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# Social Ties, Perception of Disorder and Distress: A Qualitative Examination of the Protective Effects of Social Capital in Neighborhoods

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**Abstract**

This paper examines how social ties mediate the negative impact of neighborhood disorder by changing people's perceptions of their neighborhood. It draws on and helps to advance an understanding of social capital as a protective cognitive resource that people use to frame their understandings of their local environments. This paper extends current research about the importance of social capital as a protective factor at the neighborhood level while taking advantage of a unique research setting, a Habitat for Humanity neighborhood, to begin to uncover how social capital operates at the micro-level to produce positive effects. We find that social networks operate as a resource which impacts the way people perceive and interpret agreed upon problems.

**Keywords:** neighborhood perceptions, disorder, health, social capital


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# Lazos Sociales, Percepciones de Disturbios y Aflicción: Un Examen Cualitativo de los Efectos Protectores del Capital Social en los Barrios

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**Resumen**

Este artículo examina cómo los lazos sociales median en el impacto negativo de los disturbios en los barrios a partir de cambiar la percepción de los habitantes respecto de sus barrios. Para ello recurre al estudio de cómo las personas utilizan el capital social como recurso cognitivo para entender su entorno local. Este artículo extiende la investigación actual sobre la importancia del capital social como un factor protector a nivel de los barrios, mientras saca provecho de un escenario único de investigación, el barrio como hábitat para un marco de convivencia humanitario, y con ello esta investigación empieza a descubrir de qué manera el capital social funciona a nivel micro para producir efectos positivos. Encontramos que las redes sociales funcionan como un recurso que incide en la manera en que las personas perciben e interpretan los problemas de una forma acordada.

**Palabras clave:** percepción del barrio, disturbio, salud, capital social


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In recent years health scholars have increasingly turned their attention to the social determinants of health. The social determinants of health refer to the environmental conditions and social structures in which people experience their day to day lives which impact health promotion, prevention, care and quality of life, what Marmot calls "the causes of the causes" (Marmot, 2006, p. 2-3). Rather than understanding health strictly, or even primarily, through the lens of a medical and disease model, the social determinants model emphasizes relationships, resources and local context as primary determinants of overall health outcomes.

Key to any assessment of the "causes of the causes" is an examination of how the lived environment impacts and is perceived by groups of people (Stafford & McCarthy, 2006). The Healthy People 2020 initiative by the U.S. Department of Health and Human Services notes that "understanding the relationship between how population groups experience 'place' and the impact of 'place' on health is fundamental to the social determinants of health" (Healthy People, 2012). Somewhat surprisingly, however, researchers have repeatedly demonstrated that it is the perception of these neighborhoods by residents, rather than the objective conditions within them, which have the most impact on health outcomes (Pearce & Smith, 2003; Ross & Mirowsky, 2009; Stansfeld, 2006).

With this information in mind, researchers examining the social factors which cause psychological distress have begun focusing precisely on the impact of these neighborhood perceptions. There is a growing body of evidence which shows that neighborhood disorder and concentrated disadvantage have profound effects on psychological distress and important quality of life outcomes (Mirowsky & Ross, 2003; Song, 2011). For example, people who perceive high levels of neighborhood disorder are more likely to be depressed, experience alienation, and even have more physical health conditions (Ross & Mirowsky, 2009; Song, 2011). Some research suggests that these effects are augmented by a general lack of trust among residents leading to a loss of informal social control (Sampson et al., 1997; Wilson, 1987), and people who study the impact of social ties find that a whole host of positive effects can be derived from strong social networks including reduced levels of alienation (Putnam, 2000). These two issues, social

ties and neighborhood disorder, are among those identified by Healthy People 2020 as crucial to any understandingof overall health (Healthy People, 2012).

Unfortunately, despite substantial evidence from scholars who study social ties, or social capital, that strong relationships in a neighborhood help to offset the effects of neighborhood disorder, there are currently few, if any, studies which seek to isolate the effects of social capital at the neighborhood level (Almedom, 2005; Cockerham, 2007; Fone et al., 2007). This kind of research is inherently difficult due to the permeability of most neighborhoods and the transient nature of modern populations. In order to sufficiently account for how social capital impacts neighborhood perceptions apart from other effects one would need to find a geographically cohesive neighborhood, stage an intervention designed to increase social ties, and then measure the outcomes through long term observation and in-depth interviews (Morrow, 1999, 2001). This is an approach that would be both costly and time consuming.

However, such an "experiment" naturally arises within many Habitat for Humanity neighborhoods which exist as a physically separate and distinct communities. Our research begins to remedy the shortcomings of the current literature by drawing on this resource in order to qualitatively assess the impacts of social capital on *perceptions* of neighborhood disorder and mental distress. In particular we center our examination around one particular neighborhood issue, unsupervised children, identified in the literature as a sign of neighborhood disorder and confirmed by our respondents as a problem in a particular neighborhood in order to highlight the impact and limitations of social capital on perceptions of efficacy, isolation and disorder (Hill, Ross & Angel, 2005). Our findings not only lend qualitative support for the idea that social capital performs protective functions, but also uncover the processes wherein social relationships are activated to mediate perceptions of neighborhood disorder and provide a sense of control.

