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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.

Keywords

Trust; social engagement; neighborhood; aging; physical limitations

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, Egerter and Williams, 2011; Everson-Rose *et al.*, 2011; Moore *et al.* 2011; Jen *et al.*, 2010; Nummela *et al.*, 2008).

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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.*, 2014)? 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.

Theoretical background

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 wellbeing (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 & Clarke, 2010). As critics of the successful aging paradigm (Rowe & 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 & Uhlenberg, 1999; Elder, 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).

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 & 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 and colleagues (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] neighbourhood” (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 & 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, Hughes, & Cheney, 2011, p. 760). Our framework renders this implication an empirical question.

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 & 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 & Fitterer, 2014)? Recent responses to this question (*e.g.*, Carpiano & 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; persons/systems) of trust underscores their limitations in tracing social relations over time and space. This requires an analytic approach in which trust, like social engagement, is treated as a process, rather than a fixed entity (Frederiksen, 2014; Kohdyakov, 2007). Particularized trust is certainly a type of trust in persons, for instance, but the question of how it is lost and (re)gained over a lifetime of relations within and beyond the neighborhood remains an open one, with particular relevance for older adults.

Similarly, scholars investigating trust, engagement, and health have not explicitly considered differences between two types of *mistrust*: a relatively passive *lack* of trust and a more active *distrust*. Both are tacitly treated as equivalent counterfactuals to trust (with few exceptions – see Wang *et al.*, 2009). Trust and mistrust, however, are not necessarily diametric opposites (Giddens, 1990). That particularized trust serves as a basis for meaningful social

engagement within a neighborhood does not necessarily suggest that mistrust of one's neighbors leads to disengagement. Dealing with mistrust of some neighbors might lead one to interact, build trust, and meaningfully engage with others; alternatively, it might lead to a spatially extended network of trust in persons. A more generalized mistrust of persons might fuel efforts to build and maintain trust and engagement within the neighborhood, or to identify specific social spaces outside of the neighborhood in which to invest trust. These possibilities motivate our analysis of (mis)trust and social engagement among our sample of Baltimoreans aging in place while experiencing health declines.

Methodology

Study design and sample

The data analyzed below were collected with participants in the attention-control arm of the Community Aging in Place: Advancing Better Living for Elders (CAPABLE) pilot study, conducted from January through July 2010. CAPABLE's intervention arm comprised home-based service provision by a registered nurse, occupational therapist, and handyman. As the purely social aspects of these interactions might have influenced participants' health, CAPABLE included an attention-control arm, in which participants received a "dose" of interaction in the form of visits with one of 5 interviewers (the first author and 4 trained research assistants). These visits continued until the total time spent with each participant equaled that of the intervention-arm visits: approximately 600 minutes.

CAPABLE recruited participants from the home-based service waiting lists of three Baltimore City agencies. Eligible individuals were aged 65 or above; low-income (at or below 199 percent of the 2010 federal poverty level; Issa & Zedlewski, 2011); cognitively intact (Mini-Mental Status exam score of 24 or higher; Folstein, Folstein, & McHugh, 1975); and experiencing difficulty with at least one Activity of Daily Living (ADL; Katz *et al.*, 1963) or at least two Instrumental Activities of Daily Living (IADL; Lawton & Brody, 1969). CAPABLE excluded those who were already receiving home rehabilitation; unable to stand; hospitalized more than three times in the previous three years; undergoing cancer treatment; or terminally ill. Participants signed an informed consent form, and the Johns Hopkins Medical Institutional Review Board approved the study. Eligible individuals were randomly assigned to the intervention or attention-control arm. The latter comprised 14 participants from 9 different neighborhoods. They ranged in age from 66 to 87 (mean age: 75). Thirteen of the 14 were women: 12 African American, one white. The 14th participant was a white Hasidic ("ultra-orthodox") Jewish man. Table 1 provides further information about each participant. All names in this paper are pseudonyms, to protect participants' privacy.

