Commentary: Social capital, social class, and the slow progress of psychosocial epidemiology

Carles Muntaner

Simon Szreter and Michael Woolcock are to be congratulated for their effort to clarify the theory underlying the use of ‘social capital’ in social epidemiology.1 This is one of the ways in which scientific knowledge advances. Particular credit is due to Richard Wilkinson and his US collaborators2,3 for rescuing the income inequality hypothesis, promoting genuine social constructs and generating a series of heuristic hypotheses on the relationships among income inequality, social cohesion, and health. Robert K Merton has pointed to this type of creativity as one of the engines of disciplinary progress. That is, contrary to the conventional wisdom,4 criticism is not the only engine of disciplinary advance; indeed, an excess of criticism thwarts the development of innovative methods, concepts and models. It is harder to launch innovative hypotheses, as Wilkinson and his collaborators did a few years ago,2,3 than to criticize them. However, criticism is also an essential part of scientific progress.4,5

In an earlier analysis of Wilkinson’s Unhealthy Societies,6 my co-authors and I predicted that the psychosocial aspects of his model (e.g. the breakdown of social cohesion) would gain a life of their own, independent of income inequality considerations. This expectation was based on the key criticism of Wilkinson’s model, namely that its mechanisms are exclusively psychosocial, since the determinants of income inequality are absent from the model. We also pointed out that class, gender, and race should be included in a model aimed at explaining social inequalities in health, both as determinants of income inequality and of other mediators (e.g. working conditions). In a series of publications, my co-authors and I have addressed this basic failing of the ‘income inequality and social cohesion’ hypothesis as well as many of its associated psychosocial explanations.6–14 In other publications we have addressed the ‘social capital’ hypothesis, without focusing on the income inequality/social cohesion model.10,15–19 While the core criticism of ‘income inequality and social cohesion’ is that it is insufficient but useful and interesting, our criticism of the ‘stand alone’ social capital literature is sharper, because it omits structural economic inequality and political conflict.18–25

In this analysis of Szreter and Woolcock’s article,1 I shall concentrate on new arguments in the ‘social capital’ debate and refer the reader to the publications mentioned above for other philosophical, theoretical, methodological, and historical criticisms of ‘social capital’. I discuss several issues raised by Szreter and Woolcock: the ‘neo-material’ versus ‘psychosocial’ controversy, the different concepts of ‘social capital’ in social epidemiology and the social sciences, Joseph Chamberlain and the model of the successful public health administrator with ‘plenty of social capital’, and end by analysing the difficulties of building scientific knowledge in psychosocial epidemiology with constructs such as ‘social capital’.

The ‘material’ versus ‘psychosocial’ debate: ontological monism and epistemological indeterminism

The nervous system ... by means of which relations, connections, are established between the numerous parts of the organism, as well as between the organism, as a highly complex system, and the innumerable, external influences.

IP Pavlov

The critique of the aetiological claims associated with psychosocial constructs in epidemiology is not new (e.g. the ‘demand/control’ model26 and sense of coherence.27 The current debate on the relevance of psychosocial constructs in
epidemiology reflects some of the longstanding problems with psychosocial models (e.g. idealist [anti-materialist] ontology, over-reliance on self-reports, and disregard for the economic, political, and historical context of psychological events). Some of the elements of the debate are innovative (e.g. the debate on methods and evidence), but others have already been dealt with extensively in the past. The separation of the ‘material’ from the ‘psychological’ (i.e. mind from body) is not sustainable in contemporary science.6,8 In fact ‘material’ is a proxy for physical, chemical, and biological exposures, while ‘psychosocial’ exposures are also material (i.e. monism is the standard). In addition both ‘psychosocial’ and ‘material’ exposures are socially determined, and both sets of exposures can affect population health (e.g. in a deprived and segregated neighborhood, children may be exposed to both lead and interpersonal violence). The relative importance of psychological exposures for specific conditions depends on historically determined economic, political, and cultural factors. Thus, there are ‘neo-material’ and ‘neo-psychosocial’ exposures (e.g. health effects of long hours of TV watching, corporate electronic surveillance of workers, ‘junk food’ diet, excessive internet use, long car commutes etc).

