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NATURAL DISASTERS THAT REVEAL CRACKS IN OUR SOCIAL FOUNDATION

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The recent deaths of more than 13,000 French elderly in the European heat wave of 2003 revealed cracks in the social foundation of urban communities, here and abroad. The breakdown occurred in community services, neighborhood networks, and governmental agencies that were responsible for warning of impending dangers to at-risk elderly. This paper provides a profile of the at-risk elderly, the means to reach them, and a plan to match needs to resources.

Shamed by the deaths of more than 13,000 people in the August 2003 heat wave, France is trying to answer why so many elderly people succumbed in this disaster, some alone in sweltering city apartments, others in overwhelmed hospitals. This natural disaster followed the recent publication of Eric Klinenberg's book, *Heat Wave*, a sobering social autoposy of the Chicago heat wave of 1995 that claimed the lives of over 700, mostly elderly Chicago residents. Both the Chicago and French disasters made visible a series of social/community conditions that are always present for which the social organization of the cities were responsible, not nature. Evolution of urban society has made it possible for so many elderly to die in the heat wave as well as the circumstances that make their deaths so easy to dismiss and forget. Both heat waves hastened the demise of vulnerable and "hidden" elderly who were likely to survive had the crises not occurred.

> When . . . people die slowly, alone and at home unprotected by friends and family and unassisted by the state, it is a sign of social breakdown in

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> which communities, neighborhoods, networks, governmental agencies, and the media charged with signaling warnings, are all implicated (Klinenberg, 2003, p. 32.).

To meet human needs, essential resources and opportunities must be available. Unmet and undermet needs constitute the incongruities of social institutions and systems to adequately match needs to resources. The aim of social work, according to Rosenfeld is "to match resources with needs to increase the 'goodness of fit' between them " (Rosenfeld, 1983). Federal, state, and local governments and agencies are struggling to confront the needs of an expanded pool of elderly. Resources, however, even when they are available, are often underused by elderly clients.

WHO ARE THE VULNERABLE ELDERLY?

Klinenberg has made a distinction between living alone (residing without other people in a household), being isolated (having limited social contacts), and being reclusive (choosing to remain confined to one's home) (Klinenberg, 2003). Being isolated and reclusive have more negative consequences than living alone. However, regardless of the degree of removal from sources of support, elderly in any of these categories are at risk and often remain hidden from the formal social service/health care networks.

Historically, adult children, primarily daughters and daughters-in-law, have provided the vast majority of care services for the aged. Women's changing roles and lifestyles, specifically their rapidly increasing rate of entry into the labor force have made them less available as providers of certain concrete care services. Older people have not been abandoned by their children and other kin in the United States. However, as U.S. society has become more mobile, the trend toward greater residential separation between generations suggests that future cohorts of the elderly may have increasing proportions of distant children and other kin (Tittito, Nathanson, & Langer, 1996).

Focus on the family should not obscure the fact that there are significant numbers of older people who never chose to have children or currently have no surviving children. Of all seniors living alone, those who never had children or who have grown estranged from their families are more likely to be socially isolated. People who have mental illnesses and substance abuse problems, especially those who fail to get proper care, are also more likely to be living alone and in poverty. When there is no guardian or hired caregiver, sometimes a network of friends and neighbors substitute for family in the lives of the elderly

who have become "elder orphans;" at other times it may be the "village" that watches out for the elderly survivors. More often than not, this group of elderly are a largely ignored population whose numbers are expected to burgeon as Americans live longer and have smaller families. These people become vulnerable, at-risk elderly (Tittito, Nathanson, & Langer, 1996).

Finally, persons of color are significantly less likely to use community services than are their white counterparts (Langer, 1995). Each group of minority elderly has had a history of hostile treatment in American society. Their cohort has been raised in an era when discrimination and segregation were often upheld by law and resources, status, and opportunities were determined exclusively by race and/or ethnicity. Despite increased awareness of the need for a multicultural approach to health and social welfare services delivery, minority elderly often continue to be treated by care providers and institutions who often disregard or are insensitive to the client's cultural norms and their impact on service consumption. Minority older adults do not receive a share of social welfare benefits in proportion to their number and needs. Studies have identified illiteracy, language problems, and economic and cultural roadblocks that hinder minority groups' access to services. Cultural barriers represent another reason for underutilization of social services. The lack of familiarity with services, fear of coercion or sanctions when accessing services, and injury to personal pride at having to request services are important reasons for low utilization rates among minority older adults (Langer, 1995).

