

## **CHAPTER ONE: INTRODUCTION**

### **1.1 Introduction**

This chapter focused on the background to the study by giving an overview of the global, regional and local contexts on community mental health and psychological well being. Further issues discussed on this section include, statement of the problem, significance, aim, objectives, research questions, delimitations and definitions of terms to the study.

### **1.2 Background to the study**

Mental health is fundamental to health; as reflected by the definition of health as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (WHO, 2008). The definition outlines that there is no health without mental health; furthermore, research conducted in recent years has shown that mental health inherently affects physical health and physical health affects mental health (WHO, 2008). The two are inseparable in terms of achieving a more complete state of wellness; more so, mental health is paramount to personal well-being, self actualization and social capital at macro and micro levels leading to successful contributions by individuals to society. This has proven that, mental health is the foundation for well-being: behavioural, emotional, cognitively and effective functioning for an individual and community. The Mental Health Foundation (2016), ascertain that, the pursuit of happiness and state of complete, physical and social wellbeing, is a critical aspect of humanity, however, most often the focus is given to the physical and physiological state using the medical approach and less endeavour has been given to the use of social prescriptions, based on the idea that we are made to connect, each and every one of us is made for community in fact we cannot thrive without good relationships. Kloss, Hill, Thomas, Wandersman, Elias and Dalton (2012) concur that humans seek communities, relationships with others are a central part of human existence, people cannot live in isolation from each other; individual lives and community lives are intertwined, therefore, in pursuit of health and happiness the role of social capital cannot be ignored.

Lack of investment in social capital in promoting psychological well being and community mental health are failing to thrive because communities are facing major challenges in dealing with political socio- economic situations, which have created new boundaries for communities and social relationships negatively impacting on the individual and community well-being. However, more often likewise the impact of these challenges have been discussed

using economic rhetoric leading to the minimisation of the psychological effects, poor community mental health and the lack of appreciation of the disease burden caused by mental health (Oreskovic,2016). In essence, mental health conditions affect the well-being of hundreds of millions of individuals; they are a disinvestment into the individual and community social capital as they incur high economic and social costs, yet the provision of mental health services remains one the most neglected of all global health concerns. The circumstances surrounding the neglect are from an economic perspective, underfunding in social budgets in low income countries or the continuous cuts in social funding in the developed countries. In addition, from a psychosocial perspective lack of awareness, the negative perceptions and myths surrounding mental health has led to the neglect in mental health care, thereby negatively affecting communities to be at risk or suffer from ‘community paralyses’, at micro level; individuals fail to lead fulfilling quality lives because of the neglect and single prone approach to mental health.

The medical approach and use of clinical based settings has created a deficit in promoting and raising awareness in mental health issues at individual and community levels. The medical approach is devoid in service provision that is acceptable, affordable, accessible and available and has a lot of stigma attached. More so, the lack of awareness on mental health has been compounded by the misconception that nothing much can be done, even though there are a great many effective psychosocial-ecological interventions available such as investing in social capital for mental health service provision, promotion and prevention. In addition the individualistic orientation and pathological framed interventions by the medical approach lack of informed community based perspectives, theoretical understandings, and available evidence to answer questions about what is required to effectively address indigenous people’s community mental health and psychological (social and emotional) wellbeing. The medical approach adopts a curative, prescriptive approach at a tertiary level and not effective on early preventative interventions to reduce emotional suffering; heal the communities and save lives as evidenced by the high rates of suicide deaths and non communicable diseases related to psychological well being and mental health across the globe.

Put simply, the vast majority of people affected by mental health problems do not receive the treatment and care that can transform their lives as more than 450 million people around the world suffer from mental health or neurological disorders positioning mental illness and disorders among the leading causes of ill health and disability worldwide. Close to “30% of

the population worldwide has some form of mental disorder, and at least two-thirds of those people receive no treatment, even in countries with the most resources” (WHO 2007). In the USA, for example, 31% of individuals are affected by mental disorder every year, but 67% of them are not treated (Kohn et al. 2004). In Europe, the mental disorder affects 27% of people every year, 74% of whom receive no treatment (Kessler et al.2005). In Africa, mental, neurological and substance disorders have become the second biggest cause of disease burden (Mather, 2006). The treatment gap is vast, with more than 90% of mentally ill persons in Africa going untreated (Kohn, 2004). The research gap is also vast and there is an urgent need for research from Africa on ways to improve mental health and psychological well being, by changing the culture of psychological well being and community mental health using a multi- pronged approach that changes the conative (behavioural tendencies), cognitive, (thought patterns, perceptions) and the affective (attitudes) characteristics to psychological well being and community mental health.

Failure to use social capital/community relations in the promotion, prevention and treatment of mental health issues is a major concern in Zimbabwe. In Zimbabwe over 30% of people utilizing primary health care facilities suffer from common mental disorders (CMD). This term describes the presentation of anxiety, depressive and somatic symptoms (Verhey, Turner and Chibanda, 2014). Using extrapolation based on the prevalence of H.I.V and AIDS which is at 14% the increased levels of unemployed at 80% and economic uncertainty will give a conservative figure of more than 1.3 million people suffering from mental health in Zimbabwe. The medical approach in mental health issues has created a barrier by adopting a silo approach into mental health issues in which promotion, prevention and treatment of mental health is influenced by clinic based instructions and interventions leading to low detection, one directional treatment pathway and high treatment gap compounded by lack of mental health practitioners. Therefore, this approach in addressing community mental health and psychological well being is not only costly but inadequate, thereby, justifying the need for a shift in perspective from an individualistic perspective to a structural/ecological one. Within this broader perspective, exploring social capital from a psychosocial-ecological perspective has much to contribute in community mental health and psychological well-being through promotion, prevention and treatment.

Summarily, the medical approach provides a first order change, as addressing the individual in dealing with mental health and psychological well being may only ameliorate the problem for a short while and for it to recur again. Therefore, in exploring social capital in addressing

community mental health and psychological well-being presents an opportunity to effect a second order change; understanding that a group is not just a collection of individuals but a network of relationships. Changing those relationships, especially changing shared goals, roles, rules, and power relationships, is second-order change (Linney, 1990) which is the missing piece of the puzzle offered by the medical approach in dealing with mental health and psychological well being.

The need to carry this study was based on the praxis of the medical approach which is individualistic, costly and stigmatized in addressing psychological well being and community mental health. Therefore, the researcher explored how community psychology practice and principles may affect second order change by using indigenous resources like investing in social capital among young adults at Mpopoma-Bulawayo to influence community mental health and psychological well being.

### **1.3 Statement of the problem**

The single pronged medical approach to psychological well being and community mental health has led to stigmatisation, high treatment gap and non availability of community based initiatives to address psychological well being and community mental health. The medical approach focus on the physical and physiological determinants of mental health and psychological well being does not give a holistic approach to health and well being as it does not consider the social determinants. Globally, there is the minimization of the burden of disease relating to mental health due to lack of awareness, diagnosis and treatment in mental health issues, yet in reality an estimated 14 million deaths across the globe are attributed to mental health and it is estimated that by 2030 mental health related diseases are going to be the leading cause of death. More so, the approach gives individualistic prescriptive solutions and limited referral pathway and is not reflective of the ecological structures of communities leading to high prevalence and incidences in mental disorders, poor quality of life and lack of mental health literacy in communities.

### **1.4 Aim of the study**

The study sought to investigate how social capital can be used to address psychological well-being and community mental health among young adults.

