

Researching social capital for young people's health

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Social capital has the potential to be a resource for societies, contributing to a range of beneficial economic, social and health outcomes. The concept of social capital has emerged as an idea which can help us further articulate the relationship between health and its broader determinants. In the context of young people's health and wellbeing, the more we invest in social capital as a health asset early on in life, the more young people can experience its positive effects within their families, from their friends, at school and in their local neighborhoods and communities. However, our ability to construct a robust and rigorous evidence base that helps to link and explain the sub domains of social capital to understand how it might be built require a more consistent and systematic approach to research. A range of issues concerning, theory, definition and measurement need to be considered during the planning of such research if the challenges of the concept's complexity are to be overcome. This paper rehearses 8 of the key issues that have arisen out of past social capital research in order to advance thinking about how it might be best utilized for promoting young people's health and wellbeing.

Introduction

In this article an eight point programme (Table I) is presented with key issues that have arisen out of past social capital research in order to advance thinking about how it might be best utilized for promoting young people's health and wellbeing. The aim is to highlight how future research might be planned and implemented to ensure that a future evidence base can be translated into a set of effective actions for youth development.

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resource for societies, contributing to a range of beneficial economic, social and health outcomes. The concept of social capital has emerged as an idea which can help us further articulate the relationship between health and its broader determinants. In the context of young people's health and wellbeing, Morgan (2010) highlights the possibility for social capital to be a 'health asset' - that is any factor (or resource), which enhances the ability of individuals, communities and populations to maintain and sustain health and well-

Table 1. Eight point programme on research social capital among young people

1	Definitions – be clear about the disciplinary perspective being taken
2	Theory – make explicit the hypothesised mechanisms for change
3	Measurement – make use of indicators with an established evidence base
4	Social capital as a multi-component concept – map and link the indicators used to make explicit the inter-relationships between them
5	Social capital - ensure the definitions and measurement of the concept take account of age, gender and culture
6	Use bonding, bridging and linking social capital to understand the relative importance of individual and collective notions of the concept
7	Research on social capital as it relates to young people needs to ensure they are included as active social agents
8	Asset based approaches to young people’s health and wellbeing can help overcome notions of the ‘downside’ to social capital

being (Morgan and Ziglio, 2007) - and argues that the more we invest in social capital and its related constructs early on in life, the more young people can experience its positive effects within their families, from their friends, at school and in their local neighbourhoods and communities.

Research studies aiming to examining the links between social capital and health have been accumulating since the early 1990’s. Whilst, the vast majority of these studies explored social capital’s importance to adult health (for example: Kawachi et al., 1996, 1997, 2001; Cooper et al., 1999; Lindstrom et al., 2001; Stafford et al., 2004; Mohan et al., 2005), youth studies started to appear in the latter half of this first decade (Lundberg 2005; Ferguson 2006; Boyce et al., 2008; Morgan and Haglund 2009; Elgar et al., 2011).

A review and critical synthesis published by Ferguson in 2006, summarised what had be learned about the relationship between social capital and

children’s wellbeing up to 2002. A wide range of social capital indicators were used in these studies broadly categorised as family or community social capital. More specifically, family indicators were broken down into family structure, quality of parent-child relations, adult interest and monitoring and extended family exchange and support. Community social capital indicators covered: the exchanges of social support between families; parents’ engagement within civic institutions and religious networks; and perceptions of school and neighbourhood quality (i.e. children and young people’s social capital as expressed by the parent’s views or actions).

Ferguson concluded that there was *‘considerable empirical evidence to indicate that family and community based interactions and relationships have a positive effect on children’s overall wellbeing’*.

However, existing social capital studies of both adults and young people remain fraught with a number of con-

ceptual, measurement and design issues. Kawachi (2010) highlighted that the heterogeneity in measurement approaches which is common across all studies makes higher level synthesis difficult. Lin (2001) criticised work on social capital from a design perspective. He argued that the tautological issues associated with social capital and its links to health could only be overcome through longitudinal studies which are more capable of determining the causal direction of the associations already established in the research literature.

