Title

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Journal

Gerontologist, 58(1)

Authors

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Publication Date

2018-01-18

DOI

10.1093/geront/gnw268

Peer reviewed

THE GERONTOLOGICAL SOCIETY OF AMERICA®

The Gerontologist
cite as: *Gerontologist*, 2018, Vol. 58, No. 1, 79–88
doi:10.1093/geront/gnw268
Advance Access publication 17 February 2017

OXFORD

Special Issue: Aging in Context: Research Article

"I Feel Trapped": The Tension Between Personal and Structural Factors of Social Isolation and the Desire for Social Integration Among Older Residents of a High-Crime Neighborhood

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Received August 19, 2016; Editorial Decision Date December 27, 2016

Decision Editor: Barbara J. Bowers, PhD

Abstract

Background and Objectives: The aim of this study was to examine the factors contributing to the social isolation of older residents of a high-crime neighborhood through the in-depth examination of their lived experiences. A deeper understanding of factors contributing to social isolation can allow policymakers and health care providers to create policies and programs to alleviate the social isolation of these vulnerable and understudied individuals.

Research Design and Methods: Participants were recruited through the support of the Housing Authority and Police and Fire Departments of Richmond, California, a town with a high-crime rate. Fifty-nine ethnographic interviews were conducted with 20 individuals of 58–95 years of age. Transcripts and fieldnotes were analyzed with a focus on the specific factors contributing the social isolation of participants.

Results: An overarching theme of tension between personal and structural factors of social isolation and desire for social integration emerged from qualitative content analysis. A tension emerged between a longing to participate in society and the immersion in a reality so dense with obstacles that made participation in society difficult to attain. Four specific themes also emerged. Three themes demonstrated underlying factors of social isolation stemming from the personal sphere and the physical and social environment. The fourth theme illustrated participants' desire for social integration.

Discussion and Implications: Findings demonstrate the salience of interventions and programs to make neighborhoods safe and accessible to older residents. Findings also suggest a need to reframe the conceptual framework for social isolation to better measure and alleviate this public health problem.

Keywords: Social isolation, Crime, Sociology of aging/social, Gerontology, Public policy, Disparities (health, racial), Health care policy, Environment (ergonomics), Urban

Social isolation is a public health problem whose damages have been compared in scale with cigarette smoking (House, 2001). Although a universal definition is missing, social isolation is usually defined as the objective paucity of meaningful social contact measured in terms of network size and community involvement (Cloutier-Fisher, Kobayashi, &

Smith, 2011; Machielse, 2006; Victor, Scambler, Bond, & Bowling, 2000). Older adults are especially prone to experience social isolation. Their social ties may decrease with the passing of years due to retirement, death or institutionalization of friends and relatives, likelihood of living alone, and an increasing geographical mobility of their social network (Cacioppo & Hawkley, 2003). Isolated older adults are at high risk for poor health outcomes (Cornwell & Waite, 2009; Steptoe, Shankar, Demakakos, & Wardle, 2013), especially those with diabetes (Liu, 2011), cancer (Zhou et al., 2010), and coronary-heart disease (Berkman, Leo-Summers, & Horwitz, 1992).

Despite evidence deriving mostly from quantitative studies, little is known about the lived experience of socially isolated older adults, particularly those who face additional stressors such as living in neighborhoods with high crime. This is a concerning gap in knowledge because it is well known that older residents of disadvantaged neighborhoods die earlier and are not as healthy as older residents of affluent neighborhoods (Buys et al., 2015; Pruchno, Wilson-Genderson, & Cartwright, 2012). Older adults are particularly affected by the character of their neighborhood because they are likely to be less mobile and have smaller social networks than younger generations (Yen, Michael, & Perdue, 2009). Socially isolated older adults are also likely to fear surrounding crime (Acierno, Rheingold, Resnick, & Kilpatrick, 2004), which further exacerbates their isolation.

The few qualitative studies on socially isolated older residents of high-crime neighborhoods raised awareness about their dire living conditions (Abramson, 2015; Newman, 2003). Klinenberg's (2002) examinations of the factors of social isolation in these individuals mostly relied on the examination of their belongings after deaths resulting from natural disasters; his study was titled "social autopsy" for this reason. Cohen and Sokolvsky (1980) examined the social networks of older residents residing in Single Occupancy Rooms (SROs). These studies laid a foundation for inquiry in this area. But limitations from these studies also suggest that additional studies are needed to extend the understanding for social isolation beyond the very specific contexts of postdisaster settings or SROs. More depth is also needed from protracted observations with subjects in their environment over time.