### **1.5 Objectives of the study**

The objectives of the study were to:

- a) assess participants understanding of social capital, psychological well being and community mental health.
- b) establish association between social capital, psychological well being and community mental health.
- c) evaluate strategies to promote social capital for psychological well being and community mental health

## **1.6 Research Questions**

Research questions ask what relationships exist between different variables in the study. For the purpose of this study the main research question was formulated as follows;

*RQ How is social capital relevant to psychological well-being and community mental health among young adults?*

In addition to the main research question, the following sub research questions were formulated to illustrate the relationship in social capital to psychological well-being and community mental health among young adults.

### **1.6.1 Sub Research Questions**

**1.6.i.** What is social capital?

**1.6.ii.** How is social capital related to psychological well-being and community mental health among young adults?

**1.6.iii.** Which strategies can be used to promote social capital and enhance psychological well-being and community mental health among young adults?

## **1.7 Hypotheses**

Hypothesis is defined as logical supposition that gives an uncertain description for a phenomenon under exploration (Leedy and Ormard, 2001). Mann (2010), further explains that null hypothesis is a claim (or statement) about a population parameter that is assumed to be true until it is declared false and alternative hypothesis is a claim about a population parameter that will be true if the null hypothesis is false.

Therefore, hypotheses for this study were formulated as follows:

- i. **H<sub>0</sub>** social capital has no effect on psychological well being and community mental health among young adults
- ii. **H<sub>1</sub>** social capital has an effect on psychological well being and community mental health among young adults

For the purpose of this study the alternative hypothesis (H<sub>1</sub>) was used.

## **1.8 Significance of the study**

The study is of significance and beneficial to individuals, family institution, neighbourhood/localities, community organisations, policy makers and academia;

**1.8.1 Individuals:** it will help individuals to maximise their potentials by promoting social-emotional competence, build resilience, coping strategies on mental health issues among individuals and remove the barrier and shame in expressing ones' emotions and increase individual quality of life and positive social networks.

**1.8.2 Family Institution:** it will strengthen the family institution, promoting the values of the 'family community' by drawing on the strength that social capital resonates on a communal self which has a protective value. Therefore, by promoting investment in social capital it will benefit families by fostering a sense of belonging, resilience and promoting mental health and psychological well-being.

**1.8.3 Neighbourhoods/ Localities:** will aid in building neighbourhoods that are proactive in promoting mental health and psychological well-being as the study will raise awareness on the value of 'safer' neighbourhoods by showing the radiating effects of how positive social capital may impact on children school success, adolescent health, behavioural problems, reduce anxiety and depression in the neighbourhood.

**1.8.4 Organisations:** enable community based organisations, government departments, local authority departments, faith based organisations, private and public institutions to use the research findings as they will have an understanding on the value of social capital in programme planning and community activities in mental health and psychological well-being. The study anticipates that the research will offer information to the various organisations in the community for example, work settings, schools, churches, to build on social capital to develop strategies that promote mental health and psychological well-being. Furthermore, organisations dealing in human service and health care settings will benefit from the study as it fits a good moral and economic obligation to prevent mental illness and promote mental health and psychological well being in communities.

**1.8.5 Policy makers:** it will further, benefit policy makers at various levels of governance and institutions, for example it will help local level to build networks and community activities that promote mental health and psychological well-being, at national level it will help to bring opinion leaders to discuss and advocate for national investment and policy frameworks in mental health and psychological wellbeing. It is also of significance to international funders as the study will acknowledge the significance of promoting mental

health as a health priority as much as it has been included in the Sustainable Development Agenda 2015, Agenda 3.

**1.8.6 Academia:** it will establish a framework for future studies and discourse on mental health and psychological well-being in community psychology and health research. The outcomes of the study on social capital will benefit researchers as they will form the basis for further research in the development of social policy in psychological well being and community mental health in low middle income countries.

### **1.9 Assumptions of the study**

The study was based on the assumptions that in the community there is the existence of positive connections/ networks and relationships which have a bearing on psychological well being and community mental health. The study further assumed that participants drawn from *stokvels*/community social clubs will be willing to provide information related to their psychological well being and community mental health and data collected had the characteristics of a normal distribution.

### **1.10 Delimitations of the study**

The variables psychological well being and mental health are sometimes used interchangeably. The conceptual framework of *ubuntu* and theoretical framework of social capital are specific to connectedness, social competency and communally oriented rather than individuation. Therefore, the study seeks to redress individually oriented approaches to psychological well being and mental health in the community. The demographic nature of the participants is an entry point to a life approach in promoting psychological well being and community mental health. The study will be conducted in Mpopoma and the number of *stokvels*/community social club members may not be a full representation of the community.

### **1.11 Limitations of the study**

Though this study provided some strong insights it has limitations in terms of the measurement of social capital. The measure of social capital on two variables psychological well being and community mental health is a mix which has been looked at from different perspectives, with various indicators both in the theoretical and conceptual framework. Therefore in this study the major anchoring themes and indicator of social capital have been adopted.

## **1.12. Definitions of key terms**

Community mental health: activated mediating structures/networks which are productive, having fulfilling relationships and ability to cope with adversity.

Community social clubs: a group of people who enter into an agreement to participate in social activities either for leisure or profit making

Community well-being: is an umbrella concept, related terms such as well-being, happiness, quality of life and community development.

Mental health: relates to well-being in whereby individual realize their own abilities, be able to cope with normal daily stresses of life, be able to work productively and contribute to their communities (WHO , 2008)

Psychological well-being: as a multidimensional construct that consists of six distinct facets: a) positive attitude toward oneself (self acceptance); b) satisfying relationships with others (positive relationships with others); c) independence and self-determination (autonomy); d) sense of mastery and competence (environmental mastery); e) sense of goal directedness in life (purpose in life); f) feeling of personal continued development (personal growth). (Ryff & Keyes, 1995)

Social capital: relates to networks, way of life, and trust that allow participants to act together more effectively to pursue shared objectives' (Putnam, 1996).

Stokvels: a type of a credit union in which a group of people enter into an agreement to contribute a fixed amount of money to a common pool weekly, fortnightly or monthly (Lukhele, 1990)

## **1.14 Chapter Summary**

This chapter presented the research basis for exploring social capital, as an investment to psychological well-being and community mental health among young adults in Mpopoma-Bulawayo. It highlighted the specific theoretical gaps in mental health, with the particular single prone approach to mental health, which limit promotion and raising of awareness in psychological and community mental health issues. The focus and direction of the research



was explained in the statement of the problem, with the potential value of the study explained in the significance of the study, with the aim of the study highlighting the knowledge that the research obtained and the specific actions explained in the objectives of the study. The research questions which point to the identified gaps by giving the specific variables and the relationships identified. With imagined guesses of the research outlined, as well as the delimitations, finally, the definition of key terms as they have been used in the research have been explained in this chapter.

## **CHAPTER TWO: REVIEW OF RELATED LITERATURE**

### **2.1 Introduction**

The chapter reviewed the work of authors on social capital, psychological well-being and mental health, giving an important starting point to enable researcher to understand the historical background, growth, development of social capital research. The section pulled together theoretical perspectives on social capital and examined the conceptual debates and around and made inferences on how social capital can be used to promote psychological well being and community mental health. VUSSC (2013), states that literature review involves accessing a selection of relevant previous work, resources and materials with a strong relation to the research topic in question accompanied by a description and a critical evaluation/critique and comparative analysis of each work. Therefore, this chapter gave an overview of social capital; an examination of empirical relationships between social capital, health and wellbeing, the theoretical, conceptual frameworks, studies carried out from the international, regional and local contexts on the variables of social capital and drawing the knowledge gap of the study. For this purpose, journals, peer reviewed papers and grey literature were sourced with key words social capital, psychological wellbeing and mental health used to get data sources.