Data

This paper draws on 69 interviews with the 14 participants, as well as on interviewers' field notes, which included observations of the participants; their interactions with family members, neighbors, and other visitors; and their residences and neighborhoods. Interviewers initially conducted oral histories with each participant, guided by a broad research question: what aspects of participants' built and social environments were most

important to their health and wellbeing as they aged in place? A common, semi-structured protocol guided these oral histories, which included questions about childhood (*e.g.*, memories of family, residential neighborhoods, and school experiences); adult life (including major events like marriages, child-bearing, divorce, and deaths of family members and friends; changes in residence and employment; shifts in socioeconomic position, and experiences of racial, class, and gender discrimination); current circumstances; and future plans. In follow-up sessions, interviewers probed more deeply into domains that emerged as particularly meaningful to participants (see description of analysis, below). Interviews ranged from 60 to 150 minutes in length (with participants interviewed four to eight times) and were recorded and transcribed.

Analysis

We analyzed our data using an informed grounded theory approach (Thornberg, 2012; Charmaz 2006; Glaser and Strauss 1967; Reichertz 2007). Data collection and analysis were thus iterative and concurrent, and coincided with reviews of relevant literature on trust, social relations, neighborhoods, and health, particularly with respect to aging populations. Alongside interview transcripts, interviewers produced independent summaries of their visits (including field observations and post-visit reflections). Throughout fieldwork, all interviewers met to review these transcripts and summaries, and to discuss emergent findings, via the constant-comparative method (Charmaz 2006). These discussions led to identification of key domains to be investigated in more detail in subsequent visits – including participants' experiences of trust and engagement within their neighborhoods, as well as the ways their social relations transcended neighborhood boundaries. After fieldwork concluded, we conducted a final comparative analysis of all transcripts and summaries. We gave special attention to exceptional and divergent cases and their explanatory value.

Findings

Thirteen of the 14 participants expressed the desire to continue aging in place. Frances, the lone exception, said she wanted the convenience of a "senior place," but maintained her house because her son lived with her. Eleven of the 13 who preferred aging-in-place wanted to do so in their current neighborhoods. Bernice wanted to move out of her crowded central Baltimore neighborhood to an area where she could own a single-family home. Ann stated that she needed a more manageable house, and that she no longer felt comfortable in her East Baltimore neighborhood, exclaiming, "It's not the same!"

Despite their aging-in-place preferences, the other 13 participants echoed Ann's sentiment throughout their interviews – expressing ambivalence, if not outright antipathy, about their neighborhood environments. They cited the increasing presence of vacant houses, decaying infrastructure, drug dealing, and other problems within blocks of their homes (though only two, Denise and Jeremiah, cited a lack of safety in their neighborhoods as a reason they might not go out). They described how as a result of these dynamics, their social engagement, once almost exclusively located within their neighborhoods, had distended and sometimes disintegrated over time.

Our participants' descriptions of their neighborhoods thus featured many commonalities. Yet they reacted to the challenges they described in a variety of different ways. In this paper, we focus on the 12 African-American women in our sample, and consider two contrasting cases in depth: Joyce and Carol. Both had serious physical health limitations, yet described strong, meaningful social engagement within or beyond their residential neighborhoods. Each also illustrated how that engagement emerged from distinct, complex mixes of trust and mistrust in individuals and institutions, which had been shaped over the courses of their lives, and remained subject to both internal and external pressures as they aged in place. Joyce provides a representative example of the majority of our participants, whose most meaningful engagement took place primarily outside of their residential neighborhoods. Carol, by contrast, was exceptional for her intense engagement within her neighborhood.

Joyce, an “East Side kid” in West Baltimore

Joyce drew on her East Baltimore history, cynical sense of humor, and firm commitment to volunteerism to cope with her deep-seated feeling of detachment from her West Baltimore neighborhood. Born and raised in East Baltimore, Joyce had moved (with her now-deceased husband) to West Baltimore in 1951. Even after 60 years on the West Side, however, Joyce still considered East Baltimore home: “Yes, I’m still an East Side kid. I just never adapted over here.... I never wanted to live over here. But they were not selling houses [on the East Side] to [African Americans] then.”

