John Bruhn

The Group Effect

Social Cohesion and Health Outcomes

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The group thinks, feels and acts entirely differently from the way its members would if they were isolated.

Emile Durkheim (1895/1982)

To Stewart Wolf

Preface

This book is the result of many years of research into many facets of social cohesion and how it affects health. The richness of research is that in the process of doing it, the insights and satisfactions as well as the frustrations and setbacks usually lead to new and greater understanding. Along the way, especially in the case of interdisciplinary research, strong personal collegial bonds enable frank critique of ideas and how to frame them for testing. When research involves complex, changing, and multidimensional concepts such as social cohesion, it becomes even more challenging.

I have benefited from academic environments where colleagues engaged in tackling complex research questions involving the social and behavioral sciences and medicine. Social cohesion and its relationship to health outcomes is one area of research that engaged the energy and intellect of many different colleagues, especially Stewart Wolf, W. W. Schottstaedt, David Gochman, Chester Pierce, Phil Nader, Guy Parcel, and Billy Philips, to mention a few. I am grateful for the opportunity to have worked with them. This book is the result of some of the questions, and unexplored and challenging areas of social cohesion and health that continue to exist in 2009. I propose to integrate and analyze what we know and point to the persistent gaps in our knowledge about the viability and efficacy of social cohesion as a mediating variable in health outcomes.

Scottsdale, Arizona — John Bruhn

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Chapter 1
The Significance of the Social Group

Introduction

Man is a social being who requires the support and companionship of others throughout life. In addition to learning, social cooperation has played an essential part in man's survival as a species, just as it has in the survival of sub-human primates. Konrad Lorenz[1] pointed out, men are neither fleet of foot nor equipped by nature with a tough hide, powerful tusks, claws, or other natural weapons. In order to protect themselves from more powerful species and in order to succeed in hunting large animals, primitive men had to learn cooperation; their survival depended upon it. Modern man has moved a long way from the social condition of the hunter-gatherer, but his need for social interaction and positive ties with others has persisted.

Some sociologists doubt whether the individual possesses significance when considered apart from the social groups of which he is a member. It is close social ties that give individual lives significance. From our birth onward, it is our socialization experiences with others that help shape our identity. Relationships act as points of reference in our life cycles that help us make sense of our experiences. We are embedded in networks of unique social relationships which serve as supporting pillars in our lives. People need people to survive and thrive. The most workable adaptation is our connections to others through groups.

The Concept of Group

In sociology, a group is defined as two or more interacting and interdependent people who come together to achieve particular objectives. This broad definition encompasses groups of many kinds and sizes, ranging from dyads to entire societies. Generally, sociologists have focused on macro aspects

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of group life, such as social structure and social integration. In social psychology, on the other hand, interest has focused on the micro aspects of groups, especially on the interaction of how individual's thoughts, feelings, and behaviors are influenced by the actual, imagined, or implied presence of others. As an interdisciplinary field, social psychology bridges many of the knowledge gaps about groups between sociology and psychology. Many of the linkages, pathways, or mechanisms yet to be discovered about how group behavior affects individual health and well-being lie in the interdisciplinary domain that bridges the gap between the macro focus of sociology and the micro focus of social psychology.

Common Characteristics of Social Groups

Strong disciplinary conceptual and methodological biases have characterized studies investigating the relationship between social ties and health.[2] Nonetheless, there are some characteristics of groups that have emerged as significant correlates of health even when studied as separate variables and unidimensionally. There are at least six such characteristics that emerge from studies that relate to the concepts of social support and social cohesion. The *first* characteristic is the interdependence of group members, e.g., social support. The *second* characteristic is the relationship of the group to the external environment such as networks, i.e., links to other groups. The *third* characteristic is the forces that bind parts of a group together and resist disruptive influences, e.g., cohesiveness. The *fourth* characteristic is the motives for group membership and the degree of identification individuals have with the group, e.g., conformity. The *fifth* characteristic is leadership behavior, e.g., how leadership style affects the group climate. The *sixth* characteristic is the group's culture, e.g., common values, beliefs, and expectations that provide the context for group behavior.

Interdependence of Members

Kurt Lewin[3] said,the essence of a group is not the similarity or dissimilarity of its members, but their interdependence. A group can be characterized as a "dynamic whole"; this means that a change in the state of any subpart changes the state of any other subpart. The degree of interdependence of the subparts of members of the group varies all the way from a "loose mass to a compact unit." A group is composed of members who mutually perceive themselves to be cooperatively or positively interdependent in some respects and to some degree.

Sociologist George Homans proposed that human behavior is an exchange of tangible and intangible activities and rewards/costs between individuals on the grounds that social interaction is guided by what each person stands to gain or lose from others. He said, "social behavior in a group or elsewhere,is a continuous process of members influencing other members, and the success of influence in the past changes the probability of success in the future. One result of the process of influence is that members of a group become differentiated in a more or less stable way – stable as long as external influences do not change very much."[4]

External Relationships

A group can be conceived in terms of its relationship to its external environment. Most of the research in group dynamics has focused on the internal structure and the dynamic properties of groups. However, groups are parts of larger social systems and, therefore, are in various kinds and degrees of relationships with other groups. Individuals can also simultaneously be members of several real and virtual groups that may be networked. These relationships, whether cooperative or competitive, have significant effects on the stability and durability of groups and the behavior of their members.

The Internet is transforming the collective interactions between people and ideas throughout the world. Increasingly online worlds enable people to create virtual lives through "avatars" or identities that they can tailor to their desires. People can become members of virtual groups where they can share intimate details about themselves while remaining anonymous. Investigators have found differences in the social relationships of small group members who carry out a task in a virtual environment and then continue the same task in a similar real-world environment. Results suggest that the person who emerged as the leader in the virtual group was not the leader in the real (immersed) group. Group accord tended to be higher in the real group than in the virtual group. Accord in the group increased with presence, the performance of the group, and the presence of women in the group.[5]

Cohesion

Social cohesion is a function of a member's level and type of group involvement.[6] Cohesion can be a continually changing or an enduring state of a group dependent upon the member's identification with and commitment to group norms. The cohesiveness of groups can change as some

members leave and new members join the group. Homans points out that a group controls its members by creating rewards for them, which it can threaten to withdraw. Cohesiveness refers to the value of rewards available in a group; the more valuable the activities a member receives from other members, the more cohesive the group.

The stronger the identification with a group's norms and the higher the value given to group rewards, the greater the group cohesion. On the other hand, a weak identification with a group's norms and a lack of rewards for members result in tentative cohesion and tenuous group survivability. The optimum level of cohesion is one where group identification is not so strong that it cannot appreciate differences in other groups and where the self-concept of individual members is not exclusively dependent upon one group.

Identification with the Group and Membership Motives

Membership in a group presupposes identification with the group. When people join a group they do so for a social motive, especially belonging. The motive of belonging appears to be universal across cultures, but it is enacted and managed differently in different cultures. For example, in Eastern cultures there is a greater focus on relational motives to maintain harmony while Western cultures focus more on self-enhancing motives to keep autonomy. Similarly, Japanese caution requires a long confirmation of trust compared to a shorter confirmation and openness to strangers among Americans.[7] There are different rules for belonging to and surviving in groups in different cultures.

Every group has a unique culture with different rules for group conformity. Conformity can have positive and negative effects. Many people see themselves as unique individuals, but at the same time comply with a set of societal and group rules most of the time. Nonetheless, in order to belong it is necessary to conform, and we must conform to survive.

The causes of conformity have been researched and debated for many years. Nail and his colleagues[8] have proposed five reasons for our conformity: (1) the desire to be correct; (2) the desire to be socially accepted and to avoid rejection and conflict; (3) the need to accomplish group goals; (4) the necessity of establishing and maintaining a self-concept and social identity; and (5) the alignment of oneself with similar individuals and forming an in-group. According to Nail, people comply with societal rules under most circumstances. Groups shape their members' behavior and members, in turn, help to shape the culture of groups. The predominate direction of this influence depends upon the self-esteem of the individual and the individual's

status in the group. The extent to which a group can be influential on individuals is conditional upon the individual's inclusion in the group; once the individual leaves the group, he/she will be free from that group's pressures to conform. Strong individual personalities, who assume leadership positions, can greatly influence group dynamics and goals.

Leadership Behavior

The effects of different types of leadership behavior have been shown to determine the climate of a group. A member's position in the group's communication network influences member behavior. Indeed, the nature of a group's communication network can affect group productivity and individual satisfaction. Who communicates with whom, about what, and with what frequency, in what manner, in what circumstances, and with what effects can characterize a group's structure and locate the status positions of various members of the group. Studies of the effects of autocratic, democratic, and laissez-faire group leadership have found that democratically led groups are more cohesive.[9] Also, members rewarded on a cooperative basis were more cohesive than members rewarded on a competitive basis.[10]

Group Culture

People join groups to share in similar values, beliefs, and lifestyles as their own. Every group has a "web of meaning" that frames the way members perceive the world and behave in it.[11] The web of meaning includes how members of a group collectively experience health and health problems. An understanding of a group's collective web of meaning also provides a context for understanding individual differences, which will occur even in the most homogeneous of groups. Research evidence has shown that health is valued and experienced differently by different cultural groups, there are variations in disease morbidity and overall mortality within and between cultural groups, and rates of the utilization of health services differ by cultural groups and their subgroups. Groups are continually subject to the external forces that surround them and, therefore, experience change. The consequences of cultural change have been shown to effect the health and well-being of groups differently. These consequences can vary among individuals in a given group depending on the significance of change for them. A group's culture can, itself, be a risk factor or a protective factor in the experience of health and disease. The challenge is to deeply explore the interactions between macro and micro processes that produce effects on health outcomes.

Types of Groups

The six characteristics of groups just discussed will vary by type of group. Sociologists distinguish between two types of groups, depending on the degree of personal ties between the members. Members of primary groups share personal and enduring relationships with one another. Primary groups are small in size and consequently their members know each other well and spend a great deal of time together. Primary groups include the immediate and extended family, friendship cliques, ethnic neighborhoods, and small rural communities. On the other hand, secondary groups are large and formal, and members share a specific goal or activity. Secondary groups range from an Internet chat room, to membership in a gym, to being a contributor to a political party. Cohesiveness can be an attribute of either primary or secondary groups.

While almost everyone seeks the experience of group life, groups differ widely in their size, structure, purposes, benefits and consequences, and the characteristics of their members. Our choices in belonging to groups vary greatly with our developmental needs and life circumstances. We establish superficial, temporary connections with groups to meet specific time-limited needs and at the same time become embedded in other groups that are an integral part of our lives for decades. Group membership is a powerful message of acceptance, but not all groups are open to those who would like to become a member. In-groups have strong boundaries and clear identities, and members hold overly positive views of themselves to distinguish themselves, sometimes unfairly, from out-groups.[12]

The Individual Versus the Group as the Unit of Analysis

Wilkinson[13] asks, "Why are some societies healthier than others?" He notes that researchers have grown used to thinking about the determinants of individual health that they have neglected a broader view. As a result Wilkinson muses, "we have learned a great deal more about individuals than we have about their health." Wilkinson proposes that health is a social product and that some forms of social organization are healthier than others. He states that what really moves societies may be factors that account for only a small part of the individual variation in health and so escape detection. Alternatively, factors responsible for major differences in the health of populations may be invariant among individuals and go undetected in studies of individuals. Different levels of analysis produce different pictures of the determinants of health – differences between individual and societal determinants as well as between different groups within the same society.

The French sociologist, Emile Durkheim, saw suicide as a social product. In his studies of suicide, Durkheim found that suicide rates showed a pattern over time and place. He observed that suicide rates were consistently higher in certain countries and in certain groups, even though individuals joined or left those groups.[14] Durkheim reasoned that there must be something that promoted a high or low rate of suicide in some groups compared to other groups. The lesson learned from Durkheim is that if effective methods of intervention and prevention are to be developed, we need to know the characteristics of the broader community and population.

Most of the rates of disease today reflect differences in the social and economic organization of societies. Most of the main causes look sociological. We need more attempts to identify group characteristics associated with good and poor health in the hope of discovering underlying causal factors. Many of the conventional explanations of the determinants of health – why some people are healthy and others not – are at best seriously incomplete, if not simply wrong.[15]

In recent literature public health researchers, especially epidemiologists, have debated on the contribution of social epidemiology.[16] Many large-scale studies have fallen short of expectations in identifying specific risk factors for disease onset and recurrence and many interventions to change individual's high-risk behaviors for certain diseases have been only minimally successful. Glass[17] believes that these limitations are due to risk factors being viewed as discrete, voluntary, and individually modifiable lifestyle choices, detached from the social context in which behaviors arise. Syme,[18]in surveying his career in social epidemiology, stated that most of the successes in smoking cessation have come about because they have been the subject of a multipronged, multilevel, multidisciplinary approach. These approaches involve not only information but also regulations and laws, mass media programs, workplace rules, and better environmental engineering and design. Inevitably, he said, "We in public health need to think across disciplinary lines."

Much of public health epidemiological research and interventions have focused on individual-level factors in understanding the cause of between-population differences in disease rates and have promoted interventions that rely on change emerging from individual-level behavioral choices.[19,20] Cohen and Syme[21] explain, "an individual perspective... addresses the question of why one person gets sick while another person does not. A social perspective addresses the question of why one group or aggregation has a higher rate of disease than another... interventions can be viewed from both perspectives... the issue is not whether one approach is better than another but the usefulness of different approaches depending on their purpose" (p. 19).

Krieger[22] discusses the limitations of what she calls "biomedical individualism" and challenges the current rigid distinction between individual and group-level analyses. She notes that there are health effects of groups that cannot be reduced to individual attributes. Corin[23] states that individual health behavior cannot be fully understood unless the social and cultural context in which it is embedded is understood. The context for studying the health behavior of groups is complex and dynamic and needs to utilize diverse methods. Therefore, analyses of group behavior involves more than simply aggregating or averaging individual measures, or gathering observational data, or using multiple regression methods to control for individual-level confounding variables. When a determinant of health at the societal or group level of analysis is not confirmed as a risk factor in studies at the individual level of analysis, the societal finding is labeled an "ecological fallacy."

The health dynamics of societies or groups may involve factors that account for only a small part of individual variation in health and may escape detection. On the other hand, factors responsible for major differences in populations or groups may be so common that they go undetected in studies of individuals.[24] The influence of social factors shared by most everyone in a society or group can only be detected by comparing different societies or groups. Important explanations for health differences between individuals do not explain differences within or between societies or groups. As Wilkinson points out, different levels of analyses produce different pictures of the determinants of health. Studies of individuals lead to attempts to distinguish between people with and without some disease or social problem who all belong to the same population or social group. Comparisons of different groups with and without the same disease or social problem help to identify shared and unshared characteristics common to the problem or help to identify common mechanisms by which the same problem is generated or prevented from occurring across different social and cultural contexts.

Table 1.1 shows an algorithm for studying behavior at the individual, group, and population levels. Basically the table points out that *how* a problem is studied will determine *what* is discovered about it. We will see in Chapter 2 that approaches to problems, such as group cohesion, have been discipline specific. As Geertsen[25] has noted, attempts to link group characteristics, especially ethnic and socioeconomic groups, to health behavior have a long history dating back to the early 1950s. Suchman's[26] pioneering research relating small group structure to health and medical behavior is an example. He found that individuals with social ties characterized by high family authority, friendship solidarity, and ethnic exclusivity had in-group tendencies or "parochial" group structures. Social ties characterized by the opposite attributes were called "cosmopolitan" group structures.

Table 1.1 Algorithm for studying behaviour at the individual, group, and population levels of analysis

Level of Analysis	Individual	Group	Population
Study Design	Focus on micro-level factors	Focus on meso-level factors	Focus on macro-level factors
Scope of Inquiry	Focus on specific cause-effect variables	Focus on mediating variables, mechanisms, pathways and linkages	Focus on specific cause-effect variables
Research Questions	What and when	How and why	What and when
Outcomes	Effects of micro phenomena generalized to group attributes (ecologic fallacy)	How and why micro and macro factors interact to produce positive and negative effects (contextual or ecosocial approach)	Effects of macro phenomena reduced to individual attributes (individualistic fallacy)
Intervention Expectations	Individuals seen in a social and environmental context and better understanding of their behavioral choices	Comprehensive (holistic) understanding of risks and protective factors that give rise to certain behaviors	Understanding of sub-groups and their differences with the population as a whole

These group characteristics were then related to individual medical orientations about how people thought, felt, and behaved with respect to illness and medical care. Unfortunately, Suchman's social group structures were not easily identically measurable by other investigators and it was, therefore, difficult to replicate his findings. This has led to cautiousness about using group-level methodology.

Methodological concerns have been raised about the complexity of studying health at the group-level, especially the limitations of observational data.[19] Corin[23]addresses this issue pointing out that group-level methodologies, such as participant observation, questionnaires, interviews, and the use of diaries and journals, can themselves produce different kinds of qualitative and quantitative data. Furthermore, if both individual and group-level factors are studied simultaneously, valuable insights might be gained about causal chains.

Groups, Relationships, Health, and Well-Being

The literature on the effects of social relationships on physical and mental health and well-being is substantial.[27] The basic assumption underlying most of these studies is that social relationships are good for us.[28] This assumption along with the belief that all health determinants can be conceptualized as individual-level attributes has led to a long list of investigations studying the causes of ill health, and its treatment and prevention as an individual matter. Only in the past few years has it been realized that aggregating individual-level data as a proxy for group-level variables is not a productive way to intervene to effect health outcomes. A common approach has been a unidimensional cause–effect model that has largely ignored the dynamic, multidimensional aspects of social relationships and health. This approach has been to study the presence or absence of social ties in unnatural groups (usually diagnostic groups) and estimate the strength of social ties (usually by quantifying the number of groups or close relationships) and how ties vary with different health outcomes (usually by comparing the rates of certain diseases across different kinds of groups). The results are crude correlations or associations between certain social variables and health outcomes. Despite these limitations, there are some consistent themes that have emerged in identifying relationships between the presence of social ties and positive health outcomes.

Effects of Social Ties on Health

The determination of the extent of the benefit of social ties is based more on qualitative than quantitative properties of relationships. The majority of studies have examined interpersonal relationships among individuals such as marital relationships and friendships to determine how emotional and social support work to sustain health and well-being.[29] In general, the preponderance of findings has shown that individuals who experience strong social relationships have better overall health, have a lower incidence and prevalence of certain diseases, especially chronic diseases, and have faster and less complicated recoveries from illness when they do become sick compared to individuals with weak non-supportive social ties. Studies of social ties at the community level have also demonstrated links between shared emotional connections, the feeling of belonging, and fulfillment of needs of residents and the social and physical environmental health of their community.[30] There is considerable evidence that suggests that community characteristics and community processes affect both health behaviors and health outcomes.

Several authors have cautioned, however, that it is not only the number of social ties, but their *quality* that appears to extend health benefits.[31] Furthermore, the impact of social ties on health is associated with different sources of social ties and the *dynamic interchange* between them.[32]What may matter is not the preponderance of either positive or negative social ties but rather the *interplay* between them and the effects of this interaction on physical and psychological health and well-being.

Berbrier and Schulte[33] found that the effects of social ties can have negative as well as positive effects. Relationships have different responsibilities and obligations and different costs and rewards. They found that it was the "degree of bindingness" related to costs and rewards that determined whether the effects on individuals would be positive or negative. What these authors called *binding integration* (relationships with close ties and many responsibilities) was more closely related to costs while *non-binding integration* was more closely related to rewards. Therefore, binding integration is more likely to result in negative consequences for mental health, while non-binding integration is more likely to have positive effects. They found that it was the *cumulative* effects of costs and rewards in binding and non-binding relationships that affected psychological well-being.

Only recently have investigators begun to examine the positive and negative components of social interaction.[34] Perhaps the more limited study of negative support has to do with the term itself, which is the difficulty of conceptualizing negative interactions in terms of support. Yet, social exchange theory has long emphasized that social interaction entails both rewards and costs. Rook[35] found that negative social ties had strong effects on well-being. Positive social ties were unlikely to enhance well-being unless an acute need for support existed. Rook[36] pursued the question of how interpersonal ties can be facilitated among the lonely and isolated. She suggested that attention be given to structural variables and features of social settings that inhibit the development of positive social ties, what she called "the ecological roots of loneliness." While the usual antidote to loneliness is perceived to be establishing a primary relationship, Rook suggested that alternative interventions should also be considered, such as helping lonely people develop a repertoire of enjoyable solitary activities. It is important that efforts to alleviate loneliness not be construed as endorsing an ethic of sociability. It is easy to exaggerate the benefits of social ties and to forget that loneliness is not always inevitably bad.

Social relationships provide a complex mix of uplifting and disheartening experiences. Neglecting either kind of experience will hinder efforts to develop a comprehensive understanding of how social ties affect health and well-being.[37]

The Effects of Social Ostracism on Health

Ostracism is more powerful now than ever because people have fewer strong family and friend support systems to fall back on when faced with exclusion in relationships, the workplace, and even Internet chat rooms. The effects of ostracism are a health concern, according to Kipling Williams, who studies ostracism.[38,39] Excluding or ignoring people, such as giving them the cold shoulder or silent treatment, is used to punish or manipulate. Some people purposely hurt others while others may not realize they are ostracizing someone. When a person is ostracized, even for a brief period of time, the anterior cingulated cortex, the part of the brain that detects pain, is activated. People experience the same initial pain when excluded by close friends, strangers, or enemies. The pain abates once the person talks with a friend about being excluded. Williams' findings were confirmed in a neuroimaging study that examined the neural correlates of social ostracism and tested the hypothesis that the brain's bases of social pain are similar to those of physical pain.[40] Participants were scanned while playing a virtual game in which they were ultimately excluded. This study suggested that social pain is analogous in its neurocognitive function to physical pain.

Psychiatrists and mental health workers who work in correctional facilities frequently have to assess and treat clients in solitary confinement. Results of studies are mixed, but most suggest that solitary confinement is not harmful to the majority of people but conclude that some may be less resilient due to their personality or mental illness.[41,42] Suicides have been documented among state prisoners with long-term assignments to single cell disciplinary housing.[43] Patients with chronic somatic disease tend to deteriorate in solitary confinement. Most patients recover when seclusion is terminated.

Overall, social rejection, exclusion, and marginality are powerful mechanisms of behavior control that may be effective as threats in maintaining group norms or individual integrity.[44] Indeed, the social pain resulting from the threat of social exclusion can persist throughout life.

The Effects of Social Isolation on Health

There is substantial research evidence showing that more socially isolated and less socially integrated individuals are less healthy physically and psychologically, and that they are more likely to commit suicide or to die prematurely.[45,46] Epidemiologists have found that mortality rates from all causes of death are consistently higher among the unmarried than the married. Unmarried and more socially isolated individuals also have higher rates

of tuberculosis, accidents, and mental illness.[47] Social isolation also damages the immune system and threatens cardiovascular health. Findings from a longitudinal cohort of over 1000 children from birth to age 26 showed that chronic social isolation across multiple developmental periods had a cumulative relationship to poor adult health, in particular risk factor clustering for end points of cardiovascular disease.[48] Social isolation has been linked to poor survival in patients with coronary artery disease and breast cancer and is predictive of poor post-stroke outcomes and more rapid progression from human immunodeficiency virus (HIV) to full-blown acquired immuno deficiency syndrome (AIDS).[49]

Studies of young adults who felt socially isolated perceived the hassles and stresses of daily life to be more severe even in the presence of others in the situation. They were more likely to passively cope with stress and show greater vascular resistance, a risk factor for hypertension. Finally, individuals who felt socially isolated also reported poorer sleep quality, longer sleep, and greater daytime dysfunction due to sleepiness compared to socially connected individuals.[49]

The magnitude of risk associated with social isolation is comparable to that of cigarette smoking and other major biomedical and psychosocial risk factors. However, our understanding of how and why social isolation is risky for health – or conversely how and why social ties and relationships are protective of health – still remains limited. Some authors have suggested that socially integrated relationships provide direct social rewards through reinforcement and increased meaning in life and also the regulation of behavior through mechanisms of social constraint, obligation, and responsibility. It is in groups that we develop a conception of ourselves as persons, which we learn from the attitudes and behavior of others with whom we interact in daily life. Anthropologist Ralph Linton summarized the benefits of social integration stating that "every human has the need for companionship and for the reassurance and emotional security which comes from belonging to a social unit whose members share the same ideas and patterns of behavior."[50]

George Homans pointed out the costs of social isolation stating, "If there is one truth that modern psychology has established it is that an isolated individual is sick. He is sick in mind: he will exhibit disorders of behavior, emotion, and thought. This does not mean that, for health, he must be a member of any particular group: not every group will be good for him. It does mean that unless he is a fully accepted member of *some* group – a family, a group of friends, a group of fellow workers – he will be in trouble."[51] Interestingly, while a serious deficiency of social relationships is risky to health, once the deficiency is removed, simply adding relationships to a social network does not produce substantial or significant increases in health and well-being.[52] What may be critical is not the effects of individual

behavior but how individual behavior is embedded within larger collectivities such as groups and communities and the effects of these collectivities on the health of individuals.

The Effects of Loneliness on Health

Loneliness is a potent but little understood risk factor for morbidity and mortality.[53] The research on loneliness suggests that different mechanisms operate to explain short-term and long-term effects of loneliness on health and well-being. Loneliness is a feeling or perception. Sometimes people feel lonely even though they have friends and enjoy social interaction. Sometimes people who tend to isolate themselves or choose solitude will not feel lonely at all. Pressman and her colleagues[54] found that *feeling* lonely is more significant than actually *being* isolated. In other words, individuals who *felt* lonely were more distressed and their distress was linked to a compromised immune function. On the other hand, it appears that even the intimacy and emotional nourishment provided by at least one other person has a buffering effect on stress. House et al.[55] concluded,

> . . . the mere presence of, or sense of relatedness with, another organism may have relatively direct motivational, emotional, and neuroendocrinal effects that promote health either directly or in the face of stress or other health hazards but that operate independently of cognitive appraisal or behavioral coping and adaptation (p. 544).

It is presumptuous to assume that persons who live alone are lonely. In a study of the effects of living alone on mental health, mental well-being, and maladaptive behaviors, researchers found no evidence that persons who live alone are selected into that living arrangement because of preexisting psychological problems, noxious personality characteristics, or incompetent behavior.[56] Contrary to what might be expected, results showed that unmarried persons who live alone are in no worse, and on some indicators are in better, mental health than unmarried persons who live with others. Furthermore, divorced and never-married persons who live alone have more in common with married persons in terms of their mental health characteristics, than do such persons who live with others. Unmarried persons who live alone showed a slight tendency to be more likely to engage in drug or alcohol use than unmarried persons who live with others. These findings point out that social integration has not only rewards but also costs.

On the other hand, living alone has been found to be an independent risk factor for recurrent myocardial infarction and cardiac death.[57] Similarly, researchers have found that persons with smaller or less diverse social networks, less frequent social interactions, or fewer people living in the

household had significantly increased risk for cardiac and all-cause mortality 2–15 years later.[58]

Psychologists have found that lonely individuals were more anxious, angry, and negative, and less positive, optimistic, comfortable, and secure than socially embedded individuals. Lonely individuals, in contrast to socially embedded individuals, made less use of social capital, expected negative outcomes, were less likely to reach out to seek help from others, and were more likely to think they were already doing all they could do in their relationships. Loneliness was associated with a range of altered physiological processes, especially among the chronically lonely, including sleep disturbances, distractibility, and emotional withdrawal.[59]

There is a continuum of choices of social connectedness for individuals ranging from social isolation to enmeshment. Usually individuals experience a variety of types and degrees of social connectedness throughout their lifecycle. Some individuals choose to join groups with lifestyles that have established certain boundaries and expectations with respect to social relationships, such as religious groups. Strong group attachments will be purposely sought by some individuals and avoided by others. Several cohesive groups in the United States and elsewhere have been the focus of studies of health and well-being.

Effects of Group Culture on Health and Well-Being

There are many groups in the United States that have been found to have lower mortality rates and lower morbidity rates for specific diseases compared to the general population as a whole. These groups share several social characteristics: (1) they place a high value on healthiness and maintaining good health; (2) they view health comprehensively: body, mind, and spirit are linked into a concept of unity or wholeness; (3) there is group pressure to conform to a lifestyle that emphasizes good health and the prevention of disease; (4) there are prescribed ways of coping with disease and illness; (5) there is continuous group support for and acknowledgement of the individual who is ill; and (6) social change is monitored and controlled.

Several of these groups have been studied by health professionals longitudinally so that the evidence linking culture and social structure to health and well-being is well documented.

Old Order Amish

The Old Order Amish, who live mainly in the Midwestern states in the United States, maintain a separateness from the larger society by

maintaining a simple lifestyle without material luxuries, a distinctive style of dress, an agricultural way of life, travel by horse and buggy, and absolute pacifism. Studies of their health beliefs and behaviors have shown that the Amish value being healthy, the ability to work hard and to have a sense of freedom to enjoy life, family responsibility, physical well-being, and spiritual well-being.[60] Being in poor health and unable to work is stigmatized and avoided.

The current life expectancy of members of the Old Order Amish community is about 72 years, nearly the same as the life expectancy for the average American. There are two significant differences, however. Among the Amish, the 72-year life expectancy is for men and women, while in the general United States population women tend to outlive men by about 7 years. Second, the Amish have had a 72-year life expectancy for the last 300 years since they settled in the United States in the 1700s, when most Americans were dying in their 40s. This is in spite of little or no medical or preventive care and eating a high-fat diet. What gives the Amish their exceptional longevity? This is a question being pursued by researchers who are studying the genetics of longevity.[61] Other questions arise related to the added contributions of Amish communal lifestyle and culture to their longevity.

Amish children have a relatively high incidence of certain rare genetic diseases and low incidence of others because the Amish population was founded by relatively few individuals. The first systematic survey of Amish women in 2004–2005 showed that Amish women rated their physical health about the same level as the general population; however, the Amish women reported less stress, fewer symptoms of depression, and higher scores for mental health. Amish women reported less partner violence, high levels of social support, and low levels of unfair gender treatment compared to the general population.[62]

Much of what is known about Amish behavior and culture is based on personal accounts or surveys. There is little evidence-based research on Amish health care; most of the information has come from interviews with healthcare providers. Yet, from what is known about Amish culture, the significance of the group is essential to their health and well-being.

Mormons

Devout Mormons follow the "Word of Wisdom," a health code revealed to Joseph Smith in 1833. The Word of Wisdom prohibits smoking or any use of tobacco, use of illegal drugs, drinking coffee or black tea, and drinking alcohol.[63] The Word of Wisdom does not prohibit the use of caffeine, but

some Mormons regard this as the intent of the prohibition of coffee and tea so they also avoid caffeinated sodas.

A 14-year study of the health of 10,000 Mormons in California showed that Mormons who follow the mandates barring smoking and drinking have one of the lowest death rates from cancer and cardiovascular diseases in the United States. The healthiest Mormons enjoy a life expectancy of 8–11 years longer than the general white population in the United States.[64] In a comparison of Mormons and non-Mormons in Utah, inactive Mormons were more like the non-Mormon population in the incidence of cancer with the exception of cancer of the lip, the prostate, and malignant melanoma of the skin.[65] Other research has found that Mormons tend to be more family-oriented, less likely to be involved in a crime, to be more socially conservative, have high self-esteem, yet also experience depression.[66] Young Mormon men living in Utah who closely adhere to their faith are less likely to commit suicide than their peers who are less active in the church.[67]

Seventh-Day Adventists

Seventh-day Adventists believe their bodies to be the temples of the Holy Spirit. Therefore, they feel a duty to take care of their bodies by a healthy lifestyle which includes avoiding pork, vegetarianism, and abstinence from shellfish and other foods proscribed as unclean. They also abstain from alcohol, smoking, and non-medical drug use. In addition, some Adventists avoid coffee and other beverages containing caffeine. Wholeness and health have been an emphasis of Seventh-day Adventists since 1863 when the church was founded. Many Adventists choose careers in health care. The health ministry of the church includes a health-care delivery system of church-operated clinics and hospitals throughout the world. The Breathe-Free Plan to Stop Smoking is one of the oldest programs in the world to help people quit smoking.

