SOCIAL VULNERABILITIES AND AGEING

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Abstract. Social vulnerabilities are often linked to the ageing process and to persons or cohorts over a certain age. The social dimension of vulnerability reflects the exogenous or extrinsic factor and mechanism of vulnerabilities. Among these, the most cited factors having the potential to influence older adults' life are: socioeconomic status (SES), deprivation, social support, social isolation or exclusion, social networks, social engagement, mastery and sense of control over life circumstances, social capital, and social cohesion. Article brings up these issues focusing on the danger of stereotyping on ageing. Features of social vulnerability are highlighted in specific contexts, including that of migration. We are concluding on aging as an individual process, underpinned by different lifestyles, various personal and social problems of older persons, their expectations and the solutions proposed. A stereotype on the homogeneity of the ageing process and the association of a certain age with frailty and risks are factors that sustain social vulnerability on this context.

***Keywords**: social vulnerability, labelying, older people, social networks, stereotype, migration.*

Résumé. Les vulnérabilités sociales sont souvent liées au processus du vieillissement des personnes ou des cohortes d'un certain âge. La dimension sociale de la vulnérabilité reflète les facteurs et le mécanismes de vulnérabilités exogènes ou extrinsèques. Parmi ceux-ci, les facteurs les plus cités ayant le potentiel d'influencer la vie de personnes âgées sont: le statut socioéconomique (SSE), la deprivation, le soutien social, l'isolement ou l'exclusion sociale, les réseaux sociaux, l'engagement social, la maîtrise et le sens de contrôle sur les circonstances de la vie, capital social, et la cohésion sociale. L'article soulève ces questions portant sur le danger des stéréotypes concernant vieillissement. Un stéréotype est celui sur

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l'homogénéité du processus de vieillissement et de l'association d'un certain âge à la fragilité et aux risques.Les caractéristiques de la vulnérabilité sociale sont mis en évidence dans de contextes spécifiques, y compris celui de la migration. Nous terminons sur le vieillissement comme processus individuel, soutenu par différents modes de vie, divers problèmes personnels et sociaux des personnes âgées, de leurs attentes et les solutions proposées.
Mots-clés: *la vulnérabilité sociale, l'étiquetage, les personnes âgées, les réseaux sociaux, les stéréotypes, la migration*

Rezumat. Vulnerabilitatea socială este adesea legată de procesul de îmbatranire a persoanelor sau cohortelor de peste o anumită vârstă. Dimensiunea socială a vulnerabilității reflectă factori şi mecanisme ale vulnerabilității exogene sau extrinseci. Dintre aceştia, factorii care au potential major de a influenta viata adultilor mai în vârstă sunt: statusul socio-economic (SES), deprivarea, suportul social, izolarea sau excluderea socială, reţelele sociale, implicarea socială, sentimentul de control asupra circumstanţelor de viaţă, implicarea socială, reţelele şi coeziunea socială. Articolul aduce în prim plan aceste probleme concentrându-se pe pericolul stereotipizărilor. Caracteristici ale vulnerabilităţii sociale sunt evidenţiate în contexte specifice, inclusiv cel al migraţiei. Concluzionăm privind îmbătrânirea ca un proces individual, susţinut de stiluri de viaţă diferite, de diverse probleme personale şi sociale ale persoanelor în etate, de aşteptările lor, de soluţiile existente şi propuse. Pretinderea omogenităţii procesului de imbatranire şi asocierea unei vârste cronologice – în situaţia de faţă vârsta înaintată - cu fragilitatea, neputinţa, riscul, constituie factori care susţin vulnerabilitatea socială.
Cuvinte cheie: *vulnerabilitate socială, etichetare, persoane în vârstă, reţele sociale, stereotipuri, migraţie.*

Vulnerability has been studied as a significant endogenous and also exogenous factor for the ageing process. The social dimension reflects the exogenous or extrinsic factor and mechanism of vulnerabilities. Among these, the most cited factors having the potential to influence older adults' life are: socioeconomic status (SES), deprivation, social support, social isolation or exclusion, social networks, social engagement, mastery and sense of control over life circumstances, social capital, and social cohesion.

