ABSTRACT

Broadly defined, social capital refers to the resources—such as social support, financial assistance, or access to shelter—available to individuals or communities due to their networks and social connections, and their perceived and real opportunity to draw upon social and organizational ties for assistance when needed. This paper introduces a synthesis of the research, applications, and potential impacts of interventions that aim to build and preserve social capital as a means to advance public health efforts. It then identifies new avenues and suggests next steps for research and practice.

WHAT IS SOCIAL CAPITAL? TYPES, BENEFITS, AND MEASUREMENT TOOLS

Types of Social Capital

The term “social capital” refers to the resources available to individuals and communities as a result of having connections to and relationships with other people. Increased social capital has benefits for both the individual and the collective community. These benefits include heightened cooperation among groups of people, stronger informal social networks among community members, and a shared sense of mutual benefit. Communities exhibiting strong social capital are able to make progress on issues and resolve problems more easily than communities with weak social capital. Individually, social capital can increase a person’s web of social connections, which has a range of benefits, including the ability to facilitate healthy coping strategies, decrease rates of illness, promote educational attainment, increase access to healthy food, and prevent interpersonal violence.

Researchers have identified three primary categories of social capital: bonding, bridging, and linking. Bonding refers to relationships of trust between members of communities that share similarities in social identities or demographics. Examples of bonding include intimate relationships between members of a church, school, or neighborhood that provide feelings of support and trust. Indicators used to identify and measure bonding include levels of trust, reciprocity (i.e., of ideas, social support, physical assistance), social cohesion, social networks, and social support.

While bonding occurs between members of similar groups, bridging refers to the connections between groups or individuals dissimilar in their individual and community identities. Bridging connections can occur when distinct social groups come together to collaborate on a common cause. Examples of bridging include participation in neighborhood associations or a network of community health workers. Strong bridging social capital could lead an individual to job opportunities and employment via their network and contacts. Indicators used to measure bridging social capital include levels of civic engagement, group membership, and number of contacts in an individual’s social network.

Linking, which is a form of bridging, refers to the relationships and interactions between systems of institutionalized authority and the communities they serve. An example includes the relationship between political figures and their constituents. The level of access an individual or community perceives to have with these formalized structures exhibits their level of linking social capital. Levels of civic engagement and group membership are used as indicators for this kind of social capital.
Another form of categorization—in addition to the distinction between bonding, bridging, and linking—is how social capital is expressed on both cognitive and structural levels. **Cognitive** social capital measures level of trust an individual or community feels toward others, and their related attitudes regarding social connections, including the perception of connectedness or available support. Trust, sense of belonging, social harmony, and perceived fairness provide indicators of cognitive social capital.

A recent study in rural Iowa illustrates cognitive social capital by assessing how connections to family and friends and perceptions of civic structure impacted levels of food security. Results showed that residents who lived in low income, rural areas with low food access but with perceptions of high interconnectedness in their community were significantly less likely to be food insecure.

In contrast, **structural** social capital refers to an individual's actual participation and/or membership in groups, as well as the amount of groups in a community and the behaviors that form the connections between individuals and groups. An example includes the degree of civic engagement of a community or individual. Indicators used to measure structural social capital include civic engagement, group membership, and support received from groups.

In summary, social capital can be described in the categories of bridging, bonding, and linking, as well as cognitive and structural social capital. These categories describe informal individual relationships, such as those between friends and family members, as well as formal community-level relationships, such as active membership in a group or voluntary organization. Other indicators of social capital not specific to the above categories include crime rates, newspaper readership, volunteering, and voting behavior.

**Potential Benefits of Social Capital**

Communities and individuals with high levels of social capital experience many benefits. Communities that have a shared sense of respect and trust toward each other experience lower levels of crime, as well as cleaner, friendlier, and safer neighborhoods. The breadth and depth of social connections often correlate to levels of happiness, and individuals living in communities with higher levels of social support are less likely to have colds or suffer from heart attack, stroke, depression, cancer, and mental illness, and have better maternal and child health outcomes. Overall, people living in communities with higher social capital often live longer, healthier lives, and have a higher self-reported health status after cardiac events or stroke.