Joyce frequently discussed socializing with family and friends outside of her neighborhood, particularly on the East Side. Her mobility was constrained, however, by symptoms from her diabetes, and particularly pain in her joints. She also noted that she restrained her trips to restaurants and entertainment venues (she especially enjoyed theater) because of her limited income. This combination of physical and financial limitations (alongside her children’s busy schedules) prevented her from going out as often as she would have liked. She often received telephone calls from friends and relatives during our interviews, though, and described the satisfaction she took in their long, daily conversations.

Despite Joyce’s lack of attachment to West Baltimore, she vividly recalled the close relationships she had formed there in the 1950s. “[Our neighbors] were professionals,” Joyce (who had worked as a healthcare assistant) related. “They were doctors, and teachers, maybe a few pastors. We were all very young, around the same age when we moved here... our kids grew up with their kids, and it was like a real family.” She coupled this nostalgia with a trenchant critique of 60 years of marginalization, emphasizing discrimination against Black people and the poor by local and national institutions. She vividly traced the effects of this discrimination on her life, the lives of her family members and friends, and their neighborhoods, concluding:

I can only speak for African Americans, I think. They don’t see how things have gotten better. OK? That’s the bottom line. You don’t have better jobs. You don’t have good schools. You don’t get a living wage. [Pause.] You don’t get second chances, and maybe... you’re incarcerated. It, [sighs], it’s society. They make laws for certain people, that benefit from them, but the African Americans are all in

jail.... I thought things were differently but they're not, and it makes me sad that they're not.

She coupled these observations with descriptions of her social distance from many of her current neighbors. This was not because she feared them. She stated that she felt safe walking around, and that she was respected by everyone in the area – “even,” she scoffed, “these little guys that run around, and beat up folks, and smoking that pot, and all that stuff.” She recounted her struggles to deal with generational differences in upbringing and lifestyle, describing her current neighbors as “people that did not grow up with the neighborhood... they [don't] have a real interest in the area.” She even spoke somewhat wistfully about segregation, noting that while she had hated it, it had kept her professional, African-American neighbors in her neighborhood. She truculently expressed her disinterest in intimate ties within her neighborhood, at one point noting, “Maybe I don't talk to my neighbors at all. How about that? Yeah, because I don't. Now I don't have anything against them... but I guess I don't really know them.”

Yet she later detailed how some of her neighbors actively sought her out – both to provide and ask for assistance:

A young lady from two doors down, she called me a few minutes ago and wanted to know how I was and what have you.... and so she tries to help me. No neighborly stuff like, “Oh, I'll help you”... “Oh, Miss [Joyce],” she say, “You want me to get your trash up?” I said, “No.” She said, “Because I'll get it up for a few dollars.” I said, “That's all right, I'll get it up for no dollars”.... She'll often say, “You don't want anybody to help you.” And I don't.... Because we weren't brought up like that... The neighbors, we all grew up here together and what have you, but you didn't really depend on them. We got neighbors here, I don't believe they ever go to the store, and if they go there, they must leave the stuff in the store or something, because they want two teaspoons of vanilla and a this and a that, and I never heard such stuff! And most times I will give it to [them].... And you know why I do it? I do it because I'm here by myself, and you need somebody to talk to. And somebody... now she will knock on the door and say, “Now, how are you feeling today?” or something like that.

Later, the young lady from two doors down did, in fact, stop by to check on Joyce. After she left (promising to return later) another neighbor stopped by – also to check on Joyce. He began lecturing her on eating habits, as he knew about her diabetes. She told him, only half-jokingly, to go home, and refused to take his new mobile number when he offered it in case she needed assistance. Prompted about the concern the pair had expressed about her, and the apparently friendly conversation the three had shared, Joyce acknowledged that she appreciated their support. Slipping into second person, she observed, “You feel comfortable because you see them every day,” she said. “If you have a problem, you can feel free to call on them.” Asked what sort of problems might result in her calling on them, Joyce responded:

Joyce: If I was ill. If I could get to a pharmacy if I was ill. That's the only thing I can think of.