Research has shown that the average Adventist in California lives 4–10 years longer than the average Californian.[68] Compared to others, Adventists have lower mortality rates for many cancers. Vegetarian Adventists use fewer medications and are less likely to have had an overnight hospital stay or an X-ray during the previous year. The cohesiveness of Adventists' social networks has also been suggested as contributing to their extended lifespan. A comparison study of health status between Seventh-day Adventists and persons referred by general practitioners, and volunteers, found that depression, sleeplessness, and the use of sedatives and tranquilizers were lower in Seventh-day Adventists. Seventh-day Adventists showed less blood pressure impairment, less obesity, less problems with lung capacity, and lower

plasma concentrations of cholesterol and urate concentrations than the other two groups. It was concluded that the lifestyle of Seventh-day Adventists lessened morbidity, delayed mortality, and decreased the use of health services in comparison to the general population.

Certain structural and functional aspects of networks and support were studied among middle-aged male Adventists and their neighbors. The Adventist men were more likely to be married and had more trusted friends and more trusted relatives compared to their neighbors. At least weekly church attendance was practiced by 84% of the Adventists compared to 30% for their neighbors. The authors suggested that the favorable mortality experience of Adventists may be causally related to these increased levels of social support.[69]

Most commonly the immediate families and closest friends of Adventists are Adventists also. Many Adventists live in Adventist communities providing social ties in their medical, educational, and commercial health food institutions. There is community social pressure against deviating too far from community values. Parental values and modeling influence children at an early age.

Israeli Kibbutzim

A Kibbutz is an Israeli collective community that combines socialism and Zionism in a communal way of living. Kibbutzim are mainly agricultural where property is owned by the Kibbutz. Members live together and share work. The life experience of males and females is similar. The Kibbutz looks after all of the needs of its members and their families. About 3% of Israel's population lives in 270 Kibbutzim ranging in size from 200 to 2,000 members. They produce about 50% of Israel's agricultural produce and 9% of its industrial goods.

There have been several studies of Israeli Kibbutzim, religious and secular Kibbutzim in particular, regarding the protective effects of different lifestyles and degrees of religiosity on health. Research has shown that Kibbutz members as a whole have a higher life expectancy compared to other developed countries. Indeed Kibbutz males gain more years than females in comparison to their counterparts in other societies. Lower mortality rates have been found in religious Kibbutzim for all major causes of death.[70] While the reasons are unclear, the importance of environmental and societal factors appears to be of greater significance in determining life expectancy.[71]

Mortality in 11 secular Kibbutzim was found to be nearly twice that of 11 matched religious Kibbutzim. A study was undertaken in 10 of these

settlements (5 secular, 5 religious) to explain the unequal survival.[72] The authors concluded that religious Kibbutzim may enhance the formation of certain protective personality characteristics. Membership in a cohesive religious Kibbutz community may increase host resistance to stressors and thereby promote overall well-being and a positive health status. It seems that the regulative and integrative function of belonging to a religious community makes for a healthier lifestyle and promotes health,[73] especially among women.[74,75]

Clergy and Religious Orders

An exhaustive literature search was undertaken to find studies on mortality rates among clergy.[76] A total of 12 studies published between 1959 and 2000 examined mortality among American and European clergy. All but one of the reports found lower all-cause death rates for clergy compared to the general population of similar age. Protestant ministers were found to have more than a 25% mortality advantage. Catholic nuns had a mortality advantage of 20–25%, whereas the mortality advantage of Catholic priests was just over 10%. Studies of the contemplative order of monks, the Trappists, have shown a lower mortality compared to the general population.[77]

The Nun Study is a longitudinal study of 678 Catholic sisters aged 75–107, who are members of the School Sisters of Notre Dame.[78] Three sources of data are available to study mortality and aging, in particular Alzheimer's disease, among the sisters: (1) archives provide personal data from the time of entry to the convent; (2) annual examinations provide changes in the physical and cognitive function of each participant; and (3) each sister has agreed to brain donation at death for autopsy. These data, along with detailed case histories of healthy centenarians, have provided insights into the protective and health-enhancing environment of convent life. The stable and consistent environment and the similar lifestyles of the nuns made it possible to minimize confounding variables.

The autopsied brains of nine centenarians have shown that the progression of Alzheimer's disease increases with age, then reaches a plateau, and declines. The study's most striking finding is that Alzheimer's disease is not an inevitable consequence of aging. Snowden obtained the early life biographies of 74 sisters who had brain autopsies by 2001 and found that the power of "idea density" in predicting Alzheimer's disease was about 80%.[78] Idea density reflects language processing ability. It was assessed by a psycholinguist who read the nun's autobiographies, which they wrote on entry to the convent. Autobiographies that were more grammatically complex were

judged to have higher idea density, a protective factor against developing Alzheimer's disease.

Snowden observed two factors that he could not quantitate or test, but which he regarded as important to the nun's longevity. The first was the profound faith and positive outlook that these women shared. The second was the power of community. The nuns benefited from a constant network of support and love. Snowden commented, "the community not only stimulated their minds, celebrated their accomplishments, shared the aspirations, but also encouraged silence, understood defeat, and nurtured each other when their bodies failed."

Jarvis and Northcott[79] reviewed key literature on the relationship between religion and morbidity and mortality. They concluded, "by whatever theological viewpoint, it is becoming evident that religion has a powerful effect on the way people live, on the quality of their life, and on the length of time they live to experience that quality" (p. 822).

Okinawans

Elderly Okinawans have among the lowest mortality rates in the world and enjoy what may be the world's longest life expectancy. Centenarians, in particular, have a history of aging slowly and delaying or sometimes escaping the chronic diseases of aging including dementia, cardiovascular disease, and cancer. The Okinawa Centenarian Study is a population-based study of centenarians and other elderly in Okinawa, Japan.[80] The study began in 1976, after the Japanese Ministry of Health, Labor and Welfare confirmed reports of outstanding health and long life through validation of birth certificates and other statistical data. Since then Dr. M. Suzuki, the principal investigator, and his research team has studied over 800 centenarians. Studies have concentrated on the genetics, diets, exercise habits, and psychospiritual beliefs and practices of the Okinawan elders.

By 1995, according to the Japanese Ministry of Health and Welfare life tables, Okinawan life expectancy had even surpassed the absolute limits of population life expectancy estimated by the Japan Population Research Institute and many demographers.[81]

Personality testing found that centenarians scored low on time urgency and tension and high in self-confidence and unyieldingness. Interviews revealed optimistic attitudes, adaptability, and an easy-going approach to life. Moderation was found to be a key cultural value. Strong social integration and a deep spirituality were particularly evident among older women. Japan has frequently been cited as a socially cohesive society with a traditional culture that puts a high value on social relationships. Although social

contact was found to be high in Okinawa, elders retained independence. Independence was particularly important for elderly women. Many of them live alone, especially in rural areas, yet at the same time they have active and strong social networks that support independent living.[82] A traditional support system known as *Yuimaru* and mutual support organizations known as *Moai* may be part of the reasons the oldest Okinawans can remain active and independent at extreme old ages.[83]

The Okinawans incorporate both Eastern and Western healing methods in their health care system. It is interesting that two of the societies in the world that have the highest life expectancy (Okinawa, Japan, and Hong Kong) have incorporated both Eastern and Western approaches to healing.

Tarahumara Indians

The Tarahumara Indians live in the Sierra Madre of northwestern Mexico.[84] They live in small isolated clusters and are semi-nomadic and cave dwellers for part of the year. The area is rugged; so foot travel is the best option for getting from one place to another. Running is used to perform daily tasks. It is not uncommon for Tarahumara to travel between 50 and 80 miles every day at a running pace. Their hunting practices are widely known in Mexico and ranchers have been known to hire the Indians to chase down wild horses. Several scientific tests have concluded that the Taramuhara's endurance is based more on conditioning than on heredity. Diet plays a role in that their diet is practically meatless and consists mostly of complex carbohydrates.

Running is important in Taramuhara culture. They take great pride in their running abilities and the best runners receive great status in their society. They center their entire culture around running. There are races in which people of the same sex compete. In the men's races the teams kick along a wooden, baseball-shaped ball as they run. Each man takes his turn dribbling the ball similar to soccer for a total distance that may reach 150 miles over rugged terrain. Runners smoke and drink until the day of the race. Women run a similar race except they throw and catch interconnected loops while they run.

The Tarahumara culture has changed little over six centuries. Sharing, especially land sharing, is common. When trouble arises, the Tarahumara practice passivity.

One of the most important social events in the lives of the Tarahumara, aside from running, is tesquinado, an event that takes place following one Indian helping another Indian in some type of project such as fence building.

The gathering is a symbol of gratitude and thanks and involves large amounts of alcohol called tesquino. Drunkenness is a matter of pride rather than shame.

Adulthood is usually short with the average life expectancy of 45. There is a very high infant mortality rate and a very high birth rate. The average Tarahumara woman gives birth to about 10 babies hoping that 3 or 4 will survive to adulthood.

The Tarahumara have come into public spotlight as they have recently entered ultra marathons to call attention to deforestation and increased logging. Drug traffickers have forced the Tarahumara to grow marijuana, heroin, and opium and used the Indians as cheap labor. To combat the drug problem, the Mexican government has been spraying a herbicide over their fields and polluting the Tarahumara's drinking water.

Medical studies have been conducted substituting an "affluent" diet for a group of Tarahumaras who are known to consume a low-fat, high-fiber diet and to have a very low incidence of risk factors for coronary heart disease. When Tarahumaras consumed, for a short time, the hypercaloric diet typical of the United States population, they had dramatic increases in plasma lipid and lipoprotein levels and body weight. If sustained, such changes would increase their risk of coronary heart disease.[85]

Costa Rica's Nicoyans

Dr. Luis Rosero-Bixby, a Costa Rican demographer, has claimed to have discovered a group of people who have the longest life expectancy in the world. The Nicoya Peninsula, about 70 miles long and 30 miles wide, in northwestern Costa Rica, has a population of about 75,000. Life exists much the way it has for hundreds of years. Nicoyans make their living as farmers, laborers, or sabaneros – cowboys who work on large cattle ranches. Dr. Rosero-Bixby along with Dr. Michel Poulain, a longevity expert, interviewed 90–100 year olds to verify their ages, then checked them against birth certificates in the archives that have existed since 1888.

Dan Buettner, a National Geographic writer, learned about Nicoyan longevity. Successful centenarians were religious, family oriented, unconcerned with money, flexible, but decisive, and likable. These were traits he had found in his interview of 200 centenarians throughout the world. Among the Costa Ricans' secrets to a long life were strong social networks that included frequent visits from neighbors and a focus on family that provides support and a sense of purpose and belonging. Their spiritual traditions have enabled them to remain relatively free of stress.[86]

Longevity has been studied in other ethnic groups throughout the world including the Abkhazians of the Caucasus Mountains of Georgia in Russia

and the Hunzas of Northern Pakistan.[87,88] The unusual longevity of these groups is often ascribed to genetics and little remains known about how culture may be a contributing factor.

Table 1.2 lists some of the social characteristics common to societies and social groups with low rates of disease, high rates of life expectancy, and exceptional longevity that have emerged from the studies we have reviewed. Wilkinson[89] has aptly summarized,

> Looking at a number of different examples of healthy egalitarian societies, an important characteristic they all seem to share is their social cohesion. They have a strong community life... individualism and the values of the market are restrained by a social morality... there are fewer signs of anti-social aggressiveness and society appears more caring. In short, the social fabric is in better condition.

Summary

Much of research in health has been focused on identifying risk factors in individuals or populations and then either using aggregated individual data to understand the health of populations or generalizing population data to implement health interventions among individuals. The social group as a unit of analysis has been largely ignored.

We have taken the position that all behavior is the result of individual–group interactions. All learning is determined by an individual's attachment to various groups and their members. Social cohesion is a function of member's levels of involvement and types of involvement in various networks.

Table 1.2 Some social characteristics common to groups and societies with low rates of disease, high rates of life expectancy, and exceptional longevity

- Egalitarian social structure
- Ethnic homogeneity
- Geographic stability
- Health is valued and viewed and practiced holistically
- Strong religious beliefs
- Mutual social support
- Consistency/predictability in lifestyle, habits
- Family stability and responsibility
- Shared moral and ethical values
- Civility and respect for persons
- Personal behavior contributes and supports the common good
- Controlled social change
- Clear boundaries

Group membership and involvement is key to understanding health lifestyles and behavior.

We discussed the individual versus the group as a unit of analysis and agree with those authors who propose that the health effects of groups cannot be reduced to individual attributes and individual attributes cannot be summed or averaged to understand the effects of groups. We reviewed significant literature that has shown positive as well as negative effects of social ties or connections on health, especially studies of the effects of social isolation, social ostracism, and loneliness on health.

Of key importance in this chapter was the exploration of how group culture and social structure influence health and well-being. There are a number of studies of group health. For example, the Old Order Amish, the Mormons, the Seventh-day Adventists, the Israeli Kibbutz, clergy and religious orders, and the Okinawan and Costa Rican centenarians, all provided examples of how culture and health and well-being are interrelated. Several social characteristics common to groups and societies with low rates of disease, high rates of life expectancy, and exceptional longevity were identified.

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geographic exchanges of favors and obligations to one another, see B. J. Wilcox, et al., *op. cit.*, Chapter 9. *Moai* means "meeting for a common purpose." Essentially a moai is a group of friends, relatives, workmates, or groups that meet regularly for reciprocal support. The support is financial, emotional, and social. Okinawans are like natural "social support convoys" that follow one throughout life. Over 50% of all Okinawans, young and old, participate in a moai.

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Chapter 2
The Concept of Social Cohesion

Introduction

Cohesiveness has been a topic of long-term interest in sociology and psychology as well as in mental health and more recently in public health. While the concept of social cohesion is intriguing, it has also been frustrating because its multiple definitions prevent its meaningful measurement and application. Investigators have conceptualized social cohesion, and developed methods for studying it, based on the theoretical assumptions of their own discipline. In sociology, social structure provides the framework for studying the behavior of social groups and organizations.[1] In social psychology, cohesiveness is considered an attribute along with other processes operating within and between small groups.[2] In psychology, cohesiveness relates to the members of a group who share emotional and behavioral characteristics with one another and with the group as a whole.[3] In mental health, the small group is viewed as a dynamic system in which the differentiation of roles during phases of group development is dependent upon a cohesive group bond.[4] And, in public health, cohesiveness is viewed as part of the social and environmental context of individuals and societies that influence health risks and protective factors.[5] Disciplinary boundaries have protected the definitions of social cohesion and made it difficult to investigate multidisciplinary, multilevel aspects of the concept.[6]

Historical Overview of Conceptions of Social Cohesion

There has been much theoretical and empirical research on social cohesion in both sociology and social psychology. A review of key studies of the concept from the late 19th century to the early 21st century showed that they seemed to cluster around three methodological approaches: empirical, experimental, and social network analysis (see Table 2.1).

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Table 2.1 Historical overview of conceptions of social cohesion in sociology and social psychology

Theorist/investigator*	Key observations and findings
Le Bon (1896)	*Solidarity* of the crowd is *due to its uniformity of action* which, in turn, is largely due to its anonymity and contagion. Antisocial motives are released through suggestion
Durkheim (1897)	Different rates of suicide reflect differences in *social integration*; categories of people with *strong social ties* had low suicide rates, whereas individualistic categories of people had high suicide rates
Cooley (1909)	A primary group is a small social group whose members *share personal and enduring relationships* in contrast to secondary groups, which are large, impersonal whose members pursue a specific goal or activity
Freud (1921)	Primary identification explains loyalty and attachment to the group leader and to group members by *intense emotional ties* which represent the social bonds of groups
MacDougall (1921)	The group is more than the sum of individuals; it has a life of its own, a collective soul, or group mind, *a common mode of feeling, and reciprocal influence* among members
Moreno (1934)	Founder of sociometry; deals with the inner structure of social groups and the forms emerging from forces of attraction and repulsion among group members. *Selective relations among individuals give social groups their reality*. Social configurations can be determined by measurement of *choices and patterns of the degree of group reality*
Lewin (1943)	The essence of a group is the *interdependence of its members*. A group is a dynamic whole; a change in any subpart changes the state of any other subpart. The degree of interdependence depends upon the size, organization, and *intimacy of the group*
Lippett & White (1943)	The cohesiveness of a group is higher under conditions of *democratic leadership*. Cohesiveness and high morale are largely the result of *having one's expectations met*
Deutsch (1949)	Provided analysis of group problem-solving and interaction process when members of groups are placed in a situation where *cooperation is to their mutual benefit*. Group members rewarded on a cooperative basis were more cohesive than members rewarded on a competitive basis
Homans (1950/1961)	Social behavior is an exchange of more or less valuable rewards. Cohesiveness refers to the *value of the rewards available in a group*. The more valuable the rewards, the greater the cohesiveness
Festinger et al. (1950)	Formalized a theory of group cohesiveness. Cohesiveness is a key phenomenon of membership continuity – *the "cement" binding together group members and maintaining their relationships* to one another. Investigated how face-to-face small, informal, social groups exerted pressure upon members to adhere to group norms
Back (1951)	In experimental groups Back found that in *more cohesive groups, members made more effort to reach agreement and were more influenced by discussion* than in less cohesive groups
Schachter (1951)	Schachter *produced* clubs with *high cohesiveness by grouping students who expressed moderate or high interest in their activities*; he created clubs with low cohesiveness by grouping students who expressed little or no interest in their activities

Table 2.1 (continued)

Theorist/investigator*	Key observations and findings
Cartwright (1950); Cartwright & Zander (1953)	A group in which *norms are well institutionalized* will be able to *present a secure front* to the outside world. When a group member accepts and conforms to group norms his security is enhanced by the *supportive power of the group*
Asch (1952)	Showed the *power of groups to generate conformity*. In an experiment, he showed that group members are *willing to compromise their own judgment to avoid being different* even from others they do not know
French (1956)	Proposed a *theory of social power* that defined seven sources of power for changing conditions inside or outside a social group
Miligram (1965)	Studied *pressures of conformity* – in an experiment demonstrated that people are likely to follow directions from not only legitimate authority figures but from groups of ordinary individuals, even when it means inflicting harm on another person
Lott & Lott (1966)	Cohesiveness is that property which is *inferred from the number and strength of mutual positive attitudes among the members of a group*. . . where. . . the primary condition for the development of mutual positive attitudes among group members is seen as the attainment of goals or receipt of rewards in one another's presence
Sherif & Sherif (1969)	*Cooperative interdependence in the pursuit of shared goals which cannot be achieved by an individual alone* results in a well-defined group structure. Mutual need satisfaction through cooperative interaction imbues group members with positive valence and so makes the group attractive and encourages members to remain in it
Janis (1972)	"Groupthink" is a term coined by Janis. Groupthink occurs when a group makes faulty decisions because group pressures lead to a deterioration of mental efficiency, reality testing, and moral judgment
Granovetter (1973)	Most network models deal with strong ties in small, well-defined groups. Granovetter suggests the *power of weak ties* in linking micro and macro levels of sociological theory. *Personal experiences of individuals are bound up with larger scale aspects of social structure*. Weak ties are a bridge to parts of the social system that otherwise might be disconnected
Stokes et al. (1983)	Studied the relationship between self-disclosure and intimacy in groups. Intimate self-disclosure more desirable in the early life of a group to create cohesion

Table 2.1 (continued)

Theorist/investigator*	Key observations and findings
Piper et al. (1983)	Studied group dynamics in six member learning groups where participants assessed cohesion. Responses yielded a five item factor authors called "*commitment to the group*," which they said represented their conception of group cohesion
Friedkin (1984)	Examines the use of *network cohesion* for studying the emergence of *consensus among group members*
Wellman (1979); Wellman et al. (1988)	Studied residential area in central Toronto with a tradition of cohesion. The community ties they found did not fit sociological criteria for community. Only some ties provided strong support, only a few were part of densely knit solidarities. *Treated networks as personal communities*; *ways in which networks fit persons*. Treating communities as networks helped in understanding how resources were channeled to members and how small interpersonal ties fit into larger social networks
Braaten (1991)	Proposes a multidimensional model of group cohesion based on an extensive literature review. Two factors are generic in models of cohesion namely attraction and bonding, and self-disclosure and feedback
Wellman & Wortley (1990)	*Different types of ties provide different kinds of supportive resources*. Not all types of ties are supportive. *Most relationships provide specialized support. Strong ties provide emotional aide, small services, and companionship*. Physically accessible ties provide services. Friends, neighbors, and siblings provide about half of all supportive relationships
Bollen & Hoyle (1990)	Propose that individual group members' perceptions of their cohesion is important for the behavior of the individual and the group. They say that perceived cohesion has two dimensions: *a sense of belonging* and *feelings of morale*. They use a Perceived Cohesion Scale to test and confirm their theory in two random samples
Carron & Hausenblas (1998)	Defined cohesion as a dynamic process that reflects a group's tendency to stick together and remain united in satisfying member needs. They believed this definition applies to most groups such as sports teams, military units, fraternities, and friendship groups
Moody & White (2003)	Focused on the basic network features of social cohesion. They differentiate *relational togetherness* from a *sense of togetherness*. They believe cohesion is a property of relationships. They examine the paths by which group members are linked

* References for investigators are listed in the References section at end of book.

Empirical Studies (Late 19th and Early 20th Centuries)

Gustave Le Bon, a French social psychologist, in 1896, formulated an explanation for collective behavior. He observed that crowds exerted a hypnotic influence over their members. Crowds could assume a life of their own, stirring up emotions and driving people toward irrational acts. Le Bon's contagion theory was, perhaps, the earliest precursor of the concept of social cohesion. About the same time, Emile Durkheim, a French sociologist, in 1897, studied the relationship between social cohesion and suicide.[6] He collected data that revealed patterns showing that certain categories of people were more likely to commit suicide. He found that different rates of suicide were the consequence of variations in social structure, especially of differences in the degree and type of social solidarity. Charles Horton Cooley (1909) formulated the idea of primary groups. Primary groups were characterized by intimate, face-to-face communication, exhibited cooperation and conflict, and had members who spent a great deal of time together and knew each other well. Sigmund Freud, in 1921, observed that an individual's primary identification came from the intense emotional ties they experienced in closely bonded groups. William MacDougall, in 1921, pointed out that a group is more than the sum of individuals; it has a life and mind of its own. He introduced the idea of reciprocity and a common mode of feeling members have for each other.

These social theorists interpreted social data as they *observed* them. What they lacked was a method for checking and extending their observations.

Experimental Studies (Early- to Mid-20th Century)

The early- to mid-20th century was the period during which experimental studies of social cohesion flourished. Jacob Moreno, a Romanian psychiatrist, theorist, and educator, founded psychodrama, sociometry, and group psychotherapy. Recognized by Harvard University as one of the greatest social scientists in the world, Moreno became interested in the potential of group settings in therapeutic practice. Sociometry is a quasi-quantitative technique invented by Moreno that measures the degree of relatedness between people. Measurement of relatedness can be useful in the assessment of behavior in groups and for interventions to bring about positive change and determining the extent of change. Group sociometry can be used to enhance communication and reduce conflict because it allows the group to see itself objectively and to analyze its own dynamics.

In 1946, Kurt Lewin founded the Research Center for Group Dynamics at the Massachusetts Institute of Technology. He is known for his field

theory that is based on the proposition that human behavior is the function of both the person and the environment. This means that one's behavior is related to both one's personal characteristics and to the social situation in which one finds oneself. Lewin found that experiential learning is best facilitated when there is a conflict between immediate concrete experience and detached analysis within the individual. A cycle of action, reflection, generalization, and testing is characteristic of experiential learning.

The most fundamental construct of Lewin's is that of the psychological field or life space. All psychological events are a function of life space, which consists of the independence of the person and the environment. He saw the individual as an equilibrium-maintaining system. He viewed the group as a dynamic whole – the interdependence of its members – in which a change in any subpart changes the state of other subparts. The degree of a group's interdependence depends on the group's size, organization, and intimacy.

The early experiments of Ronald Lippitt and Robert White and others such as J. R. P. French and Leon Festinger, were instrumental in initiating experimental investigations of group life in social psychology and sociology. Lewin, Lippitt, and White's study of the effects of different types of leadership behavior demonstrated how crucial the position of leadership is in determining the atmosphere of a group. Lippitt also studied behavioral contagion in groups, specifically the relationship between status and the ability to influence others in the group. These studies provided the rationale for the use of communication as a key instrument for characterizing group structure and for locating the occupants of various positions within this structure. Lippitt and White also studied the influence of process in organizations. They believed that behavior is primarily influenced by authority, that is, the control over reward and punishment and by persuasion, or by a combination of these. The way in which these modes of influence are used by superiors determines their style of leadership.

Morton Deutsch, a student of Lewin's, is considered the founder of the theory and intervention in conflict resolution. He found that a group may be defined as a set of members who mutually perceive themselves to be cooperatively or promotively interdependent in varying respects and degrees. He stated that it was clear that cohesiveness refers to the forces that bind the parts of a group together and which resist disruptive influences. He believed that the study of the conditions affecting social cohesiveness and of the effects the variations in social cohesiveness have on group functioning was at the basis for understanding group life. Deutsch found that group members who were rewarded on a cooperative basis were more cohesive than members rewarded on a competitive basis. He proposed that members of cohesive groups were (1) more ready to accept the actions of other group members as

substitutable for intended actions of their own, (2) more ready to be influenced by other group members, and (3) more likely to positively respond to the actions of other group members. Deutsch also found that the motivation of members to continue working with the group, feeling an obligation to the group, and the evaluation of the group's performance were affected more by the group's dynamics than by its goal attainment.

George Homans was the founder of social exchange theory. This perspective explains social change and stability as a process of negotiated exchanges between parties. For example, when a person perceives the costs of a relationship as outweighing the perceived benefits, the theory predicted that the person will choose to leave the relationship. When the costs and benefits are equal in a relationship, then that relationship is considered as equitable. Cohesiveness refers to the value of rewards in a group. The more valuable the rewards, the greater the group's cohesiveness.

Leon Festinger, Stanley Schachter, and Kurt Back defined cohesiveness as "the total field of forces which act on members to remain in the group." The nature and strength of forces acting on a member to remain in the group may vary from member to member. There may be many different forces acting upon an individual as well as those they initiate. However, Back found that in more cohesive groups, members made more efforts to reach agreement and were more influenced by discussion than in less cohesive groups, no matter what the basis of attractiveness was for joining the group. People in groups composed of members attracted to the group by a liking for other group members were more chatty, but where cohesiveness was based on the prestige of the group, members were more cautious and less relational with one another, and where cohesiveness was based on the group as a means to a goal, members were more impersonal and task-oriented.

A number of experimental investigations bear on the factors determining group cohesiveness. Back found that he could produce high cohesiveness by stressing to members how much they would like each other, how important it was for the group to do well on the task since the task was a test of ability, or how prestigious the group was. Schachter produced clubs with high cohesiveness by grouping students who expressed moderate or high interest in their activities; he created clubs with low cohesiveness by grouping students who expressed little or no interest in their activities.

Festinger's theory of social comparison had significant implications for group formation and group structure. He found that the drive for self-evaluation can lead people to associate with one another and to join groups. His theory suggests that the selective tendencies to associate with others of similar opinion and ability guarantee relative homogeneity of opinions and abilities within groups. The theory of social comparison was extended by

Schachter to apply to the evaluation of emotions as well as to the evaluation of opinions and abilities. He demonstrated that the tendency to affiliate with others undergoing a similar experience increases when people are anxious. Schachter proposed that the emotions experienced by an individual are often influenced by the process of social comparison.

Dorwin Cartwright succeeded Kurt Lewin at his death in 1947 as the Director of the Research Center for Group Dynamics at MIT and oversaw the Center's move to a new Institute for Social Research at the University of Michigan. Alvin Zander joined the faculty and Cartwright and Zander became collaborators. The two colleagues facilitated the growth of group dynamics as a field of inquiry. Cartwright endorsed the concept of "power field" – a field that could induce changes in the life space within its area of influence. He acknowledged that power was not the attribute of a single person but rather a relationship between persons. The mechanism by which power is demonstrated is in the form of control. Cartwright found that if a superior is expected to control subordinates, he/she must be given that authority. To support his/her authority, the superior is generally given some control over inducements as well as some control over the fate of the subordinate. The superior may also use informal means of influence such as persuasion.

Solomon Asch's conformity experiments were a series of studies that demonstrated the power of conformity in groups. People conform because they want to be liked by the group and because they believe the group is better informed than they are. Asch found that one of the situational factors that influences conformity is the size of the opposing majority. People conform less if they have an ally. It is difficult to be a minority of one but less difficult to be a minority of two. Asch concluded that it is difficult to maintain a perception or opinion when no one else does. Group pressure can lead to the modifications and distortions making a person see or believe almost anything.

J. R. P. French analyzed how conditions can be changed inside and outside a group drawing upon seven sources of social power: (1) *connection power* – the ability to draw on the resources of influential people and organizations; (2) *expert power* – having the knowledge to help the group achieve a particular goal; (3) *information power* – possessing information that is needed by the group; (4) *legitimate power* – holding an official position and the authority, rights, and privileges that go with that position; (5) *reference power* – being liked and admired by group members; (6) *reward power* – the ability to offer social or tangible rewards; and (7) *coercive power* – the ability to sanction, punish, or deny access to resources, rewards, and privileges.

Stanley Miligram tested Asch's theory of conformity by conducting a series of experiments that described the relationship between the group of

reference and the individual person. A person who has neither the ability nor expertise to make decisions, especially in a crisis, will leave decision-making to the group and its hierarchy. The group is the person's behavioral model. Miligram set up an experiment to test how much pain a person would inflict on another person simply because he/she was told to do so by an experimenter. He found that people would go to almost any length to obey a command by an authoritatives figure. His work pointed out that people will carry out orders which have destructive effects and are incompatible with fundamental standards of morality when they have few resources to resist authority. Miligram repeated his experiments throughout the world with similar results.

Albert Lott and Bernice Lott were interested in the relationship between group cohesiveness and individual learning. They predicted that children would learn better if they studied with children they liked than if they studied with children they liked less. They presumed that the degree of member liking was an indicator of group cohesiveness. They found that high IQ children who were in high cohesive groups performed better on learning tests than high IQ children who were in low cohesive groups. For low IQ children, however, cohesiveness, or the degree of interpersonal attraction among group members, made no difference, although there was a tendency for low IQ children to do better in high cohesive groups. The investigators believed that children who worked with other children they liked would be more likely to have a greater drive to learn than children who were neutral or had negative attitudes toward their fellow group members. However, cohesiveness made little difference in learning among high IQ children.

Social psychologists Muzafer Sherif and Carolyn Sherif studied the origin of conflict in social groups in a classic study called the Robbers Cave experiment, a Boy Scout Camp surrounded by Robbers Cave State Park in Oklahoma. During the study, M. Sherif posed as an observer in the role of camp janitor. Twenty-two 11-year-old boys who did not know each other were assigned to two groups of 11 each. They chose names for their groups and developed internal social hierarchies. Contact between the two groups in the form of sports competitions elicited hostility between the groups. To lessen friction and promote cooperation Sherif devised tasks, or superordinate goals, that required the two groups to work together. Hostilities subsided and the groups bonded to the extent that all the boys insisted that they ride the same bus home. The experiment provides an example of how superordinate goals can transcend intergroup conflict and promote social cohesion.