A deeper understanding of the lived experience of socially isolated older residents of high-crime neighborhoods is important for several reasons. First, through this understanding, we can gain critical information on factors that foster isolation. Understanding the lived experience of these individuals also refine the framework of reference for scholars of social isolation. This information matters because some scholars have examined social isolation and loneliness as interchangeable concepts when in fact there are differences and overlaps in these terms (Perissinotto & Covinsky, 2014). Whereas social isolation has been defined as an objective paucity of meaningful relationships, loneliness has a more subjective connotation. Specifically, loneliness can be explained as the "discrepancy between one's desired relationship and one's actual relationship" (Perissinotto, Stijacic Cenzer, & Covinsky, 2012, p. 1079). As a result, a sense of "perceived" and therefore subjective isolation is treated as a component of loneliness. Second, understanding the lived experience of socially isolated older residents of high-crime neighborhoods can refine measures of social isolation. As a result of an emphasis on individual traits, measures have focused on personal and unidimensional factors contributing to isolation, including perceived lack of companionship (Cacioppo & Hawkley, 2003), size of discussion networks (McPherson & Smith-Lovin, 2006), number of persons in the household, contact with friends and relatives, or religious attendance (Yang, McClintock, Kozloski, & Li, 2013). Considering that researchers have grappled for decades with multiple definitions and measures of social isolation, a public health problem that lacks agreed-upon standards and well-validated measures (Perissinotto & Covinsky, 2014; Victor et al., 2000), it is particularly important to understand the lived experience of socially isolated people.

In an attempt to address the three reasons mentioned earlier, we designed a qualitative study to better understand the lived experience of socially isolated older residents of high-crime neighborhoods in order to identify factors that contributed to their isolation. This aim was addressed through qualitative research methods. This choice was driven by the experiential nature of the information we wished to collect (Creswell, 1998) and by the exploratory character of this research. In this exploratory study, a source of theoretical inspiration was C. Wright Mills' (1957) call to identify the influence of political, economic, and social dynamics in the words, assumptions, and behaviors of our study participants. Under the paradigm that the personal is political and the political is personal, Mills invites social scientists to uncover and describe the influence of larger dynamics in subjective experiences.

To identify factors that contributed to isolation, we had to overcome the major limitations of previous, foundational studies on this topic, which were limited by sample and short-term study period. To study a more diverse group of community-dwelling older adults, we focused on older residents of Richmond, CA, a low-income and racially/ethnically diverse community of 100,000 inhabitants. Richmond is a high-crime community with one of the highest homicide rates among similar-sized communities in the United States, with, for example, 26 murders in 2015 (Mercury News, 2015). To extend the depth of our findings, we followed participants longitudinally and conducted multiple interviews in their homes. Finally, to identify participants who are "off the grid," we partnered with emergency services (Fire and Police Departments) to recruit participants who were housed within the community but would otherwise be "invisible" because they did not utilize senior centers or other community resources. Collectively, these innovative elements of our approach enabled us to

study social isolation in new ways that will expand our collective understanding of key factors in social isolation, refine its theoretical framework, and lead to improved measures to develop better interventions.

Design and Methods

Study Design, Participants, and Setting

This analysis used participant observation and in-depth ethnographic interviews conducted between February 2014 and October 2015 with 20 older residents of Richmond, California, met 59 times overall. The average age of participants was 72 (standard deviation 12, range 58–95). To account for the early mortality of African American men (Chae et al., 2014), we enrolled adults aged 55 and over. The sample comprised 50% women. The majority (60%) of informants were African Americans, followed by 30% Non-Latino White, and 20% Latinos. Participants were recruited through Richmond Police and Fire Departments and Housing Authority. With regard to recruitment, a Captain of the Police Department wrote letters to 66 residents with cases of elder abuse reported between January 2013 and May 2015 and invited them to join the study. His rationale was that victims of elder abuse are likely to have limited meaningful social ties. Three of them joined the study. Crews of the Fire Department gave handouts about the study to rescued older adults, one of whom joined the study. The remainder of the participants joined the study after the first author participated in cockroach inspections with an officer of the Housing Authority, and handed fliers about the study. At the end of the data collection (December 2015), preliminary findings were discussed in a focus group with eight officers from Police and Fire Departments, Housing Authority, and agencies providing legal and health services.