While it is generally accepted that socially determined physical, chemical, biological, and psychological exposures are important to understand population differences in specific health outcomes, there is controversy about the strength of the evidence on the effects of psychosocial factors on both overall mortality and specific diseases. For example, the use of social capital as a macro-social mechanism accounting for trends in mortality has limited usefulness because aetiological explanations require understanding proximal risk factor exposures.28,29 Such macro-social mechanisms are also easily disconfirmed at the aggregate level (e.g. during periods of declining ‘social capital’ or social cohesion, cardiovascular rates have experienced a major decline).10,28 In addition, recent individual-level observational studies cast doubt on the psychosocial hypothesis (of which social capital is an example), suggesting that bias and confounding are the more likely explanations for the noted association between psychosocial factors and physical health.30 Therefore, the health effects of ‘social capital’ cannot be taken for granted and in spite of some promising findings, the burden of proof is still on the ‘social capital’ hypothesis. In short, while the ontological aspect of ‘social capital’ controversy is not at issue, the epistemological aspect of the debate is important for ‘social capital’ as well as for most psychosocial epidemiology.

Social capital as poor terminology

‘Social capital … A good term it is not.’

Samuel Bowles and Herbert Gintis

Putnam himself admitted that social capital is ‘…to some extent merely a new language for an old debate’.31 Thus social capital as defined by Putnam and social epidemiologists (‘social networks and the norms of reciprocity and trustworthiness that arise from them’) sounds quite similar to more familiar terms such as social cohesion and social integration, which are also used in epidemiology, with similar referents.3,32–37 The definition given by Szreter and Woolcock is even more general, ‘identifying the nature and extent of social relationships’, making ‘social capital’ literally synonymous with ‘sociology’. Why use a new term when its definition is so similar to that of other terms already in the literature? Samuel Bowles has suggested that in a period when both state interventionism and individualistic rational choice were rejected, ‘social capital’ offers an alternative to social scientists.38 The key here lies in the use of ‘capital’. The term conveys the idea (of great appeal to many in public health) that capitalism (i.e. the private production of goods and services for profit and their exchange in markets) and social cohesion/social integration are compatible. To many public health researchers, ‘social capital’ seems to function as a comforting metaphor. If Putnam had used a term such as ‘social anarchy’ or ‘social socialism’ instead of ‘social capital’, I doubt that these terms would have been received with such enthusiasm. Most probably they would have been considered weird and redundant (e.g. aren’t all forms of capital ‘social’?), in spite of being more suitable metaphors for the communitarian idea (i.e. while capitalism creates competition and inequality, and thus tends to erode social integration, anarchism is based on co-operation and lack of hierarchy [e.g. co-operatives]).

In a recent study of the institutional relations between a not-for-profit organization, the local government and neighborhood organizations and urban health39 we tried using the terminology of ‘bonding’, ‘linking’, and ‘bridging’ social capital. However, we found that such terminology concealed the power differentials between the institutions and thus obscured, rather than explained, how institutional relations might result in poor health. For example, the process of ‘land banking’, by which a neighborhood is allowed to deteriorate (e.g. vacant lots, unoccupied houses, drug and other criminal activity, lack of services) so that its real estate value declines further and allows for major private-public partnerships later on (i.e. redevelopment), cannot be properly understood with these social capital mechanisms. In fact, using concepts such as lack of ‘bonding’, social capital focuses on poor community members (e.g. drug use), rather than explaining drug use as the outcome of urban policies designed by powerful institutional actors (e.g. a major corporation and the local government it controls). Szreter and Woolcock’s ‘social capital’ reading of Klinenberg’s ‘Heat Wave’ provides another example in which ‘social capital’ analysis obscures the social mechanisms that generate social inequalities (see section below). Thus, there seems to be little payoff in using ‘social capital’ rather than social integration or cohesion when the latter is implied. Moreover, social capital can easily obscure class and other power relations between groups and institutions.

The case for ‘social capital’: cultural capital and productivity

[social capital] … It has become the one-size-fits-all explanation for just about everything in society today. It’s not that I think the concept is useless … Social capital properly refers to productive value that can be extracted from social networks and organizations.