Szreter and Woolcock's (2004) highlight that many of the conceptual and theoretical issues associated with social capital can be overcome if studies are more precisely framed within a clear theoretical perspective. They summarise the 3 perspectives as: social support (accrual of benefits through participation in social networks); inequalities (widening economic disparities eroding citizens' sense of social justice and inclusion; and political economy (poor health being determined exclusively from exclusion to material resources). Morgan (2010) adds a 4th perspective for thinking about young people's health and wellbeing. That is the health asset perspective. It suggests that the more we provide young people with opportunities to experience and accumulate the positive effects of a range of protective factors ('health assets') that outweigh negative risk factors, the more likely they are to achieve health and wellbeing during critical development periods and in later life.

In sum, varying definitions and measu-

rement in social capital research in its early phase have been helpful in generating an array of hypotheses that can be tested empirically. However, as Kawachi (2010) suggests the heterogeneity in approaches makes higher level synthesis difficult. More importantly a reluctance to embrace the complexity of the concept has inhibited the growth of research that attempts to provide more insights into how social capital might work to produce health. This paper argues that our ability to construct a robust and rigorous evidence base that helps to link and explain the sub domains of the concept requires a more systematic approach to research. Here we outline a 8 point plan that might help those interested in progressing social capital research as it relates to young people, onto its next developmental phase.

Definitions – be clear about the disciplinary perspective being taken

The varying disciplinary perspectives put forward by the 3 main perpetrators of social capital Pierre Bourdieu (1986), James Coleman (1988) and Robert Putnam (1995) have already been well rehearsed (see Ottebjer (2005) for example). Whilst each of these authors describes social capital through a different disciplinary lens, their common thread relates to the importance of positive social networks of different types, shapes and sizes in bringing about social, economic and health development between different groups, hierarchies and societies.

Morrow (2001) argued early on that Putnam's definition of social capital

had little utility for young people as *'by definition they are excluded from civic participation by their very nature as children'*. She suggested that Bourdieu's concept of sociability (the ability and disposition to sustain networks) might be more relevant as it recognizes that these networks are not just neighbourhood and geographically bound. However, Schaefer-McDaniel (2004) purports that all the main perspectives can contribute to new theories for younger age groups. For example, Bourdieu's more individualistic notion of social capital might be helpful in understanding how to build the competences to access and work successfully within social networks, as a precursor to their willingness and ability to contribute to the civic networks important to the values expressed in Putnam's more collective definition.

In research terms, therefore it is not helpful to place the different perspectives in opposition. However, making more explicit our intentions and goals for young people will facilitate why one might be more important than the other, for the purposes of the research question in mind.

Theory – make explicit the hypothesised mechanism for change

Baum (2010) raises the concern that considering social capital's utility alone without situating it in a broader set of social theories is meaningless. The assets approach is helpful here, as it promotes the use of a range of existing theories and ideas to identify those factors that are protective of health (Morgan et al, 2010; Eriksson

and Lindstrom, 2010). The premise being that young people with a good sense of well-being possess problem-solving skills, social competence and a sense of purpose, which can be utilised as health assets that can help them rebound from setbacks, thrive in the face of poor circumstances, avoid risk-taking behaviour and generally continue on to a productive life (Scales, 1999, Morgan et al, 2008).

A range of health assets have already been identified for youth health and development (Scales, 1999), stemming from 3 types of applied research - positive youth development, prevention and resiliency (Resnick, et al., 1997; Lerner et al., 2003; Benson et al, 2006). They include: family dynamics, support from community adults, school effectiveness, peer influence, values development, and a range of specific skills and competencies required for young people to thrive.

However, there remains a task to understand: the precise mechanisms or pathways which operate between these assets and health; whether some assets are more important than others; how the cumulative effects of different assets benefit young people as they grow up; and how different social and cultural contexts impact on the benefits of them.

Included in these assets are many of the underlying constructs of social capital such as sense of belonging to the family and community, trust and safety and a willingness to contribute and participate in a wide range of commu-

nity activities. Social capital therefore has the potential to provide an organizing framework which can help to link and explain the assets that are seen to be important for young people's health and development.