Data Collection

To obtain in-depth information, data were collected through ethnographic interviews and participant observation, as well as the focus group. Ethnographic interviews provide a process that tailors questions in a fluid manner to respondents' trains of thought (Spradley, 1979). Most interviews occurred in the morning, when crimes rates are lower. Participant observation is defined as "the observation carried out when the researcher is playing an established participant role in the scene studied" (Atkinson & Hammersley, 1994, p. 4). In this project, participant observation included taking walks, eating together, watching TV, and going on errands. Ethnographic interviews and participant observation were used to investigate how older adults described their lived experience in their homes and in their neighborhoods. Interviews were also used to elicit participants' perspective on isolation. We also wanted to understand the relationship of participants to their support networks: therefore, we explored which support networks they relied upon, and how these networks linked to needed or preferred services. Interviews lasted approximately 1.5 hr and were conducted in English (two in Spanish with an interpreter). We met with each participant at least twice and several times with some participants who provided particularly rich information. Fieldnotes were captured in an audio-recorder at the end of each encounter. Fieldnotes contained a description of each participant (clothes, demeanor, appearance), their surroundings (temperature, noise, odors), and investigators' reactions to each encounter (unease, biases, confusion, surprises). To test their understanding, investigators often shared with participants what they genuinely thought was going on. A professional transcriptionist transcribed recordings of interviews, fieldnotes, and focus group. Transcripts were then imported in Atlas.ti. This study was approved by the Committee on Human Research at the University of California–San Francisco. All the names are pseudonyms and potentially identifying features of participants were omitted or slightly changed.

Data Analysis

Qualitative content analysis (Schreier, 2012) of transcripts of interviews, fieldnotes, and focus group was initially used to identify factors that contributed to the isolation of study participants. This method of analysis of qualitative, narrative, and ethnographic data focuses on the information coming from the data without the use or creation of a priori theoretical constructs (Forman & Damschroder, 2008). In the first stage, transcripts of interviews and fieldnotes were analyzed line by line by two authors to identify specific factors that contributed to isolation and how isolation was defined by participants. A code was created every time a particular factor was identified. For example, the code "surrounding crime" was created every time local crime made participants wary to entertain social relations of any kind, as in the participant's quote: "People come to visit and they steal everything you've got" and in the fieldnote quote about another participant: "Now, she has people around but they are kind of sketchy or they are dirty. She said, 'They are dirty. They tell lies'." Similarly, the code "body" was created every time participants mentioned that anything in their body refrained from engaging in social relations as in participant's quote "Look at me and the situation I'm in: Eight per cent bedridden all the time, and stuck." During this stage, we also noted that participants often mentioned their longing to engage in social relations. For example, the bedridden participant also shared her desire to understand how to join a local program and stop wearing "gowns." She noted, "So I want to go to the day care place and show my outfits off." Quotes like this one were coded as "longing for social integration." E Portacolone coded a subset of transcripts, created the codebook with the description and example of each code, and wrote memos to reflect on the data. Another researcher (J Yeh) coded the rest of the transcripts with frequent iterative discussion with E Portacolone to make sure that both

researchers' criteria agreed (Luborsky, 1994). As the coding progressed, E Portacolone discovered themes through the process of connecting codes and writing memos (Crabtree & Miller, 1999). In this stage, we noted that the source of the recruitment of participants did not have an obvious effect on the themes that emerged. Thematic saturation was found with regard to four themes. Saturation is found when no new types of information or themes are added as new informants come to be interviewed. One theme was "longing for social integration." This theme was unexpected and originated from the inductive analysis of the data. The other three themes generated from the original aim of the research, which was to understand which broad categories of factors contributed to the isolation of participants. These themes were social isolation stemming from (a) the personal sphere (which included quotes coded as "body"), (b) the social environment (which included quotes coded as "surrounding crime"), and (c) the physical environment (which included quotes coded as "surrounding unclean"). Finally, after a review of themes and codes, R Greysen identified the "tension between personal and structural factors of social isolation, and the desire for social-integration" as the overarching theme that well captured the overall findings of this investigation.

