



The relative influence of neighbourhood incivilities, cognitive social capital, club membership and individual characteristics on positive mental health

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ABSTRACT

Previous research indicates that residents' perceptions of their neighbourhoods can have an adverse influence on their health and wellbeing over and above the influence of structural disadvantage. Contrary to most prior research, this study employed an indicator of positive wellbeing and assessed the impact of individual characteristics, perceived social and environmental incivilities, indicators of cognitive and structural social capital, and perceived safety. Analyses of data from a large regional UK representative study ($n=8237$; 69.64% response rate) found the most influential determinants of wellbeing were physical health problems, age, SES and cognitive social capital. Smaller, significant effects were also found for environmental and social incivilities, and for perceived safety. The effect of cognitive social capital was moderated by age, with a stronger effect found among those aged 65 years and over than among younger participants. Findings indicate that the promotion of positive mental health within communities may be facilitated by efforts to foster a greater sense of belonging among residents, and that older adults may benefit most from such efforts.

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1. Introduction

Over the past two decades, the pace at which researchers have sought to uncover how local environments and the contexts in which we live relate to our health and wellbeing has quickened. Consideration of how built and social environments interact with individual factors to influence health and bring about health inequalities has been of particular interest. By now, it has become apparent that while individual characteristics and behaviours are distinctly important, the community settings in which people reside also exert influences on the life chances of residents. An ever-expanding body of research thus points to place/community effects on physical health (e.g. Curtis and Rees Jones, 1998; Cummins et al., 2005; Ellaway et al., 2001; Pickett and Pearl, 2001; Wilson et al., 2004) and mental health (see Truong and Ma (2006) and Chu et al. (2004) for reviews). Some researchers, however, caution that individual and household characteristics are more influential than neighbourhood features on levels of common

mental disorders (Propper et al., 2005) while others argue that individual-level and place characteristics should not be conceptualised as 'independent' from each other (Cummins et al., 2007). In this way Cummins et al. (2007) relational view of place and space emphasises a dynamic and mutually reinforcing the inter-relationship between psychological, social and physical aspects of the environment.

A particular focus of research in this domain has been consideration of the extent to which deprivation interacts with place to compound the negative impact on health and wellbeing for people already facing socioeconomic disadvantage. Sooman and Macintyre (1995), for example, found that residents from advantaged local areas in Glasgow (UK) had positive views of their local areas, and that these perceptions were related to comparatively lower levels of self-reported anxiety and depression. Conversely, Ross (2000) found that depression levels in disadvantaged local areas with a high proportion of female-headed households were mediated by perceived neighbourhood disorder, while Silver et al. (2002) found that neighbourhood disadvantage was associated with depression and substance abuse. A study by Haney (2007) explored the relative importance of objective measures of poverty vis-à-vis perceived neighbourhood disorder on self-esteem. Haney found that while perceived incivilities do not replace the association between poverty and self-esteem, the

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relationship is actually stronger in magnitude. He argues that blighted neighbourhoods and the stigma attached to them is internalised by residents and becomes part of their psychological make-up.

Research has also considered the diverse types of incivilities that people experience. Distinctions are generally drawn between physical (e.g. quality of physical environment) and social (e.g. issues such as levels of vandalism/graffiti) forms of these problems. Ellaway et al. (2009) found that physical street-level incivilities and the perceived absence of environmental goods (e.g. children's play areas) were linked to anxiety, depression and poorer general health, while large-scale incivilities such as telephone masts were of lesser importance in shaping self-reported health outcomes. It is not only the manner in which the physical environment is perceived by local area residents that appears important in shaping wellbeing; Other significant influences are social capital and perceptions of safety (e.g. Austin et al., 2002; Baum et al., 2009; De Jesus et al., 2010; Franzini et al., 2005; Miles, 2008). Social relationships, or social capital, act as protective factors (Elliot, 2000; Gidlow et al., 2010; Kim, 2010; Kim and Ross, 2009; Mair et al., 2010) and findings by Nyqvist et al. (2008) indicate that cognitive aspects of social capital (i.e., a sense of trust) are predictors of wellbeing, while structural aspects (i.e., participation in social activities and social contacts) are not. However, a recent study in Japan by Hamano et al. (2010) found that both high levels of cognitive social capital, measured by trust, and also high levels of structural social capital, measured by membership of recreational groups, were associated with increased mental health after adjusting for demographic variables.