It is timely for social capital research to advance such that it can move beyond a concept with potential towards a theory with explanatory power. Theories help us to predict what may happen by creating structure and systems out of sets of observations, thus helping us to understand the empirical world in a systematic way. However, as Szreter and Woolcock (2004) emphasise the development of social capital as a theory can only be advanced if the reason we are interested in it is made explicit. Those interested in progressing social capital research for young people's health should at the very least state the intended perspective from the outset. The perspectives put forward by Szreter and Woolcock, 2004 and Morgan (2010) provide a useful starting point for consideration.

Measurement – make use of indicators with an established evidence base

Our ability to construct a robust and rigorous evidence base on the links between social capital and health relies on valid and reliable means of measuring it and developing indicators that can represent it.

The majority of adult social capital studies have been carried out using either ecological or cross sectional study designs to investigate the associations

between the indicators of social capital and a range of mortality, health and behavioural indicators, although there are some examples of other designs (Lindstrom, et al., 2003). These were important in the early days of social capital research to establish a platform for creating more sophisticated hypotheses. For example, original work by Kawachi et al (1997) used single measures of trust as a high level indicator of social capital to correlate its relationship to mortality levels across US states. This study was influential in stimulating interest within the research and policy communities and led to a rapid growth in adult related social capital research.

Some authors (for example Harpham et al, 2002, Blaxter, 2004) warn of the dangers of relying solely on surveys to determine levels of social capital in different populations and the limitations that this may have in determining the relationship between social capital and health. In particular, they refer to issues relating to the subjectivity of people's responses to survey questions, the need for detailed question sets to tap into any one aspect of social capital (often not viable in social surveys) and the static nature of surveys which cannot capture the dynamic characteristic of the concept.

All these issues are directly relevant to the pursuit of an evidence base on the links between social capital and young people's health. In particular social surveys have a role to play in setting out the most meaningful indicators of social capital which can be conti-

nually refined and developed as more is understood about the range of underlying constructs that underpin it. Morgan and Haglund (2009) have previously argued that further work needs to be done to unravel the concept of social capital into its lowest constituent parts so that future empirical research can more systematically attempt to link and explain the antecedents and consequences of social capital – see next section, *social capital as a multi-component concept*. That is what are the factors that can help to build social capital and what might result as the benefits of doing so.

There are two things that researchers can do to advance the measurement of social capital in future studies. Firstly, assess whether from existing studies indicators can be replicated and secondly to continue to map well validated indicators against an explicit theoretical perspective of the concept. In this way a more detailed knowledge base will be built on the potential pathways to health and other related outcomes.

Social capital as a multi-component concept – map and link the indicators used to make explicit the inter-relationships between them

The multi-component nature of social capital has often been argued to be its weakness, some questioning whether by incorporating so many disparate social phenomena into one concept, leads to a loss of distinct meaning (Portes, 1998). The individual constructs which underpin it cut across many pre-existing concepts as sociability, social networks, trust, reciprocity,

and community and civic engagement, causing some to question the worth of changing linguistics to further health development (Lynch et al., 2000).

In the context of young people's health, it might be argued that the dimensions of social capital become even more complex. Firstly, a wider range of social environments that take account of where young people's health is experienced needs to be considered. Young people's social spaces are different to those of adults and indeed the community (or neighbourhood) may be less important than the home and school (Morrow, 2001). More recently their social spaces have expanded to include the internet which has the potential to influence both the positive and negative aspects of social capital (Jung et al, 2005; Sally and Morrison, 2006).

Morgan and Haglund (2009) have made attempts to understand the contexts within which young people's health and wellbeing takes place, by developing social capital measures which take account of 3 domains of social capital (sense of belonging; autonomy and control; and social networking) in 3 different environmental contexts (family, school and the neighbourhood). In doing so they answer Morrow's (2002) call to have a tool for the analysis of the social environment, which can accommodate the way that families, children, friendships, social networks, institutions, norms and values change temporally (through the life course) and spatially (migration in and out of geographic boundaries).