Interviewer: Who would you call?

Joyce: Oh, I'd call maybe the girl that's two doors, lives two doors from me. I have her phone number. I think that's about it.... So, I would have to be ill. Other than that I wouldn't bother.

Interviewer: The girl two doors down, what makes...

Joyce: Because she's close. She's close. My daughter doesn't live that far from me but [the neighbor] is right there. And it depends on the illness, so...

It required repeated probing questions, however, to garner such positive evaluations. Joyce repeatedly stressed that she did not consider these neighbors "real family" – drawing a clear distinction between them and her erstwhile neighbors, as well as her children, grandchildren, and what she called her "church family."

At the same time, Joyce spoke proudly of volunteering at a nursing home once a week, and helping other older people who remained in her neighborhood. These were not people she considered close friends, she noted, and they couldn't pay her back for any costs she incurred in the process. But despite (and, perhaps, because of) her own physical and financial limitations, she felt fulfilled by these efforts:

They don't have cars and then they're very sickly. Like a lot of them are on dialysis.... a lot of them get like five hundred dollars a month.... So then I feel like I can't ask for any money. But I still feel like I'm helped. I'm helped by helping them.... I just feel that the little bit that I do for others, it comes back to me. You know? It comes back to me.

These activities were essential to her concept of meaningful engagement as an aging adult. She explicitly situated them in her commitment to the legacy of the Civil Rights movement, despite – and again, *because of* – her disappointment in the local and national progress of race relations. But she also made it clear that these volunteer activities, like her interactions with her neighbors, reinforced her sense of independence and wellbeing. "We're standing on Martin [Luther King, Jr.]'s shoulders," she observed. "We're standing on Rosa Park's shoulders. We're standing on a whole heap of shoulders. So you've got to come to the plate, honey. And bring something along with you."

Carol: Respect within, respite without

Carol was exceptional among our participants for the intensity of her engagement within her neighborhood. Like Joyce, she had grown up in East Baltimore; as a young woman, she had moved to Park Heights, in northwest Baltimore. Unlike Joyce, however, Carol had embraced her new neighborhood, and reacted to its decline by assuming a strong leadership role. This was despite serious physical limitations. She could stand, and walk for short stretches, but had used a wheelchair since 1992. She often grumbled self-deprecatingly about how her limited mobility prevented her from being as socially active as she would have liked. She was nevertheless president of her neighborhood association, and had been for ten years. "I've been trying to get someone else to take it over, because I'm getting old and I'm getting tired and I can't go to all the meetings that we require to go to," she said. "But you know... they keep voting me right back in, voting me right back in!"

Still, Carol lamented changes in her neighborhood: complaining about *de facto* segregation, a rise in drug dealing, an ineffective police force, and a growing ratio of renters to homeowners. She recounted that while northwest Baltimore's population was now primarily African American, during the 1950s and 1960s, there had been a mix of Black and Jewish people. She spoke of Jewish neighbors who had been good friends as well as employers. (Carol had worked in retail and in secretarial jobs.) One Jewish family had suggested that she purchase her house in the neighborhood, and helped her do so. Over the past three decades, however, most of those families had moved. While parts of the neighborhood still intersected with a Hasidic enclave, these very religious Jews eschewed social interactions with their African-American neighbors. These shifting demographics changed the nature of Carol's engagement within and beyond her neighborhood. Most of her neighbors were now from younger generations, and she felt increasingly disconnected from them. This was especially true of neighbors her grandchildren's age, whom she saw gathering on corners, and described as drug-dealers. Like Joyce, however, she insisted that she felt perfectly safe in her area, and described how as the neighborhood association president, she had organized members around this issue:

At one time [the association] had kind of dropped down.... A lot of people didn't want to participate in it because they was afraid that the boys would retaliate against them.... [So] we had [neighborhood watch] numbers. And you don't have to give your name or nothing. You [called the police and] said my neighborhood watch number is such and such and such. And young men are on such and such corner. And [the police] only come – they don't come into the house and meet [the callers]. So we finally got that through some of 'em's head.... [And] the neighborhood got a little stronger...

