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Where does the neighborhood go? Trust, social engagement, and health among older adults in Baltimore City

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ABSTRACT

Trust is often cited as a necessary predecessor of social engagement, and a public-health good. We question those suppositions through analysis of the life histories of lower-income older adults aging in place in Baltimore. These people desired to continue living independently, but also expressed a complex mix of trust and mistrust in their neighbors, neighborhoods, and broader environments. This was the product of interrelated processes of multilevel physical and social changes over time and space – and, we argue, often featured a "healthy mistrust" that pushed participants to pursue personally meaningful forms of social engagement, whether new or continued.

1. Introduction

Public health studies have repeatedly reported positive associations between health outcomes and a range of variables with the "social" qualifier (*e.g.*, capital, cohesion, disorder, engagement, inclusion/exclusion, and integration). These studies have frequently taken a neighborhood approach, focusing on individuals' face-to-face relationships with people in their residential areas, usually termed "neighborhoods", as well as those neighborhoods' collective characteristics (see Jones et al., 2014; Poortinga, 2012; Braveman et al., 2011; Everson-Rose et al., 2011; Moore et al., 2011; Jen et al., 2010; Nummela et al., 2008).

Relative to its conceptual cousins, social engagement has been especially influential in such investigations. "Continued engagement with life, which includes relations with others and productive activity" is the key social component of Rowe and Kahn's (2015) influential model of successful aging (p. 593). The neighborhood approach is prominent in this literature, particularly in studies involving individuals who are "aging in place": remaining in their homes, rather than moving into assisted living or skilled nursing facilities (Golant, 2016; Smith, 2009; Cutchin, 2003). Health and social factors certainly influence the neighborhoods in which people reside (by choice and/or selection), but the long neighborhood tenures characteristic of adults aging in place have led researchers to concentrate on the ways in which the neighborhood conditions shape residents' social engagement, and how, in turn, the neighborhood-engagement nexus affects their health. Interventions motivated by this approach focus on individuals, their neighbors, and their neighborhoods, with the aim of (re)building the local trust deemed necessary to sustain social engagement, and thus healthy aging (Cagney and Cornwell, 2010; Levasseur et al., 2010; Glass and Balfour, 2003).

This approach raises fundamental yet still-debated questions: what constitutes "social engagement" for people aging in place, and where and when does it take place (Mendes de Leon, 2005)? How does such engagement relate to the trusts older adults place in their neighbors, neighborhoods, and others (Cagney et al., 2013)? This paper directly addresses those questions. Drawing on a rich set of qualitative data from a sample of functionally limited, lower-income older adults aging in place in Baltimore, it illustrates how the lifelong formation and disruption of trusts are critical to people's decisions about social engagement as they experience both neighborhood and health declines. It argues for a more complex approach to the way older adults experience and explain such engagement with the individuals and environments around them.

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2. Theoretical background

2.1. Aging and (dis)engaging

The study of social engagement, aging, and health has its foundations in two seminal gerontological theories: disengagement theory and activity theory. Disengagement theory depicts older adults as "participating with others in [their] social systems in a process of mutual withdrawal" (Cumming et al., 1960), which reflects a normal, inevitable part of aging – paralleling an age-related decline in health. Activity theorists, by contrast, view disengagement among older adults as a socially pathological condition, and present social engagement as necessary for normal, healthy aging (Havighurst, 1963). Both theories have undergone adaptations, and remain deeply influential. They also raise a pair of intertwined questions: what, exactly, do we mean by social engagement – and what does social engagement mean (Hochschild, 1975; Mendes de Leon, 2005)?

Researchers have most commonly conceptualized social engagement as a component of social capital, and distinguished it from other components, including social support and cohesion (Poortinga, 2012; Carpiano, 2007). They have operationalized older adults' social engagement in various ways, unified by the aim of investigating how everyday activities promote health and well-being (Ziegler, 2012; Levasseur et al., 2010). In the original formulation of disengagement theory, however, Cumming (1963) clearly argues, "activity and engagement are not in the same dimension" (p. 380) – or, as Hochschild (1975) summarizes it, "being *active* in the sense of 'seeing people' is not the same thing as being *engaged*" (p. 556). Hochschild argues that understanding social engagement requires understanding the *meaning* individuals make of it, in addition to the forms that it takes. This represents a challenge to both disengagement and activity theories, which both tend to downplay individual agents (Marshall and Clarke, 2010). As critics of the successful aging paradigm (Rowe and Kahn, 2015) have pointed out, however, there is a risk of overemphasizing the power of agency, and thus engaging in ahistorical, asocial explanations of aging adults' engagement and health (Minkler, Fadem, 2002; Dannefer and Uhlenberg, 1999; Elder and Glen, 1975). Accordingly, scholars have encouraged theoretical approaches that elucidate "the relative influence of agency and structural constraint" (Marshall and Clarke, 2010, p. 300), and particularly constraints rooted in issues of race, gender, and socioeconomic status. Our response, in this paper, is to emphasize "the everyday experiences of older people as the product of both individual and structural factors intersecting across time and space" (Ziegler, 2012, p. 1298).