Social capital complexity can be its strength over other concepts as long as researchers pay attention to the measurement of its constituent parts and to the range of potential theoretical perspectives that may be relevant to elucidate pathways to health. Its strength as a multi-component concept can only be realized if we are able to develop a structural framework, which outlines, links and explains the relationship between the dimensions that underpin it (Hean et al., 2003). Such a framework would take account of the fact that social capital is dynamic in that it may take different forms in different circumstances and over time

Earl and Carlson's (2001) view is that evidence on the social-environmental influences of child health and well-being can only be accrued if theory, measurement and analysis advance together. A complete and robust taxonomy of social capital indicators is therefore needed, involving an iterative process of testing and re-development.

Social capital - ensure the definitions and measurement of the concept take account of age, gender and culture

It soon became apparent in the adult literature that social capital is not a 'one size fits all' concept and the ability to acquire it may differ across gender, age, culture and the life course. People's networks, self-concepts and communities are fluid and dynamic, which means that notions of communities may be different and have relative importance to different groups at different times (Swann and Morgan, 2002).

Qualitative research has been useful in helping us to look beneath the surface at the hard-to-measure processes and actions of people's relationships to others, at community structures, and the 'life' of communities and networks and hence understand how social capital might be conceptualised for different purposes. Some examples of these manifestations include: the lack of relevant community spaces for positive social interaction (Campbell et al, 1999), individual constructions of health and relations to community by males and females (Sixsmith and Boneham, 2003; Boneham and Sixsmith, 2005) and the need to place the voices of social participants at the centre of social capital studies (Morrow, 2001). The latter is particularly important for young people as they are often excluded from the possibilities to participate in community life (Weller, 2006) – see section on *young people as social agents* for further discussion.

In sum, any research that aims to progress the applicability of social capital to young people's health must deal with the fact that their networks and communities are likely to inhabit different spaces than adults and therefore the vocabulary needs to be extended beyond community to include, the family, school and peers. The need to understand how social capital might manifest itself across and between different population groups, provides an additional rationale for the development of a framework that helps the unravelling of the concept to its lowest common denominator, so that it can more easily be assembled for different

purposes, contexts and populations. For example even the small age range of 11-15 year olds, reflect different needs: the onset of adolescence; the time when young people face the challenges of physical and emotional changes; and the middle years when young people start to consider important life and career decisions (Currie, et al, 2009) and consequently may require particular definitions or theoretical underpinnings of social capital to be applied.

Use bonding, bridging and linking social capital to understand the relative importance of individual and collective notions of the concept

Rostila's (2011) describes differences between individualistic and collective notions of social capital as either individual social resources that 'signify capital that an individual can acquire through their social relationships across geographical boundaries whereas, collective social capital signifies non-exclusive resources within a social structure that are formed through coordinated action by people in a social structure'

Individualistic and collective notions of social capital have been further differentiated by developments in types of social capital such as: bridging; bonding; and linking (Narayan, 1999; Putnam, 2000; Szreter and Woolcock, 2004). The rationale for these distinctions arose because of the growing recognition that social capital can have different consequences in different contexts.

Bonding

Bonding social capital is characterised by the internally focused strong bonds held by groups of similar ethnic groups, families or communities of interest. As Putnam (2000) described it, '*bonding social capital links you to people just like you, the same gender, or age, or race. These sorts of links are good for some and not for others*'. At the community level particularly in diverse multi-cultural communities, levels of social capital may be high within groups - but less so across groups - which can sometimes lead to tension and adverse outcomes (Abada et al., 2007).

Bonding social capital is most associated with its 'downside' which reflects the assumption that all strong networks and bonds are good. Some networks are not necessarily conducive to community health, such as the Mafia or teen gangs - in these cases social capital can be used as a resource for social control - effectively excluding certain parts of a community (Leonard, 2008). In the context of young people particularly during early to mid adolescence, the establishment of friendships with peers represents a critical developmental task, and may have a long-term impact on young people's adjustment (Poulin and Chan, 2010). Positive friendships can facilitate opportunities for the development of social competencies, afford different kinds of social support, and help young people to face new situations and stressful life experiences (Hartup, 1996). However, some bonded peer relationships can lead to detrimental outcomes and therefore it is important to be able to understand

the prerequisites and conditions that support youth relationships that are positive for them and not detrimental to others (Sussman et al., 1997).