Old age may be detracting, yet older people are often happy with themselves and their circumstances. Older individuals may not feel that their age is a prominent trait, even though most human service professionals think it is a highly relevant factor. Most older people will inevitably suffer multiple losses. Some will need to learn the roles and responsibilities of becoming widows or widowers. Other losses might include loss of mobility or independence. Older adults who develop health problems will necessarily have to adjust from an unrestricted lifestyle to one with greater confinements. As individuals experience a diminution in control and an inability to solve their problems independently, fear—such as fear of the onset of additional health problems, of living alone, or of becoming a crime victim—can become a major concern. How each person copes with these life changes will often depend on individual differences as well as the "modus operandi" that has been the vehicle for overcoming crises in the past. Regardless of the often sudden and multiple losses in old age, many older adults adjust and compensate, in an as yet undefined process, and maintain high levels of self-esteem (Coleman, Ivani-Chalian, & Robinson, 1998).

How the elderly who often encounter unforeseen physical, emotional, social, and spiritual assaults to their person cope with multiple losses has been one of the cornerstones of aging research that has yet to be fully understood.

Whereas some older adults find ways to adapt to the vicissitudes of getting old, many, for whatever reason, are unable to compensate for inevitable losses, and these elderly become the vulnerable or hidden elderly. Economic status is a powerful determinant of an elderly person's ability to cope; intelligence and education also play a considerable role, as does an individual's degree of physical and mental health. To a highly dependent individual who has never had to make important life decisions, losses may seem insurmountable and some may lose their hope that conditions will improve. A person accustomed to taking charge in times of difficulty or crisis may have the resilience, that is, the ability to maintain competent despite adversity, and be able to cope with problems far more easily (Wacker, Roberto, & Piper, 2002).

BARRIERS TO SERVICE USE BY THE VULNERABLE ELDERLY

Uncomfortable Accessing the System

In the field of aging we may successfully argue the need for increased social and health services. Yet the greater problem may be our inability to deliver what we do have to those who need the services most. Many elderly become vulnerable when they are unaware of available services, cannot utilize them when they are available, or refuse to access services.

The decision about whether to seek help involves weighing the psychological costs of asking for assistance against the benefits that might occur. The at-risk elderly do not usually self-refer. If they receive help, it is typically because someone else obtained it for them. For many of them, no effective family support system exists. When help is needed, this group has no one to turn to outside the formal support system. If connection with the formal support system is not achieved by or for these individuals, they remain hidden and will not receive help at all, often with disastrous results.

Researchers have identified a number of factors related to formal service use, but studies often report conflicting results regarding which factors predict service use. As age increases, so does service use; older women are more likely to use services than are older men; those with access to transportation are more likely to use services; older adults who are married are less likely to use services than are older

adults who live alone (Wacker, Roberto, & Piper, 2002). Although there are multiple system problems, a significant factor in the at-risk population's failure to access the formal system lies in psychosocial barriers to service use. Individuals who may be experiencing physical, emotional, or economic losses may minimize or deny their problems and the severity of their impact because the distress of having to acknowledge their need, and their inability to resolve their problems represents an admission of failure too difficult to confront. A person's image of self-reliance may be compromised when he or she experiences a decline in physical health and is unable to continue some activities. Furthermore, American culture places a high premium on independence and self-reliance, and, as a result, people feel uncomfortable when they need to ask for assistance. For the current cohort of older adults who survived such hardships as the Depression, this admission might be difficult. Maintaining independence is one of the most frequently recurring life themes. Many older people worry that they will lose their independence and their value in society through reliance on a fixed income or through a loss of ability to maintain their own home. Feelings of fear, suspicion, shame, and depression lead, almost inevitably, to further isolation and resistance to outside intervention, especially by an agency (Jette & Winnett, 1987).

Unable to Contact Services

Many vulnerable elderly, having made the decision to access formal services are unable to contact them. The inability to contact needed services stems from insufficient insight, motivation, and resources to contact and access service agencies. Minority group members may be unable to speak the language of the service provider and contact persons of the relevant agency. The notion of seeking help from the formal social services establishment may seem frightening or intimidating, or as outside their common frame of reference. To foreign-born minority elderly, accustomed to a culturally different support system, just the search for aid may seem forbidding. Perhaps the individual was accustomed to seeking medical assistance from the village herbalist. The village herbalist was your friend; you saw him or her every day; he or she didn′t wear a white coat and ask questions in unfamiliar words. It was easy to tell him or her your problems, because he or she knew you and was a member of your community. Contrast this with the atmosphere so often encountered in a big-city clinic. First of all, just finding one's way to the proper section of the building, let alone the correct room, may be a major obstacle, especially if one does not speak English well. Then, once in the presence of the service provider,

there is the struggle to explain the problem. The service provider often does not speak the language of the client, and the use of an interpreter may create additional problems related to gender, cohort, interpretation of emotional components, as well as an inability to speak the correct dialect or speak the language without having any cultural experience.