## Social Capital and Health

Social capital has a long and varied history in the social sciences. Nearly thirty years after Bourdieu and Coleman first brought popular attention

to the concept; researchers still disagree about definitional necessities. At its most basic, social capital is understood as the "quality and quantity of social relations in a given population" (Harpham et al., 2002). Most researchers, making an attempt at operational specificity, focus on either group level interactions or individual level networks. Kawachi, Subramanian and Kim (2008), assessing the use of social capital in health research, call this the difference between the social cohesion school, which focuses on resources held by the group, and the network school, which conceptualizes social capital as residing in the networks of a particular individual. Scholars with a neighborhood level of analysis naturally tend more toward social cohesion definitions of social capital.

It is only recently that researchers have begun to pay attention to the cohesive resources social capital as a determinant of health outcomes (Cockerham, 2007; Song, 2011; Stansfeld, 2006). This burgeoning research area has already demonstrated the impact of social capital on "life expectancy, infant mortality rate, heart disease, violent crime and self-related health" even after controlling for income (Harpham et al., 2002, p. 107). In fact, the investigation of social capital has become so important for health researchers that the topic is among the most popular in the leading journals in the field (Kawachi, Subramanian & Kim, 2008). Examinations of the impact of social capital on health at the neighborhood level confirms these findings and extends our understanding of the importance of local context in determining health outcomes (Giordano et al., 2011; Lindén-Boström et al., 2010).

Indeed, the power of subjective relationships and neighborhood perceptions can even overcome structural deficiencies. In one of the few studies to pay attention to social cohesion and mental health, Fone et al. (2007) conclude that greater levels of cohesion serve as a protective mediator against the negative mental health outcomes brought on by income deprivation. Even more importantly, in their conceptualization of a neighborhood as a relational space, Bernard et al. (2007) emphasize the importance of social resources at the neighborhood level over material resources in term of health outcomes. Vicky Cattell (2001, 2012), in her studies in poor neighborhoods, confirms these basic findings and finds that social capital and positive neighborhood perceptions have strong links to good health. Although she places great

emphasis on social networks, she is quick to point out the importance of the community within which these networks operate.

Echoing the resource perspective discussed above, Cattell's work emphasizes that reciprocal sharing of concrete resources and social networks are of paramount importance for realizing higher health outcomes. She points out that, in some studies, higher outcome levels were realized when people worked together to overcome poverty and cope with their surroundings. Unfortunately, this concept of social capital as a resource is an important one that has garnered relatively little attention in the literature especially with regard to how these resources are actually utilized by residents in a neighborhood. Cattell's own work, however, provides a framework from which we can begin to successfully investigate the importance of social capital from a resource perspective.

**Neigborhood Disorder and Distress**

In addition to documenting the ways that social capital is developed and maintained at the neighborhood level, Cattell's work also points to the growing body of evidence which shows that strong social capital provides not only a stronger connection to one's own neighborhood, but also provides "social support, self-esteem, identity and perceptions of control" (2001, p. 1502). It is these perceptions, of one's own neighborhood and one's own sense of control, that are coming to be considered more vital to overall health, as a perceived lack of control has negative impacts on health outcomes (Mirowsky & Ross, 2003).

Catherine Ross and John Mirowsky (2003) have been at the forefront of this field of research. Recently they have turned their attention to the impact of perceptions of neighborhood disorder on mental distress. They write that "living amid signs of neighborhood disorder may produce emotions of anxiety, anger and depression because residents find the neighborhood threatening and alienating" (Ross & Mirowsky, 2009, p. 49). They go on to point out that signs of neighborhood disorder erode feelings of control, mastery and self-efficacy (Ross & Mirowsky, 2009). Furthermore, they work from the same implicit model of social capital as resource model when they note that the single biggest link between perceptions of neighborhood disorder and distress is a sense of mistrust

(Ross & Mirowsky 2009, p. 61). Drawing on conditions-cognition-emotions theory, they show that trust is the mediating variable which directly impacts the way that individuals perceive their environments and the corresponding level of distress felt (Mirowsky & Ross, 2003; Ross & Mirowsky, 2009). Trust, of course, sits at the foundation of social capital formation. In fact, some researchers have suggested that social capital is nearly synonymous with trust (Putnam, 2000). It stands to reason, then, that people who have higher levels of social capital in their neighborhood would perceive lower levels of neighborhood disorder than people with fewer social connections and correspondingly lower levels of trust among their neighbors. However, this link has not been adequately theorized or empirically examined. This research accomplishes both of those tasks by drawing on the qualitative and interventionist strategies that are needed in this field.

Despite the substantial progress made toward connecting social capital and health outcomes through neighborhood perceptions, there still remains much work to be done to determine exactly how these variables work together in real life. Writing in 2002, Harpham and colleagues point out that hypotheses abound, but empirical work is lacking and furthermore, there were, and remain, few if any studies that pursue an intervention model to assess whether social capital can be increased or strengthened at the neighborhood level and if so, what the health outcomes might be (Harpham et al., 2002). Alstier Almedom echoes this sentiment and notes that the lack of this kind of research has been holding the field back when he writes that "[s]carcity of primary data purposely gathered to investigate associations between social capital and health and/or mental/emotional wellbeing has been a major constraint" (Almedom, 2005, p. 944). In other words, while there is a some empirical evidence and a strong theoretical reason to believe that neighborhoods play a significant role in structuring health outcomes, more research is needed which draws upon original data sources at the neighborhood level for both empirical validation and theoretical development.

