Invited Commentary

Invited Commentary: Social Capital, Social Contexts, and Depression

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Received for publication February 5, 2008; accepted for publication February 25, 2008.

The literature concerning social capital and health has grown exponentially during the past somewhat more than 10 years. The study by Kouvonen et al. (Am J Epidemiol 2008;167:1143–1151) is a longitudinal multilevel analysis of 33,577 public sector employees in Finland. The study shows a significant association between workplace social capital and depression, which is an interesting finding in a very new field of the study of social capital and health. However, the study also serves as an inspiration for further studies in important research areas. Workplace social capital may be investigated according to both horizontal, that is, social contacts and level of trust in relation to coworkers, and vertical, that is, relation with employer/supervisor across power gradients, dimensions. The fact that workplace social capital may affect social capital outside work and vice versa is also of interest. It is also important to define and identify the social context level in a correct way in multilevel studies. In the study by Kouvonen et al., the social context is not a geographic entity but an entity defined according to place of work, and the definition of such a social context entails several difficulties. This study presents interesting findings and provides a basis for future studies.

depression; mental health; psychology, social; workplace

This invited commentary concerns the study by Kouvonen et al. (1), entitled “Low Workplace Social Capital as a Predictor of Depression: The Finnish Public Sector Study.” The study of the association between social capital and health has grown exponentially over the past somewhat more than 10 years. Social capital has been suggested to have an impact on health through a number of distinct pathways, of which the psychosocial/psychological pathway is one (2). The recent developments in the area of social capital and mental health are well covered in the references of the article (1). Social capital has also been defined in the article as the norms of reciprocity and trust, formal and informal associations, and civic participation that facilitate collective action for mutual benefit. Social capital is thus a multifaceted concept. Although some authors regard it as a microphenomenon entailing the social networks and trust of individuals (3), most authors emphasize its contextual nature (4, 5). The association with health has already at an early stage been studied in macro- (countries, regions), meso- (municipalities), micro- (social networks of the individual), and psychological (trust)-level studies (6). Social capital also has both a horizontal dimension, that is, trust between individuals, and a vertical dimension, that is, trust between individuals and institutions across a power gradient (7). The horizontal aspect of social capital has so far been studied in relation to health to a much greater extent than the vertical aspect of social capital, which is surprising considering the importance of different public institutions within the welfare state for the creation and maintenance of public health (8).

The association between social capital and health has been studied in both individual-level (9) and multilevel (10) studies. Multilevel and other contextual-level studies have mostly concerned the effects of social capital, social cohesion, or other social traits within geographic entities, such as neighborhoods, city parts, regions, US states, or entire countries, on health. However, the notion of social context does not necessarily imply a geographic entity of whatever small or huge format. A social context may also be an ethnic, occupational, socioeconomic, or workplace entity. People that constitute parts of a social context may thus
reside in different streets, neighborhoods, city parts, or regions but still belong to the same social context during, for example, work time. Such social contexts defined in dimensions other than the geographic have been analyzed in multilevel studies, such as for ethnic communities (11). The idea that the workplace may constitute an important social context follows from this highly plausible idea. In modern or postmodern societies, people in the workforce often spend 8 hours or more per day in the workplace. It seems highly plausible that both the psychosocial work environment and the norms and values concerning health-related behaviors may have an impact on the health of the individual working in the workplace.