Carol did not shy from interacting with the corner boys herself, waving off any fear of retaliation and insisting,

When somebody move around here and, the boys... [tell the newcomers], "Hold it. That's Ms. Carol. Whatever she say, you move"... I told them, "Don't come on my corner and do what you all are doing. You got plenty of places to go. And the police will get you because I will call them"... Up until the day now, I can come up there and the bus come up there to [drop me off]. And there on the corner, they'll start walking. I don't have to say a word, they'll start walking... it's just the way you carry yourself and the way you talk to people.

Carol admitted, however, that she had seriously considered moving to another neighborhood in Baltimore. She remained in Park Heights in part because her limited mobility and finances constrained her to moving to a similar but unfamiliar neighborhood, with potentially dangerous repercussions. "If I go and move into another neighborhood it might not be like [this]," she said. "The [corner] boys [there] don't know me, you know."

Carol's continued leadership in her neighborhood association spoke less to particularized trust than her trust in her neighborhood as a collective – and, importantly, in the effectiveness of working with Baltimore government institutions, including the police, to improve it. Her original engagement with the association had been sparked by positive interactions with the Baltimore political system, not her neighbors. She initially approached

her (then and present) City Council representative about making the neighborhood more wheelchair-friendly, and the success of that effort had built her trust in the system. “When I found out that I would have to be in a chair, I started working on the neighborhood right then and there,” she recalled. “You know, that’s what I needed. I started with [my City Council representative].... When you tell [city officials] something, they see that it’s going to benefit the neighborhood – yeah, they listen! They listen!”

In discussing her dissatisfaction with her neighborhood environment, Carol also highlighted the importance of the senior day-care institution she attended four days a week. The center was six miles from her house; she took public transportation there and back. At the center, she said, she was able to meet and learn from people she considered more like herself, and whom she trusted: older people, whose life experiences she felt she either shared or could learn from. Her closest friends were at the center, and without that respite, she said, she would not have continued her neighborhood leadership. She would feel “isolated” and “negative,” she noted, despite the central social role she played within her own neighborhood.

Discussion: Where does the neighborhood go?

Our findings provide a new perspective on the three elements discussed in the theoretical background: the longitudinal *stability* of trust; the *sociospatial contexts* of trust and social engagement; and the *causal relationship(s)* between trust, social engagement, and health.

Trust and engagement as processes: A healthy mistrust?

The cases of Joyce and Carol illustrate the relative instability of trust and social engagement over time and space. This instability is produced by the intersection of individual changes (from physical experiences of growing older to the psychosocial effects of major life events) and environmental changes (from those within their neighborhood, such as changing demographics and the decline of the built environment, to those outside). Most of our participants followed a similar trajectory to Joyce’s: over the long term, their everyday experiences in declining neighborhoods yielded a complex mix of trust and mistrust, marked by a decreasing particularized trust, as well as a rising distrust in more distant individuals and institutions. They were also actively aware of the ways in which national and local histories had intertwined with their own. Government policies, market forces, and racism interacted to limit the neighborhoods into which they could move, and the resources available to them. Over the subsequent decades, their neighborhoods were fundamentally affected by the death of Baltimore’s manufacturing and transportation industries in the 1960s and 1970s; the narcotic and crime epidemics of the 1980s and 1990s, and accompanying mass incarceration; and steep declines in the city’s population and infrastructure, which have continued to the present day (Pietila, 2010; Levine, 2000).