Bridging

Bridging social capital in contrast to bonding social capital captures a range of less strong bonds, which are more outward looking between and across groups, friends or businesses. In this instance, individuals may foster ties with people unlike themselves – most likely from different races or generations. It is argued that this type of social capital is more likely to foster diverse democratic societies (Putnam, 2000). Kim and colleagues (2006) studied the relationship between bonding social capital and bridging social capital on health and found that both were important, however according to Granovetter (1973, 1983) the benefits of weak ties as a social resource have much more potential for health than strong and lasting ties. Weak ties are important to individual health as they can open up access to a wide range and amount of information, access to services and other resources, whilst strong bonding networks tend to be more inward looking and in particular cases they can produce harmful effects (Portes, 1998).

It might be suggested that Bourdieu's definition of social capital is helpful as it identifies the importance of not only being able to accumulate weak ties but also the need to understand how to utilise the resources from them. That said, the central theory associated with his definition is the role that social capital

plays in the process of preserving and reproducing class structures within society, especially through mediating economic capital. Given that much of the context of social capital is concerned with understanding processes that can reduce health and social inequalities, the benefits of weak ties could easily be placed within a negative context.

Bridging social capital (as with bonding social capital) can be beneficial to health but only if there is a predetermined reason for putting them to use and there are set of societal values behind them. The research task therefore is to assess the nature of weak ties that help to enhance individual social skills and competencies that allow young people to operate within and across a range of networks that may or may not be geographically bound. Some suggest such networks may enable community integration across different groups which can be even more health enhancing (Berkman, 2000; Kawachi, 2000; Swann and Morgan, 2002).

Linking

The third type of social capital acknowledges that for the development of good community health, there needs to be a range of positive connections between members of local communities and the institutions that govern them. Linking social capital refers to the relations between these groups and the potential to break down the power imbalance that might exist between groups in different social strata. High 'linking social capital' communities build the capacity to involve local people in the decisions which affect

their lives, facilitating the leverage of resources, ideas and information from formal institutions (Sreter and Woolcock, 2004). At first glance, this type of social capital may not seem relevant during adolescent years, however given the argument for more active involvement of them in the health development process (Moore, 1999; Weller 2007; Holland, 2009) – linking social capital might provide the facility for enhancing youth participation in matters that concern them.

Weller (2006) provides a good example of how young people can actively contribute to shaping their communities as long as adults (parents, professionals, policy makers) recognise that all civic engagement does not have to take place in town halls. In this example, young people (in the main boys) campaigned for, developed and managed their own skate boarding facilities through networks of consultation, solidarity and social capital between friends, family and those with links to decision making bodies. Such research could be tested empirically if the use and further development of indicators used by Morgan and Haglund (2009) to reflect levels of autonomy and control in decision making are embraced.

In sum, bridging and bonding social capital have the potential to be health enhancing but only if there is a predetermined reason for putting them to use. Halpern (2005) suggests that policies supportive of social capital should contribute to creating *"a contemporary shared 'moral' discourse"* and develop processes that facilitate mutual respect.

These initiatives would aim at creating "pro-social" behaviour. Explicit suggestions include the development of forums appropriate to the 21st century for deliberating and agreeing common moral and behavioural habits (perhaps through deliberative polling or conventional citizenship education).

There is still work to be done in relation to young people's health and well-being to understand what the optimum balance between outward looking weak ties and those that are geographically bound. It should be possible to preserve the rights and liberties of individuals to pursue their own life and goals and the need to foster the values that provide individuals with a sense of duty and obligation to contribute to community both within and outside of geographical boundaries.

Research on social capital as it relates to young people needs to ensure they are included as active social agents

Given the increasing commitments made by policy at an international and national level (WHO, 2005, DH, 2009) to involve young people in the health development process, social capital by definition provides an opportunity for young people to be seen as active social agents, who shape the structures and processes around them (Moore, 1999). The spirit of involvement during childhood and adolescence may lead to better capacity and willingness to become active citizens in future years, hence fulfilling Putnam's name to regain the notion of the civic community.