Aging is an individual process, underpinned by different lifestyles, various personal and social problems of older persons, their expectations and the solutions proposed (Gîrleanu-Şoitu 2006, 37). Aging is a period of existence during which losses and decline in physiological, psychological, economic also social areas are the worst, these losses are not always due to biological evolution,

but also simultaneously involving social, economic and cultural factors (Bogdan 1997, 21). The heterogeneity of old people has led to subdivisions such as: young-old (60-75 years) and old-old (over 75 years of age). The germ of scientific dispute lies in the lack of homogeneity of the aging process. If we are looking at the fundamental type of activities and at the relationships of people over 65, we can find the following under the heading "age regression": a sub-period of transition to old age: 65-75; medium old age: 75-85; and longevity: over 85 (Papalia, Wendkos Olds, Duskin Feldman, 2010; Verza and Verza 2000; Santrock 1997; WHO 1963). Comprising the longest stage of the existence of the individual, the category of "late adult" will still be subject to other sub-classifications. For men, the periods of development outlined by Daniel Levinson (1978) include, at the end: late adult transition for the ages of 60-65, and late adult status for the period beyond 65.

Starting from the ability to perform daily activities, one's individual autonomy or dependence will determine one's social status: independent people who successfully carry out daily activities without any difficulty; fragile people, who are impaired in one activity or more; the disabled, who are unable to carry our many necessary instrumental activities. Thus we have those of the third age, usually autonomous and spending their third youth on holydays and volunteering activities, and those of the fourth or the fifth ages, losing part of their autonomy and being in need of social and health care. A classification according to functional status varies by age distribution. The group of persons with disabilities include many of those over the age of 80, but also a subset in the interval 60-79. Also, some people over 80 are independent, while others are frail or disabled (Caradec 2001; Guilmard 1991). These considerations demonstrate the difficulty of defining ages - third, fourth and possibly fifth - and the ageing process using only chronological criteria.

Sociological literature on aging oscillates between a deeply pessimistic version, which highlights the sad fate of the elderly, and an optimistic version (Guillemard et.all. 1991). The status of "late adulthood", as some authors call it in sociology, is considered one of the most challenging periods of life, marked by dramatic changes: retirement, death of husband / wife, increased helplessness, possible move to a nursing home, preparing for death, all of these requiring of the individual to change and adapt. An essential element for some of the ageing discourses in modern times is their fundamentally negative image. Today, the elders constitute a social problem. Their withdrawal from active life causes a hostile attitude in society on the one hand, and, on the other hand, in the elderly themselves, feelings of worthlessness and marginalization.

The dependence of the elderly is due to lack of resources (Gîrleanu-Şoitu, 2006), but also to diseases that disrupt health (i.e. cardiovascular diseases and cerebral-vascular disease (Lupu, Rădoi and Cojocaru 2015), degenerative diseases, as well as other imbalances: diabetes, asthma, arthritis, lung problems, reduced

mobility, incontinence, impaired sight; the above explain the statements according to which five out of seven people with these conditions have difficulty getting around. They will thus be in a vulnerable state, dependent on their family, their caregivers or the community. The quality of these relationships will create trustful frameworks or frameworks marked by social vulnerability, especially when general care for geriatric conditions is undeveloped (Steel et.all., 2014).

Social vulnerability has been operationalised according to the approach of deficits of accumulation; it has been compared with frailty, and placed in relation to mortality. A social vulnerability index has been created by geriatrics and gerontologists as a holistic measure. It includes 40 items related to social conditions like: marital status, living situations, social relationship and social support, social capital, social engagement, feelings of mastery and empowerment, socio-economic status. As a parallel to this social vulnerability index, another one has been developed by the same authors, the frailty index, comprising 31 items on health deficits – symptoms, signs, diseases, disabilities or laboratory abnormalities. (Andrew, Mitnitski, Kirkland and Rockwood 2012).

Social vulnerability may refer to the degree of susceptibility to financial or material exploitation of older people and also to degree of risk to be abused and neglected (Fulmer et. all., 2005). A clinical assessment framework of social vulnerability for older persons has started from the central aspects of social vulnerability underlined by Greenspan, Loughlin and Black (2001) and outlines a tendency toward credulity and gullibility. At the same time, personal competence factors may interact with environmental circumstances, influencing the vulnerability of outcomes. Personal competence factors are covered by four domains: everyday intelligence, communication, physical competence, and motivation/personality. Other studies developed by Australian gerontologists highlight the personal competence factors – such as cognitive and social intelligence and functioning, social skill, personality traits and physical functioning, lessons from personal experiences, decision making process – that can be helpful in this matter (Pinsker, McFarland and Pachana 2010).

