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Disentangling the directions of associations between structural social capital and mental health: Longitudinal analyses of gender, civic engagement and depressive symptoms

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ABSTRACT

The present paper analysed the directions of associations between individual-level structural social capital, in the form of civic engagement, and depressive symptoms across time from age 16–42 years in Swedish men and women. More specifically, we asked whether civic engagement was related to changes in depressive symptoms, if it was the other way around, or whether the association was bi-directional. This longitudinal study used data from a 26-year prospective cohort material of 1001 individuals in Northern Sweden (482 women and 519 men). Civic engagement was measured by a single-item question reflecting the level of engagement in clubs/organisations. Depressive symptoms were assessed by a composite index. Directions of associations were analysed by means of gender-separate cross-lagged structural equation models. Models were adjusted for parental social class, parental unemployment, parental health, and family type at baseline (age 16). Levels of both civic engagement and depressive symptoms were relatively stable across time. The model with the best fit to data showed that, in men, youth civic engagement was negatively associated with depressive symptoms in adulthood, thus supporting the hypothesis that involvement in social networks promotes health, most likely through provision of social and psychological support, perceived influence, and sense of belonging. Accordingly, interventions to promote civic engagement in young men could be a way to prevent poor mental health for men later on in life. No cross-lagged effects were found among women. We discuss this gender difference in terms of gendered experiences of civic engagement which in turn generate different meanings and consequences for men and women, such as civic engagement not being as positive for women's mental health as for that of men. We conclude that theories on structural social capital and interventions to facilitate civic engagement for health promoting purposes need to acknowledge gendered life circumstances.

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1. Background

Poor mental health, and depression in particular, constitutes a major threat to the wellbeing of both adults and young people worldwide (Patel et al., 2007; Van de Velde et al., 2010). Research on the determinants of depression and depressive symptoms is therefore crucial to develop successful strategies to promote mental health and prevent ill health. This paper contributes to this by focusing on the longitudinal relationships between structural social capital (as in civic engagement) and depressive symptoms across the life course.

1.1. Social capital

Over recent decades, aspects of social relationships, including civic engagement, social networks, trust, and social cohesion, have been conceptualised in terms of social capital (Bourdieu, 1986; Portes, 1998; Putnam, 2000). Social capital is a complex concept with many general definitions as well as a number of forms and dimensions (Ejlskov et al., 2014; Murayama et al., 2012). A commonly used characterisation is that social capital represents

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the degree of connectedness and the quality as well as quantity of social relations (Harpham et al., 2002). Generally, two main approaches coexist: on the one hand, social capital is conceptualised in relation to collective action and integration (social cohesion approach); on the other hand, it is observed as an approach that focuses on issues of social inequality (Murayama et al., 2012). The main advocators of the integrationist approach are Putnam and Coleman, whereas the inequality approach is predominantly represented by the work of Bourdieu (Adkins, 2005).

To date, the integrationist approach has been most commonly used in public health research and primarily the work by Putnam (Murayama et al., 2012). According to Putnam (see e.g., Putnam, 2000), social capital is a combination of patterns of civic engagement and social cohesion. In addition to this 'social cohesion approach' in which social capital is viewed as a collective feature characterising whole communities, an individual-level social-network approach to social capital also exists. This latter approach - on which the present study rests – applies the sociological definition of social capital as the ability of individuals to secure benefits and resources through membership in social networks and other social structures (Portes, 1998).

Social capital can further be divided into structural and cognitive components. The structural component reflects activity, i.e., the extent and quantity of the actual participation in social networks, while the cognitive component represents the individual's appraisal of this activity, e.g., his or her perceptions of support or trust (Harpham et al., 2002; Krishna and Shrader, 2000). The term structural does not refer to levels or distances but, rather, to participatory features, such as: "externally observable aspects of social organisation and is characterized by behavioral manifestations of network connections or civic engagement." (Murayama et al., 2012 p. 180). In other words, civic engagement is a part of structural social capital alongside support networks or density of community organisations (Derose and Varda, 2009).