Irving Janis is known for the formulation of "groupthink." Groupthink occurs when a group makes faulty decisions because group pressures lead to a deterioration of mental efficiency, reality testing, and moral judgment. Groups affected by groupthink ignore alternatives and tend to take irrational

actions. A group is especially vulnerable to groupthink when its members are similar in background and there is a desire to avoid being seen as foolish, or a desire to avoid embarrassing or angering other members of the group. Groupthink can cause groups to make hasty decisions, or irrational decisions where individual doubts are put aside for fear of upsetting the group's balance. Classic examples of groupthink are the Bay of Pigs Invasion (1959–1962) and the Space Shuttle Challenger disaster (1986).

Mark Granovetter said that a fundamental weakness of current sociological theory is that it does not relate micro-level interactions to macro-level patterns. He suggested the analysis of social networks as a tool for linking these levels. Most network models focus on strong social ties; instead Granovetter proposed the power of weak ties. He defined the strength of a tie as a combination of time, emotional intensity, intimacy, and reciprocal services that characterize the tie. Weak ties are viewed as indispensable to individuals' opportunities and to their integration into communities. Strong ties, on the other hand, foster local cohesion and lead to fragmentation.

During the 1970s and 1980s especially, there was considerable interest among group therapists in how preconditions in a group and members' perceptions of each other affected cohesion in the group as a whole. Stokes and his colleagues found that groups in which members disclosed intimate topics were perceived to be more cohesive than were groups in which members disclosed less intimate topics. This finding supported studies that showed a positive relation between risk-taking and cohesion. These authors suggest that too much as well as too little risk-taking inhibits the development of cohesion in groups. The time in the life of a group in which disclosures occur is important in influencing the cohesiveness of a group.

William Piper and colleagues attempted to provide an empirical basis for the clarification of the concept of cohesion. They gathered self-report data from 45 adults who participated in nine groups that met on eight occasions. Each group was led by an experienced psychologist or psychiatrist. Three sets of factors that dealt with the participant's perception of the other participants, the leader, and the group as a whole were obtained through a questionnaire, leader ratings of participants, and five behavioral variables that were monitored by the leaders at each group session. The researchers concluded that defining cohesion as a basic bond does not define the term "group cohesion," nor does it indicate a cohesive group. They believed that these were separate issues. They defined group cohesion as the group property that emerges from the set of bonds that exist in a group. A cohesive group is one where a majority of the participants possess a commitment to the group, to one another, and to the leader. These three factors focused on the group as a whole, but each factor had a different meaning and a different set of empirical properties. Piper and his colleagues stated that their approach helped to

restrict the definition of cohesion, distinguish it from other concepts, and was a good representation of cohesion as defined as a basic bond or uniting force in a group.

Braaten reviewed major studies of group cohesion from 1968 to 1989, which showed a consensus that a cohesive group climate in group psychotherapy was an analogue of a good therapist–client relationship. Based on this review, he advocated a multidimensional model of group cohesion. He proposed three pre-group conditions necessary to attain a high degree of group cohesion: the selection of suitable participants, a balanced composition of the group, and effective orientation, training, and contracting. Furthermore, three early group conditions must be met for cohesion to occur: resolving conflict and rebellion, constructive norming and culture building, and reducing avoidance and defensiveness. Finally, several in-group factors including attraction and bonding, self-disclosure and feedback, support and caring, listening and empathy, and process performance and cooperation toward group goals must be part of the group climate in order for it to achieve a high degree of cohesiveness.

Social Network Analysis (Late 20th and Early 21st Centuries)

Barry Wellman and several colleagues studied the Toronto borough of East York. They documented the prevalence of non-local friendship and kinship ties, demonstrating that community is no longer confined to geographical areas but rather communities exist as personal networks. Analyzing the intimate networks of 845 adult residents of East York, Wellman found close ties to be prevalent, composed of kin and non-kin, non-local, asymmetric, and of sparse density. He found that help in dealing with both emergencies and everyday matters was available from almost all intimate networks, but only from a minority of intimate ties. Different kinds of social ties provide different kinds of social support. Most relationships provide specialized support. The kinds of support provided are related more to characteristics of the relationship than to characteristics of the network itself.

Bollen and Hoyle proposed a theoretical definition of cohesion that they believed captured the extent to which individual group members feel "stuck to," or a part of, particular social groups. They introduced the concept of *perceived cohesion*. They did not claim that this is the only aspect of cohesion but it was an aspect not considered in previous studies. They wished to identify elements of a member's perception of their group membership that might reflect a tendency to cohere or "stick to" the group. Furthermore, they believed that perceived cohesion mediates much of cohesion's objective influences. These authors believed that it is possible to combine group

members' perceptions to characterize the cohesion of the group as a whole. Thus, at the individual level perceived cohesion reflects the role of the group in the lives of group members and, at the group level, perceived cohesion reflects the role of individuals in the life of the group.

Albert Carron and several colleagues proposed a model to understand and measure cohesion in sport teams. They considered cohesion to be a multidimensional construct and developed an 18-item inventory to measure cohesiveness in sports teams and exercise groups. They believed that their definition of cohesiveness incorporated its dynamic nature, its instrumental basis, and its affective dimension; therefore, the multidimensional character of their instrument could be utilized in a variety of groups in addition to the sports teams.

James Moody and Douglas White suggested that to be analytically useful, it was important to differentiate the *relational togetherness* of a group from the *sense of togetherness* that members express. They defined *structural cohesion* in terms of sets of relationships rather than as sets of individuals.

Structural cohesion has five features: (1) it describes how a collection of individuals are united; (2) it is expressed as a group property; (3) it is continuous; (4) it rests on observable social relationships among individuals; and (5) it makes no reference to group size. Cohesion begins when every group member can reach every other member through at least one relational path – the paths that link members are the social glue that hold them together. Group cohesion varies in strength depending on the number of connected individuals. The strongest cohesive groups are those in which every member is connected to all other members, but the group has a status beyond any individual group member.

Moody and White also pointed out that cohesive groups are nested within one another. Nestedness captures the idea of sets of relationship that are embedded in a social network. For example, ethnic ties constitute a strong basis for cohesion and stability in immigrant communities where the readiness of direct assistance and the reliability of information are critical to successful accommodation. It has been found that Asian immigrants typically turn to friends, acquaintances, and relatives in their immigrant community during the initial period of transition as few have social connections outside their kin and ethnic groups. The deep embeddedness of ethnic ties, however, can come at a cost to their acculturation if immigrants rely exclusively on permanent jobs in the ethnic community.[7]

Measuring Social Cohesion in Small Groups

Efforts to measure cohesiveness began in the early 1950s. Some of these studies were undertaken at the Research Center for Group Dynamics at

the University of Michigan and are summarized in a monograph by Lester Libo.[8] These particular studies were conducted by social psychologists who were concerned with determining how the strength of attraction-to-group is affected and how it affects individual behavior and group process. The most widely used method of measuring attraction-to-group has been the paper-and-pencil questionnaire. A projective picture technique (the Group Picture Impression), less obvious in its intent than a questionnaire, and more sensitive to situational influences, has been used with varying degrees of success. Self-report instruments have also been developed and continue to be used to measure different aspects of social cohesion.[9]

Table 2.2 presents a list of some of the more commonly used quantitative instruments to measure cohesion in small groups from 1952 to the present. As would be expected the objectives of these various instruments reflect the diversity of definitions of group cohesion and the ways they have been operationalized, resulting in what Friedkin[10] has called "the disarray of research on social cohesion."

What is particularly striking is that the developers of instruments to measure group cohesion were usually not the same investigators who sought theoretical connections and offered definitions for the concept. Sociologists Neal Gross and William Martin[11] in 1952 were critical of investigators who were only focused on social cohesiveness in specific situations. They said,

> . . .such schemes are devoid of any roots to theory. Methodologically, the experimenter is left adrift; his only basis for choice of technique of investigation lies in the immediate situation (p. 546).

Bruner's[12] comment on progress in measuring social cohesion in social psychology was: "Our methods become increasingly exquisite; their use remains ad hoc" (p. 119).

According to Gross and Martin, the most stimulating and ingenious studies of group cohesion were those of the Research Center of Group Dynamics at the University of Michigan because "the hypotheses that are tested are not ad hoc hypotheses but rather flow from the deduced logical interrelationships of clearly stated nominal definitions" (p. 546).

How social cohesion should be defined and measured has been debated since the 1950s and there is no widely accepted operational definition or method of measuring it. The central issues in the debate relate to whether social cohesion is unidimensional or multi-dimensional[13] and the micro–macro linkage of individual and group levels.[14] Friedkin[15] has urged that we deconstruct the various definitions of social cohesion so that we might focus on the specific constructs that are involved in the definitions and explore the causal interrelationships between these constructs. In other words, we need to rethink causal models and discover new network structures that provide

Table 2.2 Instruments to measure social cohesion in small groups

Investigator(s)*	Instrument/method	Objective of instrument
Gross & Martin (1952)	Gross Cohesiveness Scale	A self-report measure of 9 items taps aspects of group cohesion considered to be unidimensional
Moos & Humphrey (1974)	Group Environment Scale	Assesses 10 dimensions of the social climate of psychotherapy and mutual support groups and task-oriented groups
Silbergeld et al. (1975)	Group Atmosphere Scale	Measures the psycho-social environment of therapy groups – distinguishes different therapy groups
Mackenzie (1981)	Group Climate Questionnaire	Assesses group climate and process development in therapy groups
Piper et al. (1983)	Group-Member-Leader Cohesion Scale	Obtains self-report and behavioral data on a number of aspects of cohesion
Carron et al. (1985)	Group Environment Questionnaire	To develop an instrument to measure group cohesion in different groups and contexts
Evans & Jarvis (1986)	Group Attitude Scale	A measure of attraction to a group
Budman et al. (1987)	Harvard Group Cohesiveness Scale	Assesses global group cohesiveness and observable behaviors related to group cohesion
Hinkle et al. (1989)	Group Identification Scale	To measure intragroup identification
Bollen & Hoyle (1990)	Perceived Cohesion Scale	To measure sense of belonging and feelings of morale as two dimensions of group cohesion
Treadwell et al. (2001); Veeraraghavan et al. (1996)	The Group Cohesion Scale-Revised	Measure group cohesion at a specific point

* References for investigators are listed in the Reference section at the end of the book.

the theoretical framework for understanding the social processes that create and sustain social cohesion. Furthermore, Scott Budge[16] pointed out the need to abandon current assumptions about cohesiveness that define it as a static, positive, totality, in favor of a paradigm that views cohesion as a dynamic process through which cohesiveness develops. Similarly, Kaplan[17] and his colleagues have suggested that small groups are dynamic equilibrium-seeking social systems that evolve gradually, through sequences of developmental phases or stages. The fact that a group develops over time also suggests that its adaptive capacities will allow it to become cohesive.[18] This should indicate that an assessment of a group's degree or level of cohesiveness must be both situationally and developmentally sensitive.

Measuring Social Cohesion in Large Groups

Social cohesiveness in large groups is difficult to study partly because large groups may be geographically dispersed making it impossible to follow up individuals in the group. Also, not all of the instruments used to assess cohesiveness in small groups are appropriate to large groups. Several different approaches have been developed to study cohesion in large groups.

Feelings of Social Cohesiveness

Galanter[19] developed a model based on the empirical relationship between members' feelings of social cohesiveness and their potential to experience distress when alienated from a larger group. Empirical data were obtained from the investigation of two contemporary religious sects, the Divine Light Mission and the Unification Church ("Moonies").

The Divine Light Mission members were followers of Guru Maharaj, Jr., a Hindu preacher who came to the United States from India in 1971. Most members lived in communal residences of 2–15 people. Group cohesiveness was assessed using eight statements rated on a five-point Likert scale. The scale tapped feelings toward immediate acquaintances in the sect as well as the more abstract sense of cohesiveness in relation to the sect as a whole. A second scale assessed the level of subjective distress the respondents were experiencing, both immediately before and immediately after joining the sect. Findings indicated that individuals experienced diminished distress upon affiliation with a large group. The degree to which they experienced a decrease in stress was significantly correlated with the degree to which they felt cohesively toward the group. While it is possible that some members actually recalled a higher level of distress prior to joining than they had actually felt at the time, this would not detract from an individual's continued commitment to the group.

Galanter proposed that a consensually validated system of beliefs would serve to sustain the integrity of a large group. As a consequence, it was reasonable to consider that the human capacity to adopt, and adhere to, a cognitive framework supported by the group would augment the affective basis for social cohesiveness. In order to examine this issue, Galanter undertook a second study with members of the Unification Church. This group followed the Reverend Sun Myung Moon, a Korean Christian. This sect is more highly structured than the Divine Light Mission, with members living in large communal residences, and devoting long hours every day to church activities. A sample of 237 American-born members was selected from the New York area. These individuals were given the same scale of well-being

given to the Divine Light members. In addition, they were given a series of items reflecting their religious beliefs. Not surprisingly, a strong adherence to group norms was found. The cohesion items (beliefs) were found to be strong predictors of psychological well-being.

According to Galanter, these two studies lend support to the hypothesis that there is an innate relationship within the individual between distress and alienation on the one hand, and between psychological well-being and affiliation on the other hand. Large groups play a major role in defining the identity and social roles of their individual members. Members' social affiliations lie in large part with individuals who have joined the group. Finally, large groups rely on their members and eschew the surrounding culture.

Perceptions of Social Cohesiveness

Carron and Spink,[20] in a series of studies of group size effects in exercise groups, found that members of small exercise groups hold stronger perceptions of cohesiveness of their group than members of large exercise groups. The results of a related study showed, however, that differences in the perceptions of cohesiveness between members of small and large exercise group disappeared when a team-building intervention program was introduced. They concluded that, in larger groups, it may be possible and desirable to offset the negative effects of group size on cohesiveness and effectiveness through the use of team-building strategies.

Social Network Analysis

Another way to understand the significance of cohesion in large social groups is by using social network analysis to study the patterns of interactions or "ties" that members have with other members, their so-called degrees of separation. It has been found that in many networks, the distribution of degrees among members is highly skewed, with a small number of members having an unusually large number of ties. Research has shown that this skewness could have an impact on the way groups operate, including the way information travels through the network and the stability of groups when certain members are absent or removed.[21]

Recent work on social networks has focused on three features of network structure. The first is the "small world" effect meaning how people can have a short connecting path of acquaintances in a network that has an insular or culturally homogeneous social structure. This relates to the second

characteristic of social networks and that is clustering or the probability that two friends getting together is greater than that of two people at random. A high degree of clustering indicates greater cliquishness. Third, the feature of a skewed degree distribution is of interest in network analysis. Having a knowledge of skewed degree distribution in a group can provide insights, for example, into how decisions are made, sources of group power, and how group boundaries are established and maintained.[22]

The benefit of social network analysis is that it focuses on how group ties affect individuals and their relationships. For example, smaller, tighter networks are often less useful to the members than networks with many loose connections (weak ties) to individuals outside the network. More open networks with many weak ties are more likely to introduce new ideas and opportunities to their members than closed networks with redundant ties. It is usually better for individual success to have connections in a variety of networks rather than many connections within a single network.

Summary

Carron and Spink[20] said, "It could be argued that the terms *cohesion* and *group* are tautological; if a group exists, it must be cohesive to some degree. Thus it is probably no surprise that even in collectives where minimal group characteristics are present, manifestations of cohesion are evident" (pp. 86–87). There seems little doubt that group cohesion exists, but disciplinary eyes see it differently and, in turn, researchers have different ways of measuring what they see. Therefore, there are only disciplinary pockets of agreement on the definition of cohesiveness. We seem to define cohesiveness best by identifying consequences when it is absent and are less clear about how cohesiveness is created, nourished, and sustained.

As definitions of cohesiveness have evolved over time and become more specific, the concept has become fragmented and specialized, which is reflected in the diverse instruments used to measure it. Issues of the measurement of cohesiveness differ in small and in large groups. Because of the complexities of assessing cohesiveness most attention has been given to small group cohesion.

Despite repeated calls for consensus in the definition of cohesiveness in the literature there appears little progress in this regard. There are some fresh approaches to theorizing and studying cohesion using social network analysis. This approach is appealing because it stresses the patterns of social ties and network connections that are conducive to different degrees of cohesiveness irrespective of group size.

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Chapter 3
Social Cohesion and Related Concepts: Social Support and Social Capital

Introduction

In the previous chapter, we learned that social cohesion has a long history, and despite the lack of consensus in its definition and measurement, it is used as a viable variable in research, especially as it relates to the health of individuals, groups, communities, and societies. Moody and White[1] summarize this situation stating:

> We study "cohesion" in almost all our substantive domains, and in its ambiguity, it seems to serve as a useful theoretical placeholder. Ubiquity, however, does not yield theoretical consistency. Instead, the exact meaning of cohesion is often left vague, or when specified, done in a particularistic manner that makes it difficult to connect insights from one subfield to another (p. 104).

Complicating the definition, measurement, and application of cohesion, researchers use it in association with two related concepts, social support and social capital, which also have meaning and measurement issues. Kawachi and Berkman[2] explain the relationship between these concepts as follows:

> . . . social cohesion and social capital are both collective or ecological dimensions of society, to be distinguished from the concepts of social networks and social support, which are characteristically measured at the level of the individual (p. 175).

What remains unresolved is how the individual and collective levels interact to create support, cohesion, and capital. Indeed, it is the *dynamics* between levels and their collateral effects that create support, cohesion, and capital. Christakis[3] explains the collateral effects of social ties using an example from health care. Since a patient is connected to other people through social network ties, medical interventions delivered to a patient, apart from their health effects in that person, may have unintended effects in others to whom he is connected. These effects, in both the patient and in their social contacts, might be positive or negative. For example, delivering a

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weight loss intervention to one person may trigger substantial weight loss in that person's friends or an ex-smoker may organize a group in his community for smoking cessation. Social networks imply that people and events are connected, interdependent, and transcend different levels of human interaction. In this chapter, we consider the elements that social support and social capital share with social cohesion as well as their different dynamics.

Social Support

Concept

While social support is usually directly experienced and measured at the individual level, social support is also operational, although perhaps less obvious, at neighborhood, group, community, and societal levels. For some people social support is so enmeshed in their daily lives that they take it for granted, others experience it when people rally around them in a crisis, and still others may never experience it at all. Social support can be tangible and/or intangible. Social support is the network of family, friends, neighbors, and community members that is available in time of need to give psychological, physical, financial, or other kinds of help. The term "social support" is generally not used in everyday conversation; rather it is expressed as "she is always there when I need her," "he is the only person I can confide in," or "I can always count on my neighbors." Socially supportive behavior indicates that people have a reciprocal helping relationship, that they genuinely care about one another, and that the needs of others equal or exceed one's own needs.

The way social support is expressed and the contexts for sharing it vary culturally. The main feature of social support is the acknowledgement that humans are social animals and need other people throughout their lives to provide nourishment to their spirits and hope and encouragement to overcome barriers to experiencing meaning and satisfaction in their lives. Social support is what helps us maintain our sociability, persist in our goals, and resist isolation and despair. Social contacts with others promote our social integration into groups, neighborhoods, communities, and societies.

We form social ties of different types and complexity (density) for different reasons, at different times in our lives. The dynamics of social support are intertwined with lifestyles, that is, how involved individuals are in their external world, how outgoing and gregarious they are, their degree of volunteerism and organizational memberships. Also, our need for, and the availability and use of supportive networks, vary with age. It is through these networks of social support that we have access to coping resources to use

on a daily basis. Not all of our social networks are available all of the time, not all are continuously supportive, and not all provide the same kind of support. We connect more strongly with networks that meet our needs at a given time. Social networks can be real or virtual, or both. Most people seek out social connections that enhance their well-being, while other people may become enmeshed in networks of people who are engaged in unhealthy or destructive behaviors and lifestyles.

The major point related to social networks is that we can choose to make connections of different intensities ranging from intimacy to aloofness and detachment. Sometimes just knowing support is available is sufficient. Other times, we need to ask for help. Social support is like having different cushions of different sizes and composition available for use when needed. We have networks we use for general purposes and some for special purposes, e.g., counseling or self-help. Research has shown that people who have extensive sources of social support are well networked into their communities.

Evidence of Effects

What is striking is that, despite the diverse ways social support has been measured, a considerable number of studies have shown the beneficial health effects of social contact between people. Various forms of social support are now generally accepted as having important beneficial effects on health especially in buffering the effects of stressful events and circumstances. For example, the lack of a confiding relationship with a close friend, relative, or partner, or little involvement with wider networks, is associated with poorer health.[4]

Social support has been found to influence survival itself. Using a unique longitudinal database of Union Army soldiers captured during the American Civil War, and a cross-sectional database of the population of Andersonville, Georgia, Costa and Kahn[5] examined the role of social networks in ensuring survival in Confederate POW camps. They found that Civil War diaries indicated that friends in POW camps provided moral support, extra food and clothing through the trade of valuables, protected one another, and tended to the sick. In two independent data sets, these researchers found that friends had a statistically significant positive effect on survival probabilities and that the closer the ties between friends, the bigger the effect. Even under the duress of being in war camps, friends continued to have a positive effect on survival probabilities. Social support networks have been shown to play the same role in American survivor accounts from Nazi concentration camps and Vietnamese internment camps.

Barrera[6] suggested that social support is insufficiently specific to be useful as a research concept. Indeed social support is a broad concept which is complex because it varies or changes with time, cultural context, and the persons involved. Efforts to narrow the concept to quantify it will obviate many important aspects of its context; therefore, its broadness is both an asset and a liability to its measurement and application. However, despite differences in how social support has been measured, a consistent link has been found between social support and mortality. Epidemiological studies indicate that individuals with low levels of social support have higher mortality rates, especially from cardiovascular diseases.[7] The challenge, as Uchino points out, is to discover the mechanism(s) or major pathway(s) by which social support influences disease processes at the individual, group, community, and societal levels.

Cohen and his colleagues[8] found that socially supportive networks have a direct effect on reducing physical symptoms. The greatest symptom reducing effects were found to occur among individuals experiencing high degrees of stress. The authors concluded that intervention to reinforce a network is a caring act, and can be as clinically significant as implementing a medical procedure.

Social support appears to be a salient factor for patients with heart disease in maintaining compliance with their rehabilitation programs. Patients who receive support from family and friends are more likely than others to comply with risk factor modification and post-coronary rehabilitation programs. It is not completely clear how social support influences recovery from illness. There are speculations that it may enhance patients' motivation to adhere to difficult treatment regimens.

Dimensions of Social Support

The term "social support" like the terms social network and social integration refers to a number of different aspects of social relationships. Social support is sometimes defined in terms of the total number of social relationships, or specific types of relationships such as organizational memberships, or civic activities, or number of friends. Social support is sometimes defined in terms of the functional context of relationships, such as the degree to which the relationships involve tangible aid. Social support is sometimes defined in terms of how the social structure of a group, or community facilitates or inhibits supportive relationships. Because social support has been used to refer to each of these aspects of relationships each must be considered a domain of social support. However, most commonly, social support refers to the functional content of support (how it is used).

It is necessary to consider all three aspects of these relationships, according to House and Kahn[9] (quantity, structure, and function) because they are logically and empirically related.

The dimension of social support that we know little about is that provided structurally by communities and societies. Social support is more difficult to dissect and measure at these more complex levels. What is valued as support can vary according to cultural values, social structure, and social contexts. Social support is also a phenomenon that varies qualitatively or by degree. The baseline of social support available in a community is closely linked to the nature of the relationship between the community's social institutions. A community with social institutions that work together would be expected to be more cohesive than a community whose social institutions act independently and competitively. A higher degree of social integration in a community has been found to be related to lower rates of psychiatric disorders. Collective ways of coping with the hazards of life has been found to be beneficial in helping people deal with adversity.[10] Culture frames how individuals and larger collectivities react to real life circumstances. If a community's culture provides collective and positive ways for dealing with adversity and social change, for example, then individuals will benefit in similar ways. If a community's culture emphasizes a "go it alone" way of dealing with life's problems, one would expect a wide variation in individual behavior and social networks.

Wilkinson[11] studied several healthy egalitarian societies in Britain, Eastern Europe, Japan, and the United States and found that all shared social cohesion as a common characteristic. They had a strong community life. The individualism and values of the market were restrained by a social morality. People were more likely to be involved in social and voluntary activities outside the home. These societies had more social capital. There were fewer signs of anti-social aggressiveness, and these societies appeared to be caring. Wilkinson argued that the social fabric or social cohesiveness of a society is an important determinant of its quality of life, which in turn influences its health.

Measurement

Heitzmann and Kaplan,[12] in reviewing the psychometric properties of 23 methods for measuring social support, concluded that the problem of accurately measuring social support is due in part, to the lack of a common definition. Each researcher's definition of social support appears to be as unique as the subjects being studied. This is due to the widely differing academic disciplines of the researchers. Winemiller and colleagues[13]

reviewed 262 empirically based articles about social support published between 1980 and 1987. They found that many social support researchers utilized standard instruments, but failed to consider the complex, multidimensional nature of social support. Most instruments were objective and assessed support received from close, nuclear relationships, such as those with family, spouse, and friends. This means that our perspective of social support generally excludes an individual's support network, focuses on the social support received rather than on its interactive or relational nature, excludes consideration of cultural and environmental sources of social support, and tends to look at an individuals' perceptions of available support without concomitant consideration of the support the individual has used and is likely to use in certain circumstances. Finally, most quantitative approaches to measuring social support do not tie different needs for social support to the changing lifecycle; social support is not a static, fixed phenomenon, but varies with age, gender, ethnicity, and other social variables.

Perhaps social support is too complex and dynamic a phenomenon to quantify simply. Indeed, it is likely, if individuals were asked to describe how social support works in their lives, they may not recognize or identify a set of distinct relationships that they label as supportive. For example, social support may be so deeply embedded in the values and norms of a highly integrated and socially cohesive group or society that it is not recognized as a distinct phenomenon by members. Social support may be the selective observations made by outsiders, i.e. an evaluation of styles or ways of interacting by people in various social configurations and under certain conditions.

This is why the work of Granovetter,[14] of distinguishing between "strong" and "weak" social ties offers a fresh perspective in understanding social support. Strong ties are voluntary, high in intimacy, and cut across a variety of social contexts (confidants). Such ties tend to be health-promoting. Weak ties serve bridging functions that result in shared conformation between social networks such as friends, neighbors, or co-workers. Granovetter argued that there was strength in weaker ties and limitations or weakness in strong ties. The relationship between strong and weak ties will vary with context, time, and situation.

In addition, Uchino and other researchers[15] caution that we should not focus solely on the positive role of relationships on health and well-being to the exclusion of considering the negative aspects of socially supportive relationships. Social ties can become so intense that they create stress and not all types of social support have beneficial effects. As Kunitz[16] has said, "social support is not a phenomenon of dosages."

Social Capital

Concept

Social capital can be a characteristic of individuals; however, it is generally understood to be a property of a group. Social capital is tied to culture and can vary within a culture.[17] Social capital refers to connections within and between social networks. It implies shared interest and agreement among various stakeholders to induce collective action. Collective action or consensus building is a direct positive indicator of social capital. Social capital is not equally available to everyone. Geographic and social isolation limit access to social capital. In addition, not all social capital is created equally. The value of a specific type of social capital, i.e., economic, cultural, social, depends on the socioeconomic position of the source within a society. There are negative consequences of social capital such as the exclusion of outsiders, excess claims on group members, restrictions on individual freedom, and downward leveling of norms. Finally, social capital is often linked to the success of democracy and political involvement. For example, Robert Putnam[18] argues that social capital is linked to the recent decline in American political participation.

Francis Fukuyama[19] in his book *Trust* defines social capital as follows:

> Social capital is a capability that arises from the prevalence of trust in a society or certain parts of it. It can be embodied in the smallest and most basic social group, the family, as well as the largest of all groups, the nation, and in all the other groups in between. . . acquisition of social capital requires habituation to the moral norms of a community, and, in its context, the acquisition of virtues like loyalty, honesty, and dependability. . . social capital cannot be acquired by individuals acting on their own. It is based on the prevalence of social, rather than individual virtues. . . the proclivity for sociability is harder to acquire. . . because it is based on ethical habit. . . and harder to modify or destroy (p. 27).

According to Lin,[20] the premise behind the notion of social capital is simple and straightforward, namely that investment in social relations is tied to expected returns in the marketplace. Individuals engage in interactions and networking in order to produce profits. These profits can take the form of *cultural capital* (education), *economic capital* (financial), *symbolic capital* (prestige and honor), or *human capital* (investment). Social capital is seen as an asset by virtue of individuals' connections and access to resources in a network or group of which they are members. Social capital consists of a structural component, i.e., control over resources and it facilitates certain behavior of individuals within the structure. Viewed in this

way, social capital is not transferable across individuals, activities, or levels; rather social capital is in the resources gained from relationships.[21]

Evidence of Effects

Robert Putnam[22] studied the social capital of local governments in several regions of Italy and assessed the efficiency of conducting the public's business. The stock of social capital in a region, as measured by the density of citizens' participation in community organizations, was found to be the best predictor of local government performance. Citizens living in regions characterized by high levels of social capital were more likely to trust their fellow citizens and to value solidarity, equality, and mutual tolerance. They also had highly functioning governments.

Putnam[23] writes, "of all the domains in which I have traced the consequences of social capital, in none is the importance of social connectedness so well established as in the case of health and well-being." Using the terms social capital and social cohesion interchangeably, Putnam suggests that social networks furnish tangible assistance, which reduces stress and provides a safety net. Social networks reinforce healthy norms, and socially cohesive communities are best able to organize politically to ensure first-rate medical services. He further suggests that social capital might serve as a physiological triggering mechanism for stimulating the immune system to combat disease and buffer stress.

A study[24] using survey data from nearly 170,000 individuals in 50 states found that people who are African-American, lack health insurance, are overweight, smoke, have a low income, or lack a college education are at greater risk for illness than are more socioeconomically advantaged individuals. Results also showed a strong relationship between poor health and low social capital. States whose residents reported poor health were the same states where residents were more likely to distrust others, where there was low social cohesion.

Kim and his colleagues[25] carried out a systematic review of a growing number of studies that linked social capital to physical health outcomes. Much of the public health literature has focused on the health effects of social cohesion.[26] However, there is a large body of literature reporting links between social integration, social networks, and social support. Many of these studies predated the explosion of interest in social capital. Consequently, there is an amalgamation of the meanings and definitions of social capital, social cohesion, and social support.

Some researchers do not define the concepts or attempt to clarify their differences, use the concepts interchangeably, measure them using scales and

techniques that lack rigor and cultural appropriateness, view the concepts as static and dichotomous, neglect the qualitative aspect of these concepts, rely on secondary data, and do not consider sociocultural contexts in investigations of these concepts.

Despite these methodological issues and inconsistencies in the studies reviewed, this author found fairly consistent associations between trust as an indicator of social cohesion and better physical health. The evidence for trust was stronger for self-rated health than for other physical health outcomes, and stronger for individual-level perceptions than for area-level trust.[25] Regardless of the type of study (individual, ecological, or multilevel) there were generally significant positive associations between social capital and better health outcomes. Since the studies reviewed had been inconsistent with respect to controlling for confounding variables, did not carefully examine cross-level interactions between individual and broader levels of analysis, and did not examine both positive and negative affects of social capital in association with health outcomes, it is not possible to reach clear conclusions or offer methods for replication.