### **2.2 Overview of social capital on psychological well being and community mental health.**

Research has shown the value of social capital in relation to an individual's health, happiness, and improved life expectancy, as well as the benefits to a community of having social networks that can come together to support the community and make positive change happen (Smith, A., Peled, M., Poon, C., Stewart, D., Saewyc, E., & McCreary Centre Society, 2015). As a concept social capital has been mentioned across various disciplines and has found space in the social sciences in the search for answers to a broadening range of questions despite that, there has been scepticism on the term social capital which is a quasi-economic term, with broader meaning and subject to various interpretations and definition Perkins, Hughey & Speer (2002). For the purpose of this study Adler and Kwon (2002), conceptualisation of social capital has been adopted and they describe it as the good-will that is engendered by the fabric of social relations and that can be mobilized to facilitate action. It has informed the study of families, youth behaviour problems, schooling and education, public health, community life, democracy and governance, economic development, and

general problems of collective action. Understanding the perspective that it is the, 'mobilisation' of the 'social fabric' is an indication that investing in social capital may provide pathways to address the issues of psychological well being and community mental health among young adults and provide alternative means and broader interventions to address psychological well being and mental health.

Lynch in Mckenzie, Whitley and Weich (2002), further pointed out that exploration of social capital in mental health not only has intrinsic value but it may help to address some important, unresolved clinical and epidemiological questions: these include debates over the composition or context in explaining geographical and socioeconomic inequalities in mental health. Therefore, better understanding of the nature and determinants of social capital and its associations with physical and mental health might also help to resolve the debate between 'psychosocial' and 'neo-materialist' explanations for health inequalities. This perspective allows for the departure of using and focusing on traditional psychology perspectives and individualistic intervention programmes, to more inclusive psychosocial oriented approaches, because social capital has an important feature, in that it is a property of groups rather than of individuals. More so, individuals (and their ill-health) cannot be understood solely by looking inside their bodies and brains; one must also look inside their communities, their networks, their workplace, their families and even the trajectories of their life" (Lomas 1998: 1182).

Therefore, the ecological nature of social capital which distinguishes it from social networks and social support, which are properties of individuals provides for the understanding of psychological well being and community mental health distinct from the individualistic centred medical approach of psychological well being and mental health: social capital redefines this by dealing with groups to participate in their health allowing for effective preventative interventions which are acceptable to communities. Essentially, social capital provides this framework, as it plays a role in the incidence and prevalence of mental illness, and has been vaunted as the next big idea in social policy and health since its recent incorporation into public health discourse (Mckenzie et al, 2002).

Using social capital to address the implementation of community based initiatives and interventions to address mental health inequalities may give new directions in understanding psychological well being and community mental health. Furthermore, it provides an opportunity to look into the social determinants of psychological well being and mental health thereby, directing thinking to second order change interventions, by addressing

structural factors, to health inequalities found between places and groups of people and human competencies as well as understanding that problems are best understood by viewing them from a multi level ecological perspective and all aspects of their lives, including the socio-economic, cultural and geo-political dynamics. More so it may prove to give pathways for participatory preventative interventions, increasing access to mental health services, resilience, enhance psychological well being, community mental health and improve quality of life among young adults.

### **2.3 Social Capital Theory and Conceptual Framework**

Social networks, to which an individual has access, form part of his/her social capital (SC). Concepts most commonly associated with social capital include reciprocity, trust, sociability, social networks and social support, and community and civic engagement. Simply put, social capital rests on the premise that social networks are a valuable asset (Halpern, 2005). The historical foundations of this theory may be traced back to 1933, in Emile Durkheim's work which emphasized the importance of the community as an 'antidote to anomie and self-destruction' (Portes, 1998, p.2). This was further developed, by Bourdieu and Coleman who in contrast maintained that social capital is a resource available to everyone including the poor and, owing to the principle of reciprocity, its benefits go 'beyond any given individual to involve wider networks whose relationships are anchored on a high degree of trust and shared values' (Field,2003,p.24).

Coleman suggested that SC arises out of personal pursuits of self-interests, thus serving as resources for individuals. He identified obligations and expectations, trustworthiness and information flow in social structures, and norms and sanctions as three forms of social capital. In contrast to Coleman, Putnam cited in Harpham (2002) studied SC from a different perspective, defining it as 'features of social life networks, norms, and trust that can improve the efficiency of society by facilitating coordinated actions.' Redefining SC as a feature of communities rather than of individuals, he gave central importance to the 'idea of association and civil activity as a basis of social integration and well-being' (Field, 2003, p.13). He studied the links between SC and well-being and also distinguished between vertical and horizontal networks. He further, differentiated between bonding and bridging social capital the former being connections *within* the community (exclusive) and the latter being links *outside* the community (inclusive), (Onyx&Bullen,2000). Though, Coleman points to the individualistic feature of social capital the key to his definition is the 'the pursuit of self

interests', the implication is the sustainability and continued investment to social capital may positively impact on intervention programme sustainability as individuals are self motivated to be part of a social network. It is Putnam orientation and explanation that SC as a community asset is invaluable and in tandem with community psychology ecological principles for understanding psychological well being and community mental health.

This is further supported by Field (2003), who argue that SC has two fundamental points of clarification: which are; firstly SC should be looked at from a multi-level perspective primarily at the individual psychological and behavioural perspectives as well as the institutional and community network-level facets; secondly the existence of the interpersonal relationships which creates bonding which is a useful catalyst for participation and commitment, creating opportunities for increasing power, access and learning through network bridging deserve greater emphasis. Perkins, Hughey, and Speer (2002) from a community psychology perspective direct that social capital is a value of an individual's social relationships. As a value of social relations the variables considered are social support, sense of community, material and informational resources, and psychological empowerment. In this conceptualization, benefits are gained by individuals through their relationships and civic participation. Second is the understanding of SC blind side that it is the quality of groups, networks, institutions, communities, and societies which are collective in nature and the practice of norms, subjective values, reciprocity and the level of social integration within and between settings.

Among all definitions, there is a common consensus that social capital 'stands for the ability of actors to secure benefits by virtue of membership in social networks or other social structures' (Portes, 1998, p.6). The greater analysis, is that in understanding psychological well being and community mental health SC plays a critical role in the promotion and raising awareness of mental health issues among young adults at community level using the mediating structures and pre-existing community networks because of the role of the psychological and behavioural factors inherent in these networks.

### **2.3.1 Research Question 1: Social Capital Theory - Variables and Indicators**

Perkins, Hughey, and Speer (2002) point out that psychology has not been much quicker to adopt the principles and precepts of Social capital (SC); community psychologists have studied some of the precepts extensively under other discourse expressions at individual level. The precepts entailed in SC, include both informal behaviours such as, community-

focused attitudes (sense of community) together with neighbouring; as well as formally organized behaviours (citizen participation) and attitudes about those organizations and behaviours (collective efficacy or empowerment). Other, related psychological concepts, such as social support, communitarianism, place attachment, and community satisfaction, pride, and confidence also have relevance to SC. These psychological factors direct to what motivates individuals and communities to participate in particular settings and behaviour in those settings and be able to sustain relationships for a long time and evoke continuous participation, how those drives in the group networks, perceptions and attitudes interact with various setting and organizational characteristics to promote effective SC. It is these psychological factors that are important to the development of community based interventions to addressing psychological well being and community mental health.

Borgatti, Jones & Everett (1998) further elaborate on these psychological factors by expanding that SC is only about social boundaries in the constructed networks both physical and psychological takes SC to another level as it ceases to be an individual construct only. The definition refers to “norms, networks, mutual trust, and cooperative action”, each of which has been the focus of considerable psychological inquiry. Indeed, SC operates at an individual and/or across the community ecological levels. *Bonding social capital* describes the relations and interconnections among individuals who are emotionally close, such as friends or family, and result in a stronger bond to a particular group (Adler & Kwon, 2002). Bonding social capital is commonly characterized by homophily (i.e., high levels of similarity) in demographic characteristics, attitudes, by the given available information and resources (Mouw, 2006). The strong connection makes this type of social capital good for providing social support and personal assistance, especially in times of need such as disaster (Hurlbert et al., 2000).

