing race relations and economic and political incorporation. African Americans in the Mississippi Delta and the southern Black Belt crescent face exceptionally high rates of poverty (Lee & Singelmann, 2006; Parisi et al., 2005), as do Mexican-origin Hispanics in the *colonias* of the lower Rio Grande Valley (Saenz & Torres, 2003) and American Indians on reservations in the Great Plains states and the American Southwest (Snipp, 1989). The regional concentration of rural minorities, especially the poor, underemployed, and uneducated, is a historical legacy of racial subjugation and oppression, slavery, conquest, genocide, and legally sanctioned land grabs (e.g., in the historical case of Mexicans who controlled vast land holding and property in the Southwest; see Bender, 2010). The statistics are often staggering. Today, more than one half of all rural Blacks (57.9%) and 66.8% of poor rural Blacks—mostly in the South—live in high-poverty counties (Lichter et al., 2012). For rural Hispanics, the corresponding poverty figures are 31.9% and 38.7%, respectively. Rural minorities are highly segregated from their White counterparts, regardless of income (Lichter, Parisi, & Taquino, 2012). Rural racial and ethnic segregation often matches or exceeds big-city neighborhood patterns.

In the case of Hispanics, the large-scale dispersion of unskilled laborers into new rural destinations in the Midwest and Southeast (e.g., the Carolinas) has offset the rural White exodus (Donato et al., 2007; Kandel & Cromartie, 2004; Lichter & Johnson, 2007). In some rural boom towns, Hispanics now make up the majority of the school-aged population, which raises issues about the readiness of local school districts and the willingness of longtime residents to invest tax dollars in the next generation. Poverty among Hispanics is often exceptional, especially among the children of immigrants, even exceeding 50% in some fast-growing Hispanic boomtowns (Crowley, Lichter, & Qian, 2006; Lichter, 2012). These circumstances have been likened to urban processes of ghettoization, which is defined historically by rapid community growth, ethnic change, and economic transformation (Aiken, 1990; Taub et al., 1984). Yet as we see in rural America, ghettos are hardly restricted

to urban areas, and urban minority population concentration and poverty alone do not define a ghetto (Davidson, 1990).

Here, we define the rural ghetto as residentially bounded areas with high concentrations of poverty, social isolation, marginal labor force attachment, social disorganization, and racial stigma. Stigma is a key element here. The ways in which ghetto stigma exacerbates the physical and mental health vulnerabilities (e.g., high blood pressure and anxiety) of poor White and racial minority families who reside within them, as well as mostly privileged Whites who reside outside of ghetto boundaries, have been highlighted in recent ethnographic work (Duncan, 1996; Keene & Padilla, 2010; Salamon, 2003). Ghettos are an apt characterization for some of these residential areas (Eason, 2012). For example, dilapidated tracts of housing in small rural towns, subsidized housing projects, and even rundown trailer parks on the outskirts of town are visible manifestations of rural ghettoization (MacTavish & Salamon, 2001; Twiss & Mueller, 2004).

The drug trade also has often been part of the discourse on ghettos, and it is imperative, for reasons of health disparities and the future of rural America, to highlight it here. Contrary to conventional wisdom, rural America has for decades had higher rates of drug and alcohol abuse than any of the nation's urban areas (Van Gundy, 2006). Reding (2009) chronicled the crystal methamphetamine (crystal meth) economy in rural and small-town America, highlighting its notable presence and destructive impact on users of all ages. Other types of drug trafficking (e.g., crack and cocaine), as well as related violent crimes (e.g., murder), also occur at high rates in these environments. Rural America is not immune to the drug economies that plague urban ghettos, and the drug economies are not bound by race (Van Grundy, 2006). In fact, young low-income White males operate the lion's share of drug activities in many rural communities.

Beyond the "usual suspects" of characteristics associated with ghettos (e.g., poverty or crime), recent scholarship also suggests that Hispanic immigrant populations are now driving rural ghettoization. Indeed, the new immigration of typically poor Hispanics raises the specter of new rural ethnic enclaves, isolated spatially and socially from mainstream America with stigmatized characterizations (Raffaelli et al., 2012; Villenas, 2001). The spatially uneven redistribution of Hispanic growth in rural areas is evinced in the number of majority-minority rural communities, which has more than doubled from 757 in 1990 to 1,760 in 2010 (Lichter, 2012).