Dimensions of Social Capital

Social capital can be viewed from two different dimensions, whether it is accrued for the individual or the group. Individual social capital refers to how individuals access and use resources embedded in social networks to gain returns or to preserve gains resulting from their interactions with others. It is expected that individuals engage in interactions with others for some return such as profit or benefit. Aggregation of individual returns also benefits the group. Lin[27] points out that social capital at the individual level focuses on how individuals invest in social relations and how they capture the embedded resources in the relationships to create a return. Another perspective focuses on how certain groups develop and maintain social capital as a collective asset and how such a collective asset enhances group members' life chances. Bourdieu[28] sees social capital as a collective asset possessed by members of a social network or group. It is maintained and reinforced for its utility. Coleman[29] regards social capital as an aspect of social structure that facilitates certain actions of individuals within the structure. Putnam[30] argues that social associations and the degree of participation indicate the extent of social capital in a society. These associations and participation promote and enhance group norms and trust, which are central to the production and maintenance of group well-being. These various perspectives illustrate the range of definitions of social capital, how it works, and how it is measured.

Measurement

One current approach to the study of social capital is as a relational construct. From this point of view, social capital is an inherent property of social relationships, the resources they hold, and the social networks they make up.[31] Therefore, social network concepts and methods provide a useful way to measure social capital. Published studies focus primarily on three network characteristics as measures of social capital: (1) *functional measures*, which reflect the content of network ties, for example, the supportive qualities of network ties; (2) *structural measures*, which describe how people in a network are connected to one another, and (3) *positional measures*, which reflect individual's positions in a network, that is, whether certain positions confer power and advantage to individuals in the network.

Functional Measures

Functional measures of social capital are important in relation to health and health behavior. Studies suggest that the quality and quantity of network ties are negatively related to mortality risk. These relationships hold across age, gender, and health status. Similarly, the content of social ties is important for fostering positive or negative health behaviors. For example, social influences, especially support from ties to sexual partners, were positively correlated with risky needle behavior among adolescent and young adult drug users.

Social support appears to be a key social process that is a source of social capital embedded in network ties. Wellman and Frank[32] describe the potential for social capital embedded in supportive ties that are composed of ties to friends, family, and others in our lives. Therefore, studies measuring the presence of social support in an individual's network often ask whether any ties in their network provide a particular type of support.

An alternative to measuring the resources provided by particular ties is to focus on *tie strength*, that is, the time, intensity, intimacy, and reciprocal services which characterize the tie. Tie strength can generate social capital through a number of mechanisms. Strong ties may be more likely than weak ties to generate social support.

There are negative effects to strong, supportive ties. Sometimes relationships are too demanding and energy-depleting, and not mutually beneficial. In addition, strong ties are not always consistently supportive. Weak ties, on the other hand, have some advantages as they can link people across several groups. As Granovetter[33] has said, there is strength in weak ties.

Numerous measures of tie strength exist. For example, tie strength might ask individuals to rate how close they are to each person in their networks, the frequency and duration of contact, or state in what ways the tie is supportive. Ties can be more than one dimension; ties can serve several different functions within a given social network.

Structural Measures

Structural measurements of social capital are concerned with the linkages between network members. This includes size and density. The relationship between network size and social capital is obvious: the larger one's network, the greater the likelihood that any one person has many or all of the resources that an individual might need. Studies have also indicated that larger networks may generate more instrumental and emotional support than smaller networks.

Network density takes into account the extent to which individuals know one another. Density is measured by dividing the number of pairs of individuals who know one another by the total number of connections that could exist among them. The evidence for whether denser social networks provide more network resources such as social support is mixed. Yet, dense networks are likely important for influencing individual behavior.

Positional Measures

Specific individuals have the power to influence how resources flow and are distributed within a network, and affect access to resources and opportunities differently. In addition, individuals who possess power in a network can determine information flow, and through his/her leadership style influence the process of decision-making in a network.

Community Social Capital

Social capital is considered a community resource and a determinant of health, as such it is important to assess or measure its dynamics and effects at the community level. Defining "community" in a standardized, meaningful way has been problematic. Therefore, most studies use a geographical reference.[34] This is impractical and irrelevant in an increasingly virtual world of connectedness. An additional problem in social capital research at this level has been the tendency to measure attributes,

characteristics, and effects that are not social capital but are nonetheless so labeled. DeSilva's[35] review of 28 studies of social capital and mental health found several methodological weaknesses, the most common was using measurement techniques that did not reflect common definitions of social capital.

Kunitz[36] has said that what is needed is a better understanding than we now have of the conditions under which different forms of social capital emerge and how they exert their effects, for good and ill, on the health of populations. Social capital can be mobilized for very different reasons and, therefore, its benefits are not generalizable. It is not surprising, therefore, that social capital research at the community level is less common than social capital at the individual level.

There have been ambitious attempts to develop an empirically grounded definition of social capital. Onyn and Bullen[37] explored the various dimensions of social capital and the way in which these dimensions are differently distributed across different kinds of communities in Australia. They utilized a questionnaire to query 1,200 adults in five communities (two urban, two rural, and one intercity) about 68 social capital items. After a factor analysis, these items were narrowed to eight specific elements which defined social capital. The three strongest factors were: participation in local community organizations and events, social agency or proactivity in a social context, and feelings of trust and safety. The remaining five factors were: neighborhood connections, tolerance of diversity, value of life, work connections, and proactivity within the workplace. Overall, there were no significant correlations between demographic factors such as sex, age or occupation, and social capital. The authors state that social capital is evidenced equally by rich and poor, men and women, all ages, and all educational levels. However, no information was reported on the different cultures, of the communities and their social structure or dynamics.

Coleman and others suggest[38] that social capital is most likely to develop in communities with a strong sense of internal identity and boundaries. It might be expected, in this view, that rural and isolated communities would show higher levels of social capital. However, such communities might be more likely to have conservative attitudes and lack tolerance for difference, characteristics Putnam[39] believed to be associated with low levels of social capital.

Whitley[40] states that a wider question must by asked before researchers are admonished to go forth and collect more data in the area of social capital and health. Numerous authors and studies have suggested that both qualitative and quantitative aspects of the social environment affect health and well-being. Nevertheless, studies that are too narrowly focused and accept social capital as a proxy for community experience miss important elements

of the lived, communal experience. Social experience has a bearing on health and well-being and is found in qualitative factors beyond quantitative operational definitions of social capital.

Sorting Out Conceptual Relationships

The conflicting literature on the interrelationships between the concepts of social cohesion, social support, and social capital, especially their origins, the levels of analysis from which they operate, and their individual versus collective effects, is certain to leave the reader confused. The confusion extends beyond definitions of terms and methodological approaches. There are at least seven attributes that are intrinsic to distinguishing between cohesion, support, and capital that need to be sorted out before further progress can be made. First, some researchers have approached cohesion, support, and capital as static concepts. They are rarely measured more than once and at one point in time and then related to variables such as self-rated health, which is time sensitive. Cohesion, support, and capital are dynamic concepts, with changeable baselines and modifiable by crises of varying degrees. Indeed, cohesion, support, and capital are concepts with their own unique histories, so that experiences involving these concepts are cumulative; cohesion, support, or capital at one point in time can best be understood in terms of prior experiences, positive and negative.

Second, cohesion, support, and capital have often been treated as linear concepts. Indeed, they rarely occur along smooth, horizontal axes, but rather are looped and networked. Hence, social cohesion, for example, is very closely tied to social capital; an abrupt change in capital at the societal level could either further coalesce or fracture a society.

Third, some researchers have approached cohesion, support, and capital as either present or absent, rather than assess the degree to which they are present or absent. Assuming that human interaction underlies all three concepts some degree of connectedness or bondedness will exist in all social configurations, it becomes a matter of how to measure it.

Fourth, studies of cohesion, support, or capital have focused on determining which of these concepts are individually or group based. Human behavior, especially social networks, cross levels of interaction, therefore, it is misleading not to study cohesion, support, and capital from various levels of interaction.

Fifth, cohesion, support, and capital are not solely quantifiable. To quantify cohesion, support, or capital may make them more scientifically acceptable, but to ignore the social environment and dynamics which embrace these concepts because these factors are descriptive ignores important data.

Sixth, cohesion, support, and capital have both positive and negative sides to them; too often the concepts are studied from only one dimension.

Finally, seventh, aggregating individual measures of social support or social capital is not the best way to extrapolate these concepts to broader levels of complexity. Group-level variables should not be used as proxies for unavailable individual-level data and summed or averaged individual-level data should not be used to generalize to groups. Factors at the levels of both individuals and groups may be relevant to understanding the concepts of cohesion, support, and capital and their interrelationships.[41]

A review of the literature related to social support and social capital showed that the beneficial properties of these concepts can be found at the group and individual levels, however, social support or social capital do not benefit all individuals living in the same society, community, or neighborhood, the same way.[42] Furthermore, it has been found that variables measured at the group or community level are contingent upon individual responses, such as individuals perceptions of social trust or their self-rated health.[43,44] Researchers have concluded that individual social support and social capital characteristics should not only be measured differently from groups and other broader levels of interaction, because social support and social capital are contextual constructs.[45] Social support and social capital are group generated behaviors, they both involve social networks, trust, reciprocity, and collective action ranging from the micro to macro levels. Individual levels of social support or social capital cannot be isolated from their context. Groups influence individual attitudes and behavior.

Godoy and his colleagues[46] observed that social change had an impact on their study of social capital in Tsimane, a native Amazonian society in Bolivia. They found that "village level expressions of generosity were associated with individual expressions of generosity, probably from the thick web of kin binding people in small-scale societies... as societies grow in complexity one sees changes in the forms of social capital from day-to-day cooperation... to greater participation in formal political or religious organizations that might have little to do with survival. Social capital may be universal, but the forms it takes are clearly shaped by place, culture, and history" (p. 719).

Social cohesion is a group construct. All groups are cohesive to some degree. However, cohesiveness is modified by social change. Changes in group cohesiveness can have effects on a group's ability to continue to be supportive and to generate social capital. For example, Putnam[47] stated that ethnic diversity will increase substantially in virtually all modern societies over the next several decades, largely because of immigration. While ethnic diversity is an important asset, in the short term immigration challenges cohesiveness and social capital; it can cause social isolation and inhibit

acculturation. In the long term, diversity will create new forms of social solidarity and identities, but these social changes will require societies and communities to re-establish new baselines of cohesiveness and social capital. Cheong and her colleagues[48] argue that the concept of social capital is episodic, socially constructed, and value-based, depending on prevailing ideological climates. Considerations of social capital as a public policy tool to achieve social cohesion needs to be sensitive to the network of connections between people especially with respect to inequalities.

Different Concepts, Purposes, and Uses

Table 3.1 summarizes some of the basic assumptions, primary means of measurement, and practical uses of social support, social capital, and social cohesion.

The table points out that the concepts address different aspects of social experience that need to be measured differently, yet the concepts have uses that are not mutually exclusive. For example, social support is a resource that can be generated at either or both individual or group levels. Therefore, measurement approaches must be multilevel; the same is true for social capital. Social cohesion, on the other hand, is strictly a group phenomenon, and its measurement should be carried out at the group level. All three concepts have some relevance to each other, but their methods of assessment and uses differ. As mentioned earlier in this chapter, researchers and interventionists must take care not to generalize individual-level data to groups or vice versa, nor assume that social capital is a proxy measure for social support, etc. With a greater respect for the integrity of the different characters of the three concepts, progress can be made toward sharpening their respective definitions and identifying gaps for further study.

Summary

Social support, social capital, and social cohesion are important but often misunderstood and misused concepts because they have no commonly accepted definitions, and therefore no agreed-upon methodological approaches and techniques for measuring them. Therefore, the terms are frequently used in ambiguous ways, which does not further their theoretical development.

In part, the difficulty in definition arises because social support and social capital are primarily used at the individual level of analysis while social cohesion is applied at the macrolevel. Furthermore, support, capital, and

Table 3.1 Summary of key characteristics of social support, social capital, and social cohesion

Concept	Basic assumptions	Primary means of measurement	Practical uses of concept
Social support	• Social support are the resources provided by other people • Social support can be positive or negative • Meaning and significance of social support varies with lifecycle stages • Social support has a role in the etiology of health and illness	• Social network analysis • Frequency of contacts with friends and relatives • Formal membership and status • Self-report • Observation • Behavioral records	• Intervention in the adaptation and recovery from illness • Health and social policy interventions • Environmental determinants of social experience • Optimization of social support groups • Preventive interventions
Social capital	• Social networks have value • Find ways to strengthen social fabric of society • Community pride and community bonds depend upon adequate social capital • Social capital is not distributed uniformly among societies	• Social network analysis • Income as a proxy for quality of life measures • Life expectancy rates • Death rates • Health inequalities • Behavioral risk factors • Social cohesion and egalitarianism and health • Quantitative evidence of social trends from surveys, polls, records	• Reducing health risks through social policy • Reducing income differences • Increase moral collectivity • Societies with a high degree of trust will be able to create business organizations that can successfully compete in global economy
Social cohesion	• Social cohesion is an ongoing process of developing a community of shared values, challenges, and opportunities based on shared trust • Egalitarianism is an asset • Contextual factors can be mediators of health and disease • Risk and protective factors in communities are not solely explained by individual-level or lifestyle factors	• Multilevel analysis of individuals, groups, and neighborhoods • Ecological studies • Observation • Interviews • Collective Efficacy Index • Longitudinal studies of groups, neighborhoods, and communities	• High degree of social control to bring about targeted change • Design of intervention programs to target aggregate-level health

cohesion are processes that cannot be adequately assessed by only one measurement taken at one point in time using simple quantitative techniques. Social support, social capital, and social cohesion are multilevel constructs. An attempt is made in this chapter to better understand what commonalities and differences these concepts share so that they can be further developed and appropriately used.

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Chapter 4
Cohesive Societies

Introduction

Economics dominate much of our national communication. There is a need for a different kind of dialogue, one that reflects the changing conditions of the quality of life of our society and yields both a deeper and a broader view of its social health.

The concept of a society's social health would monitor how long we live, how safe we are, how educated we are, to whom we turn when we are in need, environmental quality, and general lifestyle. It would reflect the essential character and values of our society, the status of children and the elderly, wages, abuse, unemployment, poverty, housing, crime, health coverage, and so forth. Societal health is about who we are and the issues we face.[1]

Societal health is a barometer of the social cohesiveness of a society, the viability and stability of families and other social institutions, how people interact, their values and beliefs, and their collective effectiveness in dealing with crises. The challenge is to measure societal health and social cohesiveness to make them useful concepts.

Societal cohesion refers to the degree to which the social institutions of a society meet people's needs, reinforce their beliefs and values, and provide a sense of stability and predictability to the society as a whole. Societal cohesion is considered a precursor of social capital. How cohesive a society is will determine the kinds and amounts of social capital it creates and uses.

Social capital and social cohesiveness work together in helping societies adapt to social change. While normative conflicts are expected and common, some scholars have expressed great concern that long-sustained conflict in our social institutions and disparities in our social health are weakening our society's cohesiveness.[2,3]

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Social Indicators and Social Cohesion

Robert Putnam measured the effects of social change on societal cohesiveness and social capital in the United States over the period 1960–1990 using trend analysis from several national surveys.[4] He concluded that by the end of the 20th century, there was a weakening in "connectedness," and a decline in civic participation, resulting in an erosion of "community." Social institutions and informal ties that had historically linked Americans through trust and reciprocity had been altered by the combined effects of media, mobility, technology, and different generational priorities. Societal cohesiveness had gradually declined in the United States over a 40-year period. Therein lies a paradox, according to David Myers.[5] While the United States prospered economically during the later half of the 20th century, there has been a cultural erosion of the country's social fabric, what Myers has called a "social recession."

Francis Fukuyama[6] observed,

> . . .the United States had been changing rather dramatically over the past couple of generations with respect to its art of association. . . the decline of trust and sociability in the United States is also evident in any number of changes in American society: the rise of violent crime and civil litigation; the breakdown of family structure; the decline of a wide range of intermediate social structures like neighborhoods, churches, unions, clubs and charities; and the general sense among Americans of a lack of shared values and community with those around them.

Civic Health Index

A national commission on the civic renewal of America was created in 1997 and sustained until 1999 by the Pew Charitable Trust to assess our nation's civic condition and recommend efforts to improve it.[7] This group developed an Index of National Civic Health (INCH) which included 22 quantitative measures in five categories: political participation, trust, family strength, group membership, and personal security. While the information was not available prior to 1974 on all measures, it was clear that national civic health declined between 1974 and 1994 with most of the decline taking place in the second 10 years.

The National Conference on Citizenship published a civic health report on key measures of the health of US citizenship.[8] The report measured 40 indicators in nine categories – connecting to civic and religious groups, trusting other people, connecting to others through family and friends, giving and volunteering, staying informed, understanding civics and politics, participating in politics, trusting and feeling connected to major institutions, and expressing political views. The purpose of the report was to create a

Civic Health Index to promote public deliberation about the nation's civic health and to examine new ways of improving it. The Civic Health Index also ranked individual states and generally found a positive relationship between community and political participation. The index showed areas of civic decline and areas of encouragement. Five years after the attacks of September 11, a deep civic transformation of America had not occurred, but more Americans were participating in community and national service projects and encouraging people to vote.

Index of Social Health

About the time that these two commissions were completing their reports, Miringoff and Miringoff of the Institute for Innovation in Social Policy at Vassar College, published their book titled *The Social Health of the Nation*.[9] They said that if American citizens were asked about their nation's progress, the majority would probably refer to indicators such as the Gross Domestic Product (GDP), the stock market, the Index of Economic Indicators, the balance of trade, the inflation rate, the price of oil and gasoline, the unemployment rate, or similar measures. These elements reflect how well the country is doing economically. However, there are other factors that give a deeper view of how we are doing as a nation such as the well-being of our children and youth, the accessibility, availability and affordability of health care, the quality of education, the adequacy of housing, the security and satisfaction of work, the persistence of poverty and homelessness, human abuse, violence, income inequality, the growth of the prison population, and the civic and social life of our communities.

Miringoff and Miringoff said, "there's something else out there... the central subject of the nation's portrait does not assess and report many important aspects of our lives." It was this concern that led these researchers to create an Index of Social Health (ISH) to be compared with the GDP. Looking at the time period from 1959 to 1966 and using factors that were consistently measured during this time, they examined disparities between the GDP and ISH. The divergent and changing paths of the GDP and ISH over these years signaled the need for a social health perspective that delineated a whole area of national life heretofore largely unacknowledged and unmonitored.[10]

The Miringoffs selected 16 indicators that all met the same criteria, namely

- They are measured consistently and reliably over time
- They represent a distribution over the age spectrum
- They reflect a balance between social and socioeconomic dimensions

- They address major issues of public debate
- They have been studied in depth over time
- They can be viewed in an international context

The 16 indicators, listed below, are grouped according to their performance. Those that have shown relatively consistent improvement, those that have been steadily worsening, and those that have made one or two significant shifts between 1970 and 1996. The premise of the index is that American life is revealed by the combined effect of many issues acting on each other.

Improving performance	*Worsening performance*	*Shifting performance*
Infant mortality	Child abuse	Teenage drug use
High school dropouts	Child poverty	Teenage births
Poverty, aged 65 and over	Youth suicide	Alcohol-related traffic fatalities
Life expectancy	Health-care coverage	Affordable housing
	Wages	Unemployment
	Inequality	
	Violent crime	

The Miringoffs viewed their index as a new tool to observe and predict trends. The Index of Social Health was a tool to provide a comprehensive picture of the direction of our society on an annual basis. Other activities were suggested that could be initiated to support national attention to societal health. An annual conference on social health and social indicators could serve as a basis for a council of advisors to the US President. They believed that a national association of community indicators projects could create new insights into understanding social health. The Miringoff's work has created much dialogue and a flurry of projects, especially at community and local levels.

OECD Social Indicators

The Organization for Economic Cooperation and Development (OECD) is a forum of 30 democracies that work together to address the economic, social, and environmental challenges of globalization.[11] The member countries gather quantitative evidence on whether their societies are getting more or less equal, healthier, and cohesive. OECD issues periodic reports on changes in social indicators on the well-being of member countries. While

OECD countries differ in their collection of statistics in social areas, there is an attempt to obtain comparability of indicators across countries.

Promoting social cohesion is a goal for social policy in many OECD countries. Recognizing the lack of a commonly accepted definition of social cohesion, there is agreement on seven key indicators of social cohesiveness at the national level. These are voting, crime, suicides, work accidents, strikes, trust in political institutions, and life satisfaction. In addition, there are five context indicators that help to highlight different groups within a society that are exposed to special risk, including unemployment, maternal deprivation, poverty persistence, life expectancy, and sick-related absences from work.

According to OECD, social indicators are proxies for societal well-being. A feeling of belonging to a wider community and the satisfaction that derives from participation in a broader society are important to well-being. Social cohesion, according to OECD, is measured not only through positive indicators but also through negative indicators such as levels of crime, victimization, and suicide. Overall social indicators provide information about a number of dimensions of well-being that go beyond those conveyed by the gross national product (GNP).

Voting

Voting is one indicator of societal cohesiveness. It measures the participation of eligible voters in the electoral process. A high-voter turnout is a sign that a country's political system enjoys a strong degree of legitimacy. Voter turnout rates vary dramatically among OECD countries with rates below 60% in Switzerland, Poland, Canada, the United States, Luxembourg, Hungary, and the United Kingdom and above 80% in Spain, Denmark, Italy, Korea, Belgium, and Iceland. Socio-demographic characteristics such as age, income, education, and compulsory voting have an effect on voter turnout. Nonetheless, voter participation, taken together with other indicators provides a glimpse of societal cohesiveness.

Crime

Most OECD countries have experienced increases in crime and in their prison populations. The United States has the highest population rate of more than 700 per 100,000 population in 2005. Prison populations have declined only in Canada, Korea, and Iceland. There are large differences across countries in the composition of the prison population. In some

countries, the prison population has exceeded the capacity of existing institutions. Overcrowding feeds violence and rebellion against institutions. The close link between incarceration, poverty, and marginalization affects individuals with few social ties and who have experienced family breakdown, educational failure, and violence. Since imprisonment may amplify social exclusion, some countries take more aggressive steps to rehabilitate prisoners.

Suicide

The intentional killing of oneself is evidence of both personal breakdown and a deterioration of the social context in which people live. Suicide remains primarily a male behavior and is related to age, with persons under age 25 more prone to commit suicide. In general, suicide rates among the elderly have declined over time. Suicide rates across OECD countries reflect differences in the prevalence of divorce, unemployment, religious beliefs, and trust in other people and in organizations.

Work Accidents

Work accidents impose a significant economic cost on workers, firms, and communities. These costs combined with occupational illness are significant in several OECD countries, especially those where agriculture, certain manufacturing industries, construction, and road transport are predominant. Reducing work accidents requires a work environment where workers have the appropriate skills and training to perform in their jobs, and where firms have incentives to avoid the occurrence of accidents. Work accidents affect worker loyalty to their employer and to their commitment to their work through the quality of products and services delivered.

Strikes

Strikes are one indication of industrial conflict. The most comprehensive indicator of industrial conflict is the number of hours of work lost because of strikes. OECD countries with the lowest number of hours lost to work because of strikes were Germany, Japan, Netherlands, and Switzerland. On the other hand, OECD countries with the highest number of lost hours of work were Canada, Iceland, Italy, and Spain. Strikes are higher in industrial

than in service sectors. However, strike rates have declined in both of these sectors in OECD countries over the past 10 years.

Trust in Political Institutions

Trust in political institutions refers to the extent in which individuals have a high degree of confidence in the public administration and government of their country. Data on this indicator were derived from 1999 to 2004 wave of the *World Values Survey* in which individuals were asked to rate their confidence in a number of organizations. Trust in political institutions is critical for the stability of societies and for the functioning of democracy in each country; it also shapes people's willingness to cooperate in achieving collective goals. On the average, 38% of individuals across 24 OECD countries, in the early 2000s, reported high trust in their governments. About 44% of OECD citizens reported high confidence in the civil service.

It is difficult to assess how citizens' trust in political institutions has changed over time. There were also differences across countries related to the socio-demographics of citizens such as higher distrust in government among the better educated. As the OECD pointed out, satisfaction with government is related to the way democracy works in a given country; the more involvement and participation, the higher the degree of satisfaction.

Life Satisfaction

Subjective measures of life satisfaction assess the extent to which individuals favorably evaluate the overall quality of their life. Data were gathered through the *World Values Survey* of 1999–2004 that asked "how satisfied" citizens were with their lives in general and in specific domains on a scale from 1 to 10.

Results showed that life satisfaction generally increases with educational attainment, marriage, employment, income, age (in some countries), and is higher in countries characterized by a high level of trust in others and in their government.

Societal Integration and Health

Michael Marmot said, "evidence suggests that the level of cooperation and trust of a society improves health."[12] A collective tendency to social integration (societal cohesion) can affect health. Putnam[4] defined social capital as

"the connections among individuals – social networks and the norms of reciprocity and trustworthiness that arise from them." Marmot added, "if social connectedness is good for health, and if it varies systematically among societies, it would be expected that health differences would follow as a consequence. Similarly, if there were variations in social connectedness within a society, there would be accompanying differences in health" (p. 170).

Marmot continued, "a high degree of responsibility to the group, characteristic more of some societies than others, is an important determinant of health and well-being of the people who live in that society. A society with a higher degree of responsibility to the group should, other things being equal, be a healthier society" (p. 170). Japan is noted to fit this description.

Cultural Differences in Social Integration

As discussed in Chapter 1, different values, beliefs, and lifestyles are associated with different health and illness experiences in different groups. The Japanese point to their group values as the explanation for their favorable life expectancy, lower rates of chronic illness, and crime compared to a greater focus on the individual in Western countries. Indeed, evidence of how group cohesiveness can affect health is found in a large-scale study of what happens to the health of Japanese when they migrate.[13]

This classic study of Japanese in the home islands, in Hawaii, and in California showed clearly the effects of successive migrations to social environments that pose greater risks of heart disease. Studies of migrant populations demonstrate that as they take on the social patterns and customs of the host country, they take on its disease patterns as well. The farther the Japanese migrated from their homeland, the greater their risk of heart disease; their social cohesiveness was also modified as they left the collective support of their macro environment. The importance of social cohesion to individuals and groups is how and in what ways they are embedded in their society. Studies clearly show that it is not culture itself that has an impact on health, but how cultural beliefs and values influence strategies for coping with their environment, especially change.

Health Information as a Proxy for Measuring Societal Cohesiveness

There are many different indicators of health available depending on how health is defined. Similarly, there are different indicators of social cohesion depending on its definition. What has been done is to select predominately

quantifiable indicators to form aggregate indices of the health and cohesion of a society to provide an assessment of its quality of life and make comparisons periodically within and between societies to determine its progress or decline with respect to its degree of healthiness and well-being.[14]

The need for reliable and systematic measures of the health of societies is increasingly important if preventive programs and public policies are to be instituted to improve health and well-being. Preventive measures seem to have greater social value in cohesive societies. An aggregate population health index, despite its methodological imperfections, is a first step in gaining insight into the cohesive strengths of societies that might be used to mobilize individuals and institutions to engage in activities that might develop into public policies to improve health and well-being and strengthen cohesiveness.

Summary

There is evidence that societies that are both egalitarian and healthy are also more socially cohesive than others. Greater social cohesion and fewer social inequalities enable these societies to pay more attention to the psychosocial quality of life. Economic indicators have commonly been used as a barometer of the health of societies, yet these indicators do not embrace the qualitative side of life. Social indicator research is a challenging and viable avenue of inquiry toward ascertaining more accurate and comparable social and health information on the societal level.

Notes

1. M. Miringoff & S. Opdycke, 2007, *America's Social Health: Putting Social Issues Back on the Public Agenda*, Armonk, NY: M. E. Sharpe.
2. See J. D. Hunter, 1998, The American culture war, in P. L. Berger (Ed.) *The Limits of Social Cohesion: Conflict and Mediation in Pluralist Societies*, pp. 1–37, Boulder, CO: Westview Press.
3. K. C. Land, 1983, Social indicators. *Annual Review of Sociology*, 9: 1–26. Social indicator research gained momentum in the latter 1960s with a focus on social policy analysis, that is assembling data to devise explanations for social trends that led to the development of policies for coping with and/or controlling social change. Working out of a tradition of social measurement, social scientists were interested in developing measures of social conditions that could be used in longitudinal designs and analytical studies of social change. However, the systematic use of social indicators to forecast trends in social conditions, while still prominent, has remained primarily at the descriptive level and needs research attention to improve social forecasting to contribute to both theory and methodology. Because social indicators research depends more than most social science research on cooperation between the federal government and the academic community, there are continuous challenges to the continued development of national social forecasting.

4. R. D. Putnam, 2000, *Bowling Alone: The Collapse and Revival of American Community*, New York: Simon & Schuster.
5. D. G. Myers, 2000, *The American Paradox: Spiritual Hunger in an Age of Plenty*, New Haven, CT: Yale University Press.
6. F. Fukuyama, 1995, *Trust*, pp. 10–11, New York: The Free Press.
7. W. J. Bennett & S. Nunn, 1999, *A Nation of Spectators: How Civic Disengagement Weakens America and What We Can Do About It*. Final Report of the National Commission on Civic Renewal, Pew Charitable Trust, Washington, DC.
8. *America's Civic Health Index, Renewed Engagement: Building on America's Civic Core*, 2007, A report by the National Conference on Citizenship in association with Circle and Saguaro Seminar, Washington, DC, National Conference on Citizenship.
9. M. Miringoff & M. Miringoff, 1999, *The Social Health of the Nation and How America is Really Doing*, pp. 3–8, New York: Oxford University Press.
10. See US Department of Health, Education and Welfare, 1970, *Toward a Social Report*, Ann Arbor, University of Michigan Press. The idea of a social report on the nation's health is not new. In 1929 Herbert Hoover commissioned a President's Committee on Social Trends (*Recent Social Trends in the US*), 2 volumes, 1933 to analyze significant social factors in order to provide a basis for policy in the second-third of the 20th century. Federal mechanisms were established to improve the gathering of social data and monitoring social conditions. However, these efforts lapsed in the 1940s and 1950s until 1966 when President Lyndon B. Johnson directed the Department of Health, Education, and Welfare to improve the nation's ability to chart its social progress. This resulted in *Toward a Social Report*, submitted June 11, 1969. This effort was not continued. However, there have been reports from commissions such as the one created by the Russell Sage Foundation in 1965 which published *Indicators of Social Change: Concepts and Measurement* published in 1968 and edited by E. B. Sheldon and W. E. Moore. The Department of Health, Education, and Welfare published *HEW Indicators* and *HEW Trends* from 1959 to 1966. The United Nations has published a *Report of the World Social Situation* periodically since 1952. The European Union publishes reports on *Economic and Social Cohesion* among its 27 member countries.
11. Organization for Economic Cooperation and Development (OECD), 2006, *Society at a Glance: OECD Social Indicators*, Paris: OECD Publishing.
12. M. Marmot, 2004, *The Status Syndrome: How Social Standing Affects Our Health and Longevity*, pp. 166, 170, New York: Henry Holt & Co.
13. See Y. S. Matsumoto, 1970, Social stress and coronary heart disease. *Milbank Memorial Fund Quarterly*, 48: 9–36, also see A. Kagan, B. R. Harris, W. Winkelstein et al., 1974, Epidemiologic studies of coronary heart disease and stroke in Japanese men living in Japan, Hawaii and California: Demographic, physical, dietary and biochemical characteristics. *Journal of Chronic Diseases*, 27: 345–364.
14. See M. C. Wolfson, 1994, Social proprioception: Measurement, data, and information from a population health perspective, in R. G. Evans, M L. Barer & T. R. Marmor, *Why Are Some People Healthy and Others Not? The Determinants of Health of Populations*, pp. 287–316, New York: Walter de Gruyter.