In contrast, *bridging social capital* describes acquaintances or individuals loosely connected that span social groups, such as class or race. These ties are more likely to display demographic diversity and provide novel information and resources that can assist individuals in advancing in society. The classic example comes from Granovetter’s (1983) work on the strength of weak ties, in which bridging ties provided more employment opportunities than bonding ties. Bridging social capital often comes from involvement in organizations including civic and political institutions, parent–teacher associations, and sports and interest clubs along with educational and religious groups (Small, 2010). The third type of network connection is *linking social capital*, which connects regular citizens with those in

power. Scholars have defined this type of network as embodying norms of respect and networks of trusting relationships between people who are interacting across explicit, formal, or institutionalized power or authority gradients in society (Szreter & Woolcock, 2004), summarily, Putnam’s popularized language (after de Souza Briggs), bonding social capital helps people to “get by”, while bridging social capital enables them to “get ahead”. These two functions of social capital may operate at micro levels of individuals, their families and social networks; or macro levels of formal and informal institutions to which individuals and/or groups subscribe as outlined in the table below;

<b>Type (direction)</b>	<b>Component</b>	<b>Level</b>
Bonding (horizontal)	Structural (social networks); Cognitive (social control/efficacy; shared values; mutual trust and norms of reciprocity).	Micro (individual, family/household)
Bridging (horizontal: between different community and/or voluntary groups; and/or vertical: between such groups and statutory as well as non-statutory organizations with power to make decisions on the distribution and/or allocation of public goods and services.	Structural (access to public goods and services, amenities); Cognitive (participation; sense of belonging; Decision-making capacity).	Macro (statutory and/or voluntary organizations—local, national international)

**Table 2.1 Social Capital: types, components and levels**

Perkins, Hughey, and Speer (2002) further support this framework by further aggregating these into the following framework (Table 2). This framework allows for the dimensions of SC to be explained in a four-part definition of SC at the individual, psychological level. It from these dimensions that forms the basis of understanding of SC which have been explored in this study. As outlined by the table, the two cognitive components are, firstly, trust in one’s neighbours (sense of belonging/ community), followed by a belief in the reliability and functionality of formally organized action collective efficacy (empowerment). On the other hand, the two behavioural components are informal neighbouring behaviour, and formal

participation in community organizations. Though each dimension of SC at individual-level different they are closer in relation to the dimensions of SC which have implications to psychological well being and mental health. Therefore, understanding these precepts and tenants to SC is of use to community policy developers to relate what may or may not be of significance in developing and identification of a particular community's formal and informal social assets for development of community based interventions in relation to psychological well being and community mental health.

	<b>Cognition/ Trust</b>	<b>Social Behaviour</b>
<b>Informal</b>	Sense of community	Neighbouring
<b>Formally Organized</b>	Collective Efficacy/ Empowerment	Citizen Participation

**Table 2.2 Social Capital Dimensions of individual level Social Capital adapted from Perkins and Long 2002**

### **2.3.1a Sense of community as a dimension of social capital**

Many community researchers have borrowed McMillan and Chavis' (1986) definition of a psychological sense of community as including four dimensions: *membership, shared emotional connection, influence, and needs fulfilment*. Others have narrowed the definition to social connections, mutual concerns, and community values (Perkins & Long, 2002), or offered a more dynamic perspective that better captures community change in terms of shared history, common symbols, and ongoing development. A sense of belonging/community is a widely valued indicator of quality of community life and a consistent enabler for the behavioural dimensions of SC which are organized participation and informal neighbouring. Other correlations entail community satisfaction and local friendships (Perkins et al., 1990; Sampson, 1991), and these are extended to involve, residential social climate and well-being (Pretty, 1990), shared values and responsibilities (communitarianism), social sanctions (informal social control), and less fear of crime, litter, and graffiti (Perkins et al., 1990). The other antecedents to SC and sense of community relate to one's community as a physical place which is affection (place attachments: these are emotional bonds, developed over time, to particular geographic spaces). Brown and Perkins (1992) used dialectical analysis in suggesting that these bonds are integral to both how we perceive ourselves as individuals and community. More so understanding place attachments help to resolve the desire for both stability and change in our lives and in our communities and in the context of this study psychological well being and community mental health. The emotional bonds to a place drive



individuals and communities to stay and protect what we value most in our environment/communities and to put much effort and drive to further develop and raise awareness and invest economic and social capital to improve that with which we are disgruntled.

### **2.3.1b Collective efficacy as a dimension of social capital**

Empowerment (collective efficacy- formal-cognition, Table 2.2), or dependency (trust) in the effectiveness of organized community action, has been researched and has made great input in the fields of community development and community psychology. The main thrust inherent in collective efficacy is a process by which people gain understanding and control over their lives and their community (Rappaport, 1987), additionally they develop environmental mastery, autonomy, positive self image as defined by Zimmerman et al, (1992). SC gives a fresh perspective by focusing on the behavioural, emotive, affective attributions and motivations that lead community members to engage professionals as collaborators rather than as authoritative experts. The benefits of a kind of an approach are, not only limited to the individual level, but further creates an atmosphere and aptitude in empowering organizations and communities. These dimensions are important to the development of community based interventions in addressing psychological well being and community mental health. Collective efficacy as a dimension sets precedence on the importance of community participation particularly in harnessing of indigenous knowledge system in the development of intervention programmes that promote psychological well being, community mental health literacy and promotion of health seeking behaviours in mental health.

### **2.3.1c Neighbouring behaviour as a dimension of social capital**

Neighbouring behaviour (informal behaviour cell of Table 2.2) is the assistance that is available around the geophysical space it is a derivative of the relations and the co existence of people in a particular community. It includes trusting relationships exhibited by the members in the community illustrative examples are taking of your neighbour's house, child minding exchange and barter trade of goods, watching a neighbours' house or child potluck activities, sharing of events and celebrations (birthdays, funeral wakes), sharing information, and so forth (Perkins et al., 1990). The day to day ordinary conversation with neighbours helps create a buffer against some of life daily events as it helps residents get better acquainted, discuss and help each other in facing some of the day to day life challenges, thus encouraging more community involvement, either formally or informally may also be

included as a form of neighbouring (Unger & Wandersman, 1985). Of note is that neighbouring plays a key important role in the improvement of quality of life in the community yet it is the least studied of the SC factors. Unger and Wandersman (1983) found that greater development of relations among neighbours and organizing a block association might facilitate subsequent efforts towards forming an active interactive and mental health champions in the community through block association. In turn, they found that once a block organized, association members engaged in more social interaction. It is in this study that seeks to further explore the dimension of neighbouring, by exploring social capital and drawing inferences and impact of neighbouring on psychological well being and mental health.

### **2.3.1d Citizen Participation as a dimension of social capital**

Citizen participation in grassroots organizations constitutes the formal behavioural dimension of SC in Figure 1. Sociologists and political scientists have studied participation but have generally concentrated on its demographics. However, Psychologists go beyond demographic differences by controlling for them while finding that participants, and their organizations and communities, have a greater sense of collective efficacy or empowerment (Florin & Wandersman, 1984; Perkins et al., 1996; Saegert & Winkel, 1996; Speer & Hughey, 1995), sense of community (Chavis & Wandersman, 1990; Perkins & Long, 2002), neighbouring (Perkins et al., 1996; Unger & Wandersman, 1985), community satisfaction (Perkins et al., 1990), and other positive community attachments and organizational bridging activities (Perkins et al., 1996). Relevant organizations include religious congregations (especially community service or advocacy-oriented “social mission” committees; Doeckel, Newbrough, & O’Gorman, 2001; Foley, McCarthy & Chaves, 2001; Speer & Hughey, 1995); school-based associations, citizen advisory boards of government agencies, and youth sports and recreation groups; community councils, resident associations, and community crime and drug prevention coalitions; and self-help groups.