Doug Massey

Because social capital is defined in vague terms, it can make claims to the psychological literature on the health effects of social isolation.36,40,41 That makes the defence of ‘social capital’
easy, but again, adds little to what is already known. To render the concept of ‘social capital’ potentially useful in social epidemiology, it needs to be defined not as a metaphor for social cohesion, community, social integration but according to its meaning in economic sociology (e.g., ‘…features of social organization, such as trust, norms, and networks, that can improve the efficiency of society by facilitating coordinated action’). The bottom line of the ‘social capital’ metaphor is thus the increase in productivity due to norms, networks, trust, and other cultural relations. In addition, because ‘social’ refers to ‘economic’ and ‘political’ as well as ‘cultural’, in dealing with norms, social capital is de facto cultural capital (e.g. norms of trust among members of a given ethnic group that increase its productivity).

Once we adopt this definition of social capital, the magnitude and direction of its effects on health are even less obvious than with the social cohesion definition. For example according to one analysis of network mechanisms of social capital, network closure (networks where everyone is connected so no one can avoid being noticed by others) is a source of social capital. Yet, even if such an arrangement were to result in higher productivity, it is unlikely that it would also result in better health for the firm or work group in question. For example, the high level of electronic vigilance, worker monitoring, and dense and closed networks in firms that show high productivity seems to augur poor mental health among employees.

Another metaphorical version of ‘social capital’ is associated with Bourdieu and the relationship between personal networks and social class (e.g. refs. 44–49). Apart from the terminological problems noted above, research on class, stratification, and networks could inform interesting socio-epidemiological studies. Again, however, whether such research should be carried out under the term of ‘social capital’ rather than ‘hierarchically structured networks’ or ‘mediated class positions’—just to name two possibilities—is far from obvious.

A different look at Joseph Chamberlain: On social capital, imperialism, and public health

The class statesman is a man who places his abilities at the service of the existing order of things, so that it can be preserved in its hierarchies and its interests … The Liberal believes that by giving away a little you can preserve a lot. The Conservative thinks you should never surrender anything as it might whet the appetite for more … Chamberlain was a class statesman. Those are the lines upon which the English people have been governed for two centuries. The result is to be seen in the vastness of squalor and misery, and the smallness of comfort and happiness in this country.

C H Norman ‘Joseph Chamberlain’

The authors chose Joseph Chamberlain as an historical precedent to illustrate the salutary effects of social capital on population health. Although Chamberlain’s political skill is beyond doubt, their reading of Chamberlain’s times and accomplishments is quite different from many accounts, as the quotation above from his contemporary illustrates. Joseph Chamberlain was described and described himself as ‘middle class’, a member of the emerging business class; and part of his political achievement was in fact due to his success in antagonizing landowners (his shifting of political position was also typically middle class, for example as he went from free-trader to protectionist). Rather than being a person of consensus, he seems to have taken a major role in dividing the two major parties of his time (Liberals and Conservatives). Some of his contemporaries described him as ‘despotic’ and ‘ruthless’. As a Tory, he represented the interests of Birmingham’s metal industry and was known for his positions in favour of protectionism, war, and exploitation of the colonies, with notorious racist statements. In addition, far from being above suspicion, he was involved in a scandal in which government contracts were awarded to companies in which his family had interests (a form of ‘social capital’ indeed, but not the kind the authors intended). True, Chamberlain was instrumental in the so-called ‘water socialism’ for the working classes of Birmingham and promoted public health reform in Britain and in the colonies (mostly for colonizers). He also played a positive role as champion of the London School of Hygiene and Tropical Medicine. But, as stated in Chamberlain’s own words, worker illness reduces productivity. Not surprisingly, this is still a primary concern of contemporary institutions devoted to capitalist economic development such as the World Bank. It is surprising that China and India are singled out as examples of countries lacking social capital, since these countries were devastated by the British imperialism that Joseph Chamberlain came to embody. Curiously, if there is a place where the synergy between different kinds of ‘social capital’ (‘bonding’, ‘bridging’, and ‘linking’) within and between civil society, government, unions, and political parties seems to have taken place, it is in the Indian State of Kerala. However, Kerala’s success in terms of social services, health indicators, and literacy among women was fuelled by class-based and left-leaning organizations, clearly departing from the examples given by most ‘social capital’ advocates.