Results

From the qualitative content analysis, a recurrent and unifying theme emerged: The "tension between personal and structural factors of social isolation, and the desire for social integration." Within this overarching theme, four specific themes emerged. Three themes described specific factors that facilitated the isolation of older residents of high-crime neighborhoods. The fourth theme described study participants' desire for social integration.

Overarching Theme: Tension Between Personal and Structural Factors of Social Isolation, and the Desire for Social Integration

A tension emerged between participants' longing to participate in society and their immersion in a reality so dense with obstacles that made this participation difficult to attain. The social isolation of study participants manifested in different ways. In most participants, social isolation was generated by personal factors. Chronic health conditions, disabilities, and poverty limited their meaningful interactions. A nuanced analysis of the data also identified specific factors from the social and physical environment (second and third themes) that contributed to a "structural" isolation of participants. As their narratives elucidate, structural factors contributing to isolation were often beyond their control. Despite living in difficult settings, participants longed to be integrated, which is the fourth unexpected theme. This theme was unexpected because the literature on social isolation rarely mentions this longing. The contrast between the isolation of participants and their longing for social integration made tangible the tension between factors of social isolation and desire for social integration.

The description and narratives of the overarching theme and associated themes deeply resonated with the officers of local agencies of the focus group. As soon as the presentation of the findings ended, the officer of the Housing Authority said, "So many of these stories I hear every day… They are people that really need support, physical and also emotional support and the system failed them. From their own relatives, to the government, and the system." After being silent for a long time, a senior officer stated, "I am listening to these stories and they just repeat themselves over and over again and it is very widespread. It is all over the city….It is a problem. It is an epidemic. I really feel needs to be exposed." As he alluded, and other officers confirmed, the narratives of participants were not exceptional. Instead, they evoked the trajectories of many older residents of areas with a high prevalence of substance abuse, poverty, unemployment, and widespread crime.

Social Isolation Stemming From the Personal Sphere

Specific personal attributes of study participants fostered their limited meaningful social ties. These included (a) chronic health conditions; (b) limited social ties; and (c) poverty. First, chronic health issues often constrained the older adults' mobility, as well as stamina. Take Mr. John Hershon, 58, a former mechanic who, despite his rather young age, spent most of his time in his bedroom watching documentaries by himself. His lack of stamina was one of the reasons for this lifestyle. He explains, "I have like—not a heart problem but congestive heart failure. But I've been suffering from that for, shit, almost 30, 40 years." Chronic health issues can be exacerbated by substance addiction. For example Ms. Anne Bless, 64, a woman with a raspy voice and unable to walk, noted, "My health is failing some." Despite her ability to stop her heroin addiction and take methadone weekly, she is an alcoholic. She usually sits in the dark either on a wheelchair or in a single bed in an apartment oversaturated by cigarette smoke, with only a feeble light, coming from a television screen. A large bottle of vodka and some cigarettes rested next to her. Her chin tends to lie over her chest, and because she becomes tired quickly, conversations with her have been short.

Second, as studies on isolation have amply shown, the death, lack of mobility, or geographical distance of meaningful social ties is yet another factor that fosters the isolation of older adults. Mr. Cameron Jones, 58, for example, said, "My friends have either moved away or passed away or they have their own life. They are older like me, they don't get out much." This statement is representative of other study participants who lost touch with spouses, siblings, or close friends. Finally, poverty constrained the actions of most participants. For example, Mr. Hershon, the

documentaries enthusiast, could not afford taking someone on a date or fixing his car to go fishing. "I'm broke," he repeated.

Social Isolation Stemming From the Social Environment

Three factors of the social environment contributed to the social isolation of study participants: (a) immersion of participants in an environment dense with crime; (b) weak norms of reciprocity; and (c) toxic relations. First, the embeddedness of study participants in an environment where family members, neighbors, and acquaintances who were involved in criminal activities or suffered from substance abuse or mental illnesses, hampered the creation, and maintenance of meaningful social ties. As a result, participants often mentioned having "associates" rather than friends. Moreover, because of their disabilities in buildings with one unarmed guard and easy access to prostitutes, homeless, and drug dealers, study participants often feared stepping outside their apartment or using elevators. For example, Mr. Jones remained in his apartment watching movies because his slow gait made him an easy target for robberies. He explained:

> I don't like going outside. You can't visit your neighbors; nobody wants you to come in their house. Only the criminals…People robbed me up about three times up here. People come to visit and they steal everything you've got.