These community mediating structures are crucial in the promotion and harnessing community wellness and improving quality of life at community level. Speer, Gorman, Labouvie & Ontkush, (1998), assert that many urban areas are characterized by the heavy presence of spaces that have been abandoned and neglected, these in turn breed into criminal hubs promoting illicit activities such as drug abuse and drug peddling places, illicit sexual affairs, all forms of criminal activities taking place in those abandoned sites such as illicit

gambling establishments, “adult” book stores and strip clubs; despite the outside of the occasional community-engaged religious congregation, the institutional environment will provide minimal or no available opportunities for settings in which the individual experience of SC can flourish. This will be especially true when those few present institutions have thin or non-existent networks of relationship within the local community or beyond. Putnam (2000), further, states that “communities with less social capital have lower educational performance and more teen pregnancy, child suicide, low birth weight, and prenatal mortality. Social capital is also a strong predictor of crime rates and other measures of neighbourhood quality of life, as it is of our health”. The result of a community which has heavy presence of environments which are predominantly surrounded by drinking outlets may result in thin or they may more than an absence of SC; therefore breeding high levels of crime and negatively impacting on community mental health and individual psychological well being.

In sum these dimensions of Social Capital are a window in which social capital can be understood from both the individual and community level. This understanding has a bearing to the use of social capital to promote psychological well being and community mental health. Narayan and Cassidy (2001) illustrate a simplified dimension or concept of social capital that was central to this research in particular articulating the research questions and objectives as outlined in Chapter 1.

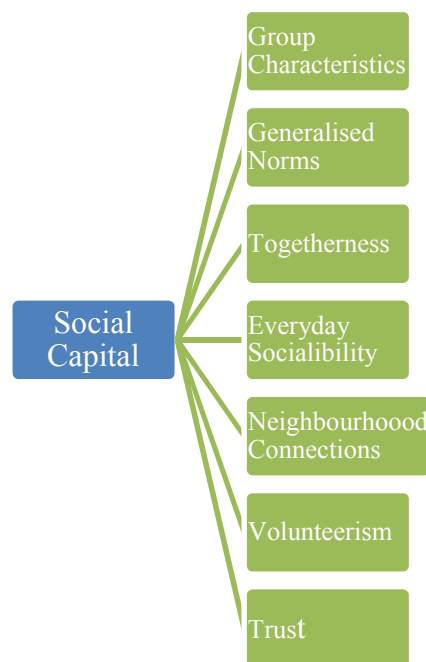


Figure 2.1 Social Capital adapted from Narayan and Cassidy 2001

The development of such communities have been noted in particular with communities that are communal in nature, in their study Ramsey and Smit (2002) in Burundi, proposed a model of well-being that argues that various conditions in the environment within which a community exists play a role in the experience of well-being. In the latter authors' model, psychological well-being is multidimensional and is characterized by:

- Suicide rates and indicators of life satisfaction and psychological assessment.
- Economic well-being is described by levels of income, poverty, unemployment and educational attainment.
- Social well-being is characterized by social support and activity, personal interaction and life satisfaction.

The term community well-being encompasses comprehensive and integrated concepts developed by synthesizing research constructs related to residents' perceptions of the community, residents' needs fulfilment, observable community conditions, and the social and cultural context of the community. Related terms such as well-being, happiness, and quality of life take on a crucial role in constructing community well-being. Maybery et al. (2009) approach community well-being as community resilience of residents coping with their stressful circumstances. They regard social connectedness and social ties as critical determinants for community resilience and well-being.

#### **2.4 Research Question 2: Social Capital, association between Psychological well-being and Community Mental Health Outcomes**

Progressive studies have been undertaken in the last two decades identifying sources of social capital that can help reduce high risk-taking behaviours among young adults and adolescents. A myriad of constructs have been investigated in association with social capital, the relations between mental health and social capital appear to be the most consistent in the literature therefore making it the most useful to test the convergent validity of the new measure. The majority of research has demonstrated that higher stocks of social capital have an advantage for psychological well being and community mental health outcomes in children, adolescents, and adults living in both privileged and underprivileged communities and the overall improvement of quality of life (De Silva et al., 2005). In a study on adolescents and teens by Stevenson's (1998) results showed that when teens had increased levels of family social and emotional support, there was no significant differences in depressive symptoms between low and high social capital neighbourhoods. More so social

support in the context of stress and coping is a concept similar to neighbouring that has been widely studied by community psychologists. It helps to explain the health benefits of both self-help (mutual aid) groups and a sense of community.

The origins of sense of belonging/community and social support research in community psychology can be traced and are related with crisis theory. The relation emanates from the density and quality of the structure of the group network in terms of its composition (family, friends, and neighbours) and these are positively related to the prevention or reductions in different stress-related physical, community paralysis and psychological pathology. For example, Briggs (1998) found that by putting an adult who is employed to a low-income minority adolescent's support network had positive effects on behavioural attitudes access to employment opportunities, school success and overall career guidance (social leverage). Thus, SC is assumed to purposefully serve at least three different variables of social support functions: which are communal (shared beliefs, opinions/ attitudes or values sense of community); instrumental (overt behaviour outcomes explicitly expressed in the community task-oriented assistance; for example watching over neighbours children); and linking which has strong informational pathways such as access to new information and contacts;(Levine and Perkins, 1997). Last but not least the fourth form of support, which is emotional, may entirely be depended upon the quality of relations which may impart negatively or positively towards an individual psychological well-being and ultimately to community mental health.

According to the Guide to community-centred approaches for health and wellbeing Full report 2015, it has been shown that good social relationships and engagement in community life are necessary for good mental health, and may offer protection in adversity or where there is exposure to stressors. It further states that, the ability to form positive relationships is an integral part of wellbeing and individuals are recommended to connect with those around them as one of the 'five ways to wellbeing'. The report further elaborates that compelling evidence from a meta-analysis of 148 studies on social relationships and mortality risk shows that communities 'with strong social relationships are likely to remain alive longer than similar individuals with poor social relations', with a 50% increase in odds of survival over an average follow-up of 7.5 years when integration in social networks, supportive social interactions and perceived social support were examined, proving that there is a social gradient across the social factors that support good health. A WHO Europe review of mental health, resilience and inequalities reports that high levels of social capital can buffer some of the effects of stress, but at the same time deprivation and inequalities 'erode' the resources

needed for good mental health, furthermore, previous research studies have revealed that there is a strong positive relation between social capital psychological well-being and community mental health, even after controlling socio-economic variables such as poverty (Aldridge et al., 2002).

Wilkinson (2002) further states that social relationships serve as a barrier against stress, the everyday challenges such as sickness and psychological pathology depression by providing psycho social care and support. Additionally, increased levels of social capital can build feelings of well-being and sense of community/ belonging, whereas the absence of SC can lead to psychopathology (Brown & Harris, 1978). In support of these views, a study by Aneshensel and Sucoff (1996) found that youth living in disadvantaged communities were significantly more likely to suffer from psychopathology and behavioural disorders. However, when the increased attitudes and on perception of social capital and cohesion among community or network members were included into the aggregation of results there was a clear relation which was negative between depression and social cohesion within these low income neighbourhoods. The conclusion drawn was that enhancing social capital within low income communities may improve and strengthen psychological well-being and community mental health outcomes for adolescent residents.