Chapter 5
Cohesive Communities

Introduction

Social cohesion is a group property where members are well bounded, connected with one another by personal relationships, and share a common purpose. Cohesiveness is not a trait or state but a process that can increase or decrease over time in response to many factors including group size, leadership, and external threats. Social and physical environments play an important role in fostering or undermining the ability to create social ties.[1]

Moos[2] pointed out several ways that individuals and environments influence each other. Some individuals find themselves in limited environments like poverty or are placed in severe environments such as prison that shape their behavior. Other individuals select social contexts that maintain and accentuate their dispositions, skills, abilities, and values, for example, retirement communities. Still others build new micro-environments that reciprocate their desired values and behaviors, for example, refugees and immigrants. This can be illustrated by the Laotian Hmong refugees to the United States who have fiercely resisted acculturation and assimilation. Anne Faidman[3] said in her book on the Hmong,

> What the Hmong wanted here was to be left alone to be Hmong: clustered in all-Hmong enclaves, protected from government interference, self-sufficient, and agrarian. Some brought hoes in their luggage (p. 183).

Cohesion can have a downside. Powerful cohesive environments can support group goals at the expense of the advancement of individuals and instill feelings of guilt and self-doubt among individuals who consider leaving the group. Cohesive groups can be highly structured and exceptionally powerful in that they exert a compelling influence over individuals' attitudes and behavior. Wilson[4] suggested that while the residents of very poor neighborhoods often tend to be tightly connected, the ties are

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excessively personalistic and parochial, therefore isolating residents from public resources. This is due, in part, because survival mechanisms and local support take precedent over activities centered amid the collective good.[5] Strong social ties can foster group sustainability while at the same time, impede efforts to produce collective resources.

How Communities Become Cohesive

Before groups can be considered cohesive, it is necessary for individual members to have strong feelings of belongingness. Feelings of belongingness are conveyed to members through an interdependence of goals with others in the group. This identification is strong enough that members feel that the group can be more effective as an organized whole; therefore, members readily sacrifice personal goals for group needs. In such groups members receive strong personal satisfactions from their memberships, are proud to belong, and are generally more secure.[6]

How do individuals acquire feelings of belongingness to a group? One method is through *community covenants* of self-help, support, and service.[7] The concept of community covenants originally arose in the work of Page Smith[8] who described "covenanted" communities as those with enduring religious and interpersonal compacts. Others[9] expanded the concept of community covenant to include generally held community assumptions, expectations, informal agreements, or lifestyles, as well as the overall character of communities. Community covenants emerge from, respond to, and influence a community's social structure, value system, history, economic activities, and leadership. Many symbols such as architectural features, use of space, welcome signs, and graffiti can express community covenants, but additional data are needed in addition to symbols to fully "read" and understand a community's unique covenant.

McAuley[7] described the origins and persistence of community covenants of care that bound the lives of older residents in all-black towns. Informal care giving is common in all African-American communities where the "ethic of caring" is a significant aspect of African-American culture. Churches have also been important sources of support to older African-Americans. Only 13 all-black towns exist in the United States in 2008; most have faded away as a consequence of the Voting Rights Act, desegregation laws, the civil rights movement, and changing attitudes. However, historically one way to minimize the unyielding pressure of the American racial code of the early 20th century was for blacks to form all-black communities.[10] Many of the characteristics and themes of all-black communities (positive racial identity, separatism, self-determination,

expectations of limited outside support, community self-reliance, and the special status of elders) continue to exist in various forms and levels in African-American neighborhoods and ghettos (an ethos of neighborliness) today. The value system sustaining the practice of covenants of care continues to coalesce members of the African-American community irrespective of their residential constraints and choices.

A second method of acquiring feelings of belongingness to a group is through *kinship and ethnic ties*. Weissbach[11] described how East European Jews who immigrated to the United States in the early decades of the 19th century established their own social milieu and constructed their own communal infrastructure in small cities where there were more than a handful of families. The intensity of Jewish communal life was strengthened by so-called “chain migration” of relatives and friends and these kinship ties were extended as intra-communal marriages. Also reinforcing the intensity of communal life was the fact that small town Jews tended to cluster in similar professions and to live and work in close proximity to each other. The fact that the immigrant Jews in small communities continued to carry out their daily lives speaking Yiddish also reinforced their ethnic identity and kept them closely tied to each other, while crating a barrier between them and the larger society around them. Furthermore, in small-town Jewish communities, with their limited populations, practical considerations often mitigated internal divisions that probably would have persisted in larger cities. Small-town congregations functioned on the basis of negotiation and compromise. However, small communities were not always able to work out compromises and maintain internal unity. Multiple congregations existed in the same town. The most common division was between Reform and Orthodox Jews, although divisions endured within each of these segments as well. Disagreements and divisions split some immigrants by their country of origin.

Weissbach explained that the communities of America’s smaller cities and towns of the late 19th and early 20th centuries were not simply miniature versions of communities in larger metropolitan areas. On the one hand, the story of small Jewish communities suggests that environmental factors could be so powerful that they fostered levels of cooperation and accommodations that might not have been expected. On the other hand, the story of these small communities indicates that divisions within Jewish society were at times so entrenched that they persisted even in the face of environmental conditions that should have promoted their moderation.

A third method of acquiring feelings of belongingness to a group is through “*cultural spirituality*.” The concept of cultural spirituality reflects the Native American’s views of connectedness of humans to all other physical and transcendental entities. Reciprocity characterizes all interpersonal

relationships. Native Americans believe everything in life is one functional whole – one system. Therefore, balance and harmony are essential to community and individual existence. For example, the family is a concept derived from sharing a kindred spirit and extends beyond blood relationships.

European contact and colonization[12] and the 1830 United States Congress Indian Removal Act were instrumental in destroying old living patterns, important to the cohesion of Native American tribes. Indeed, suicide became common, whereas it was unknown in prior times. Over the centuries a history of dispossession, impoverishment and eventual denial of sovereignty and confinement on reservations subjected Native Americans to as much stress and deprivation as any people in history. The US policy was to Americanize the Indian through missionary education and provide social services as a means of pacification. Children were often forced away from their families. A generation of Indian children grew up with little or no connection to their native homes or community life due to cultural insensitivity, assimilation goals, and racism.[13,14]

Retaining cultural identity and social cohesion is impossible for Native Americans today. Indians are more physically scattered than other minority groups. There is no barrio or neighborhood to go to. Urban Indians are not a place-based community; they are networked people who know each other.[15] Cultural ties that were once second nature on the close-knit reservation are more difficult to retain. Distance between families creates another hardship in carrying traditions from generation to generation.

Indian values include: respect for elders; living in harmony with all things and supernatural forces; oriented to the present time; and regard for spirituality. Indian children may have some difficulties with these values in Anglo schools. The urban environment conflicts with Indian values to such a degree that the Indian feels alienated and lonely. When loneliness occurs, the Indian feels disenfranchised from the spiritual bonds that tie him or her to their family and community.

Yet, different tribes experience different levels of cohesion with different consequences. For example, Van Winkle and May[16] found that suicide rates among Native Americans varied with the degree of cohesiveness of their communities. In highly cohesive communities, especially on reservations, individuals who belonged to many groups and felt strong pressure to adhere to behavioral norms had lower suicide rates than individuals who lived in low cohesive communities with few social ties beyond their immediate family. A commitment to "cultural spirituality" was significantly associated with low rates of suicide among Native Americans.[17]

A fourth method of acquiring feelings of belongingness to a group is through *collective socialization*. A study shows how community

characteristics can protect 15 to 17-year-old Latinas from the negative effects of poverty.[18] Using economic predictors, a sample of residents were interviewed in eight California communities that were identified as having either high or low teenage birthrates. The researchers found that high social capital and strong, shared, cultural norms were associated with lower than expected teen birth rates for 15 to 17-year-old Latinas. Specific protective factors included small community size, low density, with a low proportion of adults born in the United States, and a high percentage of Hispanic residents. Low teen birthrate communities had characteristics of *colonias*, which have a Latino majority and close ties to their home country. Residents who choose to live or work in these communities are close to family, have informal networks of support, and share monitoring of children. When community residents share cultural norms, it strengthens family messages about sexual behavior, supporting family connectedness, and parental monitoring that lowers teen pregnancy.

Collective socialization proposes that social norms established by adult behavior become internalized by teens. A community that practices collective socialization offers parental and kin support, relationship networks that provide collective supervision and resources for youth to pursue goals, positive opportunities, safe places, and norms that emphasize education, social control, and rule enforcement. Although poverty was higher in low birthrate communities, residents chose to live and work there because of informal support systems and a shared culture because they viewed them as better places for the children.

A fifth method of acquiring feelings of belongingness to a group is through *social transformation* following a crisis or trauma. An individual's traumatic experience can serve as the basis for the creation and transformation of a group when the traumatized individual serves as the leader for the group. Also when a group trauma occurs, it must be transformed for the group as a whole. Finally, witnessed traumatization of others can cause a group response even when the trauma has not been experienced directly by the group members. What is key is that individuals and groups search for ways to turn adversity into a strength, to turn a personal or group trauma into a community asset.[19]

On March 24, 1989, the supertanker *Exxon Valdez* ran aground on a well-marked reef in Prince William Sound, Alaska. This accident resulted in the release of over 11 million gallons of crude oil into the pristine waters of the Sound. The immediate impacts of the technological disaster were devastating to marine mammals, fish, birds, and wildlife. The immediate social and cultural impacts of the spill were very disruptive for the small fishing communities and Alaska Native villages in the Sound. Commercial fishing was suspended. Native villages were disrupted through the loss of village

members to the work of clean-up operations. Children were often left in the villages with minimal supervision as parents worked long hours in remote areas of the Sound.

Picou[20] describes the implementation of a 2-day Talking Circle as a participatory, culturally based intervention strategy for mitigating the chronic cultural disruption produced by the spill. The Talking Circle is practiced in various ways in Native American cultures. In one instance, the group gathers in a circle and uses a "talking feather." Whoever has the feather can say what is on their mind. When they are finished talking, the feather is passed to the next person in a clockwise fashion and the next person says what they have left unsaid. The largest affected village, Eyak, proposed the holding of a Talking Circle devoted to the oil spill. The social discourse which emerges from a Talking Circle is a social context for sharing oneself with the rest of the village. The Circle can be tailored to a variety of audiences and situations. The Talking Circle held by the village of Eyak, was pattered after the Community circle. Over the course of 2 days, five themes were addressed in the Circle: the ecological destruction of the spill, Exxon, traditional cultural spirit, the group, and self.

Social transformation was the approach used in helping individuals and villages in Alaska overcome chronic social and cultural disruption resulting from the spill. The Talking Circle promoted collective empowerment of local residents through participation. By designing, organizing, promoting, and participating in the Talking Circle, members of the village of Eyak became active participants in their transformation. Villages were aware of their cultural traditions while engaging in appropriate cultural behaviors for responding to the spill's ecological destruction. The response mitigated the negative cultural impacts of the spill by refocusing attention on cultural traditions and, therefore, increasing cultural consciousness.

Before the Talking Circle, the village of Eyak was characterized by a lack of cultural activities and village organization. Eyak village now has an active environmental program and has established a housing authority. The village organization is active in participative planning to establish future goals. The Talking Circle facilitated a "reflection-action-reflection cycle" in the community of Eyak. The Talking Circle transformed both individuals and the community – they became a culturally conscious collectivity as a result of talking about their common hurt. Social cohesion can emerge from social disruption when survivors recognize they have a responsibility to the whole.

A sixth method of acquiring feelings of belongingness to a group is through an *intervention* to create a social context conducive to cohesion. Overall, intervention efforts have a positive effect on short-term outcomes, but both short and long-term outcomes are more strongly determined by

ongoing social contexts. We can intervene to create social contexts that lead to cohesion, but the group members involved must maintain the structure and dynamics to experience long-term benefits.

Halpern[21] studied the effects of significant changes in the physical environment on the mental health and social cohesion of the residents of Eastlake, a housing estate in Britain that was scheduled to be refurbished to correct serious design problems. Interviews with residents prior to physical changes revealed low self-esteem, a high prevalence of depression and anxiety, poor neighboring, distrust, and dissatisfaction with the surrounding physical environment. The houses and flats were refurbished incrementally as funds became available. Residents were offered choices that improved friendliness and support among neighbors. Interviews after the physical refurbishment indicated improvements in mental health, especially decreased anxiety, as positive neighboring increased. Halpern concluded that the physical environment can determine the form and character of neighbor relationships and coping behavior. The improvements in mental health and increased social cohesiveness were due to a combination of factors including improved safety, lighting, replacement of bathrooms and kitchens, and a re-design of traffic patterns. Halpern stated that not all types or aspects of mental illness can be altered by environmental intervention, but their mutual effects on social cohesion are observable and measurable.

In Oslo, Norway, residents in five types of neighborhoods were re-interviewed after 10 years using the same questionnaire to examine a possible relationship between changes in the quality of neighborhoods and mental health.[22] The initially poor functioning neighborhood with poor mental health was where substantive improvement took place as part of the further physical development of the area. The researchers found that increased trust and interaction between residents, as well as increased feelings of community cohesion and empowerment, were critical for the improvement in mental health. Neighborhood facilities including private and public service and recreation and social activities were developed leading to an enhanced quality of life and social integration of the previously poor functioning neighborhood.

A seventh method of acquiring feelings of belongingness to a group is through the establishment of a *superordinate goal*. The introduction of a superordinate goal to reduce group frustration or intergroup conflict has been shown to enhance cooperation in achieving a common goal. A now classic experiment was carried out several decades ago in Robbers Cave State Park in Oklahoma, by Muzafer Sherif[23] and a team of social psychologists. The experiment called for the selection of 24 boys of about 12 years of age from similar social backgrounds who did not know each other. The boys were transported to a camp where they were encouraged to bond as two separate

groups and select a name for their respective group. The groups were then brought into several types of competition which resulted in considerable tension and separatism between the two groups. Several types of superordinate goals were then introduced with successive steps of activities directed toward a common solution to the problem. For example, it was announced that the water supply had failed at a time when both groups were thirsty and became progressively thirstier as the problem evolved. The discovery of a full tank of water turned the attention of both groups to ways both groups could obtain water if the faulty faucet was repaired. The faucet was repaired by one group, but the two groups worked out a way they both could obtain water in an organized fashion. Several other superordinate activities were introduced so that by the last day of the camp both groups shared the same bus and reward money they had won in contests.

Group cohesiveness can be created by introducing a superordinate goal in the context of a shared vision. For example, when people play together in a sports context, the common goal of winning may lead players of diverse ethnic backgrounds to create a superordinate goal identity – that of a "team member." Superordinate goal identities may be the key to intergroup harmony in pluralistic societies.

An eighth method of acquiring feelings of belongingness to a group is through *community building*. Community building is a process that aims to build capacity in neighborhood institutions, strengthen social ties among residents, and assist residents to work individually, and collectively toward neighborhood change. Robert Putnam and Lewis Feldstein in their book *Better Together: Restoring the American Community*[24] highlight 11 examples from the numerous communities that are moving against the nationwide tide of declining social capital and creating new forms of social connectedness. Putnam and Feldstein state that these examples involve "making connections among people, establishing bonds of trust and understanding, and building community. In other words, they all involve creating social capital: developing networks of relationships that weave individuals into groups and communities" (p. 1).

In an effort that builds on the work of Putnam, some three dozen community foundations have committed themselves to a long-term campaign to rebuild levels of connectedness in their communities.[25] The Social Capital Community Benchmark Survey is an investigation of civic engagement in a national sample of 3,000 respondents and samples in 40 communities in 29 states in the United States. The survey is designed to measure the amount of social capital in various communities, and point to inequalities in access to social capital as well as opportunities for social capital building.

Atherton Gardens is a wired community in inner Melbourne, Australia established to bridge the digital divide and promote social cohesion within

the Atherton Gardens community.[26] Atherton Gardens is a multiethnic, multilingual, multifaith public housing estate and is largely low income with 80% receiving government support. There are 800 apartments in four 20-story block towers with about 2,000 residents. Many are immigrants from Vietnam, China, Turkey, Spain, Yugoslavia, Greece, Iran, and numerous other countries. Unemployment is high and a proportion of residents have special needs. The Gardens has long been perceived as a focus for drug trading, violence, graffiti, and vandalism. Built in the 1970s, it has become the center for the poor and marginalized.

Atherton Gardens is one of several estates selected by the government for capital improvement, security, environmental planning, employment-generation, and community arts. New management schemes have been designed to give residents employment opportunities with a strong emphasis on community liaison and decision-making. Advisory boards have been established and have been empowered to develop community plans for service delivery and physical planning.

Info Xchange, a non-profit community technology organization, initiated a project that provides infrastructure and support so that all residents can be connected to a computer network. While the project set out to address the digital divide in a disadvantaged community, the project also proposed to improve access to education and employment for residents. The project is largely government funded, with Info Xchange providing the leadership and catalyst for change.

Benefits to date include information technology training enabling residents to expand employment options and foundation skills that can apply to their employment, education, and personal pursuits. Increased skills and being able to apply them have also contributed to increased self-esteem. The project has increased bonding between ethnic, language-based, and faith-based groups and contributed to increased social support for individuals. The training activities cut across traditional cultural and political structures and are increasing contact between groups.

There have been significant barriers such as identification with the whole community. Levels of trust have been low between different groups living in the community. Perhaps most significant was the absence of a supporting local social infrastructure. Info Xchange has been required to improvise their planning. Partnership building in the whole community approach is complex and sometimes tentative with limited funding.

The size and social complexity of Atherton Gardens prohibit it being regarded as a single "community," but rather as a set of associations. People and households are linked in different ways. Connections across boundaries do exist, but communication is limited. The agenda for community building in Atherton Gardens is broad, complex, and long-term. As Meredyth and

her colleagues[26] state "…it is a hopeful picture of enterprise and opportunity – although it promises more than it has been able to deliver so far and many of its benefits may be hard to predict, describe, and measure" (p. 94). The Atherton Gardens example illustrates the greater ease and acceptability of a technological intervention compared to social interventions to promote cohesiveness in a large, heterogeneous group. It raises the issue of groups being cohesive in some respects but not cohesive in other respects.

Maintaining and Strengthening Community Cohesiveness

Physical and social environments have both cohesion-enhancing and cohesion-compromising characteristics. The challenge for groups and communities is how to maintain and enhance their degree of cohesiveness. Four research projects in Teesside, London, Liverpool, and Nottingham, England, focused on the physical and social qualities of disadvantaged neighborhoods and the interaction between them. The researchers considered the factors affecting social cohesion and how it might be strengthened. They looked at what residents thought about their neighborhoods and regeneration strategies.[27]

First, the researchers discovered that the neighborhoods, even though they were defined as disadvantaged, did not lack some degree of social cohesion. The four areas had deteriorating housing, a high rate of unemployment, anti-social behavior and safety concerns, poor public service, and a bad reputation leading to active discrimination. There were social divisions among residents in the same neighborhood, between newer and older residents, between younger and older people, between tenants in new houses and those in older ones, and between various kinds of tenants. Despite some pessimism, residents had a strong sense of resilience with family and friends providing support. They had a shared sense of what a good neighborhood needed.

A re-generation plan was developed involving residents, many of whom had felt that they had no say or had no control over what happened to them, and many were ill-informed about what was taking place. Community development strategies were implemented to resolve tensions and build bridges between groups and generations. Housing management policies focused on community stakeholders and sustainability. Better transportation links were made to the wider urban area. The communities were given control over regeneration funds to ensure that regeneration met their priorities. People external to the four neighborhoods were brought into the areas to observe

the regeneration process. More outward looking communities developed because of wider social networks.

Women were important in helping to form relationships across the neighborhoods with children often a pivotal element in social networks. Involvement in local projects relating to children increased social interaction and trust. The social ties that developed from social interaction were important to residents' confidence in their communities and were enhanced through landscaping features of dwellings and the placement of local shops. While social connections were fragmented and the physical environment deteriorating, the four neighborhoods shared strong resilience and hope and increased their level of social cohesion.

All groups are cohesive to some degree, in whole or in part and maintain boundaries to protect their identities and experience a sense of community.[28] Much of the research on community cohesiveness has emphasized the negative outcomes when cohesiveness is measurably weak or absent. Oppressed and non-dominant communities have often been represented as lacking in competence and cohesiveness. They have often been described as disorganized, damaged, or lack the cohesiveness to provide adequate resources for their members to cope with adversity and change. Some communities have resisted assimilation or struggled through sustained oppression, but nonetheless have remained competent and resilient by drawing upon what has been termed by Keil[29] as the "soul" or essence of a community. Communities respond to threats to their survival by finding ways to protect and propagate what is valued and central for their survival. This is what is termed community resilience or collective efficacy. For example, Sampson and his colleagues[30] have found that collective efficacy is negatively associated with neighborhood violence and positively associated with friendship and kinship ties, organizational participation, and neighborhood services. Collective efficacy serves as a "mediator" linking neighborhood social composition and crime. However, collective efficacy does not obviate the fact that neighborhood inequities might still persist.

Sampson[31] asks what kinds of social contexts and policies promote collective efficacy? Efficacy is a measure of control. Concentrated disadvantage and lack of homeownership in particular predict lower levels of collective efficacy. Weak organizations are not able to create collective efficacy and networking. When individuals and groups cannot jointly mobilize to meet environmental challenges they are likely to continue living in an environment of inequalities. Sampson found that a high density of organizations and voluntary associations predicted higher levels of collective efficacy. The mere existence of local resources does not guarantee that communities will mobilize to exert social control over their destinies. While inner cities especially have constraints imposed upon them such as concentrated poverty

and racial segregation, it is possible within the limits of a given community to share a willingness to intervene to produce a healthy community for themselves.

Creating Cohesion Across Ethnically Diverse Communities

Ethnic diversity is increasing in the United States and in most other Western countries, driven by substantial increase in immigration. In the long run, diversity is likely to have important cultural, economic, fiscal, and other benefits. In the short run, immigration and ethnic diversity has lead to decreased social solidarity and social capital. Evidence in the United States suggests that in ethnically diverse neighborhoods, residents of all races tend to "hunker down." Trust, even of one's own race is lower, altruism and community cooperation rarer, friends fewer.[32]

To combat the growing ethnic polarization in the city of Rochester, New York, in 2001, Mayor William A. Johnson initiated the Mosaic Partnerships Program. The Program was designed to prevent conflict by creating and nurturing trusting relationships among groups. The Program's success in building and sustaining social cohesion has led to its replication in other United States cities.[33]

The Mosaic Program pairs leaders across ethnicity and over the course of a year they connect with people in ethnic groups they typically would not interact with. As trust develops the leaders open their social networks to each other allowing for the social integration of ethnic groups that were previously soloed in the community. The Mosaic process has proliferated "weak tie" relationships that are essential to the creative environment of a community. Through weak-tie relationships problems are solved, crises averted, jobs are found, new services and enterprises are launched. The social cohesion that weak ties facilitate will ultimately reduce the potential for ethnically based conflict as well as promote economic development. The purpose of the Mosaic Program is to build unity in diversity, two leaders at a time, as the foundation for social transformation.

Community leaders who have completed their year long trust building experiences have lead efforts to extend a similar experience to bi-racial neighborhoods. A group of 30 neighborhood residents are being paired across ethnicity. Also a group of students from a predominantly white high school will be paired with a group of students from a predominately African-American high school. Through pairing, partners become advocates for the Mosaic experience. Social transformation requires that social and emotional distance that exists between people of different cultures be bridged by association and fellowship. Communities that intentionally and systematically

elevate their level of social cohesion enable themselves to benefit from diversity.

Virtual Communities and Social Cohesiveness

According to Castells,[34] "networks constitute the new morphology of our societies." To some the on-line community will never replace the local neighborhood in meeting communication needs. However, Wellman states that networks are about social relationships – networks of social ties. Network analysis is a useful approach to community because, by focusing on linkages, it avoids a prior confinement of analysis to solitary groupings and territorial units. A community is a network of networks.[35] The loss of a community as a physical space does not mean that informal associations are lost. Rather, ways of communicating have become more personal, more privatized. Indeed, Foster[36] writes that an on-line community is held together by the feeling of togetherness and connectedness that confers a sense of belonging.

Neighborhood and kinship ties are only a portion of people's overall community networks. Communities do not have to be solitary groups of densely knit neighbors but can also exist as social networks of people who do not live in the same neighborhoods.[37] Wellman argues that large scale social change has neither destroyed community nor eliminated social support – they are now worldwide social networks and not local community solidarities.[37]

Harasin[38] regards on-line communities as pseudo communities. What has changed is the mechanism of communication, not its meaning. What is referred to as a virtual community enables individuals and groups to do everything they do in real life but leave their bodies behind.[39]

Virtual communities are constructed through communication and interaction that is multidirectional, multidimensional, and constantly changing. Communication may occur instantaneously on several levels and through several dimensions. Communication maybe delayed without loss of connection or credibility.[40]

Most published research on virtual communities has used qualitative approaches such as ethnography or conversation analysis. For example, Kinnevy[41] conducted an ethnographic study consisting of the non-participant observation of e-mail messages from a virtual peace activist community over a 4-month period. She concluded that electronic communities are more sensitive to the tone and content of their communication because of the lack of visual context but the normative and value constructions in electronic communities emulate those in face-to-face communities.

Effects of the Internet on Local Communities and Social Cohesion

What are the effects of the Internet on local communities and their cohesiveness?

The Pew Foundation's Social Ties Surveys of 2004 and 2005, provide some data on this question.[42] The surveys were carried out among 2,200 adults in the United States who were 18 years of age and older. The surveys found that, while households may not have family dinners and picnics as in past decades, they are connected as individuals to friends and relatives and to other household members. The Internet helps people in maintaining ties with large and diversified networks. The result is that people not only socialize online, but they incorporate the Internet into seeking information, exchanging advice, and making decisions. Much of communication is with the same friends and family who are contacted by mail, phone, or face-to-face.

The surveys found no evidence for the replacement hypothesis that email replaces other forms of contact. Indeed, to the contrary, people who have high weekly email contact with their core and significant ties also have high contact by phone and by instant messaging. Email was also not found to reduce in-person contact. The survey found the current generation of email users is communicating more than recent generations and possibly more than any previous generation.

The Pew Report concluded that the Internet has promoted "reworked individualism, that is it has transformed community from densely knit villages and neighborhoods to sparsely knit social networks" (p. 1).

A recurrent theme in most of the research on the social implications of the Internet is that the Internet tends to complement rather than displace existing media and patterns of behavior.[43] While there is some evidence that virtual communities can evoke a high sense of community from its members,[44] yet other scholars believe the Internet is a poor replacement for the close, emotional, holistic ties of *Gemeinschaft*-type relationships found in the place called "the community."[45] Galston[46] states that the Internet draws from the conflicting desires for autonomy and connection and because on-line groups are "brought together and held together by converging individual interests they neither foster mutual obligation nor lay the basis for sacrifice" (p. 202). On-line groups can fulfill important short-term emotional and utilitarian needs. Long-term effects of the Internet are yet unclear since it is a dynamic, evolving form of communication. Nonetheless, there is an emerging consensus that rather than replacing local place communities, the Internet may enhance community in local or shared space – another tool to maintain ties with family and community.

Hampton and Wellman[47] had a unique opportunity to observe the effects of new information and communication technologies in Netville, a “wired,” affluent suburban neighborhood of Toronto, Canada. Results from a survey and from participant observation showed that high-speed, always-on access to the Internet, coupled with a local online discussion group, transformed and enhanced neighboring in Netville. In comparison with non-wired residents in the same neighborhood, more neighbors were known and chatted with, and they were more geographically dispersed around the suburb. Not only did the Internet support neighboring, it also facilitated discussion and mobilization around local issues. The Netville experiment showed that when people can use the Internet to communicate at low cost, neighboring can flourish online.

Large friendship networks have been found to be associated with greater community attachment, greater empowerment, lower crime rates, watchfulness of neighbors, reduced fear and mistrust, and lower levels of mental distress and depression. However, not all ties are equal, and not all interactions have the same effects in all neighborhoods.[48] The study of “neighborhood effects” has found that the formation ties and the influence of ties vary by neighborhood characteristics, especially as they relate to socioeconomic status and residential mobility. While the Netville experiment showed that the more Netville’s wired neighbors became involved with technology the more connected they became with each other, this experience may not be generalizable to other neighborhoods and communities with technology. Similarly, the way in which neighborhoods experience social cohesion is not generalizable in all its aspects.

Trust as a Proxy for Community Cohesiveness

Social trust has become a proxy measure for cohesiveness in online communities.[49] The concept of “swift trust” has been used for temporary teams or groups who must quickly develop and maintain trust relationships with people they hardly know, and may never meet again, with the goal of producing interdependent work. There is evidence that cognitive-based trust is more important to temporary virtual work teams than the affective dimension of trust. The presence of swift cognitive trust was associated with high performance.[50] Communication partners who talk in an empathetic and supportive way are more trusted by online peers. Empathy itself does not guarantee trust; there must also be a supportive response. Other research suggests that trust is more likely to be communicated in the first email message. Communication that rallies around a project and tasks appears to be necessary to maintain trust. Social communication that complements rather

than substitutes for task communication may strengthen trust. Initial behavior such as a team member's verbalizing their commitment, excitement, and optimism and their own propensity to trust has been shown to effect the establishment of team trust.[51]

Trust behavior is a dynamic, fragile, context-dependent variable whereas social cohesion is a characteristic of social structure that transcends contexts within a given culture. Social cohesion is the result or outcome of the integration of a set of values and beliefs that are exhibited in a group lifestyle. Trust ties and relationships emerge and strengthen as members of a group or community establish their commitment to a common good[52] and shared expectations to be true to the group's values and beliefs. Some writers regard trust as a commodity to be individually acquired and retained. Others state that trust accumulates as social capital and when it is destroyed, societies falter and collapse.[53] While trust and social capital may be among the antidotes to restore or strengthen social cohesion, social cohesion is not easily restored through interventions imposed by outsiders.

The Measurement of Social Cohesion in Communities

The measurement of social cohesion remains controversial, challenging, and with the advent of virtual communities, has become more complex. Social cohesion is challenging and complex because cohesion can be observed, yet the process of how it develops or evolves is covert. Cohesiveness can be felt, sensed, or experienced, yet it is largely intangible. Cohesiveness can be taught, modeled, and learned, yet its dynamics are often unexplainable. Furthermore, cohesiveness is linked to several other concepts such as trust and social capital that are defined, used, and measured in different ways at individual, group, community, and societal levels. There is even evidence that cohesion, trust, and social capital do not uniformly or concomitantly benefit individuals or groups living in the same community or society.[54] The measurement of social cohesion and related concepts is controversial because different disciplinary fields define, use, and measure these concepts idiosyncratically without concern for their generalizability or replicability.[55]

To further complicate matters, some scholars and researchers have suggested that the concepts of cohesion, trust, and social capital are dynamic and linked developmentally, and that their characteristics or traits vary in nature and strength with the time they are measured. Therefore, single measurements may be inaccurate and misleading. In order to accurately measure cohesion and determine its level of sustainability in a group or community, assessments must be made at different points in time. Two aspects of the sustainability of cohesion are at play. One aspect is *accumulated*

cohesiveness, that is, how well a group or community has maintained its cohesive features over time. This could be considered the baseline assessment of cohesion. There is also *current cohesiveness*, that is, how well, or to what degree, a group or community is maintaining its cohesiveness at the current time. This assessment is compared to the baseline or prior measurement and the observed consistency or discrepancy indicates the degree of increase or decrease in cohesiveness or sustainability. Obtaining several measurements of cohesiveness over a period of time can be used to understand the ability of groups and communities to maintain, enhance, or lose their level of cohesiveness. This is analogous to understanding an individual's behavior by assessing the presence, absence, or changes in specific factors at several points along the developmental lifecycle.