Other barriers in obtaining services exist. Getting to appointments and getting there on time are issues that are at times interpreted on a cultural basis. Bus service may not be available or, for the disabled, bus service may be difficult to utilize. Often individuals must rely on neighbors or relatives for transportation. This creates multiple other difficulties. The person providing the transportation may have to take time off from work. The elderly person may feel embarrassed or uncomfortable at inconveniencing that person; he or she may be embarrassed to the point of actually missing needed medical care. The "stakes" simply become too high, and not worth risking the goodwill of his or her current social network. Very often taking a taxi is simply beyond the means of the elderly poor—a fact that the care provider may or may not recognize because the elderly person may feel embarrassment at mentioning this fact.

Unaware of Available Services

Vulnerable elderly may not know what services are available. Among American-born minority elderly, this may be because certain minority groups were historically excluded from the provision of services in an earlier time, and so they are unaware of what services might be in place to help them today. Among the foreign born, services may either not have been available or may have existed in a different form in their native countries. To a vulnerable, isolated elderly individual, little sharing of information is available. Word of mouth from peers who have successfully interacted with a service provider is often the most trusted and most acceptable means of communicating information about benefits available to needy older clients, yet the relative isolation of the vulnerable older person often blocks the transmission of this information.

Services are Non-existent or Inadequate

Vulnerable older persons remain without access to needed assistance when there is paucity of funding or indifference to the plight of this group. Many urban and rural communities are unable to provide

Meals on Wheels programs, accessible and dependable transportation, or visiting nurse services. Regardless of the reasons why, vulnerable older persons remain without access to needed assistance.

It has been estimated that there are between one and four million Americans over 65 years of age who are gay, lesbian, or bisexual (GLB) in the United States (National Gay and Lesbian Task Force [NGLTF], 2003). The number of GLB older adults is expected to rise as the population ages. Despite this demographic fact, modest interest, expenditure, and planning have been focused on the social problems faced by gay and lesbian adults (Tirrito, 2003). GLB older adults face many barriers to accessing services—particularly during periods of care giving and post-care giving when many GLB partners are ignored or excluded (NGLTF, 2003). Such exclusion often leaves GLB older adults isolated in later life as most GLB older adults live alone.

Professional Providers' Avoidance of Vulnerable Elderly

Harel et al. (1990) have suggested that formal social service providers may in fact be hiding from the at-risk elderly just as the elderly are avoiding engaging them. Care providers may eventually experience the losses incurred by these potential clients and avoid confronting a frail client particularly in a time of crisis. The vulnerable elderly may remind them of their own mortality and they may not be able or willing to overcome their fears, real or imagined, to create a suitable service plan in light of so much client loss.

MATCHING RESOURCES TO NEEDS

Before relief and possible resolution of problems, strategies for locating and identifying the vulnerable elderly need to be a priority. Isolates and recluses are by definition difficult to locate and contact because they have few ties to informal or formal services. Because of reluctance on the part of many at-risk elderly to seek resolution of their problems, the person or persons entrusted with locating the vulnerable elderly must first gain their trust. Violence in urban areas has bred fear and isolation. The vulnerable elderly often refuse to open their doors or respond to most professional personnel who have tried to track them down. For many it is a survival strategy for living alone in the city where preying on the elderly is a standard and recurrent practice of neighborhood hoodlums who besiege them when Social Security checks are delivered or outsiders, that is, visitors, who seek to separate them from their scarce dollars. The result is enhanced suspicion and reluctance on the part of the elderly to respond to

unannounced and unknown visitors to their homes. The fear from an aggressive act stems from an awareness of their frailty and a concern that they will not be able to defend themselves and that an assault will further disable them (Klinenberg, 2003).

However, in order to assist clients through outreach, professionals may need to meet individuals on their own turf where their problems generally arise and where the solutions to their problems must be found; professionals must have the flexibility to meet with clients in very unconventional places, if necessary, such as low-rent hotels, welfare offices, public shelters, police lockups, street corners, and neighborhood coffee shops and grocery stores.

Neighborhood Gatekeepers

Neighborhoods provide a multiplicity of social functions that range from friendship and socialization to mutual aid and informal helping. Neighborhood-based ties provide a familiar environment, even if unsafe, that contain cues that give the individual a sense of security and continuity. To at-risk elderly, bombarded by undesirable losses and unasked-for changes, the psychological identification with the sameness and repetition that the neighborhood provides is a source of comfort.

A major source for securing formal social services to at-risk elderly in the neighborhood is through natural community gatekeepers. Gatekeepers, such as mail carriers, newspaper carriers, and meter readers have interactions with elderly persons and are nontraditional referral sources trained to identify and locate high risk elderly. Gatekeepers are trained to be on the lookout for indicators of potential problems such as a broken window or piled newspapers. They alert the appropriate agency, which then investigates the situation or notifies designated family members.