Ms. Anne Jude, 60, a woman with a long list of chronic illnesses, echoed Mr. Jones, saying, "Everybody stick to themselves," a recurrent expression among participants. Before her sister moved in with her, Ms. June always kept a can of pepper spray in her bra. As she explains, "There really is no protection…And you know inside the elevators or inside the stairwells is where you get attacked." Mr. Ray Clay, 79, an affable man, stuck to himself in his apartment because he felt unsafe to walk outside. He said, "Lots of noisy people. Just standing outside here. It's not safe. Drinking. Not safe…I mean, it's too many motherf----s, too many son of a b----s, too many pistol whippings." During a cockroach inspection, the lead author observed an older man who lived literally barricaded in his apartment. Certain days are particularly heated as Mr. John West, 67, explained, "during the first of the month you would have a lot of disturbance when people get their checks, then they start getting drunk and people can buy drugs and things of that nature. So you have a lot of activity in the area." Drug trafficking in this neighborhood was so common that an old man approached three authors of this study to solicit for drugs while they were inside a car parked near a recruitment site.

Second, weak norms of reciprocity were a feature of this harsh social environment and contributed to the paucity of social relations of many study participants. These weak norms of reciprocity may derive from the immersion of older adults and their acquaintances in the same difficult environment. This phenomenon is tangible for example in the case of Ms. Virginia Waters, 87, a sociable widow and former administrative assistant who recently, soon after the death of two family members, became wheelchair bound. Despite these accidents, Ms. Waters explained that her friends—"Well, I call them friends"—often deserted her because of her recent disability. She recalled a "friend" saying: "You are still in a wheelchair. I can't take that wheelchair with us. I can't lift it out of the car. It's heavy." As a result, after becoming wheelchair bound, her weekend outings with them stopped.

Ms. Waters' narrative also illustrates how the social environment contributes to the isolation of older residents of neighborhoods in disrepair. As a result of the lack of affordable and high-quality services (discussed in the next section), older residents often have to rely on an underground economy of informal caregivers that is often too expensive. For instance, Ms. Waters started skipping her Sunday Mass because of the costs to get there on a wheelchair. She explained,

> It's usually two people that come. I pay the woman $20, the man $20. So I'm out $40 there to take me to church and bring me back. And then I put it often in church. So I just have to put $50—I put $10 in church—just about $50 just to go to church.

The members of the focus group confirmed this trend. An officer commented: "I think it's ridiculous that they need to pay $20 to get a ride to go to church. And that's how they get taken advantage of. It's like vultures, these caretakers, they become vultures." As a part of this economy, some study participants had homeless people running errands and cleaning their home in exchange for a place to sleep. Homeless people, however, ate their food and sometimes robbed them. These complex exchanges made it difficult at times to understand dynamics during fieldwork. For instance a participant was concerned that a homeless man was taking advantage of his former wife, whereas the woman complained about the ex-husband: "I should get a restraining order." She added, "I feel trapped."

On a related note, a third factor that often contributed to the social isolation of participants was toxic ties. The toxicity of these relationships mostly derived from the immersion of participants in an environment saturated with crime, prostitution, poverty, drug addiction, and violence. An example of these toxic ties comes from Ms. Thelma Jagg, 67, a woman with depression, who became distressed after she cleaned the house of a granddaughter who had been brutally abused by her husband. Ms. Jagg cleaned the house with a daughter who hit her, ("she jumps at me"), a fact that Ms. Jagg reported to the authorities. She also cleaned the house with her 2-year-old great grandson, who was being raised by her because the mother of the toddler, described as "a hooker," was unable to do so. Caring for the toddler was so exhausting to Ms. Jagg that she often snapped at him. She said that she planned to take him to a foster home.

Social Isolation Stemming From the Physical Environment

Participants were often isolated because the physical environment surrounding them did not support social interactions. This included (a) the physical decay of building and streets in their neighborhood, including a lack of safe and accessible benches and community rooms and (b) the paucity of health care and social services available. First, the aging and disrepaired built environment contributed to the social isolation of older residents of high-crime neighborhoods. Participants avoided elevators and stairways not only for fear of being "attacked" but also because they were sometimes used as toilets. During fieldwork, we noted piles of garbage near entrance doors, cracks in the pavement, and a hole next to the sidewalk created by the surface of a manhole half sunk in the pavement (Figure 1). Furthermore, in between houses empty lots invaded by weeds were often used as dumpsters for sofas, mattresses, rugs, and garbage (Figure 2).