This study relies on a natural experimental setting provided by a self-contained Habitat for Humanity neighborhood in order to articulate exactly how social capital works as a resource to shape perceptions of neighborhood order and disorder. In the sections below, we first

describe the research setting and the integral role of sweat equity before presenting the results of the research. We ultimately find strong evidence for a resource model of social capital at the neighborhood level and show how residents draw upon this resource in ways that protect them from the distress and anxiety that would otherwise accompany the objective signs of neighborhood disorder described below.

## Research Settings and Methods

### Habitat and Sweat Equity

Habitat for Humanity is global non-profit organization founded in the United States with the stated goal of eliminating substandard housing. While they build and rehabilitate stand-alone homes, they also acquire tracts of land and construct entire neighborhoods of Habitat for Humanity homes. One of the core attributes of their program is the concept of sweat equity. While not unique to Habitat for Humanity, sweat equity is perhaps more central to their program than any other large scale poverty reduction effort. This emphasis on sweat equity, when combined with the evolution of Habitat for Humanity neighborhoods, offers a unique opportunity for researchers interested in exploring social capital.

Habitat for Humanity defines sweat equity as "the labor that Habitat homeowners expend in building their houses and the houses of their neighbors, as well as the time they spend investing in their own self-improvement" (Lassman-Eul, 2001). As homeowners have little, if any, traditional capital to invest, they are required to put in a certain number of hours (usually around 250-300) working on behalf of Habitat for Humanity. Typically, this takes the form of doing actual construction on a home; though in some cases (e.g., disability) people fulfill their sweat equity hours doing other tasks such as financial training or clerical work. Because of the construction cycle, it is not often that a homeowner accrues all of his/her hours by working on his/her house. Typically, the homeowner ends up working on other homes in the neighborhood. Through these experiences, homeowners get to know one

another as future neighbors, creating a built in network of acquaintances at minimum and, ideally, friends. Thus, walking into a relatively new Habitat for Humanity neighborhood, one can expect to find a very cohesive group of people brought together by both a sense of shared background and by an abundance of time spent with one another building each other's homes.

The implications for researchers interested in the effects of social capital in a neighborhood are clear. However, only one study, a dissertation by Yun Zhu (2006), has attempted to evaluate this natural experiment. In her research on the impact of sweat equity in Habitat neighborhoods, Zhu found that sweat equity positively impacted social capital development and that relationships continued even after participants moved into their homes. She argues that he sweat equity process contains a generalized social exchange that alleviates the pressures of sustaining human and social skill development (Zhu, 2006). Although Zhu's findings are somewhat limited in scope, her conclusions generally support the idea that Habitat neighborhoods are a prime setting for isolating the effects of social capital. As discussed above, most social capital research occurs at the macro level and thus misses out on these opportunities. We take full advantage of this dynamic by locating our research in one of these neighborhoods in order to assess what impact, if any, this kind of social capital intervention has on people's perceptions of their communities.

## Neighborhood Description

This research is located in a small, self-contained, neighborhood comprised entirely of Habitat for Humanity homes called Monarch Village located on the outskirts of a medium sized (pop 110,000), southern, U.S. city. The entire development was built over the course of approximately five years. There are thirty five houses in total, with minimal differences in color and design owing to the limited selection of floor-plans offered by Habitat for Humanity. The neighborhood consists of a series of three cul-de-sacs that have only one outlet each into the main street. There is only one way in and out of the neighborhood. In our time in the field we rarely viewed unmown lawns,

dilapidated structures or houses in need of maintenance.

The homes are all occupied and are generally well kept and orderly whereas in surrounding neighborhoods homes are allowed to fall into disrepair. We saw very little evidence of the classic signs of a breakdown in social control (e.g., graffiti, loitering, vandalism) (Skogan, 1990). However, the proximity of the neighborhood to government subsidized housing gives it a somewhat negative reputation. As one homeowner, Rhonda, told us, however, the reality is much different:

> I heard a lot of bad things about this part of town before I came here, but the particular neighborhood right here, I haven't had any trouble at all. It is very quiet and peaceful. It is not any scary tales like they tell you. There is one way in one way out. It backs up to the water…I like it over here.

In general, from both our interviews and informal interactions with residents, it is clear that the homeowners think of Monarch Village as a distinct place, separate from, and better than, government housing and the other, more run-down neighborhoods that surround it. In our own subjective reflections as a research team, we never felt unsafe or threatened and, as clear outsiders, were welcomed easily into people's homes.

Twenty-six of the homes are female headed and seven households have both a male and a female owner and only two with a sole male owner. There are nearly always children playing in the yards and streets when school is not in, even when it is raining. Indeed at the time of our interviews there were approximately eighty five children living in the neighborhood.

