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Structural Factors of Elders' Isolation in a High-Crime Neighborhood: An In-Depth Perspective

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Older residents of high-crime areas are likely to be socially isolated; in practical terms, they have limited meaningful social ties (Victor, Scambler, Bond, & Bowling, 2000). In a recent study published by *The Gerontologist* we identified factors that contribute to the social isolation of older residents of Richmond, California, a city with elevated crime rates adjacent to Berkeley and surrounded by the affluent East Bay Area of San Francisco (Portacolone, Perissinotto, Yeh, & Greysen, 2017). The isolation of study participants stemmed from their personal characteristics (e.g., poor health and poverty), as well as structural factors such as the physical and social environment of their immediate neighborhood. Social factors included the immersion of participants in an environment with dense crime, weak norms of reciprocity, and toxic relations with family and acquaintances. Physical factors included the physical decay of building and streets in their neighborhood and a paucity of appropriate health care and social services. An unexpected finding was that study participants consistently longed for company and social integration. This finding was unexpected because studies of social isolation often emphasized the inclination of socially isolated individuals to have limited social ties (Cloutier-Fisher, Kobayashi, & Smith, 2011). Another unforeseen finding that we have not yet explored in depth concerned specific features of the geographic location of study participants (as elaborated in the discussion section). Here, we present a case study that permits a more in-depth and pragmatic discussion of the findings of the Richmond investigation. It is our hope that these data will inform public policies aimed at enhancing the wellbeing of older residents of high-crime neighborhoods.

Case studies are defined as an "instance of a broader phenomenon [and] a part of a large set of parallel instances" (Feagin, Orum, & Sjgioberg, 1991, p. 2). The case study of Ms. Marie Davis was selected because it is representative of the challenges faced by most study participants. Davis represents a paradigm of every factor of social isolation we explored in the Richmond study. We will therefore examine the elements of Davis' social isolation, and how these interact with one another. A resident of a crime-ridden area, she entertained

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relations with persons who were toxic and had weak norms of reciprocity, likely because they were immersed in the same harsh environment. Davis inhabited a dilapidated building in a decayed neighborhood and entertained scattered interactions with health care and social services providers. I met with Marie Davis five times in the last five months of her life. To gain a deeper understanding of her situation, I also interacted with three acquaintances and attended her memorial service. To protect her anonymity, some of her identifying features have been slightly altered.

The Case of Marie Davis

"I am not used to this life," said Marie Davis, 95, an African American former medical assistant, from her home located in the heart of the Bay Area of San Francisco. She lived 8 miles away from Marin County, the second wealthiest county in California, and 20 miles from San Francisco, a city, according to *Time Magazine,* where only a net worth of six millions dollars makes someone wealthy (Steinmetz, 2016). A superb cook and a devout Christian, Davis was renowned for her hospitality. Faded pictures scattered in a closet showed her elegantly dressed at family gatherings. In her forties, Davis separated from an unfaithful husband who wanted her to stay at home. She quipped, "Wasn't going to let no man stop me from working." In her eighties, Davis relocated her brother from a nursing home into her home and organized his care until he died a few years later.

Confined to a wheelchair in her nineties, Davis spent most of her time in her small kitchen. The first time I met her, in winter, her gas kitchen burners were on to keep warm. Her house was a shell of the pristine house she once kept. As an informant explained, "a lot of people come and go from her house." Her bare kitchen lacked dishes; all the ceramic sets were stolen. The sink, oven, and microwave were crammed with greasy pans left by a woman occupying her spare bedroom. The dining room was dirty and dusty. Her once treasured "big old Bible" went missing from the mantel over her fireplace. And since her newer wheelchair was stolen, she used an old one that used to belong to her deceased brother. Her adult child, who suffered from substance abuse, was in jail in a town 200 miles away.