Some critics have argued that the whole social capital enterprise is a distraction from other real, more pressing issues in economic sociology (e.g. see articles by Steven Durlauf), and it takes politics out of economic development (e.g. as in the writings by Ben Fine). In addition, as the example below from a recent volume edited by Robert Putnam illustrates, using social capital to explain political conflict in cultural terms (lack of trust) can lead not just to neglect of political events but to a different moral appraisal of these events.

Beyond ‘ignoring politics’: The political uses of social capital scholarship

Such a design was based upon intense national solidarity and dependent on Catholic doctrines and strong links to authority and hierarchy, but it was also based on equality, fraternity, and comradeship (among equal neighbors, brothers in arms, and comradeship of a mystical body).*


*On the ‘social capital’ of Franco’s Fascist rebel side during the Spanish civil war (1936–1939)

‘Maria: My village is on fire. I must … find out about my family. I am so frightened [She is crying]’

‘Wars I Have Seen’

Esther Silverstein Blanch (1992)
Although this is not noted in most public health research (see ref. 39 for a counter example), social capital was coined in relation to social structure (e.g. the tradition of Bourdieu linked social class, and social and cultural capital). Unfortunately, the social capital literature provides some notable examples of neglect of history and social structure, disregarding politics, social class, patriarchy, and racism.18

A notable example appears in the social capital analysis of the Spanish civil war, 1936–1939, and the ensuing four decades of fascism in Spain, 1939–1977.59 Spain has not had the benefit of a ‘truth and reconciliation’ commission. As a consequence, young generations of Spaniards are not aware that the war started because of an illegitimate coup led by a fascist general and supported by the land-owning aristocracy, industrial capitalists, bankers, and the clergy, against a democratically elected Republican government. The repression following the coup was among the cruelest of the 20th century. The Fascists’ insurrection against the democratically elected Republican government led to 500,000 dead and 400,000 refugees during the war, close to 200,000 executed or dying in prison in the 5 years after the war, concentration camps, incarceration of tens of thousands, and 40 years of Fascism (i.e. lack of political freedom, cultural repression, and economic backwardness).60–62 Yet Putnam’s chapter on the recent history of Spain portrays the conflict of two equally legitimate camps that lacked ‘bonding’ and ‘linking’ ‘social capital.’ It also ignores the deadly repression by Fascists after the war. This misrepresentation of historical facts in the name of innovative ‘social capital’ analysis is remarkable, given what is known about Franco’s Fascist regime. As this example shows, the use of ‘social capital’ explanations is not an innocent, inconsequential academic choice of terminology. Its use can have an influence on how historical events are understood and what constitutes adequate future social and health policies. We find another example of the political use of ‘social capital’ in the World Bank’s use of supposed deficiencies in social capital or institutions to explain development failures among borrowing countries (e.g. refs 63, 64) rather than acknowledging its own policy failures.65 In a brilliant analysis of the so-called ‘epidemiological transition’ (see also the debate between Luis Avilés and others in the Journal of Epidemiology and Community Health), Simon Szreter has shown us the neo-liberal uses of epidemiology.66 I believe that the same type of critical thinking should be used with ‘social capital’ research.

Szreter and Woolcock state that social capital has been criticized for not being ‘radical enough’. The label ‘radical’ has often been used to stigmatize egalitarian perspectives in social science and public health.67 For example, Edgar Sydenstricker, one of the founders of social epidemiology, was attacked for being ‘radical’ during McCarthyism.68 Given the institutional vulnerability of egalitarian perspectives, it is unlikely that any research programme would be accused of ‘not being radical enough’. In addition, some of the strongest criticisms of ‘social capital’ have originated in the mainstream of economics and sociology.69,70 But, as the example from Putnam’s volume illustrates, the political use of social capital outside public health leans towards tolerance for social inequality and against egalitarian social change. Intense debates surrounding the uses of social capital might seem academic. However, the historical antecedents and implications for the historical record of analyses such as the ‘social capital’ explanation of Franco’s fascist regime make dispassionate academic exchanges difficult.

Are scientist administrators the engine of public health melioration?