As a final point, to some observers, impoverished rural minority communities have become "dumping grounds" for urban America (Davidson, 1990; Lichter & Brown, 2011). This is a dimension of spatial inequality that is frequently overlooked in studies of rural poverty and race inequality. Economically declining rural communities have become home for America's growing prison population, hazardous and toxic waste sites, landfills, slaughterhouses, and commercial feedlots (that are odoriferous and pollute the groundwater, rivers, and streams). These forms of economic development often involve matters of environmental justice and racial discrimination, bringing many competing economic and community interests into potential conflict. One primary interest of conflict, particularly among the poor, is population health (Tomaskovic-Devey & Roscigno, 1997).

Inequalities, Family Life, and Rural Health Risks

How Poverty Works Inside Families

Patterns of poverty and race inequalities suggest that social conditions around the procurement of economic development may exacerbate health disadvantages among racial/ethnic minorities and the poor in the new rural America. Here, we argue that monitoring family structures and processes under these conditions provide important signals for population and health scientists about how certain relational contexts and mechanisms shape health disparities through poverty and race inequalities.

One of the more visible effects of inequalities on rural health is witnessed through the impact of economic restructuring on gender relations between unemployed husbands and employed wives, especially during the Great Recession (Lichter & Graefe, 2011; Mattingly & Smith, 2012). As noted earlier, there have been significant declines in job opportunities for men in rural areas, while women's employment has markedly increased (Smith, 2008). In some communities the majority of women with children have become primary and/or sole providers for their families, adding stress to family life as women supplant men as the traditional income-earners in many homes (Harvey, 1993; Nelson, 2005; Tickamyer & Henderson, 2003). The physical and mental well-being of all concerned in these situations has suffered. Men are more likely to commit suicide (Gessert, 2003; Singh & Siahpush, 2002). Women have depressive symptoms that are double those in urban areas, and are more likely than urban women to suffer a number of health and mental health problems (Sano & Richards, 2011). And children are increasingly turning to drug and alcohol use during adolescence (Scaramella & Keyes, 2001; Van Gundy, 2006).

Other effects are noted in changes in family structures, including rises in single-parent households, nonmarital cohabitation, and multiple-partner fertility (Burton, Welsh, & Destro, in press; Snyder & McLaughlin, 2006). Snyder, McLaughlin, and Findeis (2006) and others have pointed to the negative impact of these structures on the persistence of poverty and the well-being of children (Lichter & Cimbalk, 2012; Mattingly, Johnson, & Schafer, 2011). Economic and social disadvantages associated with these family structures are highly correlated with educational deficits, which can undermine a parents' knowledge about health in ways that limit their health inputs about and access to quality health care and advanced health technologies for their families (Hartly, 2004; Loue & Quill, 2001). These inequities often get translated into health penalties for children that are manifested as outcomes of residential instability and food insecurity, both of which are known to negatively affect children's physical and cognitive development (Schafft, 2006; Sparks, McLaughlin, & Stokes, 2009).

Poor children in these situations are also more susceptible to health shocks such as infectious diseases (e.g., scabies) and injuries from accidents in unsafe environments (Cohen, Tiesman, Boarte, & Furbee, 2009). Furthermore, as Burton and Bromell (2011) and others have reported, low-income single-parent households and multiple fertility kin networks have higher incidences of family comorbidity (Sano & Richards, 2011). Comorbidity is a relatively understudied hallmark of sustained poverty and

racial inequality in rural America. It is characterized by the presence of multiple co-occurring physical and/or mental health problems within families.

Family, food, and physical activity represent yet another domain of concern for health, especially among the rural poor. This domain is represented by a set of counterintuitive circumstances coined the hunger-obesity paradox (Olson, 1999; Sano & Richards, 2011). The contradiction is that despite often living in food-producing regions, poor rural families experience food insecurities that lead to higher rates of obesity (McIntosh & Sobal, 2004). Poor families typically cannot afford to buy healthy foods and lack the transportation to get to large supermarkets (which can be a considerable distance from their residence) to purchase food at lower costs. As such, families often sacrifice quality for quantity in their food purchases, buying and in-taking calorie-dense unhealthy foods (e.g., potato chips) that lead to obesity (Kegler, Swan, Alcantar, Feldman, & Glanz, 2013). Reports also indicate that many of the rural poor, regardless of race, dine out at cafeterias and fast food restaurants, and that the communities in which they live are perceived as unpleasant environments to engage in physical activity (e.g., walking), thus intensifying their risk for obesity (Casey et al., 2008; Patterson et al., 2004). Obesity is highly relevant to current health projections in the new rural America, as it has been identified as a prominent risk factor for myriad diseases including cancer, diabetes, and cardiovascular disease, and is especially prevalent among poor rural children (Befort, Nazir, & Perri, 2012; Lutfiyya et al., 2007).