Studies also show that racially integrated communities lead to increased social support across socioeconomic and demographic lines and can increase prosperity for everyone in the community. This is a complex example of bridging social capital. Embedding familiar communication between these groups helps to facilitate access to resources, thus improving social capital. Social support can help mitigate socioeconomic disadvantages as well as provide assistance with unemployment and job searching. High community connectedness is also associated with more productive use of leisure time. Overall, higher levels of social capital are associated with a healthier environment for the individuals in those communities.

A community-based pilot program in London sought to increase social capital and improve health outcomes via the creation of a support group for new mothers. With the help of community organizers, 15 new mothers formed a peer support network, meeting weekly and discussing topics such as breastfeeding and sleep schedules. After six months, participating mothers reported a decrease in stress and an increase in social capital.

**Potential Negative Consequences of Social Capital**

Research suggests strong associations between perceived and real levels of social capital and outcomes related to health, safe communities, prosperity, educational attainment, and levels of happiness. However, a few studies explore the nuanced benefits and potential consequences of social capital, and challenge the notion that increased social capital always leads to positive health outcomes. For example, Ejlskov and colleagues studied the association between social capital and all-cause mortality. While higher levels of social capital were associated with lower mortality...
rates in women, the same was not found for men. In fact, they discovered quite the opposite: that strong social networks actually increased risk of mortality in men. Their study supports previous research suggesting that men engage in riskier behaviors—such as heavier drinking and higher fat intake—in social situations. This dynamic is different for women, as they tend to experience more emotionally fulfilling relationships that offer more social support.  

Another example includes a survey conducted in South Los Angeles that attempted to identify how communication resources and community-level trust and cooperation shape access to health-related resources. In this study, social capital did not play a significant role in extending access to health-related resources for vulnerable populations, as higher social capital only increased access to health care if the individual had health insurance and perceived their health as at least good.  

Finally, Ferlander discusses differentials in bridging and bonding based on socioeconomic status. Poorer communities tend to exhibit high bonding social capital but low bridging social capital. More privileged communities, especially financially privileged, have greater access to bridging social capital—which connects across social groups—than low-income communities.  

**Tools to Measure Social Capital**

As mentioned, there are a number of indicators used to measure social capital. The following are the most commonly mentioned tools in current literature about the topic.

1. The Social Capital Assessment Tool (SCAT), a 60-plus-question survey originally designed for use in developing countries, focuses on community and household levels of social capital by measuring levels of perceived fairness and emotional support as well as degrees of citizenship and participation in organizations.  

2. The Adapted Social Capital Assessment Tool (ASCAT), an 11-question survey, is similar to SCAT but was designed for quicker administration.  

3. The Integrated Questionnaire for the Measurement of Social Capital (SC-IQ) measures an individual or household level of social capital, with questions focusing on six dimensions: groups and networks, trust and solidarity, collective action and cooperation, information and communication, social cohesion and inclusion, and empowerment and political action. Designed for integration into larger surveys, this tool may prove well suited for projects employing other methods of data collection in addition to surveys.

The SCAT or ASCAT should be used when attempting to measure community-level social capital, whereas the SC-IQ better measures individual-level social capital.

**NEW CONNECTIONS IN SOCIAL CAPITAL**

Social capital has the potential to connect several fields of research and practice. An example is the work being done to understand the impacts of Adverse Childhood Experiences (ACES) on the risks and potential for the health and well-being of communities. ACES are considered stressful or traumatic events, which can include abuse, neglect, household dysfunction, or exposure to other traumatic stressors that occurred in the home before the age of 18. These traumatic events have been found to be a common cause of health-risk behaviors and increased health problems in adulthood. ACES also cause toxic stress, which can negatively impact brain development, learning, and behavior. The Adverse Childhood Experiences questionnaire measures 10 stressful or traumatic experiences; however, research is currently being conducted to determine if exposure to additional experiences, such as bullying, racial discrimination, community violence, natural disasters, or homelessness should also be considered indicators of ACES or toxic stress.