Figure 5.1 shows the relationship between accumulated and current community cohesiveness as a function of time. The illustration shows that social cohesion is a changeable outcome of the social structure of a group or community. Culture is key in establishing the values and beliefs that unite the group and the norms that maintain its degree of cohesion. Groups and communities are affected by the forces of social change; their cohesiveness is

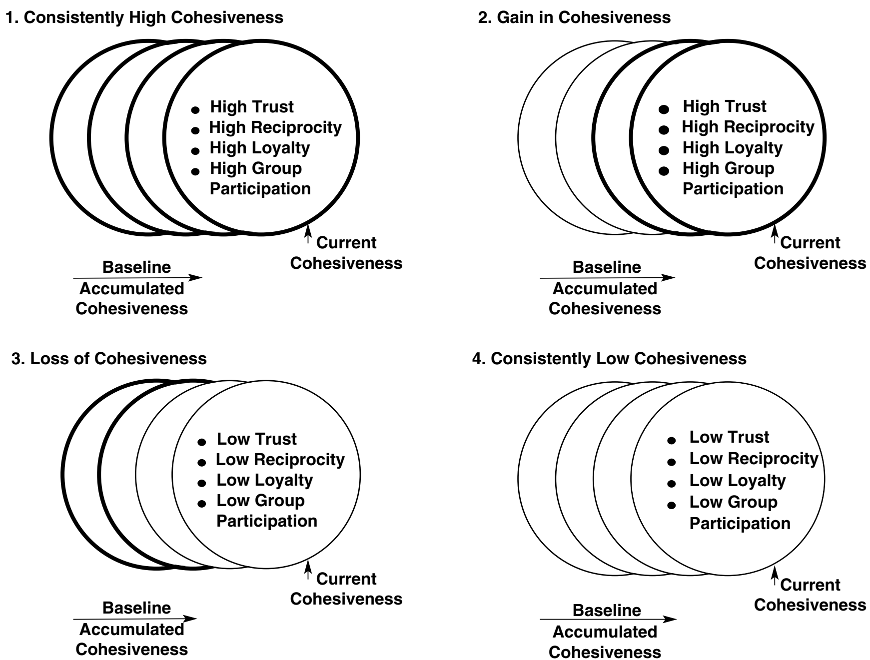

Fig. 5.1 Relationship between accumulated and current community cohesiveness as a function of time

important in their attempt to control its effects. Cohesion, in turn, influences the trust level among members and in exerting control over individual and group behavior. Finally, trust enables a repertoire of social capital to develop among individuals and collectively in the group. Through networked connections, the group or community exerts leverage with other groups in a neighborhood, community, or society. Through social capital, a group or community's culture is strengthened, which maintains and may enhance social cohesion. The interplay between the components of this dynamic system may not always be synchronous, positive, or productive. For example, a group or community can become more, or less, cohesive if its way of life is disrupted by an unexpected crisis or tragedy. Community members may be cohesive enough to bring about their community's recovery; however, the current crisis may have come at a time when the community's cohesiveness is too fragile to ensure its recovery. A fragmented, unhealthy community, on the other hand, can become cohesive through targeted intervention. There are numerous examples of the revitalization of neighborhoods and entire communities by improving the physical environment, establishing social networks, and thereby improving the health and well-being of residents.

Summary

In general, cohesiveness is a positive attribute or characteristic of communities; it has been linked to many benefits, especially health and well-being. The problem is that, while cohesiveness can be observed and described, it is difficult to measure quantitatively. There is little debate about cohesiveness being a group attribute. It is the result of individuals coming together in real or virtual time, who choose to share a common purpose and interact around that purpose to the exclusion of others. The connectedness of the group members reinforces the group's boundaries to provide a sense of belongingness and protect the group's sustainability. Cohesive communities are rooted in strong value and belief systems or are created by a superordinate goal, such as a threat to survival. Indeed, one of the challenges in our society is how refugees and immigrants, who choose to retain their cohesiveness, can become socially integrated in a country that expects acculturation, if not assimilation, and values individualism.

Cohesive communities have become victims of social change. They have largely been communities of place and less likely to have been experienced by most recent generations who lack nostalgia for a lifestyle that has little meaning in contemporary America. Despite the value shifts which have contributed to the decline of cohesiveness in the United States compared

to its earlier history, the positive stigmata of cohesiveness persists, especially in academia, and specifically in the fields of social and behavioral sciences, and health. Even though there is a lack of consensus about the definition and measurement of social cohesion, there is retrospective and prospective evidence that the absence of cohesion at key times in the lifecycle is harmful to the socialization and well-being of individuals and families.

We explored, in this chapter, ways in which communities become cohesive. One method is through community covenants such as all–African-American communities that were formed to minimize the experiences of white oppression. A second method of acquiring feelings of belongingness to a group is through kinship and ethnic ties. The example of the small Jewish communities in the United States comprised largely of European immigrants provided the opportunity to reinforce ethnic identity and practice religious traditions, and honor kinship while taking advantages of the opportunities in a new country. A third way in which communities can become cohesive is through cultural spirituality, which reflects the Native American's views of the connectedness of humans to all other entities. As urbanization, value conflicts, and the reservation and boarding school experiences have disenfranchised Native Americans, they have emerged with the highest prevalence and incidence of disease and destructive behavior in the United States. Fourth, collective socialization has been a powerful cultural strategy for establishing strong social norms for Hispanic youth to emulate. Hispanic groups that practice collective socialization offer parental and kin support, safe places, and relationship networks that discourage behavior not endorsed by cultural beliefs and values. Communities become cohesive through social transformation as exhibited by the introduction of the Community Talking Circle among Alaskan Natives to cope with the Exxon Valdez disaster. This therapeutic intervention assisted the villagers to mitigate some of the chronic cultural disruption produced by the oil spill.

A sixth approach to creating cohesive communities is through direct intervention. Interventions are usually short-term efforts to create long-term effects. In the example used, Eastlake, a housing estate in Britain, was physically transformed which, in turn, changed neighboring relationships that caused significant improvements in residents' mental health and physical safety. A similar intervention in Oslo, Norway, showed that an initially poor functioning neighborhood with poor mental health improved markedly with physical refurbishments. A seventh method of acquiring community cohesion is through the introduction of a superordinate group goal. The introduction of a common goal was found to be effective in reducing conflict and frustration between two competing groups of boys. This experiment showed that superordinate goal identities may be the way to intergroup

harmony in pluralistic societies. An eighth method of enhancing community cohesion is through community building. Community building is a process that seeks to build capacity in neighborhoods, their institutions, strengthen social ties among residents, and assist residents to work independently and collectively toward community change. The experiment in Atherton Gardens, a wired community in Canada, was used as an example of how the digital divide can be used to promote social cohesion in a community.

This chapter discussed methods for maintaining and strengthening community cohesiveness including regeneration, collective efficacy, and creating cohesiveness in ethnically diverse communities. The Mosaic Programs in several cities have been models for using ethnic pairing among community leaders as well as in schools to build community unity through diversity.

We examined the relationship between virtual communities and social cohesion. Can communities be virtual and cohesive? How can cohesiveness be assessed on the Web? Is trust a proxy for cohesiveness? Communities of place have been largely replaced by networks of social ties. Communication has become more personal, privatized, and instantaneous through virtuality. Researchers find that online communities are held together by a feeling of togetherness and connectedness that confers a sense of belonging similar to that which existed in communities of place. Virtual communities are constructed through communication and interaction that is multidimensional, multidirectional, and constantly changing. A national survey conducted by the Pew Foundation stated that the Internet has transformed community from densely knit villages and neighborhoods to sparsely knit networks.

In the virtual world, cohesiveness has become synonymous with trust. Trust online must be established quickly with people one hardly knows and may never see in order to solve a problem or work towards meeting a goal. Cohesiveness online is usually temporary, yet the ability to trust is dependent on the honest, brief disclosure of the persons involved. Trust behavior is dynamic, fragile, and context-dependent, while cohesion is the result or outcome of a set of values and beliefs that transcend situations and are evident in the lifestyle of a group. In this way, trust cannot be considered a proxy for cohesion.

Community cohesion continues to be a measurement challenge. Cohesion can change; some authors see cohesion as being developmentally dependent. Cohesion needs to be nurtured in order to be sustained and strengthened. We need to better understand the conditions that give rise to community cohesion, as well as the factors that hasten its decline. This requires longitudinal studies and multiple measurements and observations.

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Chapter 6
Cohesive Neighborhoods

Introduction

An analogy can be made between scholars debating the definition of "neighborhood" and the Indian legend of the blind men and the elephant. A group of blind men touch an elephant to learn what it is like. Each one touches a different part, but only one part. They then compare notes on what they felt and learn that they are in disagreement. The analogy is used to indicate that reality may be viewed differently depending upon one's perspective.[1]

There is no single, generalizable interpretation of neighborhood. Neighborhood has been variously defined as comprising a certain degree of physical and symbolic space or social networks within that space. Either emphasis underplays numerous characteristics of local neighborhoods that affect the qualitative uniqueness that residents perceive as "their neighborhood." While some characteristics are present to some extent in all neighborhoods, others vary dramatically between neighborhoods within a single geographical area.[2]

The Significance of Neighborhood

The generic idea of a neighborhood is the "home area," where the benefits in terms of the quality of environment and perceptions and expectations of fellow residents foster attachment and belonging, making connections with others, and demonstrating one's values. Casey[3] expressed it as "dwelling in nearness to others," which entails face-to-face contact and a reciprocal relationship. This nearness brings about "neighborhood." The reciprocity of nearness can vary for different people depending on their needs. Nearness can develop not only in the home area but in other places depending where individuals spend their time. Some Internet research has indicated that

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nearness can be experienced virtually. As someone observed, "We live in spatial neighborhoods and belong to virtual neighborhoods." Indeed, the layperson's concept of neighborhoods and communities is non-linear, not tied to boundaries, and a blend of bridging and binding capital that transcends space. The fact that "neighborhood" is something we create in different settings makes the concept more useful, but more illusive in understanding its mechanisms, measurement, and outcomes.

The analysis of neighborhood as a multi-layered phenomenon is important and relevant to the topic of social cohesion. Neighborhoods offer different opportunities for social engagement and different degrees of investment with residents depending upon neighborhood structure and social organization. Brower[4] has suggested that there are three dimensions of neighborhood environment – ambience, engagement, and choicefulness. In terms of ambience, it is clear that poorly maintained, mono-functional environments contribute to stigmatized neighborhoods. In terms of engagement, different types of neighborhoods offer different lifestyles and levels of associational activity. In terms of choicefulness, people have options for geographical location and a choice in how long they remain there. The characteristics of neighborhoods can also generate different kinds of social capital that can broaden or narrow social identities. The neighborhood is both a source of opportunity and constraint.

Neighborhood Contexts and Neighboring Patterns

Neighborhood Contexts

The resourcefulness of neighborhoods is linked with the larger community of which they are a part. With respect to cities there is what has been described as the "urban health penalty" which draws attention to the poor health conditions that persist in many inner cities, describes the resulting inequities in health, and points to the necessity of improving health conditions especially among disadvantaged neighborhoods.[5] However, "urbanness" should not be equated with issues of disadvantage. To do so fails to recognize that cities have many positive aspects, such as high levels of social support and accessible health care. Some authors have suggested that some cities instead might confer an "urban health advantage." Indicators, when taken together, suggest that health in cities is better than in non-urban areas and the benefits are greater for the rich than the poor.[6] "Urban health advantage" may not apply equally across all segments of US cities for all outcomes, and some neighborhoods might be more similar to rural areas.

Neighborhoods are the building blocks of cities. Because neighborhoods exert an important influence on children and adults, such as providing a source of identity, the majority of ecological effects are most likely to be found at the neighborhood level.[7] There are different types of neighborhoods which offer different orientations. For example, it has been found that neighborhoods which have both meaningful internal relationships and external linkages are capable of mobilizing more resources and cope more successfully with their problems than neighborhoods lacking one or both types of relationships.[8]

Differences in types of neighborhoods may be understood as differences in the form and content of social networks. Neighborhoods differ in their physical forms and social structures which affects the opportunities for social relationships to develop and, in turn, influences the cohesiveness of the neighborhood and the resilience of individuals and families. Research has shown[9] that, in disadvantaged neighborhoods, it may be the quality of neighboring which is an important element in people's ability to cope with a decaying and unattractive physical environment. Saegert[10] found that those neighborhood factors that produced resilient individuals and families also produced changes in the ecology of the neighborhood. In a study of residents in distressed housing in New York City, she found many residents were resourceful enough to take responsibility for developing a contract with the city to assume ownership of abandoned property. In more affluent areas, however, neighborhood context may be more important than neighboring – people may buy into neighborhoods as physical environments with low expectations of forming social networks. Examples could include the poor response to Neighborhood Watch programs and to Homeowner Association meetings in more affluent neighborhoods.

Neighboring Patterns

The degree of social interaction with neighbors is a key indicator of the strength of local communities in urban society.[11] National data for the three decades, 1970–1990, confirm a general decline in neighboring in the United States, except in growing small communities.[12] The national trend is toward less socializing within neighborhoods and more outside of them. In addition, data suggest that people are still socializing both in and outside the neighborhood but more commonly specializing between neighborhood and extra-neighborhood social ties. The exceptions to this trend are elderly people and those outside the labor force who appear more dependent on local ties.

There are many factors that affect the differences between neighborhoods and neighboring behavior. In general, data supports the hypothesis of a negative relationship between neighboring and community size. There is a steady decline in neighboring as one moves from rural to urban areas.[12] Riger and Lavrakas[13] point out that people's life circumstances, particularly their stage in the lifecycle or in the family life-course, may play a critical role in their degree of commitment or attachment to a local neighborhood or community. Age appears to distinguish among levels of neighborhood attachment, while the presence or absence of children distinguishes among residents who are socially linked within a neighborhood. Children serve as important information links among neighbors and may be primary initiators of neighborhood social networks.

Two determinants of neighboring seem to be the degree of self-sufficiency and autonomy of residents.[13] When there is a high degree of self-sufficiency and autonomy, neighboring is more impersonal and limited to crisis situations. Young socially mobile residents are usually the most autonomous, and have many extra-neighborhood linkages. Older residents and those who chose to be isolated usually lack linkages both within and without the neighborhood.

The contextual effects of neighborhoods directly influence neighboring behavior, which may be distinct even between immediately adjacent neighborhoods. Attitudes and behaviors that are functional in one neighborhood setting may be inappropriate, irrelevant, or divisive in another.

Neighborhood Ties

Perceptions of Neighborhood Boundaries

The form and substance of neighborhood ties are dependent on how neighborhood boundaries are defined. Neighborhood influences are the subject of an increasing number of studies, but there is concern that many investigations may be biased because they typically rely on census-based units as proxies for neighborhood boundaries.[14] Such aggregate proxies are inappropriate for learning about micro-processes.

For example, household interviews were conducted in the Los Angeles Family and Neighborhood Survey in 2000 and 2001 to address the question of whether or not residents' perceptions of the size of their neighborhood varied by their own characteristics and by neighborhood characteristics.[15] In general, residents who were more educated, had higher incomes, were not recent immigrants, and had more social ties in their neighborhood were more likely to say that their neighborhood covered a larger area than other

residents. These results are consistent with other studies showing higher levels of social isolation among recent immigrants and residents of poorer neighborhoods. The results on having friends and family members in the neighborhood and civic participation suggest that residents who interact more with their neighbors are likely to think of their neighborhood differently than those who do not. Neighborhood characteristics also were a major factor in explaining variations in resident's perceptions of neighborhood size. Neighborhood areas, density, age composition, geographic location, and socioeconomic status were all strongly associated with residents' perceptions. In particular, residents perceived their neighborhoods as larger if the population was less dense and there were more vacant buildings. Neighborhoods were perceived as smaller, if they were poorer and had a larger proportion of minority language speakers.

Data on spatial patterns showed that higher-income residents traveled longer distances to work and to buy groceries than those with lower incomes. Members of ethnic groups traveled farther to buy groceries than white residents. Latinos visited more distant health care providers, while Blacks traveled the farthest to attend church. This study showed that neighborhood boundaries are "in the eyes of the beholder" and, that perceptions of one's neighborhood boundaries affect how we carry out the activities of daily life.

A pilot study[16] tested several methods of defining a neighborhood based on maps drawn by residents, and compared the results with census definitions of neighborhoods. When residents' maps were used to create neighborhood boundary definitions, the resulting units covered different space and produced different social indicators than did census-defined units. Residents' agreement about their neighborhoods' boundaries differed among the neighborhoods. These findings suggest that discrepancies between researcher and resident-defined neighborhoods are a possible source of bias in studies of neighborhood effects.

Grannis[17] has offered a new approach to defining neighborhoods in recent studies in Los Angeles, San Francisco, Pasadena, and Ithaca, based on the geography of street patterns. Grannis defined residential units as "tertiary communities" by delineating aggregations of street blocks that are reachable by pedestrian access without crossing thoroughfares. He compares communities defined by residential street patterns to data on the social networks of neighbors, including residents' cognitive maps of their neighborhoods and areas of social interaction. He found that residents interact more with people living within their tertiary communities than with people who live nearby but who need to cross major thoroughfares.

Another approach to defining neighborhood boundaries is the work of Sampson and Raudenbush[18] who have collected observational data from neighborhood environments that cannot be captured in surveys. For

example, observations obtained by driving along streets (called "windshield surveys") can help to build new measures of micro-neighborhood contexts. Direct measures of street-level social interactions can be identified as well as observable indicators of physical and social disorder, and the physical condition of housing.

The boundaries of neighborhoods have a direct effect on neighboring patterns and social ties, and on the mortality of residents. Klinenberg[19] was a participant observer of the effects of the heat wave in Chicago between July 14 and 20, 1995, when the temperature reached 120°. There was a clear correlation between heat-related deaths and neighborhood boundaries. South Lawndale (Little Village) is one of the oldest working class neighborhoods in Chicago with a predominately Hispanic and White population. A rigid physical border separates South Lawndale from its contiguous neighbor, North Lawndale, which is largely Black. Klinenberg noted the strikingly different ecology of the two neighborhoods with North Lawndale having the ambience of a war zone, a decaying infrastructure, and suffering from decades of abandonment. Residents of North Lawndale lived in fear and isolation while the residents of South Lawndale engaged in "a beehive of activity."

During the week of the heat wave over 1,000 people were admitted to Chicago hospitals and thousands were treated in Emergency Rooms. The death toll reached 521. The medical examiner's data showed disproportionate numbers of heat wave victims were members of the city's most vulnerable groups – the elderly, African-American, and poor. The prevalence and danger of living alone without social contacts were apparent in the heat wave mortality patterns. The conditions that the heat wave revealed did not disappear when the temperatures moderated – people still died alone. The scale of isolation that the heat wave made visible defied conventional narratives of community strength and solidarity. The bodies of 41 victims were unclaimed. No family came to the cemetery for the funeral for the unclaimed. Indeed, some ministers did not show up for the service, and no one had visited the graves of the unclaimed during the 5 years after the heat wave.

Explanations for the disproportionate effects of the disaster on North Lawndale residents were that the extreme poverty and dangerous environment of the area, the non-involvement of many residents, and the dispersion of different religious leaders and churches, made it impossible to fill in the gaps in the city's social networks. While residents in North Lawndale attended church and were members of clubs, they had no place to go during the heat wave, while in South Lawndale the elderly and isolated were pulled to public places such as cafes that were safe places to go to escape the heat. This disaster illustrates the differential power of boundaries and social ties.

The social morphology of North Lawndale undermined its collective life, while South Lawndale's ecology fostered public activity and informal social support.

Neighboring

It is important not to see the neighborhood as a territorial-bounded entity but as a series of overlapping social networks. The lack of ties with neighbors does not mean that a person is devoid of friendships but that their ties are primarily with others outside their neighborhood, online, or a combination of these. Particular friendships will change with people's circumstances and interests. It is not necessarily the number of ties people have, but the availability and accessibility of connections when needed. Research has shown that in disadvantaged neighborhoods it may be the *quality* of neighboring that is most important. In more affluent areas, the *physical context* of the neighborhood and its status may be more important than neighboring. Neighboring gains greater importance for the poor, the elderly, and excluded groups. Social groups and individuals that have limited social capital are usually excluded from wider social networks; therefore, they are limited to coping with problems rather than overcoming them.

Neighboring is embedded in the social structure and culture of a neighborhood, which includes the influence of factors such as ethnicity, age, socioeconomic status, marital status, gender, and region of the country. For example, women are better neighbors not because of greater leisure time or more consistent presence in the neighborhood, but because American gender roles encourage women's involvement with others, including neighbors. There are clear racial differences in the urban neighboring behavior of blacks and whites. Blacks interact with their neighbors more often in a greater variety of ways than whites. For blacks, neighbor relations are more instrumental than casual; for whites, the opposite is true. The only similarity between the two groups was the impact of neighboring on the community. The results of this survey supported the view that neighbor relations have helped blacks cope with constrained social opportunities and provided them with access to resources unavailable through formal institutional channels.[20]

Neighborhood cohesion and group support result from the perception of collective ties. In a survey of 343 Chicago neighborhoods in which residents were asked about the likelihood that their neighbors could be counted on to take action during various socially disruptive or destructive behaviors, Sampson[21] found that the degree of collective efficacy was a predictive factor in controlling violence. Collective efficacy was defined as social cohesion among neighbors combined with their willingness to intervene on behalf of

the common good. In Sampson's view, social ties or social cohesion created the capacity for informal social control, but putting these social ties into action through collective efficacy is what strengthened the prediction of the degree of crime and violence in the neighborhoods.

Sampson explained that the willingness of local residents to intervene for the common good depends in large part on conditions of mutual trust and solidarity among neighbors. It follows that socially cohesive neighborhoods prove more fertile contexts for informal social control to occur. Therefore, it is the linkage between mutual trust and the willingness to intervene for the common good that defines the neighborhood context of collective efficacy. Collective efficacy becomes embedded in the social structure of neighborhoods and communities through the willingness and capacity of residents to achieve common goals. Collective efficacy is a means by which neighborhoods control crime and violence without regard to the demographic composition of their population.

Neighborhood Contexts, Neighboring Patterns, and Health

There is a growing body of research that has linked neighborhood physical and social characteristics with variations in individual's health. When individual variability is controlled, the direct link of health risk factors to neighborhood context remains.[22] Where people live matters with respect to their health.

After almost a decade of following 13,009 participants, researchers found that living in a disadvantaged neighborhood was associated with an increased incidence of coronary heart disease.[23] In another related study, it was found that mortality from five serious diseases, including coronary heart disease, was greater following hospital discharge for elderly Medicare patients who lived in poor neighborhoods. A number of health problems tend to cluster together at the neighborhood level including violence, low birth weight, infant mortality, child abuse and neglect, and the risk of premature adult death. Clearly neighborhood context mediates health and disease outcomes.

Neighborhood Influences on Racial and Ethnic Disparities in Health

Investigations have attempted to explain the relationship between different health outcomes and different neighborhood characteristics or contexts. Given that racial and ethnic groups are disproportionately exposed to

disadvantaged social environments, many researchers have looked to neighborhood factors such as residential segregation and poverty as explanations for racial and ethnic disparities in health. Available evidence indicates that neighborhood context accounts for a large proportion of racial and ethnic disparities in health.

To some degree, neighborhood effects research on health remains set in a "poverty paradigm," focusing mainly on socioeconomic indicators of health outcomes. The emphasis on disadvantage has drawn attention to structural and environmental factors. While these factors are important in a holistic approach, the relationship between neighborhood context and composition and health is more complex than environmental factors alone.

For example, in an intriguing study of neighborhood context and mortality among older Mexican-Americans, it was found that the sociocultural advantages conferred on Mexican-Americans by living in high-density Mexican-American neighborhoods outweigh the disadvantages conferred by the high poverty of those neighborhoods.[24] Despite their shared economic disadvantage, there are distinct differences between Mexican-American neighborhoods and other high-poverty neighborhoods. For example, rates of labor force participation, intact family structure, home ownership, and residential stability are relatively high in many disadvantaged Mexican-American neighborhoods.

The limited negative effect of neighborhood poverty and apparent protective effects of ethnic concentration in neighborhoods for Mexican-Americans are consistent with several other reports from multiethnic studies for a variety of health outcomes and behaviors.[25] This has been referred to as the "barrio advantage" and appears to contradict the thesis of the negative health effects of neighborhood economic disadvantage. However, there are some studies whose results suggest that the protective effects of social cohesion with respect to neighborhood context and health may not be uniform for Latinos.[26] Indeed, Latinos are not a uniform culture and may experience their neighborhoods in different ways.

Perceptions of Neighborhood Cohesion and Self-Rated Health

Researchers have studied the relationship between different social and physical environments and self-rated health. There is some evidence that the neighborhood environment is more important for women than men and that the genders experience their neighborhood environments differently.[27] For example, the social environment appears to be more important for women's self-ratings of health, while individual socioeconomic status is more important for men's self-ratings of health.

Self-ratings of health are also influenced by the perceived stability of the neighborhood, neighboring and perceived social cohesion. People who had lived in their neighborhoods a long time and had experienced neighboring, and perceived their neighborhood as cohesive, tended to rate their health better than people who lived in their neighborhoods a short time, were not neighborly, and did not see their neighborhood as cohesive.[28–30] Neighborhood safety is also linked with neighborhood satisfaction. The more safe and satisfied one feels about where one lives, the more likely one is to perceive one's own health and well-being as positive. With respect to ethnicity, while a barrio environment appears to have a positive effect on the health outcomes of Mexican-Americans, a ghetto environment appears to have a negative effect on the self-ratings of health among Blacks.[31,32]

Cohesive neighborhoods are often described as places where people know each other and express a feeling of togetherness – referred to as a "sense of community," that is, a feeling that residents have of belonging, that they matter to one another, and share a belief that their needs for association will be met through their common values and by solving common problems.[33] Sense of community has been used as a mediating variable to connect neighborhood context to various outcomes. For example, youth reared in closely knit neighborhoods and communities with a high level of sense of community were more likely to participate in school activities and were more successful in school than youth from less-bonded neighborhoods and communities with a low level of sense of community. Sense of community can be considered the affective component of social cohesion, which differentiates whether someone lives in a neighborhood or community or is involved in it. Sense of community not only impacts the quality of life, but affects positive and negative health outcomes as well.

Measuring Neighborhood Social Cohesion

Data Sources

The majority of studies examining the relationship between neighborhood environment and health have relied on census data which is typically constructed by aggregating the socioeconomic characteristics of neighborhood residents.[34,35] This approach to understanding neighborhoods has the advantages of aggregating large data sets rather quickly and at low cost. However, a major limitation is that census data, and other secondary data such as zip codes, electoral wards/districts, and counties, are proxies for characteristics that may be highly relevant in measuring neighborhood social cohesion. Indeed, the conceptualization of social cohesion may be limited by

the unique array of variables available in secondary data sets. Furthermore, aggregation may obscure possible important differences within neighborhoods. And since the time lapse between new sets of national census data is substantial, the effects of mobility and time-related factors affecting the nature of neighborhoods between data sets may be missed. Secondary data have their usefulness; however, with respect to understanding social cohesion, it should be regarded as an additional, not the primary, data source. Social cohesion is the result of interactive, dynamic relationships unique to various contexts, and, therefore, it is not meaningful to attempt to capture it as a static variable, to dichotomize it, to treat it uniformly, or to limit it to one level of analysis. There is significant agreement among researchers that how and when to access social cohesion as an attribute of neighborhoods is a major methodological challenge. Diez-Roux[34] expressed this challenge as follows,

> Investigating the presence and lagged health effects of neighborhoods is no easy task. It implies tracking changes in neighborhoods over long periods as well as characterizing the many different neighborhoods that persons may live in over a given period. Measuring specific attributes of neighborhoods is complex enough at a given point in time... for these reasons initial studies of the cumulative and lagged effects of neighborhood conditions may need to rely on secondary data and proxies (p. 17).

Kawachi and Subramanian[35] add, "...most studies have relied on administrative data (such as the census) to define neighborhood characteristics... there is a need to 'unpack' the specific exposures and pathways through which neighborhood disadvantage leads to poor health outcomes..." (p. 3).

Multilevel, Multifactor Approach

The challenging question is, what are the pathways or mechanisms that link neighborhood context to health outcomes? Identifying pathways or mechanisms is complex because health outcomes are multidimensional, and vary with individual age. Similarly, neighborhoods have a natural history and experience change. Therefore, meaningful investigations should be multilevel in design and focus on discovering links between specific neighborhoods and specific health outcomes. There is no single pathway to health and no unique set of neighborhood characteristics that will be universal for all health outcomes. To understand racial and ethnic health disparities means that one needs to consider both neighborhood contextual and group processes together over time.

Smith[36] argued that neighborhood cohesion must be measured on a number of different dimensions. He suggested that to focus on a limited aspect

of cohesion, we only partially measure it; as a result, we omit either the manifest or the latent types of neighboring. In addition, Smith proposed that there were four types or levels of neighborhood cohesion that, taken together, they could be considered a typology: (1) use of physical facilities, (2) personal identification, (3) social interaction, and (4) value consensus. By jointly considering these dimensions, it is more likely that the qualitative dimensions between neighborhoods will be recognized.

A secondary issue in measuring neighborhood cohesion relates to the level of analysis on which measurement is made. Two sub issues may be identified, (1) does the measure actually reflect cohesion of the neighborhood as a group? (2) are alternative measures possible which may be more easily derived and applied? These sub issues recognize the distinction between three types of variables: (1) individual, (2) aggregate, and (3) sociostructural. Aggregated individual variables are frequently used to describe groups, but because they are based on individual characteristics and not on characteristics of the social system, they allow only inferences to be made about a group. Socio-structural variables are also key as they provide data on interactions, roles, and patterns in organizations and social institutions.

Neighborhoods can be studied in different ways. Most attempts to measure neighborhood social cohesion have been at the individual or aggregate levels.[37] These data fail to portray the structure and relationships of a neighborhood as a social whole. As a result, many published studies of neighborhood cohesion report *contextual explanations for the patterning of cohesion in specific neighborhoods* or explain *the aggregated similarities or differences in cohesion between neighborhoods*. While these levels provide important, but different (uni-dimensional) types of data, what is often missing is a multidimensional approach that uses neighborhood level variables to understand neighborhood cohesion.[38,39]

One additional aspect of a multilevel, multifactor approach to studying neighborhoods is that neighborhoods should be regarded as dynamic social systems. This requires that there should be repeated measurements of variables subject to change over time such as social cohesion. In this way, neighborhood social cohesion can be seen as a *mechanism* linking neighborhood demographic and structural factors to perceived or actual outcomes.