Racial Inequalities and Family Processes

Racial inequalities, as they are experienced and processed inside families, bring yet other issues to the fore in evaluating health disparities in rural America. As mentioned above, strong evidence of economic polarization among groups has emerged in rural areas as low-income urban-origin racial/and ethnic minorities and Hispanic and Latino immigrants have relocated to predominately White rural communities. Economic disparities are often perpetuated and reinforced by racism and discrimination, two powerful predictors of health risks and behaviors. The most obvious pathway of influence involves poor and racial minority families' access to quality health care and services, a long-standing problem in economically disadvantaged rural and urban communities (Aday, Quilee, & Reyes-Gibby, 2001). A particular tension in some rural communities, however, is whether recent racial and ethnic migrants and immigrants to largely White-occupied spaces bring new demands on local health systems that are already often overtaxed.

Such issues are highlighted in McCall's (2012) recent study of urban poor Black women who relocated to rural communities as a result of so-called "Greyhound therapy." This happens when poor minority women and children are placed on Greyhound buses by urban social service providers and sent to rural destinations for care. These women often ended up in unreceptive rural areas that were ill-prepared to meet their needs. Not surprisingly, this usually leads to highly stressful social interactions between newcomers and long-term White residents. Under these circumstances, mothers are often left with few social connections to navigate their families' health needs,

resulting in bouts of anxiety and depression. Similar experiences have been documented about Latina immigrant mothers and their families who migrated to rural communities in search of work (Raffaelli et al., 2012; Villenas, 2001).

Perhaps a larger story emerging in rural America is how minority and majority families respond to each other racially and what it means for health in both groups. During periods of substantial change, as has been documented in rural communities, the ecology of the self—the set of relations with people and objects upon which the self is built—is likewise altered (Burton, Garrett-Peters, & Eason, 2011; Sherman, 2009). In visibly reinforcing ways, inequalities and structural changes taking place in rural areas, such as demographic shifts in the population and the rise of rural ghettos, have had consequences for identities and the structure of social relations around race and class (Duncan, 1999; MacTavish, 2007; Naples, 1994). With these shifts come uncertainty and anxiety that many longtime White rural residents experience as they adapt to their perceptions of “loss of their homeplace” via contextual changes and the usual social arrangements that helped to give their lives a sense of stability and coherence (see Antonovsky, 1987). These identity pressures and shifts, however, are not limited to established long-term residents. Such changes can be experienced by in-migrating poorer urbanites searching for work or low-cost housing and immigrants seeking new lives in rural areas (see Hooey, 2005, 2006; Salamon, 2003). What is ultimately at stake for those involved are the self-conceptions and physical and psychological costs that arise in the course of claiming, protecting, and/or rejecting various identities in these changing environments (see Schwalbe, 2005).

Schwalbe et al. (2000) have identified several psychosocial processes, including othering, subordinate adaptation, boundary maintenance, and emotion management, that allow some individuals in these contentious situations to maintain their identities at the cost of reproducing poverty and racism. A case in point is demonstrated through oppressive othering, which involves a dominant group (e.g., Whites) seeking advantage by defining a minority group as morally and/or intellectually inferior. Burton, Garrett-Peters, and Eason (2011) describe incidents of oppressive othering in an ethnography of poor urban-origin Blacks moving to predominately White rural communities (also see Clark, 2012). Subgroups of Whites employed in the social services sector of local economies often characterized themselves as having “impeccable morals and a sense of who they were as hard-working, law-abiding American citizens who care about others,” as compared to those “degenerate, ghetto Blacks who were ruining their town” (Burton, Garrett-Peters, & Eason, 2011, p. 91). Whites’ othering behaviors compromised newcomers’ access to much-needed social services (e.g., clothing banks) and reinforced racism and racial inequality in the town. Some even professed that the sight of poor Blacks gave them migraines, chest pains, and high blood pressure. Unfortunately, the processes that Schwalbe et al. (2000) describe have yet to be systematically examined in current studies of inequality and rural health.