These findings were also supported within the Australian research setting where, within an rural east-coastal town, Berry (2009) found that for a small sample of Indigenous Australian ( $n=84$ ), New Australians ( $n=138$ ), and Other Australian ( $n=743$ ) adults, varying measures of community participation (e.g., social connectedness) and personal social cohesion (i.e., belonging, reciprocity, and trust) were negatively associated with feelings of distress, and positively associated with happiness across all participant groups. The importance of these findings (although from a limited demographic) should not be understated not only with regards to social capital's strength across cultural groups, but also that social capital may be powerful mechanism for community members who may be from an often cited disadvantaged status (namely Indigenous Australians), especially with regards to mental health outcomes (Hunter, 2013).

Similar study on the relation of social capital and health were carried out in a study rural China, by Yipa, Subramaniana, Mitchella, Leeb, Wangc, Kawachia, (2009) they examined the relationship between social capital health and well being. The results indicated that cognitive social capital (i.e., trust) is positively associated with all three outcome measures at

the individual level and psychological health/subjective well-being at the village level as well. They found that trust affects health and well-being through pathways of social network and support. In contrast, there is little statistical association or consistent pattern between structural social capital (organizational membership) and the outcome variables. Furthermore, although organizational membership is highly correlated with collective action, neither is associated with health or well-being. From the outcome of their research they suggested that policies aimed at producing an environment that enhances social networks and facilitates the exchange of social support hold promise for improving the health and well-being of the rural Chinese population.

Understanding these allows for the drawing of evidenced based approaches in drawing a referral pathway to the enhancement of psychological well-being support, community mental health promotion and preventative measures. In another study in Norway on neighbourhood social capital showed that it is linked to favourable health-outcomes and life satisfaction. However, it has been questioned whether its impact on health has been over-rated. The study investigated relationships between neighbourhood social capital and self-rated health (SRH) and life satisfaction (LS) respectively, both directly and indirectly mediated via Sense of Coherence and self-esteem. Based on a cross sectional population-survey (N=865) in a medium size Norwegian municipality, the results showed that Social capital has a stronger impact on life satisfaction than on health. The indirect pathway via SOC had the highest impact on life satisfaction, but no significant relationship to SRH. Self-rated health was more tightly linked to personal background variables. The overall result of this study was that improving and enhancing social capital in the communities might be a beneficial strategy to promote life satisfaction, as well as strengthening, sense of coherence even in healthy, communities (Gillies and Lucey,2006).

In addition, Davidson and Cotter, (1991) in their research further, indicate that sense of community and related factors have significant positive impacts on a range of outcomes for individuals and groups. Conversely, a lack of connections, identity and supports inherent in sense of community may lead to less positive outcomes. Social epidemiologists have demonstrated how community connections, belonging, networks, cohesion, and social capital have an important role in the indicators for health, psychological well-being, and mental health outcomes of populations and sub-groups. Syme (2000) has shown that traditional epidemiological risk factors account for only about 40% of the variance when studying cardiovascular mortality and morbidity. Hence, 60% of the variance has yet to be accounted

for, and much of this relates to the social determinants that can be understood in terms of sense of community. Extending these ideas, Berkman and Glass (2000), and Kawachi and Berkman (2000) place the contexts of networks, social cohesion, and particularly social engagement and control, as crucial to the promotion of community level health and well-being.

Essentially, they show that sense of community and social capital can play a significant part in people's lives. These factors may even help to keep many people alive. The ways that neighbourhood social processes can mediate and moderate community-level socioeconomic disadvantage, and health problem related to it, have been well documented (Browning & Cagney, 2003). The key elements identified across this research are meaningful social contact and positive social cohesion. Without these, the person and the group flounder. Research by Scuderi (2005) has drawn upon this in the examination of a group of cardiac rehabilitation patients who are immigrants from Italy. His analyses demonstrated that the traditional model of rehabilitation focusing on education, diet and exercise was far from the most effective aspect of the program. Participants reported that the social contact with those who spoke the same language and who had shared similar experiences and histories were paramount. Added to this, meaningful roles and activities inside and outside the family were even more important. Similarly, Lee and Cubin (2002) identified relationships between neighbourhood factors and cardiovascular health behaviours in young people.

This research follows a basic tenet of community psychology, the need to understand the multiple levels at which a problem can be analysed, and the multiple levels at which interventions can take place. Where a traditional focus is placed on individual level interventions and individual outcomes, it is possible to miss the significance of the context in which the individual and group are functioning. The focus here is on the profound impact that type of community had on suicide rates, and what we now can learn from this about community engagement, and of valuing the ecological structures of the community, that is from the micro to the macro levels and one level in which social capital has been drawn is from the meso level which incorporates the family unit.

According to Stronski, Ireland, Michaud, Narring, & Resnick, (2000) they looked at social capital as a family attribute from the meso level. The results showed that adolescents who come from strong family backgrounds which are supportive and open had lower levels of



substance abuse, were less likely to indulge in sexual relations (Karofsky, Zeng, & Kosorok, 2000), and had a lower risk of unwanted pregnancy (Miller, Benson, & Galbraith, 2001) on unlike adolescents who had troublesome or weak relationships with their parents. Further studies looking at peer relations in the context of social capital have shown that network norms, values can either promote or discourage risk-taking behaviour (McNeely & Falci, 2004; Portes, 1998). Research has proven that networks that engage and practice risk seeking behaviours may have a negative impact on that network behaviour (Kirby, 2001; South and Baumer, 2000), whereas those networks that engage in healthy practices reduce psychopathology and increase collective efficacy among the members in the network (Browning, Leventhal, and Brooks-Gunn, 2004).

It has been shown that social capital between the micro and meso levels may positively influence psychological well being and mental health among the networks. (Watts & Nagy, 2000). Putnam (1995,p.73 cited in Leonard,2005), for example, shared Coleman's view that 'the most fundamental form of social capital is the family,' and that it is the 'primordial' social organization, and that it keeps bad things from happening to good kids' (Putnam,2000,p.296 cited in Ferguson,2006). Furstenberg & Hughes (1995) found promising links between socioeconomic achievement and social capital measures. Runyan et al. (1998), meanwhile, established a correlation between parental social capital and children's health, urging for the strengthening of interpersonal relationships in communities for the healthy development of children in the community. In support of this view, a mixed methods research did by Darlene et a (2013)l in Canada show that youth who experience less community cohesion experience more individual, relational and contextual risk. In addition, they show engagement in fewer protective processes associated with resilience than youth who are from communities with greater community cohesion.

The research studies shown as suggested by the discussions direct that SC is valuable for the development of psychological well being and community mental health. It is apparent that SC is promoted by three mechanisms: the time and effort that individuals, communities devote to each other, the establishment of strong emotional bonds from supportive networks, and the socialization process through which moral values and guidelines are communicated. Failure of activation of these three mechanisms results in 'structural deficiency' ultimately to individual and/or community paralysis. In this regard, social capital 'exists in the interest, of

each individual and community for better, improved psychological well being and community mental health as shown by its association.

### **2.5 Research Question 3: Enhancing Social Capital: Strategies for Psychological well being and Community Mental Health**

Effective mental health policy and service provision to improve psychological well being and community mental health may be built or strengthened from social capital. Therefore, enhancing social capital among individuals and in the community becomes a requisite. As shown by research Social capital can be promoted by various activities. In Columbian poor communities there exist<sup>3</sup> a web of relationships among several persons and are linked through a variety of communications and exchanges; hence, these are called a “network”. Llanos, Orozco and Garcia (1990) define the network structure by highlighting that, the many poor families, led by women, make use of kinship-based reciprocal exchanges to provide emotional support and general aid in the form of goods and services. These exchange systems evolve naturally and spontaneously as a way to guarantee survival and compensate for the lack of social programs.