Research has shown that safe, stable, nurturing relationships and environments (SSNRs) can prevent or mitigate the negative impact of childhood trauma. Communities with low social capital have less social support and access to resources that would help provide safety and stability. These communities may also lack the resources derived from family relationships and social organizations that can help aid in healthy cognitive and social development of children.
The Social Ecological Model, which emphasizes a nested or multi-level approach to social change, offers a lens through which to examine methods to combat the negative effects of ACEs by building social capital. At the core level of the model are individual and relationship-based interventions, such as psychotherapy or group counseling, building relationships between family members as well as bridging relationships between patients and therapists. The next level includes community approaches, which include outreach campaigns to raise awareness of the impacts of ACEs. For example, the Children’s Resilience Initiative (CRI) located in Walla Walla, Washington, created “a community conversant in ACEs and resilience.” CRI rallied community leaders to conduct a citywide ACEs survey and brought together different organizations and groups that seek to embed the principles of resilience into the community. CRI also encouraged organizations to integrate ACEs awareness into their operations. Societal-level strategies that influence behavior, such as policies and legislation, can also build linking relationships between legislators and constituents. For example, Washington State has sought to combat ACEs through legislation; HB 1965 established a statewide legal definition of ACEs and orchestrated the state’s commitment to addressing ACEs via state policy.

**NEXT STEPS**

A number of indicators for measuring social capital have been mentioned throughout this paper. However, not all aspects of social capital are measured evenly. Future work should include creating more specific tools to measure bonding and bridging social capital. Ferlander recommends further theoretical discussion and development of indicators to measure social capital, including the effects of different forms of social capital on health outcomes.

Many community-based interventions already include efforts to increase and preserve social capital, but their impacts have largely remained unstudied. Future research should seek to evaluate interventions to increase understanding of what works in regards to building social capital in order to demonstrate efficacy and to support the creation of more effective interventions in the future.

As described, increasing social capital in communities can be beneficial for health and well-being. However, a review of current literature suggests that there’s little evaluative research that’s been done on the topic, and as a consequence, there’s a lack of documented, validated interventions or overall best practices for increasing social capital in communities. In spite of this, many suggestions arise that can point organizations and researchers in a positive and hopeful direction. These include interventions that support community-driven solutions that garner broad community support. Increased interactions among community members can increase social capital and build competency from within, which can increase both bonding and bridging social capital. Those interested in developing and preserving social capital in communities should facilitate and support opportunities for community members to interact with one another on various levels around a variety of topics—such as peer support groups and community leadership teams—as well as advocate for policy changes to support social capital. Though the causal link between social capital and improved health remains largely undocumented by researchers, many communities have indeed demonstrated success in using interventions focused on social capital to improve the health of their members.
ENDNOTES

7 Putnam, 326.
8 Ferlander, 115-128.
9 Putnam, 299.
10 Kawachi, 989-993.
11 Ferlander, 115-128.
12 Poortinga, 255-270.
13 Poortinga, 255-270.
14 Kawachi, 989-993.
15 Poortinga, 255-270.
16 Ferlander, 115-128.
17 Putnam, 319.
18 Poortinga, 255-270.
19 Poortinga, 255-270.
24 Morton, et al., 94-112.
25 Ejlskov et al., 1025.
26 Harpham et al., Maternal Social Capital and Child Health in Vietnam, 865-871.
27 Kawachi, 989-993.
28 Kawachi, 989-993.
29 Putnam, 326.
31 Ferlander, 115-128.
32 Putnam, 326.
33 Putnam, 321-322.
36 Putnam, 307, 319-322.
38 Bolton et al., 1-7.
39 Putnam, 106-111.
40 Ejlskov et al., 1025.
41 Matsaganis and Wilkin, 377-386.
42 Ferlander, 115-128.
43 Harpham et al., Measuring Social Capital within Health Surveys: Key Issues, 106-111.
46 Ferlander, 115-128.
47 Ejlskov et al., 1025.
48 Bolton et al., 1-7.