Finally, challenges of poverty, racial inequality, and health disparities are commonplace among poor families with little power to contend with infractions concerning environmental justice and racism. We noted earlier that rural areas have become a dumping ground for toxins and waste that are harmful for health. Harrison’s (2011)

ethnography of pesticide drift in the California Central Valley poignantly describes the impact of pervasive chemically intensive agriculture practices on the health of farm workers and their families and how powerless the families were to do anything about it.

Health Disparities in Rural America

In describing patterns of poverty and racial inequalities in rural America and how they are transduced inside families and communities, we have offered an important backdrop for evaluating current knowledge about rural health and speculating about how the new rural order may influence health in future populations. It is well known that rural areas fare far worse in population health and health care than their urban counterparts despite some estimates that suggest a rural mortality advantage (Geronimus et al., 2001, 2011; Laditka et al., 2007; McLaughlin, Stokes, & Nonoyama, 2001). Overall, rural residents are significantly more likely to self-report poor or fair health status (Auchincloss & Hadden, 2002; National Center for Health Statistics, 2011) and to evince a greater prevalence of chronic diseases including heart problems, hypertension, diabetes, emphysema, and cancer (Eberhardt et al., 2001; Wallace, Grindeanu, & Cirillo, 2004). A principal contributing factor to these higher rates is obesity, with rural adults' rates at 40% of the population compared to 33% for urbanites (Befort, Nazir, & Perri, 2012). Rural residents also have higher rates of injuries and injury-related fatalities (Cohen, Tiesman, Boarte, & Furbee, 2009) due to a high incidence of motor vehicle accidents and related fatalities (Eberhardt & Pamuk, 2004; Morrisey & Grabowski, 2006) and the highest fatal work injury rates owing to jobs in agriculture, forestry, fishing and hunting, and mining (Bureau of Labor Statistics, 2011). Furthermore, rural residents are more likely to lose all their teeth and have untreated dental decay (Vargas, Dye, & Hayes, 2002). Because poor dental health is linked to poor health outcomes, such as increased risks of heart diseases (Griffin et al., 2009), severely compromised dental health in rural areas further aggravates the rural health disadvantage. Rural teens also have less access to reproductive health services (including effective contraception and abortion providers) (for discussion, see National Campaign to Prevent Teen and Unintended Pregnancy, 2013).

In addition, there are notable rural-urban mental health differences. Rural counties have higher rates of depression (Probst et al., 2004; Simmons et al., 2008) and suicide (Elberhart, 2001; Singh & Siahpush, 2002). Substance abuse is also a major mental health concern, with rural residents having much higher rates of alcohol abuse (Borders & Booth, 2007; Clayton, McBride, Roberts, & Hartssock, 2007) but significantly fewer drug treatment and prevention programs than metropolitan areas to address their problems.

Rural Health and Social Inequalities

Although the extant literature reports a health disadvantage for the general rural population, these findings obscure inequalities that exist among the poor, racial and immigrant groups, and women and men across different rural spaces (Murray et al., 2006).

As we might expect, Morton (2004) argues that there is considerable variation across rural places in health disadvantages, much more so than in rural-urban comparisons.

In terms of regional differences, the South tends to fare the worst in various health outcomes. In addition to portions of the South (e.g., Southeast, Appalachia, and the Mississippi Delta) having persistent patterns of high mortality (Cossman et al., 2007), the South also has the highest rates of chronic diseases, infant mortality, and deaths from unintentional injuries (Eberhardt et al., 2001). More recently, the increase prevalence of HIV/AIDS in the Deep South has been a growing health concern (Reif, Geonnotti, & Whetten, 2006). Scholars also find small, less populous, isolated rural counties have consistently had the highest mortality rates (Morton, 2004). High-poverty areas not adjacent to metropolitan areas are likely to report worse health and have more limitations of daily activities (Auchincloss & Hadden, 2002). These patterns of health disadvantage are consistent with the spatial patterns of poverty and racial inequality we described earlier in this article.