The residents share some similar experiences and backgrounds owing to the fact that they all pass through the Habitat for Humanity screening process in order to be approved for a home. First, Habitat for Humanity ensures some basic financial competency. In order to qualify for a house, residents must be employed or have a consistent source of income (e.g. Social Security) and must meet certain minimum and maximum income requirements depending on family size (not less than $16,700 or more than $33,500 for a family of four). Additionally,

Habitat requires evidence of desire to care for a house, commitment to a long-term, no-interest loan, current substandard living conditions, one year of good credit, local residency, ability to provide sweat equity, and ability to pay no more than 30% of family income for housing. In addition to these socioeconomic indicators, residents share other characteristics as well. Over half of them had lived in the city for their entire lives and while all had a High School diploma or G.E.D., only four of them had an Associate's degree or higher.

Despite these relatively similar background characteristics, it was not often that residents knew each other prior to moving in to the neighborhood. Indeed only three of our respondents said they knew someone in Monarch Village prior to beginning the application process. However, since moving, residents do socialize and share resources. In particular, three of the residents work at the same place. One of them got a job and then acted a sponsor to help her two neighbors get jobs there as well.

## Qualitative Approach

As we established above, social capital is considered an extremely important factor in perceptions of overall health, and several studies have shown that those who have weaker community ties are more likely to express dissatisfaction with their overall health than those with stronger ties (Cattell, 2001). However, the primary way of accounting for social capital has been through the use of statistical surveys. While these are important, there is a distinct need for qualitative work to round out our understanding of the processes that activate social capital (Almedom & Glandon, 2008; Cattell, 2001; Harpham et al., 2002; Morrow, 2001; Wilson, 1997).

Some authors of large, quantitative studies caution against underestimating the effect of individual circumstance and urge the adjustment of survey results to reflect disparities (Pickett & Pearl, 2001). With qualitative data, the problem is not nearly as pronounced – individual circumstance is not only fully considered, but is part of the main focus when dealing with qualitative research. Additionally, more emphasis is being given to qualitative research as individual factors

come into focus as valid and necessary parts of studies on health. Wilson et al. (2007) posited that research on an individual and localized level would produce more insightful findings concerning the impact of social exclusion or low social capital.

Additionally, only qualitative work will provide a full sense of how social capital is utilized on a daily basis. In particular, it is the cognitive elements of social capital (e.g. social control, shared values, mutual trust, norms of reciprocity), identified by Ross and Mirowsky (2009) as the crucial link between structural conditions and health outcomes, which need to be examined qualitatively as they do not lend themselves to adequate quantitative investigation. As Almedom (2005, p. 946) points out, these elements "may only be fully examined by means of qualitative and participatory methods of investigation and analysis" and the fact that these studies are scant in the literature "presents a serious limitation on the extent to which health and social capital relationships can be properly understood." Writing in 2008 with Glandon, Almedom echoes these sentiments in light of some qualitative research that had recently been conducted. These studies confirmed the utility of such an approach, and they argued that these contributions only reinforced the need for more qualitative work (Almedom & Glandon, 2008). Our research design contributes to this growing body of research relying primarily on qualitative data supplemented with a quantitative scale in order to make the results more robust.

We conducted in-depth, semi-structured interviews with 32 of the residents. Conversations were directed around themes of overall neighborhood satisfaction, history with Habitat for Humanity, experiences since they moved in and social networks using an interview guide. Interviews lasted approximately 20-30 minutes in length and were analyzed using MaxQDA where we looked for patterns to emerge among the data surrounding the themes identified above. We further systematized our own observations of the neighborhood using a standardized checklist of signs of disorder each time we entered the field. The items were based off of the elements in Mirowsky and Ross' "Perceptions of Neighborhood Disorder" scale (e.g., noise, vandalism, etc.) (Mirowsky & Ross, 2003). These observations were also analyzed in the same manner and served both as a form of triangulation and as a

way to refine and add to the interview guide.

Augmenting the strength of these qualitative data is the administration of a scale of neighborhood disorder developed and tested by Mirowsky and Ross (1999) and Ross and Mirowsky (2009) which uses a Likert scale to quantify people's perceptions of neighborhood disorder along both physical and social lines. Additionally, we asked questions about mood and malaise using the modified CES-D developed by Ross and Mirowsky (1984) in order to tie social connections and neighborhood perceptions to health outcomes[1]. This mixed methods approach allows not only for additional, standardized information, but also for triangulation of data which is crucial for any good research design (Neuman, 2011). Respondent's answers in the semi-structured interview can be checked against their responses to the scale and follow-up questions can be asked immediately or respondents can be re-contacted to explain discrepancies.

## Results

### Impact of Sweat Equity

The central component of sweat equity in the homeowners lives provides a unique opportunity to examine the social capital that they gain from these experiences. Many of our respondents indicated that they did indeed gain a substantial number of their current social connections in the neighborhood through the sweat equity process. For example, when we asked people if they knew their neighbors, many of them responded with a version of this comment from Melissa, who said, "I know all my neighbors, and I know all their kids. If you drive down in my cul-de-sac I know all those kids. We're all the same out here…I got to know [my neighbors] from working with them."