Of course the major criticism of earlier work on social capital and young people is that it did not take on board developments in the sociology of childhood which endowed young people with agency (James and Prout, 1997) that are capable of generating and using social capital in their own right (Morrow, 2001). Whilst there are numerous theoretical expositions to further the idea of young people as 'social agents' (Schaefer-McDaniel, 2004; Bassani, 2007), the empirical work required to provide evidence of the benefits of including young people in the health development process is under developed.

However some examples include: Pong et al's (2005) study of immigrant adolescent's school achievement which emphasised the need for appropriate parenting styles that encourage joint decision making which can improve the social functioning of young people both within and outside the home; Vieno et al's (2005), provided evidence of the benefits of democratic school processes particularly as adolescents get older; and Morgan and Haglund's (2009) inclusion of indicators relating to 'autonomy and control' perceived by English adolescents within the family school and neighbourhood and the influence this can have on young people's health and wellbeing. However further work needs to be done to explore this.

Further research should test the idea that there more opportunities young people have early on in life, to be involved in shared decision making, the

more empowered they feel to actively seek networks that they can participate in and actively contribute to, for their own and others benefit. Such research would necessarily involve the development of appropriate indicators of different levels of involvement and that manage to capture the spirit of shared decision making which necessarily entails some boundary setting and role modelling from adults.

Asset based approaches to young people's health and wellbeing can help overcome notions of the 'downside' to social capital

An increasing number of quantitative youth studies started to appear in the latter half of this first decade (Lundberg 2005; Ferguson 2006; Fitzpatrick et al., 2005; Cantillon, 2006 Boyce et al., 2008; Morgan and Haglund 2009; Parcel and Dufur, 2009 and Sclee et al., 2009; Elgar et al., 2011). This literature covered a wide range of outcomes from health and education through to delinquency and violence, however in general there were few attempts to ascertain the mechanisms through which social capital might support health development.

Some suggested reasons why this might be the case include: most of the studies used cross sectional design to establish the links between social capital and the chosen outcome; few attempts were made to embrace social capital as a multi-component concept, instead using single indicators used proxies for some aspect of it only allowing a general assessment of the relationship between social capital and the chosen

outcome; lastly and importantly as stated above, many studies have failed to make explicit the theoretical basis upon which they are based. The consequence being that the studies left out many of the contributory factors that might lead to the development of social capital and the intermediate factors that lie between it and final longer term outcome.

The asset model (Morgan and Ziglio, 2007) may provide one means of overcoming the latter issue as it uses an inclusive approach to understand all those protective factors that might have an a cumulative effect on a young person's changes for health and wellbeing. As highlighted previously this overcomes Baum's (2010) concern that social capital can only have utility if considered alongside other health concepts. The asset model asserts that the more opportunities we provide for them to experience and accumulate the positive effects of a range of health assets the more likely they are to avoid risk taking behaviour, thrive in difficult circumstances and attain positive outcomes. It does this in 3 ways. Firstly, uses a life course framework to understand the skills and competences required by individuals to maximise their opportunities for health. Secondly, it embraces the collective contribution of a wide range of health concepts - including social capital - (Bronfenbrenner, 1979, Bourdieu, 1993; Blum et al., 2002) capable of identifying resources for health. Thirdly it introduces the idea of salutogenesis (Antonovsky, 1979, 87) which identifies ways in which health can be created rather than focusing

solely on disease prevention which is the predominate focus of much health research. Antonovsky uses the 'sense of coherence' scale which estimates an individual's ability to view their world and immediate environment as comprehensible, manageable and meaningful and claims that the way that a person views life has a positive influence on their health. Lindstrom and Eriksson (2006) express this resource that enables people to manage tension, to reflect on their external and internal resources, to identify and mobilize them, to promote effective coping by finding solutions, and resolve tension in a health promoting manner.

In the context of social capital research it provides an intermediary outcome on the pathway to health providing more opportunities for making explicit the processes through which health and related outcomes are produced.

Conclusion

Existing research has been useful in establishing an evidence base on the potential for social capital to be a key protective factor for young people's health. This paper calls for the next phase of research to be more systematic so that efforts to synthesise can more easily demonstrate the benefits of investing in it. The eight point plan presented here provides a framework for achieving this by illustrating how some of the theoretical and methodological challenges associated with research efforts to date can be overcome.

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