While Black-White comparisons dominate the research on racial differences in rural health, variations in health involving other races have been documented. Rural Blacks have lower life expectancies than rural Whites (Murray et al., 2006) and also have higher rates of specific chronic diseases including obesity, heart diseases, hypertension, and diabetes (Befort, Nazir, & Perri, 2012; Peek & Zsembik, 2004). Comparatively, Latinos are more likely than rural Blacks or Whites to report fair or poor health (Albrecht, Clarke, & Miller, 1998) and, compared to rural Whites, have higher rates of diabetes (Koopmsn, Mainous, & Geesey, 2006). Lastly, Native Americans/Alaskan Indians, an often overlooked group among the rural poor, consistently have the highest mortality levels compared to racial/ethnic groups (Baldwin et al., 2002). The leading causes of death among Native Americans/Alaskan Indians are coronary heart disease and cancer (Indian Health Service, 2011) with the incidences of suicide, chronic liver disease (Rhoades & Kymberly, 2004), and substance abuse also occurring at notably high rates (National Center on Addiction and Substance Abuse, 2000; Wissow, 2000).

There are distinct gender differences in rural health as well. Gender differences are critical to consider given economic restructuring and emergent employment transitions among men and women. Rural men have higher mortality rates than women (Murray et al., 2006), a pattern reflected in men's higher rates of suicide and deaths due to heart disease, cancer (Eberhardt et al. 2001), and workplace injuries and fatalities (Schulam & Slesinger, 2004). While rural women's suicide rates have remained stable in recent years, men's suicide rates continue to rise (Singh & Siahpush, 2002), and men appear to consistently avoid treatment for mental health issues. Rural women have slightly higher rates of heart problems, hypertension, cancer, and arthritis (Wallace, Grindeanu, & Cirillo, 2004) and appear to be more at risk for depression (Simmons et al., 2008) than rural men. As women continue to surpass men in acquiring work in current rural employment markets, these gender differences in health bear close attention as they may be related to dramatic transitions in long-standing gender roles in slowly dissipating rural traditions.

Child Health and the Life Course

Child health is a serious concern in rural America, especially given that 81% of counties with persistent child poverty are in rural areas (Mattingly, Johnson, & Schaefer, 2011; U.S. Department of Health and Human Services, 2011). Unfortunately, the literature to date has focused primarily on the health of older rural adults (Glaslow et al., 2004), suggesting that a “call to arms” for social and health scientists is necessary to advance our understanding of how the new rural order is affecting children. What we do know is that obesity is a pressing problem among rural children (Patterson et al., 2004), as rural residence increases children’s risk of obesity by over 50% (McMurray et al., 1999). Other health concerns for children include a high prevalence of dental problems and tooth decay (Vargas, Ronzio, & Hayes, 2003), infectious diseases, as well as alcohol and drug use among adolescents (National Center on Addiction and Substance Abuse, 2000). Low-income rural children also have a higher incidence of psychiatric disorders, most notably depression (Costello, Keller, & Angold, 2001). Rural children’s health disadvantages raise serious concerns about their health in later life. Blackwell, Hayward, and Crimmins (2001) have found that poor childhood health increases morbidity in later life. This current lacuna of research on child health does not bode well for anticipating children’s health needs in a rural world that is rapidly changing.

Recommendations for Future Research

In this article we provided a description of the scope and sources of poverty and race inequalities in rural America, how patterns in these inequalities are transduced within families and communities, and how these inequalities are reflected in current rural health disparities. Our discussion is anchored in a detailed overview of how rural America is changing and what these changes may mean for future research on health in the new rural order. We also, where possible, integrated the theoretical perspective on social conditions as a fundamental cause in our discussion to illustrate how shifting spatial inequalities around poverty and race are reconfiguring rural racial/ethnic minorities and the poor’s procurement of money, knowledge, power, prestige, and beneficial social connections that shape their access to good health and quality health care.

Admittedly, we have painted a rather grim picture of inequalities and health in rural America that begs for extensive scientific inquiry. It is clear that knowledge of the demographics of inequality in rural America has greatly expanded (e.g., Lichter & Brown, 2011; Smith & Tickamyer, 2011), but we still lack knowledge on how these patterns may reshape family and community processes and influence health disparities in a rural America that is rapidly transforming. This field of study requires a better informed sense of how social inequalities are recasting the “health lot” of the rural poor. Accordingly, we offer several recommendations for future research.