It is not surprising, then, that many of our participants, like Joyce, expressed mistrust of their neighborhood environments – as well as the broader systems that had shaped them. This was not just a matter of their perceptions of present-day neighborhood conditions; it was also predicated on their perceptions of how and why those conditions had come about. It was not inherent in individual characters, but rather the product of complex, longitudinal social

relations – which had given participants many good reasons for mistrust. Our participants' decisions about whether and how to engage were shaped through their sharply critical assessments of given individuals and institutions in certain places, including their residential neighborhoods, over time. Joyce's relations with her neighbors, for instance, recalls Ziegler's (2012) analysis of the mismatch between the social expectations of older adults and their neighbors, with a key difference. Ziegler's older participants reported that they appreciated the support their younger neighbors provided when asked, but felt uncomfortable asking. Joyce's neighbors, by contrast, were eager to assist her – she didn't need to ask. Her discomfort emerged from the nature of the reciprocal support her neighbors expected. She was willing to provide them with smaller items when asked, counting it as a cost of their social support. But their asking contributed to the social distance Joyce described. And she was simply unwilling to pay them to do tasks (such as handling the trash) that she felt should be provided in the neighborly spirit of supporting an older person.

Overall, our 12 African-American participants described their wellbeing as deliberately rooted in meaningful engagement with primarily African-American people and institutions – but within that context, they described evaluations of others on the basis of class, values, lifestyle, and behavior. They established a racially circumscribed variation of Ziegler & Schwanen's (2011) “mobility of the self”: a willingness to engage with different or unknown individuals, institutions, and environments, which the pair argues is “crucial to subjective wellbeing” (p. 777). Their assessments of particularized trust, in short, emerged from a mix of judgments not just about specific people, but also the categories into which our participants place those people (and themselves, comparatively).

Furthermore, not every form of our participants' meaningful engagement was rooted in a firm trust in persons (whether particularized or generalized) or systems. In some cases, *mistrust* was a key part of their trajectories. Joyce and Carol exemplify how, for our participants, mistrust and trust could play complementary or agonistic roles. Neither the simple inverse of trust, nor always opposed to healthy social engagement, mistrust, like trust, could lead to crucial forms of self-reliance, social activism, and leadership. A *healthy mistrust* could drive our participants to pursue personally meaningful forms of social engagement over time and space, in the face of physical, material, and social constraints. This might lead to their decreased engagement in once-meaningful social interactions (with institutions or people) in some instances, and their continued, even increased engagement in others – with potential benefit to their health and wellbeing in either case.

Our participants' mistrust was inextricably embedded not only in their long-term, shifting relationships with their neighbors and neighborhoods, but also with their lives beyond them. While the life histories they shared with their interviewers were most often dominated by narratives of family – of the participants' relations as children, sisters, wives, mothers, and grandmothers – they also regularly featured recollections of work; all but one of the 12 women had been formally employed full time over most of their lifetimes (see Table 1). Their relationships with (and frequent critiques of) their neighbors emerged from the combination of those experiences. As relatively stable older neighbors in unstable neighborhoods, they recognized themselves as both providers and recipients of social and material support. They appreciated social support from their younger (mostly African-

American) neighbors, as well as the social challenges facing them – even as they criticized their values and choices. And, as in Joyce’s case, they acted on opportunities to support older neighbors who were, like them, aging in place while experiencing declines in both their health and their neighborhoods.

It is important, however, to recognize that our participants’ decision-making was still constrained. As with many older adults, their limited physical functioning and socioeconomic disadvantage presented significant challenges to pursuing meaningful social engagement and achieving health and wellbeing (Cagney & Cornwell, 2010; Glass & Balfour, 2003; Golant, 2008). Without dismissing our participants’ agency, we would still argue that their relatively disadvantaged status (relative to wealthier adults of similar ages and functional status) made it even more difficult for them to respond adaptively to changing circumstances; to respond to shifts in trust and mistrust; and to maintain or identify new forms of meaningful engagement. In many cases, mistrust had no upside.

Putting trust and engagement in place

The challenge of spatial mismatches between our participants and their neighborhoods was similarly important. That they preferred to remain in their current homes and neighborhoods did not mean that they had freely chosen those sites. Freed of the realities of past and present, many of them might have chosen to age in *other* places, places in which they were socially closer to those living physically nearer. Systemic as well as personal constraints not only shaped the choices they made, but also limited the possible options they could envisage. When Carol imagined a new neighborhood to which she might move, for instance, it featured a potentially dangerous (because unknown) but otherwise identical set of dangers. This was a given of the sort of neighborhood in which she could imagine herself – quite different from the middle-class, integrated neighborhood she wistfully recalled. Joyce was similarly nostalgic for the middle-class Black neighborhood from which she was half a city and six decades removed – but she had grown accustomed to the West Baltimore neighborhood that she never considered truly home.