‘...The class war will find me on the side of the educated bourgeoisie’

John Maynard Keynes

In addition to his analysis of the ‘epidemiologic transition’, Szreter’s historical analyses of the effects of economic growth on mortality have made an important contribution to social epidemiology21 and advanced our awareness of the negative effects of economic growth on population health.72–74 However, his account of how public health change occurs is less convincing. Christopher Hamlin has shown that the public health successes in the first half of the 19th century in Britain were not the result of ‘social capital’ endowed and supposedly enlightened business men like Joseph Chamberlain, but the result of social conflict, including class conflict. Public health developed thanks to the emergence of the modern state and scientific progress; nevertheless, the public health decision to pursue water and sewer sanitation implied a decision not to pursue adequate nutrition and healthy workplaces.75 Similarly, Bismarck’s social insurance was a concession to the threat of working class socialist upheaval.54 More recently, we find a counterexample of this Fabian model in the case of Joseph Stiglitz, a Nobel Prize winner in economics serving in the Clinton administration, who had plenty of ‘social capital’: personal ties to elite universities, international financial institutions, the two major political parties, and multiple independent and often conflicting government agencies.65 In spite of all that ‘social capital’, he was able to accomplish little in terms of his political objectives to reduce poverty.65 From a class analysis, this is hardly surprising given the lack of representation of working class and social democratic constituencies in US institutions.76

Was lack of social capital the cause of excess mortality among African Americans during Chicago’s Heat Wave?

Je participe, tu participes, il participe, nous participons, vous participez, ils profitent.

(From a wall in Paris, 1969)

Sidney Verba and Norman Nie

The authors’ account of Klinenberg’s Heat Wave77 is particularly illustrative of how social capital provides cultural explanations at the expense of more pressing political and economic determinants of health. Far from implying, as the authors do, that the excess mortality among elderly African Americans during summer of 1995 in Chicago was caused by lack of social capital among elderly African Americans, Klinenberg is careful to avoid this implication. Nor is the authors’ portrayal of an adjacent Latino community as ‘vibrant’ (an adjective that evokes
erroneous stereotypes of poor but happy Latinos) and full of social capital adequate. Klinenberg attributes the excess of deaths among elderly African Americans mostly to the isolation caused by material poverty, economic, and racial geographical segregation, political neglect of the neighbourhood's infrastructure, cuts in several social services, inadequate response and co-ordination of health services during the heat wave, and lack of political will by city hall. In fact social capital is used twice by Klinenberg. One mention refers to lack of co-ordination in the network of health services providers (p. 158). The second mention of ‘social capital’ (p. 230) is critical and clearly conveys Klinenberg’s views of this explanation:

Recent debates about social capital … have neglected to take seriously the obstacles to civic and social engagement of the millions of seniors who live alone or suffer from health problems. But the increasingly narrow and technocratic inquiries in to the significance of social capital have also diverted attention from what might be the key finding … Current strategies to build new forms of social protection by ‘empowering’ the poor and the elderly with choices in the market for goods and services, or with new opportunities for affiliation in local groups, will be undermined by the everyday pressures of poverty and aging.

In a study of the effects of forced urban relocation in East Baltimore, we reached a similar conclusion in regard to the factors most likely to account for the health of residents in neighbourhoods that have been characterized by public health researchers as ‘disorganized’ or lacking in ‘social capital’.39,78 Unfortunately, large empirical studies of neighbourhoods do not probe for political and economic processes such as those detailed by Klinenberg. To paraphrase Nancy Krieger’s comment on the absence of class measures79—if you don’t ask, you don’t know. As a consequence, strong evidence from large primary data studies of neighbourhoods is only available to support ‘social capital’ type explanations, with minimal implications for reducing social inequalities. Crime, isolation, drug use, ‘broken windows’, sexually transmitted diseases and other diseases are seen as the outcome of some intrinsic deficiency of the community. Such pseudo explanations are not unlike the reification of ‘low intelligence’ for non-whites that Stephen Jay Gould so compellingly exposed,80 now the object is ‘communities’, a euphemism for poor working class and non-white populations.

Social capital and the slow progress of psychosocial epidemiology

‘The first problem is to show how the individual response emerges from the forms of collective life’

LS Vygostky

Psychosocial epidemiology (a mixture of sociological and psychological social psychology) seems to lack the cumulative character of many scientific disciplines. Constructs seem to gain and lose popularity without strong empirical or conceptual justification. Some of the field’s lack of progress might be due to methodological problems such as the large number of potentially omitted variables, the large number of associations in any study that can be uncovered with a large sample, the reliance on self-reports, the difficulty of distinguishing between independent and dependent variables (e.g. social capital and violence), identification problems, lack of mechanisms linking constructs with their health effects, and the use of competing hypotheses and assumptions that are as weak as those being tested.