Social vulnerabilities are often linked to the ageing process and to persons or cohorts over a certain age (Steptoe et. all. 2013). From the origin is a significant geriatric literature highlighting a degenerative perspective that comes with ageing: the loss of mitochondrial numbers and, as a consequence, of the cells' renewal capacities, the decrease in muscle mass, the deterioration of cognitive capacities, and many others, resulting in general frailty. One of the main reasons is the result highlighted by many studies in which the relation between high social vulnerability and mortality is underscored. Morbidity and its costs for the health care system, for the community, for the family and for the individuals also support this approach (Steel et.all., 2014). Another one reveals the social and economic costs of a growing older population. On the other hand, phrases such as "elderly", "old people", "seniors" encourage the consideration of

this population as a homogeneous one, while many studies underline the opposite. From this point of view, caution should be exercised in using research data, in avoiding the extension of partial conclusions to a general entity. The sentences using statements such as: "the seniors are...", "the elderly are..." or "the elderly do...", "the aging process is the same...", "older people are vulnerable" - do not make specific differences within the studied population. A stereotype on the homogeneity of the ageing process and the association of a certain age with vulnerability are factors that sustain social vulnerability (Gîrleanu-Şoitu, 2006; Şoitu, 2014).

A growing number of studies emphasize the idea of an aging population in industrialized countries, due to increased life expectancy, changing the balance between the young and the old generations, all on the basis of statistics. In the transition to a postmodern society, chronological age is no longer at the core of analysis. We can talk instead of "states". Thus, one can be in the state of "old person" several times in one's life: giving up paid work, rethinking the meaning of life, values, attitudes, behavior and personal characteristics when enjoying leisure activities, etc. From this point of view, if the fourth age is not chronological, but instead defined by a state, then it can be considered that some people do not experience this period at all. Dusana Findeisen (2002) considers that older people have, more frequently, a better health status, are increasingly better educated, have less need for help and want to be active. For this reason they should not be excluded from the social and economic contributions to society, itself in need of such involvement. Social position changes from one age to another, and finally old age becomes an issue of social construction (Gîrleanu-Şoitu, 2006).

Withdrawal from active life gives rise to a diversity of views. Some consider pensioners to be "victims of society", excluded from social life and thus led to dependency. Others describe pensioners as a category that is active, dynamic, and even claim that the elderly dependent preserve his/her autonomy. The care center is described as an institution that destroys self-identity, or rather, as a place where the elderly recreate their own universe, trying to adapt. Ageing is inevitably theorized through disengagement or through a process of engagement in new activities. The most often invoked theories in gerontology point to the changes that occur with retirement, changes in roles, activity, continuity and / or discontinuity, economic situation.

The influence of socio-economic factors (SES) on ageing has been emphasized for more than three decades. Socio-economic factors consist in education, occupational status and income (Sen 1999). The essence is: the higher their level is, the more socially integrated and the healthier the person is, and the less vulnerable. The issue is covered in global literature. Studies developed in the European space have concluded that factors such as occupational status diminish after retirement. Still, a consistent education and healthy behaviors developed

throughout life, supported by a dignifying income, can help the individual in the ageing process. Studies developed in the US found no significant influence of socio-economic factors on mortality for older people over 70. The impact of education, occupational status and income as main dimensions of socio-economic status is still debated. In fact, a contextual analyze of SES can delineate and bring helpful meaning in understanding social vulnerabilities in ageing (McCrory et. all. 2014).

A comprehensive approach, which focuses closely on social actors, trying to understand how they give meaning to their own lives, has taken precedence in sociology over functionalist and Marxist-inspired analyses, more concerned with describing the mechanisms of the social and the macro-place assigned by society to the elderly. Some views consider that health and an adequate income are the main factors supporting the balance of ageing and fostering happy living and relationships. Most important here are factors such as: type of personality, existential satisfaction and social integration.

An important issue is the relationship between communicative integration, the cultural and the integrative perspective. Interpersonal communication can be used to transmit the cultural norms of the group, maybe even associated behaviors of those rules. This process, however, is closely related to the social participation of the elderly. If the communication structures of a group or society stress the older people's inactivity and inability to interact with others, the latter are likely to acquire precisely this cultural perspective, while others see them as such. The effects of this cultural stereotype are manifest when older people are afraid to engage in more demanding environments, in unknown or in public social service activities. The concept of functional integration allows the analysis of the lowered status of the retired people (Gîrleanu-Şoitu 2006).