Another condition that deterred one participant from walking to the only senior center located downtown was the state of the sidewalks. In his words, "The street is uneven, it's cracked, it's broken. It's sticking up." During fieldwork, most pungent smells included disinfectant in the elevators and hallways, cigarette smoke, and whiffs of garbage. Ms. Jodi Green, 71, explained that lingering smell came from the massive open-air dumpster: "The bin is never washed. The same way they take it out is the same way they bring it back." She reported this concern to the local department of public health without success. She adds, "When it's hot you've got the gnats coming in, you've got the flies swarming around your door. You can keep everything clean, but what's the good of keeping your side clean when all of the filth is right there?" Unpleasant surroundings sometimes deterred acquaintances from visiting older tenants. In addition, some tenants were embarrassed to show the deterioration of their surroundings to visitors.

Figure 1. Hole next to the sidewalk.

Figure 2. Empty lots.

Residence in developments notorious for its infestation of rats, bedbugs, and mold contributes to the social isolation of participants. For example, during a long hospitalization, Mr. Jones discovered that he was placed on isolation because of a fungus inside his nose, a fungus that he said was infested with mold. Mr. Jones also mentioned the limited choices stemming from his residence in a stigmatized building when he said: "Nobody that takes Section Eight [subsidized housing] will rent to people here because they hear there's bedbugs and stuff in this building and they don't want you to bring that in their building."

Yet another factor that contributed to the social isolation of study participants was the paucity of places where they could congregate. Community rooms of buildings for seniors were often locked. As a participant noted, "I don't know why they've got a community room if you're not allowed to use it. That one I haven't figured out." The same participant explained that the administrator of the building forbade an older tenant to play music in a weekly "breakfast club" held in an alley. In his words, "We really enjoyed the breakfast club. Would find out about each other…And we talked about having a birthday party." Once the administrator also forbade the use of the alley, the club disbanded.

Second, a critical factor stemming from the physical environment that contributed to the social isolation of participants was the paucity of good-quality health care and social services available. One reason for this paucity was that formal care providers and volunteers avoided visiting seniors tenants of high-crime neighborhoods, as a manager of a safety-net provider explained in the focus group. A seasoned social worker described the area as "a desert of resources" and said that she was too afraid to serve clients in some neighborhoods. Another reason was the uneven allocation of resources for older residents in the County. For example older residents of Richmond could use only a portion of public services available in Walnut Creek, an affluent and smaller town nearby. A result of this dearth of services was the poor quality of home care aides. For example, during 6 months of visits to Ms. Mary Davis, 95, a wheelchair-bound woman whose only daughter lived away and was drug addicted, the lead author observed a succession of four home care aides. The first filled the sink, stove, and microwave with encrusted pans, and frequently left the job to linger outside a liquor store. The second lasted 1 month. Before disappearing, the third cut Ms. Davis' phone line and explained that Ms. Davis had been suddenly taken away by her family, which was not true. (Finally, 2 months later, the last aide, who was reliable saw Ms. Davis die.)

Yet another manifestation of inappropriate services was the inability of providers to understand the specific needs of older residents of high-crime neighborhoods. For example, Mr. Jones, the man afraid of walking outside because of his slow gait, said on multiple occasions that a motorized wheelchair would make a big difference to him:

> If I had a motorized scooter I could get on public transportation, I could go to the movies, I can go out and have a nice dinner, I can go to the Marina and fish…I don't have to be a sitting duck.

Despite his insistence, his physician opposed the idea because she wanted him to use his legs. Mr. Jones respected her recommendations and did his best to follow a diet rich in fresh vegetables, even though they were almost too expensive for him.

A Desire to be Socially Integrated

A common thread among participants was a strong desire to be socially integrated. "I don't want to be a sitting duck," as Mr. Jones said from his couch, while he listed all the activities he longs to partake. Like him, participants longed for company and to go on outings to dine, fish, watch sports, pray, and date. Participants often mentioned their desire to interact more often with others. A compelling representation of this longing comes from the narrative of a gregarious participant. "I'd like to go out all the time, but it is not safe," he said. Too afraid to step out of his apartment, sometimes he stations himself near the door of his apartment, with a bag of candies in his hand, waiting for the sound of footsteps. "Sometimes I stand here maybe 10 or 15 minutes and nobody comes and I put it back and close the door." Once somebody comes by, he offers candies and invites the person to play a game with him. His efforts had limited success. He added, "No one, except one man, he comes to play. I've been here four years. And only one." The participant felt safe inviting passerby in because he interacted with them on a one-to-one basis, and he felt reassured by knowing a martial move.