At the same time, spatial mismatch does not necessarily entail social disengagement, either within the neighborhood or beyond it. As Joyce illustrates, even our most mistrustful participants did not passively accept their changing neighborhood conditions as “circumstances that cannot be changed” (Ziegler & Schwanen, 2011, p. 764). They responded with reflexive shifts of their trust and social engagement. When confronting neighborhood decline, most of our participants, like Joyce, consolidated their social engagement in other places. Yet they still found sources of meaningful engagement within their neighborhoods, particularly through service and volunteerism. Carol’s engagement within her neighborhood was thus exceptional not for its existence, but rather for its intensity. Furthermore, Carol’s case instantiates how spatial mismatch, like mistrust, could lead to meaningful relations of trust and engagement. Her leadership in her neighborhood association, while a clear example of what Lager and colleagues (2015) term a “sense of belonging to neighborhood life,” originally emerged from an apparent spatial mismatch, produced by the intersection of her declining health and her neighborhood’s built environment.

Context, composition, and complicated causality

Our study also corroborates and extends Lager *et al.*'s (2015) conclusions regarding the anisotropy of neighborhoods. Social epidemiological studies have most often framed context and composition as fixed entities (*e.g.*, low-income people living in low-income neighborhoods; see Cummins *et al.*, 2007, particularly Figure 1, p. 1827). Subramanian, Kim, & Kawachi (2002), for instance, found that a mistrustful resident in a trusting neighborhood might experience negative health effects *due* to that disjunction. Similarly, Bjornstrom (2011) found that neighborhood income inequalities create gradients of trust: higher-income residents mistrust their low-income neighbors, who nevertheless trust them. Our findings complicate the conclusions of such studies. It is one thing to note that, on average, a given level of personal trust and/or social engagement within a given neighborhood at a given time results in corresponding levels of self-reported health. It is another to consider the collective interactions that lead to such correlations, and how different people relate to changes in their neighborhood context and composition over time. For our participants, as for those in Lager and colleagues' study, places in the neighborhood "[bore] different meanings for [different] respondents in terms of the benefits derived from the social contacts in th[o]se places" (p. 95). Neighborhood context and composition were thus intertwined, and their relations varied over time. This suggests more complex causal mechanisms, extended over time and space – in which older adults' trust and social engagement must be understood as the result of interdependent personal and environmental processes.

Conclusion: Aging, engaging, and moving beyond the neighborhood

In short, when we hear, "There goes the neighborhood," we must subsequently ask, "Where?" Researchers are increasingly fighting out of the local trap (Cummins, 2007) as they address aging in place – moving beyond the neighborhood to investigate the full range of older adults' life spaces (Cagney *et al.*, 2013; Matthews & Yang, 2013). This study should both encourage and inform such approaches. It emphasizes the ways in which social engagement among older adults transcends their residential neighborhoods. It underscores the problems of viewing neighborhoods and their residents as entities fixed in time, space, and attribute. Our analysis strongly suggests that for populations and places of great interest to public health, such an approach will miss key aspects of the health-influencing nature of sociality: namely, those that involve interrelated processes of people and neighborhoods; people's responses to those processes; and the opportunities and pitfalls those responses generate. We argue that it is not sufficient to determine which engagements are (most) meaningful to people aging in place; we must also question whether and when meaning is time- and place-bound, irreplaceable, and correlated with trust in straightforward ways.

For public health professionals, evidence of mistrust and social disengagement often provokes a desire to intervene – to "prescribe" trust and engagement for people who seem to lack them, and particularly for those living in neighborhoods that might appear (to researchers, and even some residents) "undesirable". This notion of undesirability flows from a certain imagination of the successful urban life course, in which trust and social engagement are always both desirable and, given appropriate intervention, possible. The

problem with this imaginary is not just that trust and engagement might be “ungovernable” (Mendes de Leon, 2005, p. 66). In addition, as our data show, mistrust and disengagement can be justifiable and productive adaptive responses to socially challenging experiences and environments.