Erica follows up on Melissa's point and adds some further evidence about the limitations of social capital gained through the sweat equity process. She ties the building of houses directly to her current friends, but notes that the formation of new relationships basically stopped when she had accumulated her hours.

> Interviewer: How did you get to know the people you consider to be your friends?
> Erica: Well we have to build our homes. So we worked on each other's homes, yeah.
> Interviewer: Through the sweat equity process?
> Erica: Right. So we got to know each other a little bit better.
> Interviewer: So would you say you know all the people in this neighborhood?
> Erica: In this cul-de-sac, but no not in the other one, I don't know them.
> Interviewer: How come?
> Erica: Well basically, honestly, after you've worked on your house, you're done.

This notion that Erica puts forth, that after the sweat equity is accumulated the homeowner is done volunteering, was largely true in our observations. Only once in the 18 months during which this research was conducted did we observe or hear about a current homeowner helping on a build site. This impacts neighborhood relationships in two ways, primarily.

First, the lack of ongoing, shared experiences and forced interactions brings up real questions about the durability of these relationships and whether they are able to promote a cohesive neighborhood spirit in general. While many friendships did endure, on more than one occasion homeowners expressed that after the initial excitement of move-in wore off, their relationships with their neighbors tapered as well. Mark told us that,

> At one point we used to have cookouts and block parties, and I'd like to see more of that, but we don't do that so much anymore. That was like, when we first moved in, but now we all just too busy, I guess. It's funny, you know, I know what all these houses look like inside, but I don't really know these people anymore like I used to. We are still friends or whatever, and it's nice just to know who is around, but we're not as close as we used to be.

Of course, much of this is to be expected as people go about the course of their daily lives. Relationships are bound to change, but it does highlight one of the limitations of even this relatively large investment in sweat equity which essentially amounts to a social capital intervention. Mark's family was one of the first to move into the neighborhood and in the two short years since he and his family had been in their home, he had experienced a distinct change in the relationship status with his neighbors indicating that the effects of the initial blast of social capital gained during sweat equity accumulation does not last without being attended to. Thus, the protective effects of high social capital have the potential to wear off as time passes.

Other residents confirmed this feeling, with several telling us that "life just got in the way." When pressed to explain, they told us that the daily hustle and bustle of work, school, youth sports and family obligations eventually left little time for cultivating relationships with their neighbors. When the sweat equity process demanded their time, the socialization happened easily, but without those requirements and opportunities, the interactions faded away. Mark was not the only one who mentioned the block parties, but nearly every resident said they would like to see the return of the parties, but only if someone else was organizing it. In other words, while there is a desire from the residents to socialize more, there is not a structure in place which supports or demands those interactions after the sweat equity process is completed.

Second, the sweat equity process results in the formation of groups or cohorts of neighbors who know each other well as they work on phases of the neighborhood. As Terri, told us, there was a "break" when her group moved into their homes.

> Interviewer: So do you feel like you know the people in your neighborhood?
> Terri: Well the 12 or 13 one's right here, we all worked on each other's homes together and that's where you get to know them really well and the break was when we all moved in and became homeowners and then the next group of 10 or 12 came in and they worked on each other's homes, but not with us. So I don't really know them.

These "breaks" create cohorts in the neighborhood that form loose cliques around which people center their social experiences in the neighborhood. Along these same lines, the cohorts have the effect of creating a natural division among homeowners. In particular, the data show that people on the Northside of the neighborhood tend to know each other pretty well, but not people on the Southside and vice versa. Additionally, a third cohort appeared to be emerging as construction on the newest phase began.

This is seen most clearly when we asked residents about their perceptions of neighborhood disorder. Almost without fail, Northside residents pointed to Southside residents as the source of any neighborhood problems and Southside residents were equally certain that Northsiders were the main culprits. Our own observations indicated that while one house in particular on the Southside was perhaps more problematic than any other residence in the neighborhood, in general, signs of disorder were minimal and spread evenly. That is, there were about the same indications of graffiti, unmowed lawns, unsupervised children, etc.

## The Importance of Social Capital

One of the major signs of neighborhood disorder is the presence of unsupervised children, often resulting from single parent households where the parent works outside of the house (Kim, 2008; Ross, 2000). This marker of disorder was the most common complaint among the residents and was also the place where cohort divisions are seen most clearly. With only two exceptions, residents affirmed what Sandra expresses when she mentions that "there are some kids that are holy terrors and I ain't kidding they are terrors. That is a problem." But beyond agreement that unsupervised children are a problem, a pattern already established in the literature, these data reveal interesting and new insights about how that problem is perceived. For example, Lindsay, a Northside resident located the source of this problem with the newer Southside residents,

> Interviewer: What is the main source of the problem?
> Lindsay: The other people down there, the other people that have

> come in, you know everyone raises their kids different. That's my main complaint, if you will, sometimes, uh, people don't raise their families the way, you know, I was raised.

She went on to detail some of the things the children had done which caused problems. While none of the individual acts are particularly severe, the accumulation of them seems to be what troubled Lindsay and the other respondents most.