The network does not have to be enlarged to grow stronger, for it fortifies itself in relation to its members’ confidence in it and the extent to which it enables them to become self sufficient. The said multidimensional well-being is summed up in the stokvel concept in that getting into a relationship with the group members is supposed to help them meet the psychological, economic and social well-being as embraced in the group name and the group goals (Moloi, 2010). De Klerk, Boshoff, and van Wyk (2009), confirm the important role that a sense of meaning plays in a person’s life, and that having a sense of meaning in life appears to be one of the usual properties of normal functioning and well-being. In Japan Osada conducted a survey in 2011, the aim of the study was to understand the key points to maintaining social capital by way of group organization within the community because of the weak social networks in Japan. From the survey, it was thought that dog-walking influences both continuance and development, which overall promotes the growth of social capital in the community.

Alaimo, Allen, Reischl, Hutchinson, & Atkinson, (2009) in a qualitative study in Flint, Michigan, with four diverse low income neighbourhoods with community gardens to identify the range of the benefits and limitations of community gardens for building social capital and how social capital is generated in neighbourhoods. Results suggested that community

gardening and beautification activities created opportunities for the development of bonding, bridging, and linking social capital. In addition, some gardens propagated neighbourhood norms and beliefs, including reciprocity, helping others, neighbourhood involvement, collective efficacy, sense of community, and neighbourhood pride and morale. A particularly salient finding was the facilitating role existing neighbourhood organizations played, ensuring that collective action on community gardens or beautification led to increased social capital. This qualitative study, however, focused primarily on gathering insight from the individuals who were themselves participating in neighbourhood activities. Our findings evoked additional questions that we could not answer with our qualitative data.

In addition, Alaimo, Packnett, Miles, & Kruger, 2007 acknowledges that community gardens are public health promotion enterprises that can simultaneously promote good nutrition and physical activity within neighbourhoods, especially in areas with economic or structural barriers to accessing fresh produce and recreation opportunities. Community gardens are also thought to generate social benefits, such as social capital; however, only a few empirical studies on this topic have been conducted. Wakefield, Yeudall, Taron, Reynolds, and Skinner (2007) conducted surveys, participant observation, and focus groups with community gardeners in Toronto; they found that participation in the gardens elicited pride and provided a positive place for social interaction and sharing. In a study of Latino gardens in New York City, Saldivar-Tanaka and Krasny (2004) found that community gardens were sites of frequent socializing and community organizing and that gardeners viewed their gardens “more as social and cultural gathering places than as agricultural production sites” (p. 407). A survey of community garden program coordinators in upstate New York found that 51% of coordinators reported that the garden improved residents’ attitudes toward their neighbourhood (Armstrong, 2000). Glover and colleagues’ work with community gardeners in St. Louis, Missouri, describes community gardens as social contexts for the production and use of social capital and for accessing resources such as ideas, water, labour, and tools (Glover, 2004; Glover, Parry, & Shiness, 2005).

In a study of neighbours prior to and after block organizations were formed, Unger and Wandersman (1983) found that participation in block organizations was associated with an increase in members’ social interactions with their neighbours. Neighbourhood organizations and block clubs are also widely cited as mechanisms for generating social capital, although research on the topic is relatively sparse, particularly for studies examining social capital as an outcome. In another study, they found that participation in civic organizations, including

block organizations, was associated with neighbouring, a measure similar to social capital (Unger & Wandersman, 1982). Furthermore, analysis of survey data from 413 low-income neighbourhoods in 10 cities found that neighbourhood participation, defined as serving as an officer for a local community group, volunteering or attending a community festival, was a strong predictor of individual-level bonding social capital (Brisson & Usher, 2005). Citizen participation in neighbourhood organizations (participation level and participation in decision making) in four low-income Pittsburgh, Pennsylvania neighbourhoods was associated with organizational collective efficacy, but not neighbourhood collective efficacy, defined as a combination of informal social control and neighbourhood trust (Ohmer & Beck, 2006).

Arai and Pendlar (1997) completed a qualitative study with participants in a community visioning process and found that participation was associated with perceptions of group accomplishment, ability to influence change, and development of community, including development of camaraderie and connectedness to the community. Finally, Semenza, March, and Bontempo (2007) implemented an intervention involving community participation in an urban renewal project, i.e., design, approval, and construction of community art spaces. Analysis of pre- and post surveys of residents living within a two-block radius indicated that measures of sense of community, social capital, and two measures of social interaction (study participants had talked to neighbours about personal problems or asked their neighbours over to their houses to socialize) displayed statistically significant increases after the intervention. Some of these interventions include time banking, focus groups, social events, and redesign of physical and architectural structures to maximize social interactions.

One proven way to increase levels of social capital in communities has come from the practices of *time banking* and *community currency* (Lietaer, 2004). Both of these systems provide incentives or rewards for those who volunteer; in exchange for an hour of labour in a communal garden or at a school, for example, participants can receive an hour of moving aid or currency (such as Ithaca Dollars) redeemable at local merchants. By drawing out local residents who may otherwise not have volunteered and then connecting them with local small-scale merchants this approach creates a “virtuous cycle.” One study of 160 participants found both physical and mental health improvement from involvement in a time banking program (Lasker et al., 2011). Another study of community currency in a town in Japan found that “community currency involvement increases general trust, which demonstrates that it is possible to institute government programs that create social capital” (Richey, 2007, p. 69). Several disaster-affected communities including Onagawa, Japan, and Lyttleton, New

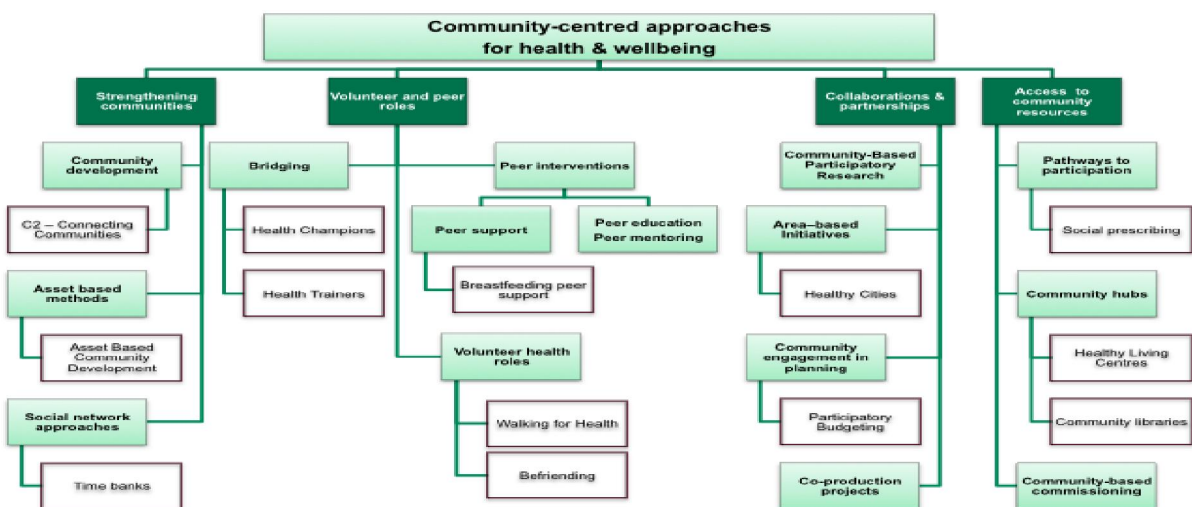
Zealand, have adopted community currency programs or time banking systems and have claimed strong material and mental health benefits as a result (Aldrich site visit to communities, 2013).