More recently, distinctions have also been made between bonding, bridging, and linking social capital (Derose and Varda, 2009; Iwase et al., 2012). Bonding social capital refers to strong ties within homogenous groups, whereas (weaker) ties made up of dissimilar people and between groups have been conceptualised as bridging social capital. According to Derose and Varda (2009 p. 282), bridging social capital is often "operationalized through voting participation and more general community participation (e.g., volunteering, membership in community associations, etc.)". Linking social capital, on the other hand, refers to ties between individuals or communities and formal institutions (Derose and Varda, 2009).

In sum, drawing on contemporary conceptualisations of social capital, the current study focuses on structural aspects of individual-level social capital in terms of 'civic engagement', operationalised as participation in associations, which, in turn, represents an aspect of bridging social capital.

1.2. Social capital and inequalities in health

Generally, access to individual social capital has been shown to be important for both physical (Hyyppa et al., 2007; Kim et al., 2008) and mental health (Almedom, 2005; Gilbert et al., 2013; Kawachi and Berkman, 2001; Ziersch, 2005). Strong associations have also been found between cognitive social capital and health; especially with regards to self-rated health (SRH) (Eriksson et al., 2010; Kim et al., 2008; Snelgrove et al., 2009) and common mental disorders (CMD, depression and anxiety) (Ehsan and De Silva, 2015).

Research on health and individual-level structural social capital is less prominent although it has been suggested that involvement in civic engagement can secure important benefits for health: social network involvement may promote health by facilitating access to social support as well as material and psychological resources and through social influence from trusted role models. In addition, social network involvement has been suggested to reduce stress, provide opportunities to learn new skills, and help to develop a sense of belonging, all of which are likely to have positive health effects (Berkman and Glass, 2000).

As shown, various aspects of social capital have been found to be linked to health status. Given that the majority of studies have relied on cross-sectional designs, in which directions of associations cannot be discerned, there is a need for longitudinal research.

1.3. Longitudinal research on social capital and health

According to a review of prospective multi-level studies (Murayama et al., 2012), there is enough evidence to suggest a general association both between 'social-cohesion social capital' and health and between 'individual-level social capital' and health (physical as well as mental). However, differences exist depending on the targeted health outcomes, as well as dimensions and measures of social capital. For example, with regard to physical health, analyses of the British Household Panel Survey have shown that area-level social capital (trust) is linked to self-rated health, whereas civic engagement (active in organisation) is not (Snelgrove et al., 2009). A Swedish study, on the other hand, suggested that an accumulation of poor social capital across the life course in terms of social participation, social influence, and social support was associated with elevated levels of functional somatic symptoms in mid-life (Jonsson et al., 2014). It has also been shown that higher levels of individual and neighbourhood social capital positively affect self-rated health among people with chronic illness (Waverijn et al., 2014). Others report weak evidence of social capital being linked to all-cause mortality, cancer, or cardio-vascular disease (Choi et al., 2014). Moreover, a recent Danish study found that the longitudinal associations between social capital and all-cause mortality depended on gender and dimension of social capital (Ejlskov et al., 2014).

1.4. Civic engagement and mental health

Individual-level structural social capital has not been as well researched as other dimensions, especially not longitudinally. However, it has been argued that individual-level social capital (as opposed to the 'social cohesion' societal aspect) is particularly important for mental health (Ziersch, 2005). According to the (primarily cross-sectional) research exploring these associations, low levels of civic engagement predict poor mental health (see, e.g., Almedom, 2005; Berkman, 2000; Berry and Welsh, 2010). There is, however, some conflicting evidence: a cross-sectional Australian study found that community participation was not strongly related to psychological distress (Phongsavan et al., 2006). Likewise, Berry and Welsh (2010) identified that civic engagement and political participation had weaker associations with mental health than informal connectedness and that the associations were present in women only. Similar findings were reported from a Canadian study; while political participation (linking social capital) was associated with depression, no such association was found for social group participation (bridging social capital) (Daoud et al., 2016). Furthermore, a systematic review found weak or no evidence for mental health effects of structural social capital, whereas some studies in low-resource settings identified civic engagement to be associated with an increased risk of common mental disorders (CMD, depression and anxiety) (Ehsan and De Silva, 2015).

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