Davis' grace and warmth—"I am a nice person" she often repeated—did not shield her from a host of structural factors that isolated her from meaningful social ties. The increase in criminal activity in her neighborhood, combined with the crack epidemic that began in the late eighties, contributed to her isolation. Yet another factor was the change in the character of her neighborhood. Whereas in the past she could count on the help of other neighbors "of color" living nearby, her neighborhood became mostly Latino. As a result, in her nineties and disabled, she was estranged from her neighbors.

However, Davis knew her healthcare providers. A plastic whiteboard hanging on the wall of her bedroom listed, in large letters, names, telephone numbers, and descriptions of eight contacts. The list included her primary care doctor, two social workers, an "overnight person," one hospital, and one "care provider." I also learned from Davis and informants about her interactions with the police, fire fighters, and a meal delivery service. Davis told me that she occasionally waved to police officers patrolling her neighborhood. She also

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enjoyed eating the food delivered in her home. I also learnt about the beatings that Davis suffered at the hands of an acquaintance, beatings that were reported to the authorities.

Despite being on the radar of several providers, Davis gave the impression of someone at the mercy of events beyond her control. For example, during the study period, Davis often lacked a reliable home care aide, an essential resource to someone like her. During my first visits, I witnessed an "aide" living in the spare bedroom who left dirty pans in the kitchen, spent time outside a liquor store, and asked me for money for a beer. When this one left, a second aide started. However, she departed after one month because she felt threatened by an acquaintance. The third aide, Kara, was eager that I visit Davis to provide her some company; however, the last time I called Kara to find the best time to visit, she explained that Davis had been taken away one morning by a family member without any notice and that she did not know her whereabouts. Alarmed by this news, I called the social worker, who told me that Davis was "in a good place" but that she could not say more. Two weeks later, noticing a car parked outside Davis's home, I met Tera, the fourth aide, who explained that Davis never went anywhere and that after telling callers that she had relocated, Kara cut Davis's phone line and disappeared. A diligent and reliable aide, Tera saw Davis die from her failing health two months later. During these transitions, Davis did her best not to be a burden and took initiative to protect herself. Four months before she died, she called the police to stop a fight that erupted in her living room between a family member and an intimate partner. She was also proud of her ability to move from the wheelchair to the bed on her own, so that nobody had to help her in the evening. In her words, "I put my butt on the bed and I got into bed. I said, thank you Jesus." Her deep connection with her "Father which is in Heaven" nurtured her. Like several other elders with whom I spoke, Davis faced these challenges by summoning her inner resources and grit, in her case seated in a deep connection with her faith. She told me, "I thank Him for watching over me all night long while I slumber and sleep."

Focus on High-Crime Neighborhoods

Although Davis' scenario may seem extreme, it is far from uncommon. Our findings invite scholars and policymakers to pay special attention to vulnerable residents of high-crime neighborhoods. In the United States, such areas include the Bronx in New York City; East Baltimore, MD; West Detroit, MI; West Oakland, CA; and North West Miami, FL. This phenomenon is by no means unique to the United States: globally, most cities have neighborhoods that are avoided by tourists and residents alike because of fear of crime, including the suburbs of Paris and Naples; Porta Palazzo in Turin; or Peckam, Brixton, and Tottenham in London. Residents of such neighborhoods would greatly benefit from programs enhancing the features of their neighborhoods, such as the Age Friendly Program of the World Health Organization (Golant, 2016), which compels city officials in member cities to shift resources towards the wellbeing and social integration of isolated elders of neighborhoods like Davis'.

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The Tipping Point of Resilience

Findings from our Richmond study also illuminate the boundaries of resilience theory. Specifically, the limitations of Davis' resilience and coping mechanisms to face a hostile environment are apparent. We therefore invite scholars of resilience to shift their attention from the influence of elders' attitude and personal traits to the influence of the environment surrounding them, especially in neighborhoods with high crime. This shift is critical because the surrounding environment can deeply affect one's resilience. Whereas scholars of resilience celebrate elders' ability to rebound from trying experiences and structural obstacles (Pruchno & Carr, 2017), Davis' case suggests the existence of a tipping point, i.e. a point beyond which an individual's strength and plasticity can no longer withstand the cascading host of external and compounding stressors.