First, different spatial scales provide alternative critical lenses for understanding how rural inequality affects population health. Using the appropriate scale can make processes of racial and gendered oppression, family structure, and immigration legible in ways that were limited in this review. While we could imagine these various aspects

of inequality causing health disparities, processes of stratification can operate differently across units of analysis. Shifts in the spatial distribution of inequality, especially new geographies of exclusion in rural communities, require new epistemological frames for investigation. Therefore, we recommend a paradigm shift that incorporates multiple spatial scales of inequality—neighborhood, community, and region.

Second, given the shifts in rural inequality, two scales or units of analysis should become a prime focus in future investigations of how the rural context shapes health disparities—the rural ghetto and the South. The rural ghetto is important because of the legacy of slavery in the rural South and new evidence of emerging Hispanic ghettos in small towns in the Midwest and elsewhere. Roughly one in five Americans live in rural areas, and the South has the largest share of rural residents at 46% (Wimberley, 2010). These rural southern places have the highest rates and numbers of rural poor (Moller, Alderson, & Nielson 2009; Weber et al., 2005). In addition to economic disparities, scholarly research also demonstrates a rural southern disadvantage for a range of other measures, including education (Roscigno et al., 2006; Wimberley, 2010), crime (Fowles & Merna, 1996; McCall, Land, & Cohen, 1992), and health (McLaughlin, Stokes, & Nonoanta, 2002). This makes the South a litmus test of regional inequality. Reorienting our view of inequality along these scales can also allow us to better understand mechanisms driving outcomes in rural communities that impact health (e.g., food deserts).

A third recommendation concerns identifying and unpacking how family and community structures and processes transduce inequalities in ways that affect how rural minorities and the poor garner capital (e.g., money, knowledge, power, prestige, and beneficial social connections) to reduce health disparities. The transformation from an economy based on extractive industries (e.g., agriculture, mining, and timber) to manufacturing in nondurable goods (e.g., food processing) has changed the face of rural America. We also have seen that shifts in male and female employment as well as increasing diversity in family structures are creating stressors and unequal access to resources in families that likely affect health outcomes. How are those issues navigated among rural residents, especially newcomers and the poor, who may lack the resources to deal effectively with America's health care bureaucracy or who lack the income or health insurance to avail themselves of needed health care?

Fourth, we believe that social and health scientists may underestimate how racism and discrimination accompany minority movement to primarily White rural destinations and possibly impact the physical and psychological health of residents. With the emergence of rural ghettos, and Whites' perceptions of a changing "homeplace," we are obligated as scientists to unpack these dynamics in search of a more comprehensive understanding of their effects on health. For example, future research might incorporate Schwalbe et al.'s (2000) sensitizing theory on generic processes in the reproduction of inequalities to examine how both long-term residents and newcomers are processing changes and contributing to economic and racial inequalities in the environment. This theory, which identifies four basic processes—othering, subordinate adaptation, boundary maintenance, and emotion management—highlights generic issues that are endemic to understanding such forces in any changing context.

Our fifth set of recommendations specifically concerns the study of rural health. Considering the lacuna of rural child health research, we strongly suggest the development of longitudinal studies that focus on health among the rural poor beginning in infancy and early childhood. While cross-sectional data has made contributions to our understanding of the rural health disadvantage in general, it prevents us from assessing change over time or from employing a life course perspective to the study of morbidity and mortality. Recent studies have found strong correlations between health in childhood and morbidity in later life (Blackwell, Hayward, & Crimmins, 2001). Surely insights on rural populations should be part of that discourse. Moreover, life course data will provide a better understanding not only of what may contribute to health issues among rural adults, but also the urban-rural disparities observed in the literature.

Sixth, in general, research on rural health embraces a perspective that focuses on individual health outcomes as compared to family outcomes. The degree to which rural families experience “family comorbidity” (i.e., multiple family members have concurrent physical and mental health problems) has not been explored extensively in rural environments. Given the poverty levels and pervasive inequalities many rural families face, it makes sense that multiple family members simultaneously experience comorbid physical and mental illnesses. Considering the rural health disadvantage, the framing of future research from a family comorbidity perspective would further our knowledge of a more expansive relationship between poverty and health.