Researchers’ concerns about people being “left behind” in disadvantaged homes and neighborhoods are nevertheless valid. That mistrust and disengagement are potentially healthy in some situations does not mean such responses will be productive in all cases. If, as Phillipson (2007) observes, “the key change over the past 50 years may lie precisely in the social division that has opened up between two groups: those that have expanding lifestyle options, and those whose experiences of their neighbourhood are dominated by marginalisation and alienation” (p. 337), we argue that, rather than aiming to override those experiences, researchers should build on them. This necessitates analysis of the longitudinal processes that have led to the current situations of neighborhoods and their residents, and social programs and policies that, accordingly, focus on shifting the fundamental dynamics responsible for adaptive responses such as mistrust, rather than on “fixing” the responses themselves. It requires moving beyond the individual to consider neighborhoods as fluid sites of intervention, and also understanding how different neighborhoods – and their residents – connect across both space and time.

This study represents only one step toward a more robust theoretical framework that would support such work. It has clear limitations. It is unclear how applicable our conclusions might be outside of Baltimore or similar locales. Our data include extensive direct observations of our participants’ houses and immediate neighborhood environments, but we have only limited observations of participants’ interactions with their neighbors, and none outside of their residential neighborhoods. All but one of our participants were women, but our data were not amenable to a comprehensive gender analysis. This paper does not address the ramifications of the second demographic transition (Dannefer and Shura, 2009), or the challenges of the “fourth age” (Gilleard and Higgs, 2010). Finally, the concept of aging in place is itself not fixed or universal; it will continue to change over time. Future studies would thus benefit from integrating the changing meanings and experiences of trust, social engagement, and health both within and across successive cohorts.

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Table 1

Selected characteristics of CAPABLE participants^a

Name	Age	Race	Childhood Home	Current Home (Baltimore)	Time in Baltimore	Employment ^d	Religion	Functional Score ^b
Ann	71	Black	East Baltimore	McElerry (East)	Since childhood	Clerical, Cleaning	Christian	2
Bernice	66	Black	Houston, TX East	Mount Vernon (Central)	16 years	Clerical Retail,	Christian/A ME	3
Carol	75	Black	Baltimore East	Park Heights (Northwest)	Lifelong	Clerical	Christian	3
Denise	79	Black	Baltimore East	Frankford (Northwest)	Lifelong	Various	Christian	5
Eunice	87	Black	Baltimore East	Mount Vernon (Central)	Lifelong	Nursing	Christian/Baptist	3
Frances	72	Black	Baltimore West	Howard Park (Northwest)	Lifelong	Various	Jehovah's Witness	8
Georgine	85	Black	Baltimore	Edmonson (West)	Lifelong	Retail, Service	Christian	4
Helen	79	Black	New York City	Park Heights (Northwest)	29 years	None	Christian	5
Jeremiah	73	White	Los Angeles East	Park Heights (Northwest)	15 years	Retail, Clerical	Jewish	8
Joyce	76	Black	Baltimore West	Winchester (West)	Lifelong	Nursing	Christian/Baptist	4
Linda	67	White	Baltimore	Brooklyn Park (South)	Lifelong	None	Privately religious	2
Margaret	66	Black	West Baltimore	East Arlington (Northwest)	Lifelong	Retail, Clerical	Christian	5
Nadine	78	Black	Houston, TX	Mount Vernon (Central)	59 years	Clerical	Christian/A ME	5
Paula	82	Black	East Baltimore	Park Heights (Northwest)	Lifelong	Clerical	Christian	5

^aNone of the participants were still employed. Only Paula was still married; the rest were divorced or widowed and lived alone, with the exception of Frances, who lived with her son. Bernice and Nadine were the only participants living in apartments. All participants reported that their friends and family were scattered across the city and/or country.

^bHigher scores indicate higher levels of functional limitations. Scores were calculated by adding the numbers of Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) that participants reported they were unable to perform.