Participants often compared a past, where they were engaged in society, to a present limited of meaningful personal interactions. "I am not used to this life," said Ms. Davies, the same woman who had four home care aides in the last 6 months of her life. Despite her warmth and grace, her social relations were scarce and mostly toxic. Confined to a wheelchair, she spent most of her time in her small kitchen, a tiny room kept warm by the flames of the kitchen burners. She longed having someone to talk to. During one of the visits of the lead author, as Ms. Davies locked eyes with her, she said, "See, I have got company [chuckles]. And I appreciate it very much."

Discussion

In this study, we investigated the lived experience of older residents of high-crime neighborhoods to identify factors that contributed to their social isolation. These findings suggest that social isolation can manifest as a structural phenomenon rooted in the physical and social environment. A tension emerged between longing to participate in society and an immersion in harsh and underserved surroundings. This finding challenges the assumption about the isolated older adult as someone who is "enjoying more solitude," is a "loner" (Cloutier-Fisher et al., 2011, p. 43), or has poor social skills. In this study, older adults with scarce meaningful social ties desired more social integration. With varying degrees, they longed for good company, outings, and intimacy. This longing to participate in society reflects some feeling of loneliness among participants and points to the overlap between a subjective feeling of loneliness and the objective paucity of meaningful social relationships. This study also hints to the consequences of social isolation in the wellbeing of study participants. Participants with chronic health conditions often were sedentary because they were afraid of walking outside and lacked resources to know about, let alone afford, healthier lifestyles.

One strength of this study is its analysis of the multiple factors that contribute to the isolation of older adults. Whereas most literature concentrated on the factors related to the personal environment (Cloutier-Fisher et al., 2011; Victor et al., 2000), this study contributes to the literature on social isolation by shifting the attention toward structural factors that exacerbate the isolation faced by older adults. Previous studies provided evidence of the harsh conditions of older residents of high-crime neighborhoods, including weak norms of reciprocity (Abramson, 2015), deteriorated neighborhoods, surrounding crime, and limited services (Cohen & Sokolvsky, 1980; Newman, 2003). They did not, however, examine the specific role of these factors in contributing to social isolation. The only study that performed the analysis mostly drew evidence from the belongings of deceased persons (Klinenberg, 2002). For its emphasis toward the role of the environment, this work underlines the importance of spatial analyses in aging studies (Andrews, Cutchin, McCracken, Phillips, & Wiles, 2007) and therefore contributes to geographical gerontology, defined as "the study of geographical dimension of aging" (Cutchin, 2009, p. 440), as well as to environmental gerontology, that is, the study of relations between older adults and their surroundings (Wahl & Weisman, 2003). Specifically, our findings confirm the conceptual framework of Diez Roux (2001), which suggests an association between poor health and living in a disadvantaged neighborhood. Findings also are consistent with the conceptual framework of King, Morenoff, and House (2011), which underscored the role of the neighborhood environment with the accumulation of biological risks and related health disparities.

With regard to the method employed, this study illustrates the importance of spending time to recruit persons who may be harder to reach using traditional recruitment settings common in gerontological research, such as

community rooms or adult day health centers. To delve into the challenges of aging in place, investigators should devise creative strategies to recruit isolated older adults. A related future direction for research is that epidemiologists should estimate the number and characteristics of older residents of high-crime neighborhoods in urban areas so that we better comprehend the size of this vulnerable population. This is important because data on their prevalence are not easily available and because the majority of older adults (58%) resides in urban areas worldwide (United Nations, 2015), and therefore, they may be likely to reside in high-crime neighborhoods, especially immigrants and those with low socioeconomic status (González-Rivera, 2013).