Lastly, we want to encourage researchers to consider using ethnographic or mixed methods approaches in future studies of inequality and rural health. Most of the studies we reviewed relied heavily on quantitative survey data. While these data are important for discerning population patterns and understanding the general scope of inequalities and rural health, the depth of ethnographic data can provide more nuanced insights on behaviors and circumstances that can help illuminate the underlying mechanisms that drive the rural health disadvantage.

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Author Biographies

Linda M. Burton is the James B. Duke Professor of Sociology at Duke University. She received her Ph.D. in Sociology from the University of Southern California in 1985. Her research integrates ethnographic and demographic approaches to examine the roles that poverty, racial inequalities, and intergenerational family dynamics play in the intimate unions of low income mothers and the life course transitions of children and adults in urban and rural families. Recently, she directed the ethnographic component of *Welfare, Children, and Families: A Three-City Study*. She also is principal investigator of a multi-site team ethnographic study (*Family Life Project*) of poverty, family processes, and child development in six rural communities in Pennsylvania and North Carolina. She is currently co-editor (with David Brady) of *The*

Oxford Handbook of Poverty and Society, and has recently published articles on race and families in *The Journal of Marriage and Family* (2010), "Critical Race Theories, Colorism, and the Decade's Research on Families of Color" and on multiple partner fertility among urban and rural mother in *Family Process* (2012), "Low-income Mothers as "Othermothers" to their Romantic Partners Children." Burton currently serves on the Institute of Medicine's Committee on Child Maltreatment Research, Policy, and Practice for the Next Decade, and recently completed terms on the Advisory Board of the National Center for Marriage and Family Research, the Board of Directors for the Family Process Institute, and the Board of Directors for the Council on Contemporary Families.

Daniel T. Lichter is the Ferris Family professor in the Department of Policy Analysis and Management, Professor of Sociology, and Director of the Cornell Population Center at Cornell University. He received his Ph.D. in Sociology in 1981 from the University of Wisconsin-Madison. His current research focuses on changing patterns of immigration, inter-racial marriage, and spatially-concentrated poverty in the United States. He is studying Hispanic population growth and race relations in new rural destinations. He has developed new estimates of racial residential segregation in Hispanic "boom towns," as well as examined the causes and consequences of high fertility rates among Mexican-origin immigrants for small towns. His paper, "Immigration and the New Racial Diversity in Rural America" was published in the March 2012 issues of *Rural Sociology*. He also is co-author (with David Brown) of "Rural America in an Urban Society: Changing Spatial and Social Boundaries" (*Annual Review of Sociology*, 2011). Lichter is current president of the Population Association of America, and immediate past-president of the Rural Sociological Society (2010-11).

Regina S. Baker is a doctoral candidate in the Department of Sociology and a Sulzberger-Levitan Social Policy Graduate Research Fellow at the Center for Child and Family Policy at Duke University, and was recently awarded an American Sociological Association Minority Fellowship. She received her Master of Social Work from the University of Georgia in 2009 and a Master of Arts in Sociology from Duke University in 2012. Baker's primary research areas are stratification and inequality, particularly in regards to poverty, work, and the family. Baker's paper, "The Declining Significance of Marriage and the Increasing Significance of Work for Child Poverty in the U.S." won the 2012 Southern Sociological Society's Odum Award for Outstanding Research Paper by a graduate student. Her current research examines how demographic, economic, racial, and political factors contribute to poverty trends in the U.S. South. She also is examining socio-economic mobility in low-income families of children with disabilities and the role of comorbidity. Baker's other recent research has examined the effects of marriage and work on child poverty over time and the effect of unionization on working poverty in the U.S.

John M. Eason is an Assistant Professor in the Department of Sociology at Texas A&M University. He received his Ph.D. in Sociology from the University of Chicago. His current research focuses on the prison boom, the racial and spatial concentration of disadvantage, and the impact of mass incarceration on rural health. His book manuscript "Big House on the Prairie: Rise of the Rural Ghetto and Prison Proliferation" examines the causes and consequence of the prison boom in rural American. His paper, "Extending the Hyperghetto: Towards a Theory of Punishment, Race, and Rural Disadvantage" was published in the July 2012 issue of the *Journal of Poverty*. Eason is the 2012 Rural Sociological Society Young Scholar Recipient.