2.2. The people in the neighborhood: (dis)engaging in place

Just as our approach to social engagement challenges a rigid structure-agency division, it also departs from a dichotomy between individual competence and environmental press (Lawton and Nahemov, 1973), which has heavily influenced neighborhood approaches to aging. Instead, we emphasize the ways in which older adults' social engagement is an iterative *process* of relating to environments. As Buffel et al. (2012) observe, "in making use of, having social contacts within, and giving meaning to their immediate social environment, older people are actually (re)constructing and shaping the[ir] neighborhood" (p. 26). As such, neither they nor their neighborhoods are "preformed… self-subsistent entities" (as a more substantialist perspective would propose – see Emirbayer (1997), p. 283, Buffel et al. (2012) and Dannefer and Uhlenberg (1999)). This is particularly relevant to individuals aging in place. Aging in place is overwhelmingly preferred by older adults (Golant, 2016), and is also attractive to others, including family members and policymakers – not least because it is often less costly than alternatives. Scholars have worried, however, that these preferences mask the risk of a spatial mismatch (Golant, 2015). In this scenario, older adults' functional limitations, alongside material and social deficits at the individual and neighborhood levels, combine to make them especially vulnerable to social disengagement and thus to (further) health decline (Golant, 2015; Smith, 2009). Such concerns place a distinct emphasis on local social relations – an emphasis implying that "meaningful social networks, trust and norms associated with social capital are accessible (or not) based on geographic proximity" (Maselko et al., 2011, p. 760). Our framework renders this implication an empirical question.

2.3. A simple matter of trust?

Maselko and colleagues' invocation of trust is notable, as quantitative measures of trust are often key underpinnings of neighborhood studies of social engagement and health (Veenstra et al., 2005). Yet the question of how, exactly, trust and social relations relate to each other and to health has given rise to considerable debate (Carpiano and Fitterer, 2014). The literature on social relationships and trust has consistently operationalized two types of trust, measured at the individual level: particularized and generalized. The former is typically defined as the trust one expresses in people in one's neighborhood; the latter, as the trust one expresses in people in general. The use of these measures is, Carpiano (2014) observes, "an institutionalized – but largely unquestioned – practice within health research," raising a key question: "[do] generalized and particular trust… adequately capture aspects of a person's real life social relationships (or network ties) and their inherent resources that matter for one's health" (Carpiano and Fitterer, 2014)? Recent responses to this question (*e.g.*, Carpiano and Fitterer, 2014; Lindström, 2014; Carpiano, 2014) highlight a lack of consensus on three interrelated elements: the *stability* of trust over the life course; the *sociospatial contexts* in which trust and social engagement take place (literally and figuratively); and the *causal relationship(s)* between trust and social engagement and health.

Examining how an alternative framing of trust (Giddens, 1990) addresses each of these elements provides an informative contrast. Giddens also delineates two main types of trust: "trust in persons" and "trust in systems" (p. 88). Both are prefigured by a "basic trust" (p. 94) established during childhood. For most people, basic trust is relatively stable throughout the life course. Trust in persons and in systems are more dynamic. Trust in persons depends on "facework engagements" (p. 99), which require physical co-presence. Historically, these engagements were almost exclusively local, and involved primarily family and friends. Innovations in a wide range of institutions and technologies, however, have dispersed individuals, altered social interactions, and transformed the nature of places (such as neighborhoods) where interpersonal trusts and facework engagements were formerly concentrated. These changes pose fundamental challenges to individuals' social relations, requiring individuals to adaptively react by extending their trust in persons over space and time. This, in turn, requires trust in systems. These interlocking systems span the public and private sectors from the local to the global levels. They include education, communications, transportation, law and criminal justice, and medicine and public health. While people regularly interact with individual representatives of these systems in their everyday lives, their trust in the systems themselves is based not solely on those interpersonal relations. It also emerges from their expectations and observations of the results the systems produce: a relatively "faceless" engagement (Giddens, 1990, p. 80).

Juxtaposing these two dichotomies (particularized/generalized;