Peer Services

Peer services for older persons have enjoyed great popularity and apparent success as exemplified in the national Retired Senior Volunteer Program. Peer service providers get the opportunity to replace roles lost due to retirement and the death of friends. For the recipient of these services, it is often less demeaning to receive service from one's peers than from members of the younger generation. Both the care provider and care recipient have a common knowledge and experience of the changes that accompany old age. The interaction can be less judgmental and richer in the provision of mutual trust and

empathy. In the past several years there has been a growth in the use of paraprofessionals providing psychological and psychosocial interventions with older adults. One type of paraprofessional program is peer counseling for older adults. These programs train and supervise older adults to provide counseling and support to other older individuals. Peer counselors receive supervision from a professional counselor employed by the agency sponsoring the program. The benefits of peer counseling programs for older adults include: older people talk more readily to older people than to professional therapists; peer counselors serve as positive models for their clients; peer counseling enriches the lives of both the client and the counselor; peer counseling may be more effective than professionals because they are often more aware of the problems of older people (Wacker, Roberto, & Piper, 2002).

Group Services

Group services represent another referral source for community practitioners. Within healthy groups, trust, altruism, and synergy are fostered. Among the many benefits provided by groups, the promotion of social connectedness is tantamount when one wants to address the needs of at risk elderly. Groups help people know that others care; they may provide a way for some people to survive and adapt in the midst of adversity. Groups foster community and self-esteem. Another major aspect of groups is altruism. Altruism is offering help to others unselfishly and without expecting help in return. The pleasant irony is that group members who give of themselves in this way also experience change; they begin to see themselves as helpers who are productive. The focus of their energy changes in the process from seeing themselves in need of help to being help providers (Gladding, 1995).

Groups also can serve as information resources and translators concerning available services. For persons experiencing difficulty accessing formal services, whether because of ethnic or cultural differences or because of individual reluctance to seek or accept help, shared experiences within the group can provide needed information, clear up misunderstandings, and bolster the confidence of reluctant individuals so that they are able to apply for and accept needed assistance. Group support can transmit the important message: "This is what you need, this is how you get it, and it is OK to take it," thus connecting the vulnerable elderly to the formal support system and providing the valuable psychological support they need to accept needed support and retain their self-esteem.

Narrative-Based Social Service

An innovative means to comprehend the social service/health care needs of at-risk elderly is through storytelling. Communicating by storytelling is fundamental to the human experience and is a powerful medium for communicating, learning, and problem solving in health and social care, whatever the language or culture. The story as a linguistic form has specific characteristics such as: requiring both a narrator and a listener whose different viewpoints are brought to bear on how it is told; focusing on characters—what they do, and what happens to them; including an emotional dimension, that is, how the characters *feel* about what is happening; inviting an interpretation, and, if told in groups, promoting the dialogue of competing interpretations.

There is a growing academic literature that gives a theoretical basis for the narrative as a more sophisticated tool for recording and analyzing an illness than the conventional clinical interview (Mattingly, 1998). Research has shown how the narrative is suited to revealing worlds that are otherwise closed to professional practitioners—such as the worlds of the profoundly physically and mentally ill, the displaced, or socially excluded (Greenhalgh, 1998). It is conceivable that the narrative will enable professionals and their agencies in health and social services not merely to compare experiences but to convert stories into action and construct the new service. There is paucity of information in the literature on how best to use storytelling as a means for gaining a holistic understanding of patient/client predicaments (physical, psychological, social, economic, etc.) of loss and illness and its impact on the individual and the community. However, there is reason to take note that although stories are simple human forms of expression and communication, they have the potential to be powerful tools for achieving understanding, building a shared perspective on a problem, and catalyzing change.

Community Empowerment to Enhance Change

Human services have not always been a transforming force in our society. If we can continue to speak of a vulnerable elderly population who was at major risk prior to the Chicago and French tragedies and continue to be so, then the safety net is full of holes. Empowerment is defined as the restoration and creation of hope in an individual or a community. Prevention has been primarily reactive, that is, trying to enhance coping abilities to deal with problems once they occur instead of focusing on proactive strategies, that is, preventing specific

problems before they occur. There is a need to invest in prevention as a means of empowerment. In the mid 1960s, when human services were first emerging in response to the failure of the established system, prevention was considered person-, family-, and society-centered. The society-centered prevention approach called for social action to provide education, community organization, development, and mobilization. Now, more than 40 years later, we are recognizing the importance of community empowerment for prevention. A prevention focus will revitalize the human services and make it almost impossible to dismiss and forget vulnerable populations. Working in the community, "we learn that survival does not belong to the 'fittest.' Survival is about learning how to fit into our community and how the community fits us" (Fox, 1991, p. 50).

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