Limitations also originate from the nature of current psychosocial theory in epidemiology. Psychosocial constructs are expected to provide generalized risk factor associations across time and place, ignoring the determining economic, political, and cultural context, as might be expected from many chemical and biological exposures. Even when constructs are conceived under historical and social constraints, researchers seem to transform them into a-historical, psychological traits. For example, the ‘Type A’ coronary prone behaviour pattern originated in clinical observations of the work-related behaviour of mostly white men middle managers in post-war US bureaucratic corporations. The construct thus referred to a specific period, cohort, age, class, gender, race, and institution. Soon however, health and social psychologists, epidemiologists and public health researchers transformed this construct into the search for a ‘Type A’ personality or trait of presumed universality devoid of relations to its social environment. The result was the narrowing of the concept to some forms of hostility (a psychological construct). Recently, however, the fact that ‘hostility’ may be associated with the social environment seems to have been rediscovered, although via its association with the much less informative ‘socio-economic status’ indicator.83 Type A is not the only psychosocial construct that has been stripped of its link to a historically specific social structure: ‘stressful life events’ are apparently randomly distributed in populations; social cohesion and social support are implicitly defined in terms of US middle class social psychology,6,9 and ‘job stress’ is presented as independent from the labour process, social class, or even social processes.26 The absence of social structure is even more evident with psychological constructs such as self-esteem or sense of coherence. Many putative socio-psychological risk factors are too dependent on changing economic, political, and cultural structures to attain great generality across time and place. Without understanding the link between social psychology and social structure (e.g. the ‘Type A’ behaviour might have been determined by post WWII upward mobility, middle management ‘heavy’ bureaucratic corporations, long-term job stability, the Protestant work ethic, and meritocratic expectations, among other ever-changing social processes), psychosocial constructs are reduced to their psychological common denominator (e.g. hostility) in a quest for replications with different populations, larger samples, longer follow-up periods, and application of new statistical techniques, but there is little payoff in terms of explanation. Although such a strategy, typical of empiricist ‘single indicator’ observational epidemiology, can lead to productive research programmes, it fails to deliver in terms of mechanisms and explanations.

Summing up: scientific progress, ideology and psychosocial epidemiology

‘The thing to judge any jazz artist is … does [s]he have ideas.’

Miles Davis

Following Miles Davis’ statement, the bottom line for ‘social capital’ is similar: does it bring new ideas and findings to social epidemiology? To its credit some public health research
using the term ‘social capital’ has both established social integration/cohesion as a group property and provided evidence of the complex relations between social inequality, social integration/cohesion and health outcomes (e.g. refs 3, 19, 21, 84, 85). However, these innovations could have been carried out under the label of ‘social integration’ or ‘social cohesion’, without reference to ‘social capital’. Social capital will be used as a metaphor for communitarian reciprocity, norms of solidarity, and social cohesion as long as the research community finds it acceptable. Given the analysis above, however, it would be more adequate to use terms such as ‘cohesion’ and ‘integration’ to avoid the confusion and implicit endorsement of this economic system that the term conveys.

Social capital proper, as exemplified by Burt’s network analysis, Bowles’ research, and the study of the enhancing productivity effect of shared cultural norms, is an area of research distinct from social cohesion and social integration. Nevertheless, the relevance and relation to health of this genuine social capital concept remain unclear. In regard to institutional ‘social capital’ as the model for public health improvements, besides the ability of well-connected local public health officials to lead coalitions that help improve the health of populations, the role of class politics and other structural conflicts are essential to understand public health change, in 19th century Britain as well as today.

In order to provide accurate accounts of how society affects health, a-historical and structure-less psychosocial constructs (‘social capital’, ‘sense of coherence’, ‘hostility’, ‘life events’, ‘job stress’, ‘social support’…) should be replaced with less ideological, historically (e.g. age-period-cohort) specific models in which social structure and psychosocial exposures are integrated into mechanisms that influence population patterns of morbidity and mortality.

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References