One of the models that highlight the dynamic interactions between the physical and psychological characteristics of individual aging and the physical and social environment is the so-called model of individual competence to environmental pressures. Environmental pressures increase when a person relocates to another home or to a care center. From a psychological point of view, as demands change, the individual must adapt to maintain wellbeing. The competence model has numerous implications in identifying interventions for improving the life of older people. Some of the skills necessary to adapt to environmental pressures include: good health, learning capacity, effective problem solving, skills and abilities, professionalism and the ability to control basic activities of daily life (dressing, self-care and cooking). The higher the level of competence of an individual, the better the environment pressure will be tolerated. An older person with multiple disabilities or chronic illness has a low level of physical competence and thus a limitation of the possibilities to cope with the demands of the environment. The physical environment of the life of elderly persons has social and psychological effects. Whether natural or built, the

environment influences the manifestations of old people, their social relations with others, their preference for a place where needs are fulfilled. Many changes often associated with age - physiological status, sensory functioning, skills and cognitive dysfunction, various diseases - are influenced by the living environment (Hooyman and Kiyak 1996).

Social vulnerabilities are related to social phenomena such as migration, cultural traditions from the countries of origin and social rules of host countries concerning intergenerational relationships and responsibilities (Zarowsky, Slim and Nguyen 2013). It is considered that many immigrant women engaged in filial care giving are at special risk for health problems due to complex contextual factors, but, at the same time, they mobilize personal and family resources to transform vulnerability into strength and well-being. Categories of membership in a group seem to be the common foundation of knowledge in social reality.

The social environment is also important. The incongruity between individual needs and specific environmental pressures can cause stress, which, in turn, requires the adaptation of the older person, and affects his/her wellbeing and self-satisfaction. For example, one senior who feels an intense need for privacy will feel uncomfortable in a care center that does not provide conditions for physical privacy and solitude, although greater loneliness is generally stressful. Adaptation can be achieved by changing the pressure from the environment or by the individual decision to withdraw from that environment, if circumstances permit. The authors of this theory argue that stress and discomfort increases when the individual response is without any modification for the desired environment - a situation often encountered among elderly people with cognitive and functional disabilities, less able to alter the environment or to leave the space that they feel is unsuitable for them (Gîrleanu-Şoitu 2014; Hooyman and Kiyak 1996; Gubrium 1973).

Factors identified as associated with successful aging pertain to the individual: autonomy, perseverance, commitment etc. When macro-level phenomena were also considered, structural links between the individual and society (social class and race were not considered structural variables of social areas) were not identified among them. One of the phrases closely related to the social inclusion of the elderly is the "norms of reciprocity", through which people help those who help,. Under such a rule, the elderly should pay in exchange for the support received with some form of help, but in the spirit of reciprocity. On the other hand, some of them are physically or financially unable to do so. Moreover, functional integration calls for adherence to the norms of reciprocity and thus for a closely related normative integration. Such analysis can provide frameworks for understanding the social exclusion of older people from the labor market and the sometimes relatively low involvement of their own family members (Hooyman and Kiyak 1996).

The labeling theory, deriving from symbolic interactionism, argues that people build self-perception through interactions with others, depending on what others say or do (Hooyman and Kiyak 1996). Theories of crisis and social reconstruction have evolved from the perspective of this theory of labeling. In other words, older people who accept negative labeling are led to precisely such a position: negative and dependent. If they believe that the society expects a certain dependent behavior from them, then their independence skills atrophy gradually, resulting in an inappropriate lifestyle. The social reconstruction theory suggests ways to intervene in this negative cycle, noting the importance of change in the lives of older people, even of those regarded as insignificant (Kuypers, Bengtson 1973).

According to the social exchange theory, a key factor in defining the status of the elderly is the balance of their contribution to society due to power control over resources and their support costs. Through the possession of material goods, skills, accomplishments and other desirable qualities as defined by society, individuals are able to exercise their power in interpersonal relationships. The status of older people compared to that of young people in our society is lower because of the difference in resources. Some public interventions on the maintenance costs of the elderly helps support their guilt for the rising cost of health care insurance or contributions (Şoitu, Rebeleanu 2012; Hooyman and Kyiak, 1996; Dowd 1980).

A negative, over-generalizing perspective loses sight of the fact that people of this chronological age are latent resources, underused and less involved in improving care and policies. Purposes such as improving quality of life at this stage of life involve structured social policies and a process of enabling multidimensional resources, including the human one. Combining top-down policies with bottom-up initiatives can stimulate and balance the protection system, can highlight new specific forms of intervention in the protection of and together with the elderly. The greatest interest of the elderly is to have that kind of care that allows them to maintain decision-making autonomy and their living environment.

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