When asked about these same kids, Southside residents gave a much different explanation. They pointed to their relationships with the other people in their cohort as the lens through which they understood their experience. Barbara explained the connection well when she discussed how she has worked with her neighbors on some of the issues that have come up:

> Well there's a family over here that has many children. That's one of the larger ones. And their kids are just they're in your driveway, they throw their bikes in my yard, they hang on my electric box. They just destruct things. And now I have another n over here and she's got just one kid and he's just he's worse. They're not disciplined. They're not watched. I'm just trying to not ruffle any feathers but at the same time trying to get these kids to respect my boundaries. So it's been a process…. I'm hopeful we can work it out. We're friends, I know her from the Habitat sweat equity thing.

The relationship Barbara gained through her sweat equity did not mean that she was unaware of the unsupervised children or that she did not consider it to be a problem, but it did significantly impact the way she understood the issue. Unlike Lindsay on the Northside who attributed the lack of supervision to fundamental differences between herself and the Southsiders, Barbara understood the issue simply as something to be worked out between friends. Her relationship with the parents gave her a resource to draw upon that influenced how she viewed this central issue in her neighborhood. Not surprisingly, Barbara also rated the neighborhood as much more orderly. Her experiences working with her neighbors gave her confidence that even the

potentially tricky issue of parenting style could be overcome.

This same dynamic is evidenced when we examined the neighborhood outliers. In this case, while the vast majority of people were overwhelmingly satisfied with Monarch Village, there was one person, Robert, who told us that he could not wait to move out. He was not friends with anyone in the neighborhood and did not know any of his neighbors other than the ones who had children that had scratched his truck and damaged his home. Because of a quirk in the construction schedule and a big Spring Break build, Robert ended up gaining nearly all of his sweat equity outside of the neighborhood at other Habitat for Humanity sites. This meant he did not have the same opportunity to build relationships with his neighbors that the other residents had.

Thus, he expressed a much different attitude than Barbara about dealing with children and parents in the neighborhood, telling us that "you can't talk to them about anything. They don't want to listen to me. They're all just into drugs and alcohol." In short, the person with the least amount of social capital in the neighborhood also expressed the highest levels of frustration and neighborhood dissatisfaction. Not surprisingly, he also had the highest depressive indicators as well, telling us in both an original and a follow up interview that he felt "trapped" in the house until he had been there long enough to sell it without penalty[2].

The general picture that begins to emerge from the residents, then, is one where relationships significantly impact how people understand their neighborhoods and how satisfied they are with their neighbors. The relationships formed through the sweat equity process produce a greater tolerance for and willingness to work with neighbors on issues. However, they also create divisions and cohorts within the neighborhood that make boundaries difficult to cross and overcome.

## Discussion

This research suggests that social capital serves as a resource of shared experience which influences the way problems and issues are perceived. In a national study of the impact of social capital on mental distress, Song (2011) found similar results about the dynamics of social relationships concluding that there is a direct relationship between social

ties and mental health. She argues that social capital may very well be so important as to be considered a fundamental cause of health within the framework set out by Link and Phelan (1995) which states that a fundamental cause of health must be a resource locator, have multiple mechanisms, persistent effects over time, and influence multiple health outcomes.

This research provides further support for this argument by articulating how the protective mechanisms of social capital work at the neighborhood level as a resource that residents draw on when dealing with local issues. While strong social ties do not blind people to the existence of problems in the neighborhood, the evidence here indicates that it does change the sense of control and mastery that people perceive over these issues.

In other words, what we see here is that neighborhood level social capital helps to foster a sense of control and ward off conditions associated with depression. The residents in Monarch Village, while they may not always know everyone in their neighborhood, are rarely completely socially isolated and thus typically report favorable overall impressions of their neighbors and neighborhood. In general, the more socially connected a resident is to other people involved in a problem or issue, the more he/she feels that the issue can be resolved.

Mirowsky and Ross (2003, p. 253) pointed to this sense of control as fundamental to mental health, writing that "all of the established and emerging social patterns of distress point to the sense of control as a critical link." In other words, a sense of control and mastery are crucial for avoiding the depression and anxiety that are associated with powerlessness in one's own life (Cattell, 2001; Mirowsky & Ross, 1983). People who are socially marginalized are also less likely to be trusting and less likely to experience a sense of collective efficacy (Sampson, Raudenbush & Earls, 1997). Robert's case illustrates this link between social isolation and collective efficacy very clearly. Whether this is a self-fulfilling prophecy or if it is due to real structural barriers remains to be seen and is, to some extent, irrelevant. As Mirowsky and Ross (1983) show, socially isolated individuals often create the conditions that augment their own initial feelings. Where some residents feel the bonding effects of social capital as protective

factors, those on the other side of those cohorts, such as Robert, might view them as exclusive or damaging.

Lindsay's comments indicate how this lack of familiarity can even lead to stereotyping and othering as she suggests that there are key fundamental differences between the two sides of the neighborhood, suggesting that they come from different backgrounds. Of course, because of the Habitat screening and selection process, Monarch Village is likely one of the most homogenous neighborhoods in town at least in terms of social standing and economic background of residents. While Lindsay no doubt understands this, it is difficult for her to understand the issue of unsupervised children in any other way because she lacks a relational context from which to understand the issue. In other words, her lack of social capital resources causes her to perceive more neighborhood disorder than she might otherwise.