Our findings contribute to the literature on social isolation in fours ways. First, they suggest that the exploration of the lived experience of isolated individuals is an opportunity to improve measures of social isolation. To do so, researchers should spend time with individuals with a paucity of meaningful social ties to understand the reasons behind this paucity and then to examine if existing measures of social isolation captured the reasons observed in the field, a practice often used to refine quantitative measures (Sofaer, 2002). Second, findings suggest the importance of including features of the social and physical environment in measures of social isolation. These features include the presence of crime, condition of sidewalks, ease of walking outside, presence of services nearby, and perception of the neighborhood. Third, considering that the traditional definition of social isolation indicates a paucity of meaningful social relations, this study provides the framework for a more accurate definition of these meaningful relationships. We provided evidence that socially isolated persons might entertain social relations that are toxic and therefore not meaningful in the positive connotation of the word. Yet these toxic relations might have meaning. It is therefore critical to emphasize that persons who are socially isolated have a paucity of "nontoxic" meaningful relations. Accordingly, findings suggest that measures of social isolation should assess whether the relations with member of one's network are toxic. Last, findings demonstrate the need to distinguish between social isolation stemming solely from personal factors and a social isolation imposed by the environment and therefore structural. For example, whereas people who avoid interactions with family members, friends, or neighbors are socially isolated by choice, people who want such interactions but miss them because they are afraid to get out are structurally socially isolated. This distinction would explain why the researchers of a qualitative study of Canadian elders found that a considerable portion of participants ascribed their isolation to their enjoyment of solitude (Cloutier-Fisher et al., 2011). We speculate that these elders did not face structural barriers to their integration, as our participants did. The social isolation of these elders, defined as "loners," was mostly subjective because it was derived from their own preference; it was not imposed by the environment. Even though "structural" and "personal" social isolations have fluid and overlapping boundaries, this novel distinction is critical when designing specific interventions.

A policy implication is that social policies and programs should consider interventions to make the community safe because residents of safe environments are less likely to be isolated (Saito, Kai, & Takizawa, 2012). Interventions might include improved sidewalks, more lightning, renovation of dilapidated buildings, presence of reliable and trustworthy security officers, home care aides, social workers, as well as of high-quality and affordable transportation services. A related policy implication is that specific resources should be allocated to support older residents of high-crime neighborhoods to interact with health care providers attuned to their priorities, as well as to access safe places, such as churches, beauty parlors, or other communal areas. Based on our findings, to identify and support vulnerable older adults in areas with high crime, we recommend the creation of partnerships between agencies serving the elder adults and the Police and Fire Departments. Finally, another implication of the findings is that older adults should not be pointed as responsible for their social isolation. Instead, greater attention needs to be devoted to identify and alleviate the external mechanisms contributing to their isolation.

Limitations

This study has three main limitations. First, the small size of the sample limits the generalizability of the findings and the observation of differences between ethnic/racial groups. Second, the limited geographical scope comprised a specific locale culturally. Third, with regard to data analysis, the interrater reliability for the two coders was not calculated.

Conclusion

As Klinenberg's (2002) "social autopsy" suggested through the examination of belongings of deceased informants, and this study confirmed with the observation of alive informants, older community-dwelling residents of high-crime neighborhoods are particularly at risk for social isolation. This is a concerning public health issue because an increasing number of people make it to old age and because most urban areas worldwide have high-crime neighborhoods. Furthermore, health disparities are often rooted in differences in social and physical environments (National Institutes of Health, 2009). We therefore look forward to future examinations and interventions on the structural determinants of social isolation in older adults.

Funding

This work was supported by the Career Development Award (EP K01AG049102) from the National Institute Aging (NIA), National Institutes of Health (NIH) and by the Pepper Center and Tideswell

at UCSF, which promote promising new research aimed at better understanding and addressing late-life disability in vulnerable populations. The UCSF School of Nursing Intramural Research Project and Chancellor Fund also supported this work. Finally, funding from the Mack Center on Mental Health and Social Conflict at the University of California, Berkeley is acknowledged. Conceived as part of the mission of the center, this project was initiated while the lead author was employed there. No funding source had any role in the study design; collection, analysis, or interpretation of data; writing of the report; or the decision to submit the article for publication. The content is solely the responsibility of the authors and does not necessarily represent the official views of the University of California or the National Institutes of Health.

Acknowledgments

The authors express their gratitude to all study participants and community partners. A special thank you goes to the two anonymous reviewers, as well as to Robert L. Rubinstein, to the reviewers of the Works-in-Progress seminars at the Division of Geriatric Medicine and at the Clinical and Translational Science Institute at the University of California in San Francisco, and to the editor Susan Griffin.

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