Duncan and her colleagues[40,41] used a multilevel, multifactor approach to examine relationships among neighborhood context and youth alcohol and drug problems. Data were collected from 55 neighborhoods in a metropolitan city. Data sources included family members, police, census, and observations in alcohol retail outlets. Social cohesion was measured using Sampson's cohesion scale. At the neighborhood level, the study examined relations among poverty, stores selling alcohol, neighborhood social

cohesion, neighborhood problems with youth alcohol and drug use, and drug and alcohol arrests. At the individual level, gender, ethnicity, adult versus child status, neighborhood social cohesion, and neighborhood problems were examined. Results indicated that more stores sold alcohol in higher-poverty neighborhoods, which were associated with less social cohesion. Lower social cohesion was related to greater perceived neighborhood problems with youth alcohol and drug use, which was positively related to youth drug and alcohol arrests. A more complete picture of the dynamics between neighborhood, family, and individual behavior can be attained by combining various sources of data. In addition, intervention strategies can be targeted to specific subgroups rather than implemented on a global basis.

Multilevel analyses have also been carried out linking the effects of neighborhood residence on mental health problems. Fone and his colleagues[42] investigated the joint effect of community and individual-level socioeconomic deprivation and social cohesion on individual mental health status. Poor mental health was found to be associated with area-level income deprivation and low social cohesion. High social cohesion modified the association between income deprivation and mental health. In a multilevel, longitudinal study of 5–11 year olds recruited from 80 neighborhoods, Xue and fellow researchers[43] found that neighborhood concentrated disadvantage (poverty rate, percent of residents on public assistance, percent of female headed families, unemployment ratio, and percent of African-American residents) was associated with more mental health problems and a higher number in youth. Neighborhood collective efficacy (social cohesion) and organizational participation were associated with better mental health. Collective efficacy mediated the effect of concentrated disadvantage.

Cohen[44] persuasively points out the limitations of relying on one conceptual model, illustrating a multilevel, multifactor approach on the effects of the relationship between poverty, mental illness, and various outcomes such as homelessness or unemployment. He states that this relationship can be understood by at least three different, but not mutually exclusive, models: first, that the relationship may be *additive*; second, that the relationship may be *interactive*; and third, that the relationship may be *dialectical* or mutually transforming. This argument can be applied to investigations of the effects of the relationship between neighborhood, social cohesion, and various outcomes such as specific diseases, crime, or alcohol and drug abuse.

Ellis[45] argues that the mixed effectiveness of many preventive intervention programs suggests that they are insufficiently comprehensive. He points out that intervention programs frequently address only one or a few risk factors, and often neglect protective factors. Additionally, programs address only one of the social systems in which risk factors occur. Ellis proposes a model for optimal intervention programming with three characteristics.

Interventions must be multifactor, addressing all risk factors, not just those related to a specific problem. *Interventions must be multisystem*. Since risk factors are interactive, systems interact with one another. How each system interacts is important to understanding its unique nature. *Interventions must be multilevel*. Like multifactor and multisystem intervention, multilevel intervention is both individual and collective.

Social Structure Plus Subjective Experience

Nicotera[46] reminds us as we move from the conceptual realm to the measurement of neighborhood cohesion, we need to account for neighborhood as both an objective entity and a subjective experience. To focus on neighborhood structure alone to understand social cohesion would neglect the meanings residents place on their neighborhood experiences. Measurements of neighborhood social cohesion need to include both of these elements. This is one of the limitations of secondary data (e.g., census tract) which focuses on context and lacks information about social processes and residents' perceptions, what Pretty[47] has called "social climate factors." Pretty found that a sense of community extended beyond personal networks and support. It also included perceptions of the interactions with others including what individuals felt was expected of them, that is, the "press" of their environment.

Incorporating the objective and subjective components in the measurement of neighborhood cohesion is challenging because neighborhoods are multidimensional, dynamic and change as they are being studied. Some of the research approaches that have incorporated the objective and subjective aspects in measuring neighborhood cohesion are presented here.

Instruments to Measure Neighborhood Cohesion

The Neighborhood Cohesion Index (NCI)

Table 6.1 lists some of the characteristics of the more common approaches for measuring neighborhood cohesiveness. The Neighborhood Cohesion Instrument (NCI) developed by John Buckner, a clinical/community psychologist, is perhaps the most frequently used instrument.[48] It has demonstrated good internal consistency and test–retest stability at the individual level. At the neighborhood level, the instrument has shown good discriminatory power and criterion-related validity. The NCI has limitations. It has not been used extensively in urbanized environments or in neighborhoods

6.1 Measurements of neighborhood cohesion and environment

Investigator(s)	Instrument	Objective	Major finding(s)
Buckner (1988)[48]	Neighborhood Cohesion Instrument (NCI)	An aggregate-individual variable method for inferring cohesion at neighborhood level	Administered to a random sample of 206 residents in three neighborhoods. This construct focuses attention at a system level rather than an individual level. Instrument showed good discriminatory power, good internal consistency and test–retest stability
Robinson & Wilkinson (1995)[49]	Neighborhood Cohesion Instrument (NCI)	Is the NCI reliable?	Administered to 1,182 mine workers in Canadian town. NCI found to be robust, stable across societies, shows systematic relationships with background variables
Wilkinson (2007)[50]	Neighborhood Cohesion Instrument (NCI)	Investigated the dimensionality of community cohesion using NCI.	Administered to 1,732 people from a random sample of 20 rural communities across Canada. Found similar multidimensionality of NCI in Canadian communities as found in Washington, DC suburbs
Fone et al. (2006)[51]	Adapted version of NCI	Assess underlying constructs of NCI and reliability of the adapted NCI	Data from 11,078 people within 325 census enumeration districts in Wales, UK. Found 8-item scale could be acceptable measure of neighborhood cohesion. Greater differences were found within neighborhoods than were found between them

6.1 (Continued)

Investigator(s)	Instrument	Objective	Major finding(s)
Sampson (2003)[52]; Sampson et al. (1997)[53]	Five Likert-type items aggregated to neighborhood level as a measure of cohesion and informal social control	To investigate effective social controls as a major source of neighborhood variation in violence	Data from project on Human Development in Chicago Neighborhoods. Combined 847 census tracts to create 343 neighborhood clusters or 8,782 residents. A measure of collective efficacy associated with variations in violence. Neighborhoods high in collective efficacy had significantly lower rates of violence
Skjaeveland et al. (1996)[54]	Multidimensional Measure of Neighboring (MMN)	Develop a short questionnaire to measure dimensions of social life within neighborhoods	Administered to three "different" samples ranging from 96 to 1,060 in Bergen, Norway. Findings showed that neighboring should be conceived of having several distinct dimensions. Instrument can discern qualitative differences between neighborhoods

with a substantial ethnic mix. When it has been administered to a random sample of residents the NCI can assess the cohesiveness of a neighborhood, its strength is that it enables analyses of cohesiveness at the individual and collective levels of analysis.

The NCI has been used cross-culturally. Robinson and Wilkinson[49] found that mine workers in a remote, stable, homogeneous Canadian town that had a strong sense of community identity, scored high on the Neighborhood Cohesion Index. They obtained data pertinent to the index by interviewing 1,182 miners. The researchers found the index to be consistent when compared to the American suburb Buckner studied. Wilkinson[50] investigated the dimensionality of the NCI by using it in a study of 20 rural communities in Canada. He found that social cohesion was composed of three dimensions as originally postulated by Buckner, psychological sense of community,

attraction, and neighboring. While further research might lead to the discovery of additional dimensions, many researchers have confirmed these three aspects.

It continues to be important to test these dimensions in different kinds of social groups. Buckner theorized that social cohesion would manifest similar characteristics in different social units. Though the three dimensions are highly intercorrelated, they appear to be separate dimensions and shed insight into how different communities and different levels of social cohesion relate to other factors at individual and community levels.

In an effort to measure specific factors within the social environment that could link neighborhood of residence to a health outcome, Fone[51] and his colleagues developed an adapted version of Buckner's neighborhood cohesion scale. They analyzed data from 11,078 individuals who were sampled from 325 census districts in a population survey of the socially diverse borough of Caerphilly, Wales. They found greater differences in social cohesion within neighborhoods than between them. Overall, results of studies suing the NCI, and adaptations of it, tend to be consistent in their measurement of neighborhood cohesion.

Collective Efficacy

Another frequently used method to measure neighborhood cohesion is the collective efficacy approach developed by Sampson.[52] It is the linkage of mutual trust and shared expectations for intervening on behalf of the common good that defines the neighborhood context of what Sampson and his colleagues[53] identify as *collective efficacy*. They believe that, just as individuals vary in their capacity for efficacious action, so, too, neighborhoods vary in their capacity to achieve common goals. The term *collective efficacy* signifies an emphasis on shared beliefs in a neighborhood's capability for action to accomplish specific goals. The theory of collective efficacy was tested in a large survey of residents in several 100 neighborhoods in Chicago in 1995. Residents were asked about the likelihood that their neighbors could be counted on to take action if: (1) children were skipping school and hanging out on a street corner; (2) children were painting graffiti on a local building; (3) children were showing disrespect for an adult; (4) a fight broke out in front of their house; and (5) the fire station closest to their home was threatened with budget cuts. Social cohesion/trust was measured by asking the respondents whether they agreed or disagreed that "People around here are willing to help their neighbors;" "this is a close-knit neighborhood," "people in the neighborhood can be trusted;" "people in this neighborhood generally don't get along with each other;" and "people in this neighborhood do not

share the same values." Social cohesion and informal social control were strongly related across neighborhoods and thus were combined into a summary measure of "collective efficacy." Collective efficacy was associated with lower rates of violence.

Sampson's premise is that social and organizational characteristics of neighborhoods explain variations in crime rates that are not solely attributable to the aggregated characteristics of individuals. Collective efficacy is embedded in, and unique to, specific cultural contexts.

Multidimensional Measure of Neighboring (MMN)

Skjaeveland and his associates[54] noted that there was a need for a psychometrically robust tool for assessing neighborhood characteristics along several dimensions. A multidimensional measure, they argued, made it possible to assess interrelationships between neighboring experiences and activities and, therefore, increase our understanding of the dynamics of neighborhood social life. They defined neighboring as the positive and negative aspects of social interactions, expectations, and attachments of individuals with the people living around them and the place in which they live. They developed a 14-item questionnaire aimed at measuring various dimensions of social life within neighborhoods and administered it to three samples of varying sizes in Bergen, Norway. Four factors emerged as theoretically meaningful dimensions topping the concepts supportive acts of neighboring, neighbor annoyance, neighborhood attachment, and weak social ties. While the results showed that neighboring could be conceived as having several distinct dimensions that are consistent with most theoretical notions of neighboring, perhaps one of the strongest reservations about the MMN is that its applicability in, and replicability to, culture in addition to Norway, has yet to be established.

Neighborhood Cohesion: Challenges for Future Studies

In the mid 20th century when neighborhood was "a place," it was readily identifiable by geographical boundaries and the social and cultural characteristics of its residents. Residents were more geographically stable; hence, the relational and contextual dynamics of neighborhoods were easily observed, described, measured, and often predictable. Now neighborhoods are artifacts of geographical mobility, social change, technology, and specialty communities. Neighborhoods are more challenging to define and study. Therefore, it is not surprising that it is common to study neighborhoods in urban areas

of developed countries where secondary data in the form of census tracts are available. Concern for the contextual data of neighborhoods are frequently supplanted by network analyses and econometrics. One of the possible by-products of the network approach is that neighborhoods can become viewed as objective, statistically describable entities that have generic strength and cross-cultural validity.

The work of Coulton and her colleagues,[16] discussed earlier, is very important for future studies of neighborhood cohesion. They pilot-tested several methods of defining neighborhood units based on maps drawn by neighborhood residents and compared the results with census definitions of neighborhoods. Residents' maps covered different space and produced different social indicator values than did census-defined units. Also, residents' agreement about their neighborhoods' boundaries differed among the neighborhoods studied. These researchers suggest that discrepancies between researcher and resident-defined neighborhoods are a possible source of bias in studies of neighborhoods.

Entwisle and her associates[55] also found, in their study of the social networks and contexts of 51 Thai villages, that boundaries were permeable and social ties extended beyond administrative units. Social networks were sparse in some villages, porous in others, and less so in still others. Moreover, they found that variability mattered. Variability carries a message for researchers doing case studies of single communities or settings. Entwisle's results indicated that even in a region where variability between villages might not have been suspected that substantial variability was found in the structure of kin and economic networks. Entwisle concluded that network structure co-varies with context in meaningful ways, in a pattern that suggests that change in social networks might induce a change in context and vice versa.

Future studies of neighborhood cohesion need to obtain data that will bridge contextual and network effects if we are to advance our understanding of neighborhoods. Smith[36] said most current studies of neighborhood cohesion fail to portray the structure of relationships for a group as a whole. Therefore, many studies of neighborhood cohesion are only studies *within* a neighborhood context, and not *of* a neighborhood. Friedkin[56] elaborated, "Theories of social cohesion may never be fully developed if they focus on the explanation of the independent responses of persons to particular conditions and do not describe how group members interact and influence each others' membership attitudes and behaviors... theories of social cohesion should be elaborated until they can account for the group-level conditions that are most consequential in determining individuals' membership attitudes and behaviors" (p. 422).

Summary

Neighborhoods would seem to be the ideal societal level to study the structural and contextual aspects of social cohesion, that is, if there was consensus on what a neighborhood is, what neighborhood cohesion is, and what effects different levels of cohesiveness might have on outcomes such as health. There is considerable agreement among researchers with respect to several broad principles, including that neighborhoods are multifaceted; have different structures, organization, and cultures; have varying linkages to the total community and to other neighborhoods; have different histories; and experience unique challenges. One of the major challenges toward a definition of a neighborhood is that most of our knowledge about neighborhoods is based on studies of urban neighborhoods in developed countries during times of greater national social stability. Geographical mobility, immigration, and economic change are a few of the major social changes that profoundly influence the changing nature of neighborhood life. Cohesiveness is considered an indicator of the quality of neighborhood life, but its measurement is crude and developing and how cohesion links the relational and contextual aspects of a neighborhood needs substantial study. Nonetheless, there are several instruments that have been used to measure neighborhood cohesion; Buckner's Neighborhood Cohesion Instrument, Sampson's Index of Collective Efficacy, and Skjaeveland's Multidimensional Measure of Neighboring are three instruments that have shown promise.

Notes

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Chapter 7
Cohesive Families

Introduction

There has been considerable debate among social scientists for some time about whether or not there is a decline in the traditional nuclear family.[1–4] Logan and Spitz[5] have summarized the core ideas in this debate as follows: the family is suspect, generations live further apart, divorce is common, some people never marry at all, adults have fewer children or none... its traditional pillars, mothers and daughters, have taken on new roles... (yet) families still continue to be at the center of people's lives and family ties remain at the core of social relationships. Minuchin[6] points out that "families change as society changes... the family is an open-system in transformation; that is, it constantly receives and sends inputs to the extra familial, and it adapts to the different demands of the developmental stages it faces. The family will change, but it will also remain" (p. 50).

A Systems Perspective of the Family

Several different conceptual schemes and typologies have been proposed for understanding the family.[7] There is no single, widely accepted definition of a family; there is no "typical" family or normal family. Minuchin's systems perspective[6] is one of the most useful approaches. He states that family structure is an invisible set of functional demands that organizes the ways in which family members interact. A family is a system that operates through transactional patterns. Transactional patterns regulate family members' behavior. They are maintained by the universal rules governing family organization and the mutual expectations of particular family members. The family system maintains itself. It must be able to adapt when circumstances change. The continued existence of the family system depends on

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its flexibility and the range of options available to it. Family systems take on different forms and functions in different cultures; hence, it is not useful to make generalizations regarding family behavior cross-culturally without considering the larger context in which the family exists.

Whatever its form, the family needs to establish a way of resolving the opposing values of separateness and togetherness. Hess and Handel[8] have expressed it.... The family's life together is an endless process of movement in and around consensual understanding, from attachment to conflict to withdrawal – and over again. Separateness and connectedness are the underlying conditions of a family's life, and its common talk is to give form to both." Through transactions family members regulate cohesion and adaptability and develop a collective identity. Communication is central to the adaptive function of the family.[9]

An analogy has been made of the family to a mobile with various parts continuously moving in different ways and degrees in relationship to each other as they are affected by changes within the mobile's environment and forces from its external environment. A mobile, like a family, attempts to adapt within a range short of the extremes of being rigid or chaotic, except when under stress. When under stress, it is sometimes necessary to remedy the disequilibrium by intervention from outside the system.

Family Cohesion

The meaning of family structure and dynamics is not always immediately discernable to the outside observer. This is because social cohesion is an essential but largely covert aspect of the transactional patterns established by members of a family system. Cohesion refers to the emotional bonding members have with one another and the degree of individual autonomy a member experiences in the family system. There are cultural norms for cohesion; therefore, overt displays of closeness, for example, may be prohibited. Cohesion can also change in degree; family members regulate cohesion depending upon circumstances. Family cohesion also changes with the developmental changes of individual family members. Family cohesion is not a linear process, but rather it is the result of the variable interaction of subsystems. Each family member belongs to various subsystems in which she has different skills and power. The subsystems in a family system help to provide the boundaries for how members interact to create stability, cohesiveness, and change (see Fig. 7.1).

Lewis and his colleagues[10] studied 33 ostensibly psychologically healthy families to ascertain what distinguished them from families with psychological problems. They found that an individual approach highlighted problems

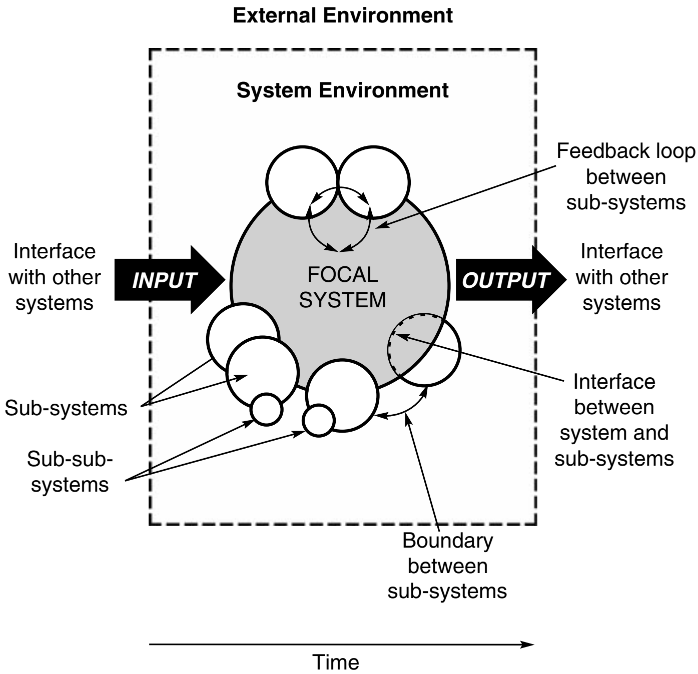

Fig. 7.1 The family as a social system

of individual family members whereas a systems approach was more apt to reveal the strengths of a family and to view it in a broader context. While no "single thread" distinguished optimally functioning families there were interactional and process variables that were more common among the more psychologically healthy families. These were closeness, clear boundaries, respectful negotiations, and a flexible family structure.

Family Cohesion and Competence

Beavers and Hampson[11] considered emotional closeness as an aspect of family competence. In healthy families, closeness and autonomy are interrelated and balanced. These researchers state, "in order for family members to experience emotional closeness, each needs to have a clear sense of his/her personal identity and to feel that such individuality is desired" (p. 18). The Closeness Scale, one of 12 among Beavers' Family Competence Scales, provides information on the clarity of boundaries within the family, as well as the distribution of power, which affects the potential for and the manner in which families express closeness, understanding, and respect. At the low end of the scale, the family shows vague interpersonal boundaries and a lack of

intimacy. At the midpoint of the cohesiveness scale, individual boundaries are clearer and more distinct. At its highest level, closeness is expressed with spontaneity and family members relate in this fashion both as individuals and as a unified whole. This forms the basis for family cohesion.

The Closeness Scale is one of the self-report scales used to assess and understand family competence toward recognizing a family's strengths, structure, and relationships. The scores on each of the scales are distributed along a continuum to show a family's relative strengths and weaknesses – areas of lesser and greater competence – which are helpful in any planned family interventions.

Beavers and Hampson's Systems Model of Family Functioning has been used as the framework for working with an array of families with and without mental health labels over several decades. The theoretical perspective of general systems theory for viewing family structure and functions along a continuum with different styles of functioning reinforces the idea that family cohesion is a process associated with overall family competence.

Family Cohesion and Culture

Cohesiveness exists in different forms, in different degrees at different times in families in different cultures. As in animal societies, cohesiveness is a protective factor for the family against external stressors, but in human societies, cohesiveness, in addition, enables the experience of loyalty, reciprocity, and solidarity among its members. Perceived cohesiveness has been identified as one of the most distinctive attributes of some cultures and families, e.g., Hispanic, Japanese, Italian. There have been many efforts to identify and measure family cohesiveness in different cultures using models and scales developed from family studies in the United States. Such attempts have been criticized by some researchers because the elements and dynamics of cohesion are not the same when applied cross-culturally and such research efforts have generally led to mixed results regarding family functioning, cohesion, and adaptability.

Several examples are provided here. A community sample of middle income Anglos and low income Mexican-Americans were studied with respect to cohesion and adaptability through the use of the Family Adaptability and Cohesion Evaluation Scale (FACES II).[12] It was hypothesized that Mexican-Americans and Anglos would experience similar levels of family cohesion and family adaptability and that acculturation would show no relationship to family cohesiveness and adaptability. There were no significant differences between the two groups on family cohesiveness and adaptability. Among the limitations of the study including the self-selection of volunteers, FACES was not designed to tap cross-cultural differences in family cohesion

and adaptability. It is not surprising therefore, that scores on FACES fell within the range of well-functioning cohesive families for both Anglos and Mexican-Americans.

Another study used a newer version of the Family Adaptability and Cohesion Scale (FACES III) to determine if family cohesion differed among three study groups over time, Mexican-American oriented to Mexican culture, Mexican-Americans oriented to majority American culture, and non-Hispanic Americans.[13] Neither group of Mexican-Americans was significantly different from non-Hispanic whites initially; however, Mexican-Americans oriented to Mexican culture showed a significant increase in family cohesion at mid-adolescence. This would indicate that family cohesion is linked to the developmental lifecycle of individuals and that the dynamics influencing family cohesion are culturally sensitive.

Riviera and his colleagues[14] found that family cohesion and family cultural conflict differed by Hispanic subethnicity. These investigators studied a sample of 2,540 Latinos who were divided into four groups based on national origin: Mexican, Puerto Rican, Cuban, and all other Latinos. They assessed family cohesion using three questions, whether family members like to spend free time with each other, whether family members feel very close to each other, and whether family togetherness was important. Interactions between family cohesion and family cultural conflict were significantly different between Cubans and Mexicans and between other Latinos and Mexicans, but not between Puerto Ricans and Mexicans. For Cubans, family cohesion appeared to function differently from the other Hispanic subgroups.[15] The researchers underscore the importance of looking at the specific nature of family cohesion for Latinos and how it interacts with other characteristics, in order to avoid cultural generalizations that may not apply universally.

This recommendation is also relevant to a community-wide survey of 65 randomly selected Native American families that utilized a subscale of the Family Environment Scale (FES) to assess family cohesiveness.[16] Several subscales measure a family member's perception of the family's internal functioning. The FES has been used in a number of countries and has differentiated family environments by how well families adapt to life transitions and crises. The researchers found that the families showed average levels of cohesion and expressiveness, concurrent with high levels of family conflict, suggesting that Native American families have a distinctive family cohesiveness profile. In the absence of comparative Native American data, it is unclear if this family profile is representative of Native American families in other tribes.

Florian and his associates[17] discuss some of the dimensions that may shape the perception of family dynamics in different cultures. For example,

in homogeneous or "tight" societies, which emphasize family ties and extended family systems, one would expect higher family cohesion than in individualistic societies. In heterogeneous or "loose" societies which emphasize individualism, one would expect lower levels of family adaptability and cohesion.

These authors examined family dynamics as perceived by 880 16- to 17-year-old boys and girls from nine high schools in Israel. The adolescents were from three of the largest groups of Israeli Arabs: Moslem, Christian and Druze, and two major Jewish groups: Middle Eastern and Western. The main instrument used was the Family Adaptability and Cohesion Evaluation Scale, FACES II, which integrates the dimensions of cohesion and adaptability. The premise of the study was that cultural diversity would affect the perceived pattern of family dynamics. Israeli Jewish adolescents of Western origin reported the lowest levels of family cohesion. Middle Eastern Israeli Jews and Israeli–Arab groups displayed high-family cohesion and high levels of family adaptability. The results also indicated differences in the perception of family dynamics by gender. Boys from a collectivist culture such as Israeli Arab society seemed to continue and maintain the cultural values of family cohesiveness in contrast to boys from an individualistic culture such as Israeli Jews. On the other hand, girls generally were less bound to cultural influences. The researchers point out that even though Israeli–Jewish boys perceived their families as less cohesive than Israeli–Arab youths, this does not suggest an unhealthy "enmeshed" type of family. On the contrary, this may reflect cross-cultural diversity as has been found when comparing different cultures like Americans and Japanese.[18]

One's notion of what constitutes a family and ideas about its structure and functioning are culturally derived. Culture enables one to see the strengths in various types of family structures and dynamics in a broader context.[19]

Family Cohesion and Change

The extent of family cohesion at any point in time is dependent upon the nature and degree of change within the family system as well as the behavior of systems external to the family that affect its functioning (see Fig. 7.2). Some types and degrees of change are expected as a normal part of the family's life course or family development, for example, a child leaving home for college, the marriage of children, changing jobs, death of a family member. While these transitions may be expected they are nonetheless stressors within the system that create changes in role relationships, modifications in boundaries, and influence power and status among family members. In addition, when unexpected changes occur inside the family system such

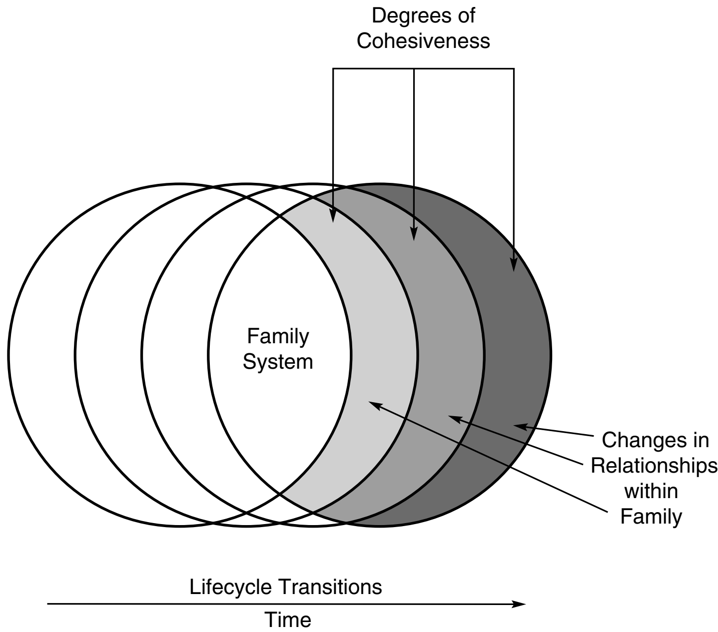

Fig. 7.2 Degrees of family cohesion and social change

as a member's sudden illness, job loss, and unexpected changes from outside the family system also occur, family functioning and adaptability are tested and taxed. Family cohesion will be mobilized to cope with the stressors, individually and collectively. The family will emerge from periods of distress, disruption, and change with a greater or lesser degree of cohesiveness.[20] Some families are fragmented or weakened by change, while others grow more cohesive. The social cohesiveness of families influences their degree of tolerance and preparation for change and how they cope with it. The greater individualization of the life course, with individuals and families having more options and choices, will continue to influence families' patterns of adaptation to change.[21]

Family Cohesion, Parental Relationships, and Child/Adolescent Behavior

Marital Satisfaction and Family Cohesion

It is tempting to focus mostly on the marital or parental pair when viewing the family system, although it is only one of the subsystems in the family.

A couple's behavior affects and is affected by other members of the system. The type of relationship the marital pair has established will influence the degree of cohesiveness in the family. A consensus on a definition of marital satisfaction or adjustment is difficult because it is a matter of degree and is a continuously changing process. Marital adjustment can best be seen as a continuum that reflects the dynamic interplay of the parts of the family system at various points in time.

Marital satisfaction and family cohesion are interdependent and covary.[22] Marital dissatisfaction has been shown to be related to lower levels of family cohesion. Lower family cohesion and higher family conflict have been associated with higher levels of child behavior problems. There is evidence that adolescents especially may be sensitive to and influenced by their parents' marital satisfaction.

In a longitudinal study of community-based adolescents, researchers found that mothers' marital satisfaction (assessed when their offspring were adolescents) influenced the social and emotional health of their young adult daughters and sons 6 years later.[23] Fathers' marital satisfaction had relatively little effect on their grown offspring's subsequent adaptation. The marital satisfaction of one parent was predictive of the grown offspring's closeness to the other parent. This suggests that spouses who are martially satisfied are likely to show characteristics that enable them to maintain intimacy and good relationships with others in the family, not just their marital partner. Family cohesion appears to mediate marital satisfaction and offspring adaptation.

A large body of research attests to the fact that marital discord has negative effects on parenting and child development. It has been reported that parents in triangulated families experienced greater marital conflict and dissatisfaction than parents in cohesive families. Minuchin described triangulation of the child in interparental problems as interfering with the marital subsystem's ability to resolve its conflicts, resulting in increased tension in the family and marital relationships. An unexpected finding was that children in triangulated families did not demonstrate significantly higher child adjustment problems than did children in cohesive families. The implications for these findings for family cohesion is that different family members may have different perceptions of the family system whether or not it is shared by other family members. Attempting to understand a family system and assessing its cohesiveness without consideration of the views of all members of the system may be misleading and inaccurate.[24]

Parenting, Social Networks, and Family Cohesion

Research has shown that parental social networks have an indirect effect on children's socioemotional development, mediated by parenting.[25] A recent

study of Mexican families suggests that networks containing more extended kin and co-resident ties offer greater support resources to mothers with young children, especially among poor households. Network structures characterized by social support and strong interaction with extended kin helped sustain healthier children.[26]

However, there are sex role differences in aspects of parents' interaction with kin networks; mothers, as compared with fathers, have been found to have larger personal networks, more contact with kin, report more feelings of need, and receive more help. Adolescents were more consonant with their mothers than with their fathers, and mother–adolescent associations were more direct, positive, significant, and robust than those of fathers'. Fathers' associations with adolescents were in the area of friendship relations while mothers were the "kin keepers" in family affairs.[27]

Sibling relationships and other kin networks can be a valuable source of support in times of crisis. Grandparents, aunts, nieces and nephews, or other relatives can help with family stressors. Families going through life crises often fall back on assistance from kin. An assessment of family cohesion needs to include the extent, depth, and availability of extended family networks. Sometimes extended family members provide some of the basic obligations associated with the nuclear family.[28]

Perceived Family Cohesion and Health Behavior

Family Cohesion as a Mediator

Research findings suggest that perceived family cohesion (or conflict) may be as, or more, important to child and adolescent health than family structure.[29] Studies of a range of topics on physical and mental health have affirmed the relationship between high family cohesion and favorable health outcomes and the relationship between low family cohesion and poor or unfavorable health outcomes. Family cohesion has been shown to be an important mediator of risk factors, risk behaviors, and a predictor of treatment outcomes.