## Conclusion

This research begins to uncover the dynamics that impact how social capital operates at the neighborhood level and lends support for recent conclusions that social capital can best be conceived of as a resource with a distinct, complex association with psychological health outcomes (Song, 2011). While it has long been understood that social networks provide protective factors, we know less about how these protective factors operate at a very local and contextual level.

This research strengthens the case for understanding social capital as a fundamental cause of health by showing how relationships directly impact people's strategies for action and sense of mastery and control. These two variables are strongly associated with overall measures of mental health and a clear understanding of how they work at the interpersonal level has largely been missing. While researchers such as Song have been able to demonstrate that the connection exists, very little has been known until now about how social capital operates at this level to ameliorate mental distress. The natural experimental conditions of the research setting utilized here, along with a qualitative approach to understanding social connections remedies that situation.

Future research would do well to continue to take advantage of these

kinds of natural experiments that exist within local contexts while paying more attention to what Carpiano and Hystad call a "sense of community belonging" (Carpiano & Hystad, 2011, p. 606). As they point out and this research confirms, we need a more thorough assessment of the impact of feelings of community belonging on activating the protective factors of social ties. The data above suggest that even as intensive as the sweat equity process is in terms of building social capital, the effects wear off after time. The residents of Monarch Village not only experienced the cohort effect discussed above, but they also were gradually losing touch with one another. In many ways, just a few short years after the initial group of houses were built; the neighborhood resembles any number of other communities in the area. While this kind of normality might be seen as a sign that residents are conforming to mainstream norms, the research documenting the ameliorative effects of social capital cited above suggests that the residents would be better off if they could sustain these relationships. That is, while the initial social capital intervention pays dividends, these benefits cannot be fully realized without some ongoing, sustainable interactions.

While more qualitative research is necessary to confirm the finding presented here, these results begin to offer a way to understand the importance of social relationships as part of a larger process of the construction of neighborhood problems. In general we find that these problems are objective in their existence but very subjective in their severity. People who are more socially connected report less severity than people who are more isolated. Our respondents indicate that this is due, at least in part, to their perceptions of control over their own environments to resolve problems with their neighbors.

## Notes

[1] The sample size is not large enough to permit serious quantitative analysis. Results from the modified CES-D are used to supplement the qualitative data and are reported at the individual level as necessary.

[2] Habitat for Humanity places restrictions on how long homeowners must live in a home before they can sell it and keep the profits.

## References

Almedom, A. (2005). Social capital and mental health. *Social Science and Medicine, 61*(5), 943-964. doi: 10.1016/j.socscimed.2004.12.025

Almedom, A., & Gladon, D. (2008). Social Capital and Mental Health: An Updated Interdisciplinary Review of Primary Evidence. In I. Kawachi, S.V. Subramanian & D. Kim (Eds.), *Social Capital and Health* (pp. 191-215). New York, Springer.

Bernard, P., Charafeddine, R., Frohlich, K., Daniel M., Kestens, Y., & Potvin, L. (2007). Health inequalities and place: a theoretical conception of neighborhood. *Social Science and Medicine, 65*(9), 1839-1852. doi: 10.1016/j.socscimed.2007.05.037

Carpiano, R., & Hystad, P. (2011). Sense of community belonging in health surveys: What social capital is it measuring? *Health and Place, 17*(2), 606-617. doi: 10.1016/j.healthplace.2010.12.018

Cattell, V. (2001). Poor people, poor places, and poor health: the mediating role of social networks and social capital. *Social Science and Medicine, 52*(10), 1501-1516. doi: 10.1016/S0277-9536(00)00259-8

Cattell, V. (2012). *Poverty, community and health: co-operation and the good society.* Basingstoke, England: Palgrave Macmillan.

Cockerham, W. (2007). *Social Causes of Health and Disease.* Malden, MA: Polity.

Fone, D., Dunstan, F., Williams, G., Lloyd, K., & Palmer, S. (2007). Places, people and mental health: a multilevel analysis of economic inactivity. *Social Science and Medicine*, 64(3), 633–645. doi: 10.1016/j.socscimed.2006.09.020

Giordano, G. N., Ohlsson, H., & Lindstrom, M. (2011). Social capital and health—purely a question of context? *Health and Place, 17*(4), 946-953. doi: 10.1016/j.healthplace.2011.04.004

Harpham, T., Grant, E., & Thomas, E. (2002). Measuring social capital within health surveys: key issues. *Health Policy and Planning, 17*(1), 106-111. doi: 10.1093/heapol/17.1.106

Healthy People (2012). *Social determinants of health*. Retrieved January 23, 2012, from

http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39

Hill, T., Ross C., & Angel, R. (2005). Neighborhood disorder, psychophysiological distress and health. *Journal of Health and Social Behavior, 46*(2), 170-186. doi: 10.1177/002214650504600204

Kawachi, I., Subramanian, S.V., & Kim, D. (2008). Social Capital and Health: A Decade of Progress and Beyond. In I. Kawachi, S. Subramanian & D. Kim (Eds.), *Social Capital and Health* (pp. 1-29). New York: Springer.