The authors are correct when they state that the association between worksite social capital and mental health is not known. This longitudinal study of Finnish public sector employees without any previous history of physician-diagnosed depression at baseline in 2000–2002 includes items concerning workplace social capital that comprise both “cognitive” and “structural” aspects of workplace social capital. However, the items included in the social capital single-factor construct may be described in terms of not only cognitive versus structural but also horizontal versus vertical. Trust in other employees and similar items related to cooperation with other fellow employees are horizontal aspects of social capital, while items such as “we can trust our supervisor” may be denoted as vertical aspects of workplace social capital. In the study, all eight workplace items are aggregated into one single-factor construct on the basis of a range of psychometric methods to evaluate the reliability and validity of this measure. It may be interesting in future studies to analyze separately the social capital items related to supervisor/employer (vertical social capital items) and the social capital items related to other fellow employees (horizontal social capital items). Although they are highly correlated in the whole population that includes employees who both develop and do not develop depression, they may still be differently associated with depression. It would be possible to separate, for instance, items 1, 2, 4, 5, and 8 (horizontal trust/horizontal social capital without a power gradient) from items 3, 6, and 7 (vertical trust/social capital across a power gradient) in the present data material. As the authors already state, future studies of workplace social capital may also benefit from more objective measures of social capital, such as number of times informally socializing with coworkers.

One factor to also take into consideration in a study of social capital in the workplace is social capital outside the workplace. Individuals meet important others not only in the workplace but also in the closest family, relatives, friends, neighborhood, associational life, and all other imaginable social networks. It is highly plausible that social capital outside work affects social capital in the workplace and vice versa. Several factors may be in play. One study showed that the psychosocial work conditions in terms of demand and control as defined by the Karasek-Theorell model affect social capital measured as different aspects of social participation in different activities outside work (12). It may also be that conditions outside work affect workplace social capital and workplace psychosocial conditions.

A well-known problem in studies that entail social contexts as one or several of the levels of analysis concerns how to define relevant social contexts (13), that is, contexts which would affect the individual, the behavior of the individual, and the health of the individual by ways of, for instance, a specific psychosocial environment, a specific culture in terms of norms, values, and symbols, or a specific and very clear-cut organization, such as a school. The authors have strived to define specific social contexts in terms of workplaces. One such context with a specific psychosocial environment and a particular set of norms, values, rules in the workplace, and leadership style should not be divided into several different contexts or entities. On the other hand, several social contexts should not mistakenly be aggregated into one entity that would contain more than one relevantly delimited social context. The authors generally seem to have done a very good job defining relevant contexts in terms of worksites as functioning social contexts. However, they are still left with a total range of 3–430 people and a interquartile range of 12–34 for the different worksites in the study. It seems plausible that the social interactions and the level of trust between individuals in a place of work with 430 employees would differ from the social interactions and levels of trust in a workplace with only three employees. The reader is left with the question of to what extent the principle of lowest possible organizational level in the hierarchy of the organization represents the most optimal functional social context in terms of a psychosocial environment and a place where specific rules, relationships with the employer/supervisor, and norms and values exist. It also seems plausible that response rates varying between 10 and 100 percent would constitute a source of selection bias that may affect the relation between workplace social capital and depression. Although only 8 percent of the workplaces had response rates below 50 percent, do these low response rates, by themselves, constitute an indicator of low worksite social capital? This issue should be further discussed in future studies concerning social capital in the workplace and its association with mental health.

The use of an antidepressant drug prescription as an indicator of the diagnosis depression seems highly relevant in view of the lack of access to register data concerning the depression diagnosis. It is highly plausible that almost all who were diagnosed with clinical depression got a prescription for an antidepressant, but it is less likely that all persons with depression were diagnosed and, in the next step, given a prescription. This may lead to an underestimation of the association between low workplace social capital and depression in the study, because it may be that individuals in workplaces with low workplace social capital got less help from their coworkers in finding a physician or specifically a psychiatrist who could provide correct treatment. The statistical analyses generally seem adequate and correct.

In sum, this is a well-conducted longitudinal study with an interesting new research question that concerns the previously not investigated relation between workplace social capital and depression. It seems that the study presents interesting findings and provides a basis for future studies within this area of research.
ACKNOWLEDGMENTS

Supported by the Swedish Research Council (Vetenskapsrådet) (K2008-70X-01-3), Swedish ALF government grant Dnr. M 2007/1656, and The Research Funds of Malmö University Hospital.

The author wishes to express his gratitude to the three sources of funding.

Conflict of interest: none declared.

REFERENCES