Isolation and Health Disparities: An Accident of Geography

On a related note, this investigation also contributes to the science of health disparities by illustrating factors contributing to differential access to essential resources such as home care aides and appropriate health and social services (Dilworth-Anderson, Pierre, & Hilliard, 2012). Specifically, the geographical location of Davis' home greatly influenced her allocation of resources. This finding is not surprising considering that the literature on the influence of neighborhoods on our wellbeing is well established (Kawachi & Berkman, 2003; Yen, Michael, & Perdue, 2009). More than a decade of qualitative investigations of elderly residents of the Bay Area of San Francisco has opened my eyes to the marked differences in lived experiences of elders who are located in geographical proximity to each other (Portacolone, 2013; Portacolone, Covinsky, Rubinstein, Halpern, & Johnson, Conditionally accepted; Portacolone et al., 2017). Had her address been in nearby Marin County, just past the Richmond bridge spanning San Francisco Bay, Davis would likely have had access to affordable and appropriate services such as vetted home care aides, a capillary system of subsidized transportation for the elderly, well-kept surroundings, as well as intellectual stimulation and social outreach from a mobile library (Portacolone & Abramson, Under preparation). Findings therefore point to an uneven allocation of resources for older adults at the city and county levels, a disparity that can be addressed with targeted social policies.

Limitation of Health Care and Social Services

With regard to physical factors of isolation, Davis' case study illustrates the limitations of healthcare and social services to provide appropriate services to older residents of high-crime neighborhoods. Even though Davis was connected to several providers, she did not appear to have a strong "captain of the ship," (to borrow the term from another study participant), in charge of her overall wellbeing. The impression was that each provider was responsible for a piece of Davis' health, with limited coordination with one another. The report of elder abuse to the authorities did not seem to have mobilized specific resources. This too, was not unique to Davis—we observed this in other study participants who reported mistreatment. Our findings, therefore, may contribute to the literature on elder abuse where scholarship has largely been concerned with its prevention (Pillemer, Burnes,

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Riffin, & Lachs, 2016) and identification (Lachs & Pillemer, 2015; Rosen et al., 2017), rather than the mitigation of its sequelae. Specifically, our findings point to the lack of appropriate services available to older residents of high-crime neighborhoods after they report the abuse to the authorities, a concerning topic that calls for further investigation.

An International Comparison

Home care aides are an essential resource for isolated older adults with impaired functional abilities such as Davis. A more capillary and regulated system providing well-qualified and monitored health care aides to the likes of Davis would have likely made a difference. The public homecare aide system of Denmark offers insights on potential enhancements to the United States' system. A recent visit in Denmark as a visitor scholar at the University of Copenhagen made me aware of a system that is difficult to comprehend only by studying the English literature. Specifically, soon after their 70th birthday, Danish elders are checked for possible impairments and if they qualify, they are offered government-subsidized services of home-care aides who work from an office located in the same municipality of their clients (Sundhedsstyrelsen, 2017). Should the home care aide be a family member, a monitoring system is in place to ensure that the family member provides the required and timed services. Danish home care aides are well paid, receive regular trainings, work in close coordination with their supervisors, and can advance in their career. As a result, older Danes can receive reliable and government-subsidized assistance in their home if needed.

Conclusion

As of 2016, an estimated 54.5% of the population worldwide lives in urban settlements and the percentage is projected to increase to 60% by 2030 (United Nations, 2016). A considerable proportion of residents of urban settlements worldwide will be over 65 years of age, and a good number of them will reside in high-crime areas. Like Davis, these people will likely be difficult to recruit into research studies because of their isolation.

My hope is that scholars devote time and resources to the specific needs of isolated elders of high-crime neighborhoods. A greater understanding of the factors leading to the isolation of Davis, as well as of other isolated study participants (Portacolone et al., 2017), will help shape programs and services to support isolated elders in high-crime neighborhoods, and wherever they are found.

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