Farrell and his colleagues[30] studied 658 families with adolescent children to examine the degree to which family cohesion buffered the effects of fathers' problem drinking in the drinking behavior of adolescent family members. They found that family cohesion buffered the effects of fathers' problem drinking. The higher the level of family cohesion, the less the effects of a father's problem drinking on adolescent distress, deviance, and heavy drinking. When family cohesion decreased, the effect of the father's drinking became more pronounced. The authors concluded that cohesive families can reduce negative outcomes in adolescents as well as buffer the

negative effects of the chronic stress of a drinking father. The implications of these findings are that interventions aimed at assisting families to build cohesion and deal with negative emotions may have a positive impact on the development of adolescent children.

Several examples illustrate family cohesion as a mediator or buffer: maternal mood disorders appear to be associated with lower family cohesion and higher family conflict among bipolar youth;[31] perceived family conflict has been found to be higher in pre-adolescents who showed depressive symptoms and/or suicidal ideation;[32] treatment gains with anxious children were less when they were from low cohesive families where parents expressed high levels of parenting stress and parental psychopathology;[33] female patients with eating disorders perceived that their families were less cohesive and less flexible and that communication with their mothers was impaired;[34] low family cohesion was found to be a significant predictor of school problems among substance-abusing runaway adolescents;[35] perceived low family cohesion and adaptability were found to be strongly related to the poorer post-treatment psychological adjustment of adolescent cancer survivors,[36] and low family cohesion, either reported by the patient or the patient's spouse, was predictive of depressive symptoms in fibromyalgia.[37]

Family Criticism as a Mediator

An interesting survey was carried out at a family medicine center to investigate the relationship between perceived family criticism and physical health. The authors hypothesized that perceived family criticism would be associated with adverse health behavior such as smoking, high fat diet, and less exercise. They expected this association to be mediated by high levels of negative affect, in particular depression and hostility.[38] Their findings supported the hypothesis that patients who perceive family criticism also report in engaging in more unhealthy behaviors. Some researchers have argued that negative family interactions are more potent than positive family interactions; to study either pole alone will lead to conflicting findings regarding family criticism and family cohesion.

Measuring Family Cohesion

One of the most widely utilized models and methods of assessing marital and family systems is the work of David Olson and his colleagues.[39] Known as the Circumplex Model it is grounded in systems theory and utilizes a series

of assessment scales known as FACES (Family Adaptability and Cohesion Evaluation Scales). Over 700 studies have been published on the model and the use of its scales. The Circumplex Model was initially developed in an attempt to bridge the gap between theory, research, and practice. The model focuses around family relationships and integrates three dimensions of the family, communication, flexibility, and family cohesion. Olson defines family cohesion as the emotional bonding that couples and family members have toward each other. Cohesion focuses on how the family system balances separateness from togetherness. Olson has identified five levels of cohesion ranging from disengaged/disconnected to enmeshed/overly connected. The middle range (somewhat connected to very connected) makes for optimal family functioning. In the model's middle area, families are able to strike equilibrium, moderating togetherness, and separateness. The various versions of FACES that have been developed and refined over the past 20 years has improved the reliability of the instruments resulting in the most recent version, FACES III (1985) and IV (2004).

In terms of cohesion, Olson's view is that families experience problems when family members have difficulty in balancing separateness (autonomy) and togetherness (intimacy) and with stability and change (Table 7.1).

The work of Rudolf Moos and his associates regarding cohesion also has a long history of development and refinement (Moos & Moos, 1974, 1981, 1986, 2002). Moos regards cohesion as only one dimension of the family environment. The three domains of family environment he was most concerned with are: (1) interpersonal relationships, (2) personal growth, and (3) the organization of the family. He developed 90 items to measure these three dimensions that ultimately comprised ten subscales of the Family Environment Scale (FES). The FES has been widely used and applied to many types of families with many different problems or in different situations and in different environments. The FES has also been used to predict treatment outcomes.

Another method of assessing family cohesion and power is the Family Systems Test (FAST), which is a figure placement technique (Gehring & Wyler, 1986). The FAST assesses cohesion by distances between figures on a board and power by the height of blocks on which the figures are elevated. This technique allows the entire family and its subsystems to be depicted simultaneously. It has been used, for example, in assessing adolescent's perceptions of cohesion and power in the family in three subsystems, marital, parental-adolescent, and sibling dyads. The strengths of FAST are that social desirability biases only minimally influence the portrayal of the family, it provides a snapshot image of specific family situations, and it provides valuable developmental perspectives that predict changing cohesion and power in families.

Table 7.1 Measurements of family cohesion

Investigator(s)	Instrument	Objective(s) of instrument
Beavers (1977, 1981, 1982)	Beavers Interactional Scales: Family competence, family style	Family competence scale is comprised of 12 items which includes a scale on the verbal expression of closeness by family members
Olson (1985)	Family Adaptation and Cohesion Scales (FACES III)	Twenty statements are answered by family members to assess the degree of separation or connection of family members. The measure can be used with families across the lifecycle, including children over age 12
Moos & Moos (1986)	Family Environment Scale (FES) 2nd edition	The FES is a 90-item instrument that assesses the social environment of families along 10 dimensions, one of which is cohesion. The FES has been translated into numerous languages and used cross-culturally in more than a dozen countries
Gehring & Wyler (1986)	Family Systems Test (FAST)	FAST is a figure placement technique designed to represent cohesion and power in the family. It assesses cohesion by distance between figures on a board, and power by height of blocks on which figures are elevated. Cohesion and power scores are derived for the family as a unit
Carver & Jones (1992)	The Family Satisfaction Scale	This 20-item scale assesses the satisfaction with one's family of origin. Scores had their highest correlation with family network characteristics and were unrelated to family structure
Moos & Moos (2002)	Family Environment Scale (FES) 3rd edition	The FES examines the social climate of the family in three ways: • The family members' perceptions of their family as it is (real) • The family members' perceptions of their ideal family (ideal) • The family members' perceptions of the family in new situations (expected)
Olson et al. (2004)	Family Adaptability and Cohesion Evaluation Scales (FACES IV)	Forty-two-item scale was developed to tap the full continuum of cohesion and flexibility dimensions of the family. Six family types were identified ranging from happy to unhappy and balanced to unbalanced

The Family Satisfaction Scale was developed to assess four broad, somewhat overlapping, domains relevant to family satisfaction: (1) general satisfaction with family life and family members; (2) affection and acceptance of family members; (3) consistency and fairness among family members; and (4) commitment of family members toward one another (Carver & Jones, 1992). The Family Satisfaction Scale has shown strong statistical relationships with other measures of family satisfaction and style, particularly family cohesion. This 20-item scale effectively determines the overall emotional satisfaction an individual has obtained from their family of origin.

Research indicates that family cohesion has an important influence on the development of self-concept in children.[40,41] Furthermore, results have shown that family structure alone does not have the most damaging effects on children's self-esteem. The adjustment and well-being of children from single parent cohesive families ranks second to that of children from two parent cohesive families.

Research results also indicate the need to examine parent–child relationships in conjunction with parent–parent relationships. When children's home environment is evaluated only on the basis of the quality of the parent's marital relationship, children's perceptions of their home environment can be distorted and misjudged, or masked.[41]

Familism, Acculturation, and Family Cohesion

There has been considerable attention given in the scientific literature about the relationship between family cohesion and familism. Familism denotes the normative commitment of family members to the family, and to family relationships, which supercedes attention to the individual. Familism has been defined as a cultural value that involves an individual's strong identification with and attachment to their nuclear and extended families and strong feelings of loyalty, reciprocity, and solidarity among family members. Familism is frequently considered a core value of Latino culture and immigrant and refugee groups. Research studies have been carried out among these groups to discern the effects of acculturation on family cohesion and familism. However, many, if not most, of the scales used to measure family cohesion are considered inappropriate for assessing cohesion among non-Anglos, especially Latinos. A familism scale for use with Latino populations has been developed and tested to fill this void.[42] It was found that more highly acculturated individuals adhered less to familism. Other studies have found that, while family obligations decrease with increased levels of acculturation, a high level of family support persisted. This would indicate

that acculturation has effects on some, but not all, of the elements of family dynamics that influence its cohesiveness.

Acculturation has been related to increases in family conflict and child and adolescent-problem behaviors. More acculturated adolescents reported that their mothers used more inconsistent discipline and less monitoring compared to less acculturated adolescents. These findings are consistent with the literature that has shown that parental control is closely related to adolescent risk for delinquency and that parental monitoring is an especially important factor that deters delinquency for early adolescents. Acculturation affects parents' ideas and values about how to control their children. Yet, the closeness or warmth of the parent/child relationship and adolescents' perceptions of family cohesion do not differ by level of acculturation.[43] This is consistent with the view that supportive family bonds are an enduring source of strength for some Latino subgroups such as Mexican-American families. These supportive bonds may not change as families acculturate despite the fact that they may experience more conflict.[44]

There have been many critics of acculturation research due to a lack of clear definition and measurement.[45] Yet, it is not possible to accurately identify and understand differences in family cohesion in an ethnically diverse society such as the United States without considering the effect of cultural change on the family and the relationships between its members.

One of the major issues underlying these difficulties is our inadequacy in studying and documenting acculturation as a process. We have used static or fixed variables such as language preference as an indicator of acculturation. Hunt and her associates pointed out that in nearly every study they reviewed, language preference was treated as diagnostic of culture, with English taken to indicate an individual's progress in taking on the traits of the mainstream culture. Culture becomes a characteristic rather than a context for understanding acculturation and family cohesion. Similarly, familism is a value that is not easily changed. Identifying the forces of change and their effects on enduring values necessitates observations and measurements over a period of time. Seemingly, then, one of the deterrents to acculturative research is our willingness to engage in longitudinal research using repeated measures.

Summary

Our society continues to hold up the nuclear family as an ideal, even though the family has changed in form and function. The systems approach is a useful way to understand the family's functions and dysfunctions because this perspective views the family as an open system, constantly adapting

to the forces that act upon it internally and externally. Whatever the form of the family, as a system, it strives for the equilibrium that it knows best. Therefore, achieving cohesiveness is a process that means different things to families in different cultures and is of importance at different times in the family's lifecycle.

Cohesiveness is the kind of relationship family members have with each other. Cohesiveness involves experiencing loyalty, reciprocity, trust, and solidarity. There is a large amount of research that indicates that highly cohesive families enjoy a greater degree of health, well-being, and longevity compared to less cohesive families. There are several scales that have been developed, tested, and refined that have proven effective in assessing family cohesion. Research from the use of these instruments has shown a strong relationship between marital satisfaction, parenting, and family cohesion as these effect the early life course of children. As would be expected, family cohesion has a direct effect on children's socioemotional development in particular. Perceived family cohesion (or perceived family conflict) has been shown to be more important to child and adolescent health than family structure. Family cohesion has been shown to be an effective mediator of risk factors, risk behaviors, and a predictor of treatment outcomes for family members.

The challenges for the future in measuring family cohesion is to ensure that studies embrace the cultural context of the families being studied so that process variables such as acculturation can be considered. Too often cohesion is considered as a variable independent of culture. We need more in-depth knowledge about how the processes of social change modify the value of familism and acculturation and, in turn, influence family cohesion.

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Chapter 8
Social Cohesion as a Mediator of Health Outcomes

Introduction

Hornsey and his colleagues[1] wrote, "Everybody can recognize situations where they have been members – or leaders – of groups that have been more or less cohesive, and the subjective experience of being in a cohesive group compared to a noncohesive group is so dramatically different that it seems obvious that this is something that researchers are obliged to examine. But we would also argue that we have an obligation to look inside cohesive groups and to isolate the specific... group processes that differentiate the cohesive from the noncohesive group" (p. 584).

A Look Inside Cohesive Groups

A look inside groups as dynamic, open systems to discover the sources and causes of their cohesiveness is easier said than done. First, groups high in cohesion are unlikely to welcome non-members and acquiesce to being studied. Cohesive groups and their leaders would be expected to be protective of each other. Even when they are permitted inside a group, non-members may be constrained by issues of access to people and information. Second, the effect of a non-member in a cohesive group even for a short time can change the group's dynamics. Third, the complexities involved in studying the dynamics of group cohesion vary greatly by level of analysis, e.g., societal, community, neighborhood, family. Fourth, information about a group's dynamics usually comes from two major sources: (1) perceptions of the group members, the leader, and the group as a whole and (2) what group members and their leaders make public. Even by utilizing both sources of information, we may not be able to fully explain the mechanisms of group

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cohesion because cohesion is complex and multidimensional, involving data from more than one level of analysis that may be obtained using different methods.

There are four components of group behavior acknowledged in the social and behavioral science literature that contribute to cohesiveness: *social identity, trust, reciprocity*, and *loyalty*. These components are the building blocks of cohesiveness; each one is interrelated with the others and all are necessary for cohesiveness to develop. Sometimes these components have been studied separately as indicators or mediators of social cohesion and related to health outcomes. To do so neglects consideration of the multidimensional aspects of social cohesion and the cumulative interaction of the components that result in cohesiveness.

Components of a Cohesive Group

Social Identity

Van Vugt and Hart[2] investigated the role of social identity in fostering group loyalty defined as remaining in a group when better alternatives exist outside of it. Loyalty can be manifested through the experience of strong, positive emotions, through trust in other members and optimism about the group's future, and by sacrifices people make to help their group, including staying when it is personally costly. These researchers tested and affirmed the social glue hypothesis of social identity which proposes that high-group identifiers would be expected to show greater group loyalty than low-group identifiers. High identifiers show a stronger desire to remain in the group when current outcomes fall short of what they can get by leaving the group. High identifiers' group loyalty is due to their holding highly positive views of their group membership. Van Vugt and Hart concluded that, as opposed to closing group boundaries or making group members feel obligated to remain, a quicker and more acceptable way is to strengthen members' identification with the group so that they remain voluntarily.

An example of how social identity works as social glue is that of support group membership among cancer survivors. Research has shown that cancer patients in general benefit from group participation. Cancer support groups provide a supportive environment, mutuality, a sense of belonging, and addresses the specific needs common to group members.[3] Yet, few cancer patients attend such groups. Participants of a community cancer support group were compared to a random sample of non-participants from a Cancer Registry. Support group participants were more likely to be female,

without a partner, younger, and have more education and formal support than non-participants. They held more favorable views of support groups, believed that significant others were more favorable toward their participation, and perceived less difficulty in joining a group. They used more active adaptive coping strategies and felt more control over their cancer, but were more distressed and anxious. On the other hand, non-participants reported more support from a special person.[4]

Cancer support groups will not be appropriate for everyone and they can vary in cohesiveness. Support groups all have a common denominator of meeting other people with cancer, which according to social identity theory, is a major factor influencing person's perceptions of groups and decisions to join. There is some indication that once patients join one group, they often subsequently join others. Support groups vary in format and how they are presented, which may be factors in increasing the chances that a group will be cohesive through self-selection.

In this example, once a person has decided to join a cancer support group, and is accepted as a member, self-identification helps to keep the group cohesive. However, people rarely obtain all they hope for through membership in one group, despite its narrowness and benefits. How well the group meets individual member needs over time will determine when members exit the group. Most survivor groups have some fluctuation in membership and, therefore, are continuously reestablishing their equilibrium and cohesion.

Trust

Trust is a mutually shared expectation. It is a critical component of group cohesion; different levels of trust result in different levels of cohesiveness.[5] Trust is a form of "social intelligence"; it enables trusted persons to have access to sensitive information that the group shares. In a cohesive group, members have the same opportunity to share "social intelligence" with other trusting members. Demonstrated trustworthiness by members, in turn, strengthens the group's bonds.

Trust is conveyed verbally and non-verbally; in either case, it is the communication of reciprocally beneficial behavior in interactions with group members. Trust is a mediator of social cohesion.

A few studies have linked structural conditions with group levels of trust. Several researchers indicate that societies and communities characterized as ethnically homogenous show higher levels of trust.[6] Putnam noted that it seems more difficult to develop and maintain high levels of trust in large-scale forms of human organizations than in smaller settings. Fukuyama

pointed out that the more a community shares a common set of values, the greater the likelihood that a high level of trust will develop. High levels of trust within communities have been shown to foster the growth of civil society and reinforce the existing moral order. For example, voluntary associations tend to be more prevalent in communities, and crime rates lower in neighborhoods, where trust is high.[7]

Trust in healthcare has been studied primarily by examining trust relations from a patient perspective vis-à-vis their relationship with providers of care, primarily physicians.[8] Little is known in the United States about how the organizational structure of healthcare and the culture of healthcare delivery affect trust relations. However, a Taiwanese study of patient perceptions of service quality at solo and group practices found that group practice patients' perceptions of quality service were significantly higher than solo practice patients and group practice patients had greater potential patient loyalty. While this study was carried out in Taiwan, a group-oriented culture, these findings have relevance for group managed care in other countries.[9]

Reciprocity

Reciprocity is a mediator of trust and social cohesion. An example of how reciprocity strengthens social bonds in a group is the Mujin, a traditional Japanese rotating saving and credit association that provided financial aid for the lower-middle class in Japan until the postwar period.[10] The traditional Mujin has largely disappeared and the surviving Mujin provides more of a social networking than a financial function for most members. An ongoing cohort study of older adults found that a higher level of engagement in the Mujin was associated with greater functional capacity (competence) and social engagement, especially social role performance. The Mujin provided a venue for community interaction that had many psychosocial benefits due to strong membership ties and mutual trust. This example points out the benefits of the collectivist value of reciprocity in groups. In cohesive groups, the norm of reciprocity is maintained by the leader's management of a balance between members' needs for competitiveness and cooperation versus the group's common good. This is what Sampson has called "collective efficacy." Collective efficacy (social cohesion and informal social control) was found to be associated with lower rates of neighborhood violence. Sampson pointed out that neighborhood characteristics influence violence in part through collective efficacy (see Chapter 6). Collective efficacy has also been found to be a significant predictor of all causes of mortality rates among middle-aged men and women.[11]

Loyalty

Carron[12] has defined loyalty as a dynamic process that is reflected in the tendency for a group to stick together and remain united in the pursuit of its goals and objectives. In order to achieve group cohesion, leaders must establish a cohesive environment. Involving members in decision making and giving the group autonomy can help foster loyalty. Trust and collaboration comes from working on the group's goals together and how all members can contribute toward reaching them. Loyalty increases conformity to group norms. Members of cohesive groups are more likely to give credit to other members, focus more attention on one another, and show coordinated patterns of behavior.

Loyalty and a high degree of morale is the result of successful teambuilding in groups. Loyalty is enhanced between group members when they make mutual commitments and meet or exceed those commitments. As one person expressed it, "You develop loyalty to a group when members deliver what they promise, when all are contributing to the same idea or goal."

Kaiser Permanente explored ways of empowering members to be more active partners in their healthcare.[13] They designed three approaches for offering an initial visit to new health-plan members and randomly assigned enrollees to one of three intervention conditions or a control group. The first model offered an individual visit with a physician with a review of preventive care needs. The second model offered the physician visit plus an additional visit with a health educator who provided additional information on preventive health and coaching. The third model was a group visit in which the physician and health educator jointly led a 90-min education and discussion program for groups each with about eight new members. After 6 months, compared to controls, those members who attended the three interventions had higher satisfaction, self-rated prevention knowledge, acceptance of health plan guidelines, and were more likely to remain in the health plan. Group visit attendees stood out as experiencing the greatest sustained benefits. The positive long-term results may have come from building a more informed, loyal, and empowered membership. Not all people prefer group visits to obtain their healthcare, yet, group visits do have some advantages over solo visits. This experiment showed that member loyalty to both the group plan and receptiveness to health prevention information can be strengthened when healthcare visits are tailored to members' healthcare needs and preferences.

There is evidence that social identity, trust, reciprocity, and loyalty are critical components of social cohesion. Since social cohesion is based on relationships, all groups experience different degrees of cohesiveness over time. Degrees of cohesiveness are affected by changes in social identity,

trust, reciprocity, and loyalty. There is considerable evidence, as we have seen in previous chapters, that either high or low degrees of social cohesion have observable and measurable effects on health at all levels of social interaction. The challenge before us is *how* cohesion mediates its effects on health.

What We Can Learn from Behavioral Health Interventions

Cutler[14] reviewed and critiqued behavioral interventions that have been undertaken at the individual, community and national levels with the goal of encouraging people who are at risk for a disease to change their behavior, such as changing one's diet and reducing one's weight to reduce the risks of hypertension and heart disease. Social cohesion was not assessed or used as part of those interventions. In general, interventions carried out at the individual and community levels yielded disappointing and mixed results; the most successful interventions were public policy interventions at the federal level to reduce tobacco consumption by increasing taxes on tobacco. Among the possible explanations for the less than expected impact of individual and community interventions was peer effects. People may decide what is appropriate behavior on the basis of what others are doing, specifically those individuals and groups with whom they identify and trust. By targeting only individuals, their peer influences are ignored or missed. By targeting only communities, they may be unrepresentative (outliers) of the larger community of which they were a part, or be disconnected for various reasons from the larger community. The major lesson learned about failed behavioral interventions is that the problem selected for intervention must be carefully matched with the level or levels of intervention to be used and involve more than input and output factors. The level of intervention will determine the methods used to change the specified behavior. Since we make decisions based, in part, on peer input, the choice of a group level intervention is often the best, but not the only, choice. To ignore process or mediating factors in changing people's behaviors is likely to lead to unsuccessful outcomes; social cohesion is a key factor in determining a group's response to an intervention designed to change a group's behavior.[15,16]

A Paradigm

A paradigm is offered to bring input, mediating, and outcome factors together. It is suggested that social and behavioral processes are important mediators between social inputs and health outcomes.

The mediating variable(s) selected for study depend on their relevance to the problem, the level of analysis selected for studying the problem, and the identified social input variables. The linking or mediating variables are identified from theories and the state of knowledge that exists about the problem and from researcher intuition. The mediating variable(s) are at the center of the paradigm; they are the vehicles or "mechanisms of action" that affect, explain, or predict the conditions under which certain outcomes occur. Some common mediating variables are social support, social efficacy, coping behavior, or attitudes.

It is important, as the paradigm points out, to quantify the mediating variable(s) and their patterns, assess their strength or weight in importance to the outcome, and determine whether the mediating effects are direct or indirect. One of the problems with social cohesion as a mediating variable is that it has been measured using many different scales; hence, its attributes as a mediator are not generalizable or comparable from study to study. Also, it is sometimes assumed that social cohesion has the same effects all on levels of analysis; hence, there is the search for a generic social cohesion scale. Finally, social cohesion is a process; therefore, it should be measured more than once over time. Figure 8.1 points out the use of social cohesion is tied to the problem and the level(s) of analyses by which the problem will be studied. The level(s) of analysis, in turn, influence the input variables selected, and the selection of appropriate mediating variables.

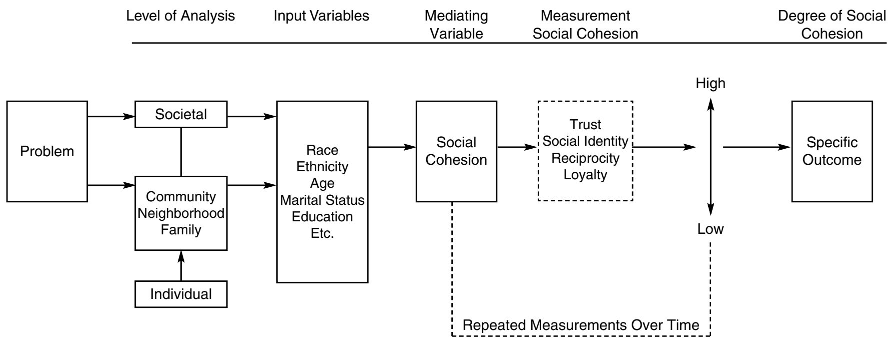

Fig. 8.1 A paradigm of input, mediating variables, and outcome

Example: Family Process and the Effects of Parental Alcoholism

Larson and Reedy[17] studied the negative effects of parental alcoholism on young-adult dating relationships by including both alcoholism and divorce in their design, which allowed them to control for the effects of one while simultaneously measuring the effects of the other. Second, they determined

if the quality of family process (cohesion, conflict resolution, and family competence), mediated the negative effects of parental alcoholism on young-adult dating relationships.

Chaotic, inconsistent, and unpredictable family process with low family affection, high anxiety, and family conflicts in families with an alcoholic parent have been shown to lead to interpersonal and intrapersonal problems for many young-adult children of alcoholics. Likewise, research suggests that young-adult offspring of divorced parents are more likely to develop interpersonal behaviors that inhibit dating relationship satisfaction and stability.

Larson and Reedy posited that there were additional mediators related to family process that interacted with divorce and alcoholism to predict the development of pathology in young adult dating relationships. These mediators were family cohesion, family competence, and family conflict resolution. Beaver's Self-Report Family Inventory (SFI) was used to measure the components of family process, including family cohesion.

The results indicated that parental alcoholism alone does not have a direct negative effect on the quality of young-adult dating relationships. Rather, the relationship between parental alcoholism and young-adult dating relationships is mediated by family process. The better a family's ability to remain cohesive to successfully negotiate conflict, the better young adults' ability to negotiate dating relationships. As family dynamics tend to be more cohesive the young adult is more likely to have a model that will lead to healthier attachments in dating relationships.

Young adults who have experienced both parental alcoholism and parental divorce have the cumulative effects of both on dating relationships. This study suggests that divorce directly harms dating relationships while alcoholism indirectly affects it through family process. These findings explain why children of alcoholics are less likely to marry and have lower levels of marital quality and stability when they do, compared to children from families that do not have alcoholic parents.

These findings have implications for family therapy, premarital counseling, and preventive interventions at the individual and group levels. In this example, the use of social cohesion was used as a mediating variable to examine dysfunctional interactions within the family that would have been missed or unexamined if the focus of the study would have been conducted at the individual level of analysis.

Example: Mediating Neighborhood Effects on Educational Achievement

The literature has focused on the causes of concentrated poverty and its link with social problems, but few studies have examined neighborhood

contextual factors that mediate neighborhood effects. Ainsworth[18] studied the mechanisms that mediate the high educational failure of youth from inner-city neighborhoods. When considering how neighborhood characteristics influence educational outcomes, theorists have proposed several mediating processes including collective socialization, social control, social capital (social networks), perception of opportunity, and institutional characteristics. Ainsworth found that these five major mediators account for about 40% of neighborhood effect on educational achievement, with collective socialization having the greatest effect.

Collective socialization, such as role modeling, influences youth's school-related behaviors and attitudes. In neighborhoods with less effective social control, peer culture plays a greater role in the activities of neighborhood youth. Parents who know other parents is an indicator of neighborhood social capital. Perception of opportunity relates to student's expectations for an occupation by age 30. Finally, institutions influenced by neighborhood context, in turn, shape occupational outcomes.

Ainsworth's study extends our knowledge beyond addressing disparities in educational performance by making connections between structural factors and individual-level processes. While the mediating variables studied are influential, they do not account for all neighborhood effects. This study provides an approach and method for addressing the mediating process through which neighborhood context influences youth.[19]

Example: Multilevel Community Project to Prevent Alcohol Use Among Adolescents

Project Northland was a randomized trial designed to create, implement, and evaluate multilevel community-wide strategies to prevent alcohol use among adolescents during the middle years (Phase 1) and high school years (Phase II).[20] The project was conducted in 24 school districts and small adjacent communities in rural northeastern Minnesota. The majority of students were white (96%), living in two-parent families (70%) and half were female (49%). The intervention consisted of a 10-session behavioral curriculum in schools, and 10 homework sessions with parents and family members; peer leadership activities; parental involvement and education; and community activities. At the end of 3 years of intervention, significantly few students in the intervention school districts reported alcohol use compared to students in the non-intervention districts. The researchers carried out an analysis of mediating variables to explain the differences in alcohol use. The most significant mediators of the 12 analyzed were: (1) a commitment to not use

substances; (2) normative beliefs; (3) lifestyle/value incongruence with substance use; and (4) a negative relationship to social skills.

The results of the mediation analysis for all students suggest that the project achieved the result of lowering the rate of alcohol use among students in Grade 8 by decreasing peer influence to use alcohol, increasing functional meanings of non-use, reducing the risk associated with alcohol and drug problems, and increasing parent–child communication around alcohol use. Process evaluation indicated that it was the combined impact of multilevel interventions including the peer-led classroom curricula, parent education and involvement, peer-planned social activities, and community education and involvement that led to decreases in alcohol use. Social cohesion was not directly measured as a mediating variable in this intervention. Yet, social cohesion appears to have had an indirect influence in the success of the intervention in several ways: through peer groups, parent–child communication, parent education and involvement, and the supportive norms of the small, rural Minnesota communities in the study.

The Group Effect: Next Steps

We have learned that the group on many different levels of complexity can have significant effects on the health of its members. One of the mechanisms that link a group to a specific health outcome is social cohesiveness. Cohesiveness is present in some degree at various times in all groups. More cohesive groups tend to be more stable, have a greater consensus about values and beliefs, and are more predictable compared to groups that are weakly cohesive. Also, cohesive groups have been found to be healthier than less cohesive groups.

Groups can change their cohesiveness by the actions of group members and/or as a result of social change. Therefore, cohesion is a process; it is often more easily observed (and even experienced) than measured. One of the difficulties in measuring cohesion is its complexity, variability, and changeability. Cohesion exists at many different levels and in different degrees at the same time. Therefore, our personal group repertoires usually include several groups of different types, sizes, degrees of cohesion, and importance.

Frequently group level attributes are aggregated and treated as if they were static; for example, one measurement of social cohesiveness in a group at one point in time at one level of analysis would be misleading and inaccurate. There needs to be more attention given to time as a factor in the design of multilevel studies, that is, a consideration of variables that are time-dependent or time-sensitive.

This also points to the importance of longitudinal studies that study group structure, characteristics, and behavior at several points in time as they relate to changes in health. Studies that follow both groups and individuals over time could provide valuable insight into mediating factors that cause changes in health outcomes. Rather than consider numerous mediating variables it seems more useful to focus on one or two targeted mediators and analyze their effects much like was done in the Project Northland. For example, social cohesion may be more significant as a mediator in some health outcomes than in others.

As we have seen in the previous chapters, numerous scales and indices exist for measuring social cohesion at different levels of analysis. These techniques vary in validity, reliability, and cross-disciplinary acceptability. We need studies of refinement and replicability of existing instruments to measure social cohesion. Social cohesion is too complex to assume that someone will develop a generic approach to measuring it that will result in meaningful cross-level inferences and generalizations.

Social cohesion has value as a marker variable.[21] The search for marker conditions usually includes data from more than a single level of analysis. Marker variables, e.g., race, ethnicity, income, and marker conditions have been useful in predicting behaviors ranging from the use of certain health services to the occurrence of destructive behavior such as suicide or decreasing the risk of death by wearing seat belts. Social cohesion could be an important social marker. Social and psychological markers or benchmarks accompany the physical events throughout the lifecycle. We are challenged to consider how social cohesion effects certain health outcomes at different points in the life course.

Summary

Social cohesion is recognized as a real attribute of groups. Cohesiveness has been shown to influence the different types of experiences people have in groups and different degrees of success resulting from different configurations of cohesiveness. Social cohesion has been shown to affect or mediate a variety of health outcomes. Yet, social cohesion has received ambiguous support in the scientific community because it is complex, difficult to measure quantitatively, and the precise mechanisms by which it links input to outcome has not been clearly outlined.

Social cohesion is a process that is time-dependent and may work differently at different levels of human interaction. Answers to how social cohesion works will come from its refinement and replication as a mediating factor in longitudinal studies. We know some of the key factors that make a

group cohesive. Several examples of how social cohesion affects health outcomes at different levels of analysis are described in this chapter. Suggested next steps are offered to increase our scope and depth of social cohesion as a variable worthy of more study and analysis.

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