Kim, D. (2008). Blues from the Neighborhood? Neighborhood Characteristics and Depression. *Epidemiologic Reviews, 30*(1), 100-117. doi: 10.1093/epirev/mxn009

Lassman-Eul, M. ( 2001). Sweat equity: labor of hope, investment for tomorrow. *Habitat World.* August/September.

Lindén-Boström, M., Persson, C., & Eriksson, C. (2010). Neighbourhood characteristics, social capital and self-rated health - a population-based survey in Sweden. *BMC Public Health, 10,* 628. doi: 10.1186/1471-2458-10-628

Link, B., & Phelan, J. (1995). Social conditions as fundamental causes of disease. *Journal of Health and Social Behavior, 35, Extra Issue,* 80-94. http://hsb.sagepub.com/

Marmot, M., (2006). Introduction. In M. Marmot & R. Wilkinson (Eds.), *The Social Determinants of Health* (pp. 1-6). Oxford, UK: Oxford University Press.

Mirowsky, J., & Ross, C. (1983). Paranoia and the structure of powerlessness. *American Sociological Review, 48*(2), 228-239. doi: 10.2307/2095107

Mirowsky, J., & Ross, C. (1999). Economic hardship across the life course. *American Sociological Review, 64*(4), 548-569. doi: 10.2307/2657255

Mirowsky, J. & Ross, C. (2003). *Social Causes of Psychological Distress* (2nd ed.) New York: Aldine de Gruyter.

Morrow, V. (1999). Conceptualizing social capital in relation to the well-being of children and young people: a critical review. *The Sociological Review, 47*(4), 744-765. doi: 10.1111/1467-

954X.00194

Morrow, V. (2001). Using qualitative methods to elicit young people's perspectives on their environments: some ideas for community health initiatives. *Health Education Research, 16*(3), 255-268. doi: 10.1093/her/16.3.255

Neuman, L. (2011). *Social Research Methods: Qualitative and Quantitative Approaches.* Boston: Allyn and Bacon.

Pearce, N., & Smith, G. (2003). Is social capital the key to inequalities in health? *American Journal of Public Health, 93*(1), 122-129. doi: 10.1136/jech.54.6.404

Pickett, K. E., & Pearl, M. (2001). Multilevel analyses of neighborhood socioeconomic context and health outcomes: a critical review. *Journal of Epidemiology and Community Health, 55*(2), 111-122. doi: 10.1136/jech.55.2.111

Putnam, R. (2000). *Bowling Alone: The Collapse and Revival of American Community.* New York: Simon and Schuster.

Ross, C. (2000). Neighborhood disadvantage and adult depression. *Journal of Health and Social Behavior, 41*(2), 177-187. doi: 10.2307/2676304

Ross, C., & Mirowsky, J. (1984). Components of depressed mood in married men and women: the center for epidemiologic studies' depression scale. *American Journal of Epidemiology, 119*(6), 997-1004.

Ross, C., & Mirowsky, J. (2009). Neighborhood disorder, subjective alienation and distress. *Journal of Health and Social Behavior, 50*(1), 49-64. doi: 10.1177/002214650905000104

Sampson, R., Raudenbush, S. & Earls, F. (1997). Neighborhoods and violent crime: a multilevel study of collective efficacy. *Science, 277*(5328), 918-924. doi: 10.1126/science.277.5328.918

Skogan, W. (1990). *Disorder and Decline: Crime and the Spiral of Decay in American Neighborhood.* Berkeley: University of California Press.

Song, L. (2011). Social capital and psychological distress. *Journal of Health and Social Behavior, 52*(4), 478. doi: 10.1177/0022146511411921

Stafford, M., & McCarthy, M. (2006). Neighborhoods, housing and health. In M. Marmot & R. Wilkinson (Eds.), *The Social*

*Determinants of Health* (pp. 297-318). Oxford, UK: Oxford University Press.

Stansfeld, S. (2006). Social Support and Social Cohesion. In M. Marmot & R. Wilkinson (Eds.), *The Social Determinants of Health*. Oxford, UK: Oxford University Press.

Wilson, K., Eyles, J., Elliott, S., Keller-Olaman, S., & Devcic, D. (2007). Linking social exclusion and health: explorations in contrasting neighbourhoods in Hamilton, Ontario. *Canadian Journal of Urban Research, 16*(2), 126-148. http://www.uwinnipeg.ca/index/ius-canadian-journal-of-urban-research

Wilson, P. (1997). Building social capital: a learning agenda for the twenty-first century. *Urban Studies, 34*(5-6), 745-760. doi: 10.1080/0042098975808

Wilson, W.J. (1987). *The Truly Disadvantaged: The Inner City, the Underclass, and Public Policy.* Chicago: University of Chicago Press.

Zhu, Y. (2006). *Participation as Learning-by-Doing in Habitat for Humanity.* (Unpublished doctoral dissertation). University of Florida, Gainesville, FL.

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