Despite progress that has been made in examining place effects on health and the role that physical attributes of the environment influence mental health both directly or via its determinants (e.g. social relations) (see Atkinson et al., 2012; Curtis, 2010; Williams, 2007), the mechanisms through which social and environmental factors interact to influence wellbeing remain in need of further clarification (Aneshensel and Sucoff, 1996; Macintyre et al., 2002; Wood and Giles-Corti, 2008). The increasingly recognised importance of people's subjective impressions of and engagement with the localities in which they spend their time (Atkinson et al., 2012) underpins the use of a subjective measure of the local neighbourhood in this study, specifically perceived environmental and social incivilities. Existing literature regarding place effects on mental health is also characterised by studies which tend to utilise scales that measure psychological problems (see Schaefer-McDaniel et al., 2010) such as depression or anxiety. Rather than focusing on mental ill-health it is also useful to investigate how positive wellbeing may be shaped by the physical and social environments people inhabit (Bond et al., 2012). Furthermore, Seaman et al. (2010) suggest that this relationship may be reciprocal in that improved wellbeing facilitates greater access to community health enhancing resources, such as parks and greenspace which in return benefits both individual outcomes, as well as levels of community social cohesion and capital.

Wellbeing has been conceptualised in one of two ways. The hedonic view assesses wellbeing via emotional states, such as happiness while the eudaimonic view emphasises satisfaction and human flourishing over time (Conradson, 2012; Deci and Ryan, 2008). It has been recommended that the two concepts are integrated, recognising the value of both (Henderson and Knight, 2012; Huta and Ryan, 2010). The current study therefore utilises a scale that incorporates both of these wellbeing conceptualisations (Tennant et al., 2007).

Our study builds on a recent investigation by Gale et al. (2011) who examined the effects of neighbourhood on positive mental health in older people. Utilising a cross-sectional postal-survey design, they found that older adults (aged between 69 and 78

years) with a strong sense of social cohesion, and a positive perception of their neighbourhood were more likely to exhibit positive mental health. This was independent of socioeconomic status (SES), income, health status and perceived social support. They point out that perceptions of neighbourhood characteristics are likely to be more influential on wellbeing for older people "... because such individuals are less likely to go out to work and have an increased risk of mobility limitations" (Gale et al., 2011, p. 867). The relationship between perceptions of place and wellbeing may therefore differ in the general population, which has yet to be explored using a quantitative measure of positive mental health. Our study is the first to investigate whether the findings of Gale and colleagues (2011) extend to a general population sample, and systematically investigates a model that seeks to establish the relative importance of a variety of social and environmental factors on wellbeing. We hypothesised that positive mental wellbeing would be influenced by the degree of integration with others in the area, the perception of problems in the neighbourhood and how safe individuals felt. Our analyses controlled for sex, age, SES, length of residence in current neighbourhood, whether participants were members of social clubs, and self-reported physical health problems.

2. Methods

The secondary data analyses reported in this paper is based on data obtained from a sample of residents in Glasgow (Scotland) and the surrounding region. Glasgow experiences relatively high levels of poor health and deprivation and is sometimes referred to as the 'sick man' of Europe. Even compared to similarly deprived cities in the UK, Glasgow experiences elevated mortality rates across all age groups (except the very young), often referred to as the "Glasgow effect" (Walsh et al., 2010). The data were obtained from the 2008 Health and Wellbeing Study conducted by NHS Greater Glasgow and Clyde, UK. The study utilised a multi-stage stratified random sampling technique and was conducted using computer assisted software in the respondents' own homes. Data collection was commissioned by the local NHS board and, as a community-based survey where sampling was not based on information about patients, clients or staff of the NHS, formal ethical approval was not required from the local NHS research ethics committee. Data collection was undertaken by a market research company who adhered to the UK Market Research Company Code of Conduct and was overseen by a steering group. 8237 interviews with residents aged 16 years and over living within the boundaries of NHS Greater Glasgow and Clyde were achieved, reflecting a 69.64% response rate. Data were weighted in a two stage weighting process to ensure representativeness, first for household size, then for age, sex and deprivation. Weighting was removed for imputation, then reapplied for the analysis.

2.1. Measures

2.1.1. Wellbeing

The indicator chosen for positive mental health was the Warwick Edinburgh Mental Well Being Scale (WEMWBS) which was developed to assess a variety of components of wellbeing, including both hedonic and eudaimonic perspectives. The measure has been validated on a representative sample of adults in UK population (Tennant et al., 2007). Fourteen positive statements (e.g. "I've been feeling optimistic about the future"; "I've been feeling useful") are answered on a scale from 1 (none of the time) to 5 (all of the time) and summed to calculate an overall score. The higher the score, the higher the mental wellbeing. The Cronbach's alpha for these data was .96 indicating good internal consistency.

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