Another way to increase trust and social cohesion comes from focus group meetings and social events; this approach includes general social activities such as parades, fairs, and block parties along with moderator-led discussions of topics such as the environment and school choice (Aldrich, 2010). Field experiments in Nicaragua and South Africa have demonstrated that regular meetings of neighbourhood-level groups can create higher levels of trust not only in group participants but in society as a whole (Brune & Bossert, 2009; Pronyk et al., 2008). One small town affected by a tornado adopted various community volunteering projects such as a community garden and a mentoring program along with children's activities including local sports leagues and after school programs (Meyer site visit, 2014). In addition, Social capital may be further increased through the deliberate and careful *planning of community layout and architectural structures*.

The physical layout of communities, neighbourhoods, and even housing complexes affect creation and maintenance of social capital. For example, interaction can occur in areas where residents can meet and spend time—however short—together. One scholar labelled these meeting areas as “Third Places” because they are not residential locations, which are private, or work spaces, where specific activities are required (Oldenburg, 1999). Coffee shops, bookstores, bars, hair salons, public squares, and libraries serve as third places for social capital to be generated and regenerated. Following the Tohoku disaster in Japan, many NGOs have worked to create spaces where displaced residents can socialize. Other environmental effects on social capital include incorporating spaces or activities that encourage community members to participate in their maintenance. The classic example is Ostrom's (1990) common pool resources thesis, in which years of working together to maintain a harbour created informal social mechanisms that prevented overharvesting by any one member. Another example comes from Newman's (1996) *Defensible Space* approach to city planning in which urban communities are reorganized so that residents have control over the areas around their homes, including lobbies, streets, and grounds, such communities where residents feel connected to their space and to their neighbours have lower rates of crime and higher levels of bridging social capital.

Capacity building for mental health service providers (community psychosocial and non-specialized healthcare providers) is often a prerequisite for evidence-based. It can be as simple as a walking group that meets each week or a book club. Farmers markets provide healthy foods and foster social connections. Churches and religious organizations are also a good source of community social capital. The evidence on the relationship between social capital and mental health is generally more consistent than that on the relationship between social capital and physical health and overwhelmingly supports the hypothesis that individuals with higher levels of social capital or who live in areas with high levels of social capital enjoy good mental health. Studies of individual-level social capital and mental health generally find that individuals with high levels of social capital are less likely to suffer from mental disorders than individuals with low levels of social capital De Silva *et al.*, 2005; and Almedon, 2005.

The above strategies form the basis of the intervention programme with the clearly defined goals and objectives giving a structured plan to guide collaborative program planning and delivery (Barry, 2007). The model illustrates the pathway of the intervention model to community mental health and well being across the lifespan. The core of the intervention model is that of strengthening communities (collective efficacy), promoting pro social behaviour, creating partnerships and synergies and using community resources through mobilisation. In addition to the intervention model the nature based approaches such as the creation of third spaces/ psychological informed environments, these will be supported by arts based programs in which mental health is a promoted through performing arts and creative art displays.



**Figure 2.2 Community centred approaches for health and well being**

In addition to the intervention model, critical community psychology looks at the processes through which social contexts mediate individual representations and experiences of health and healing. As such, it looks towards the transformative opportunities that promote awareness of these understandings may create for marginalised communities (Burges, 2013).

## **2.6 Knowledge Gap**

This is the gap that has been identified in the research process from the research process mainly informed by the research questions, statement of the problem and noted gaps in the gathered literature review. The existing gaps in exploring social capital an investment to psychological well being and community mental health have been noted from a theoretical and conceptual perspective and

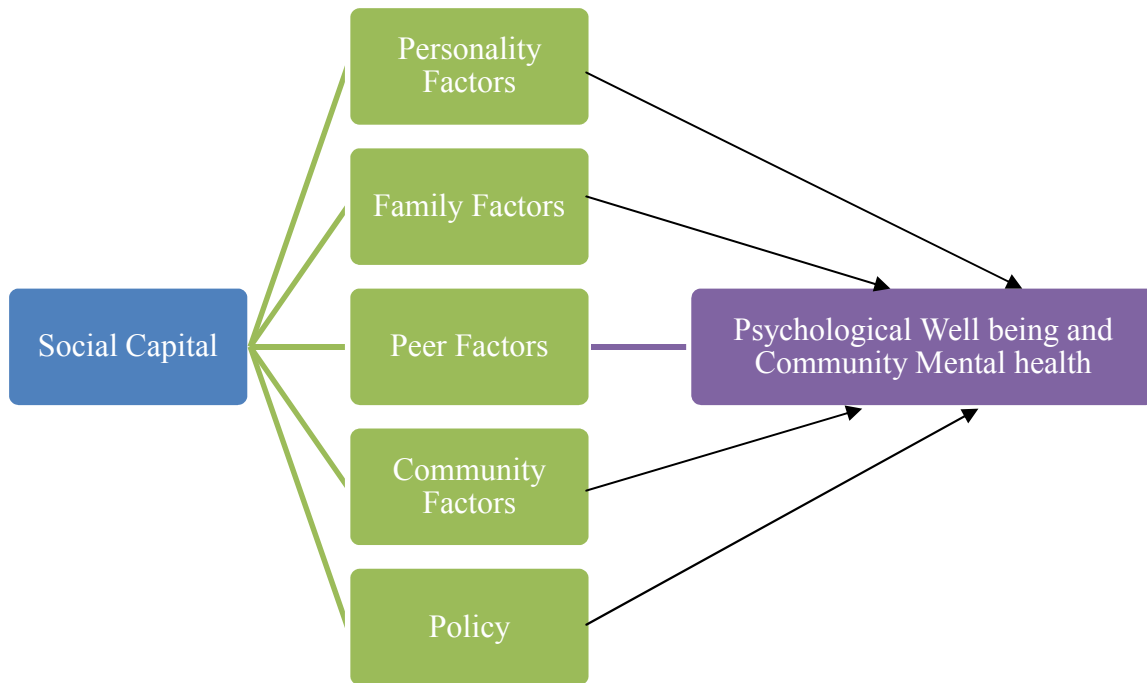
### **2.6a Theoretical Gap**

From the theoretical perspective and moving towards evidenced based approaches, Whitley and McKenzie (2005), suggest that strong evidence that shows that social capital promotes mental health and protects from the risks of developing mental illness is currently lacking especially among individuals who face a high risk of developing mental health conditions in adulthood (Borgonovi and Huerta, 2008). More so, the literature that measures social capital at the area level is much smaller than the literature that measures social capital at the individual level, this is despite increasing acknowledgement that social capital is an important determinant of health and overall well-being, empirical evidence regarding the direction and strength of these linkages in the developing world is limited and inconclusive. In addition, studies that employ combined research design are rare or non-existent. Multi-method investigations and analyses are called for in order to unravel mechanisms whereby social capital and mental health might be meaningfully associated. In sum, the research seeks to cover the theoretical gap by broadening the scope and understanding of social capital, filling the gap in ways of improving psychological well being and mental health by closing the gap on the limitations of the praxis of the medical approach in dealing with mental health to broader inclusive broader community based interventions.

### **2.6b. Conceptual Gap**

The missing conceptual framework which is an ecological framework of social capital in relation to psychological well being and community mental health as outlined in figure 4. There is no conceptual framework which entails various factors that ultimately lead to the

understanding the concept of social capital from a holistic perspective. Therefore, understanding the psycho-social ecological perspectives allows for the understanding of and development of inclusive community based interventions.



**Figure 2.3 An Ecological Framework of Social Capital, Psychological Well being and Community Mental health**

## 2.7 Chapter Summary

This chapter highlighted the various the various perspectives to the theoretical and conceptual framework of social capital. In addition the variables and indicators of social capital have been discussed with the research questions used as the reference point for theoretical review, and further outlining the knowledge gap of the study, from the theoretical and conceptual perspectives.



## **CHAPTER THREE: METHODOLOGY**

### **3.1 Introduction**

This chapter presented the methodological procedures which correspond to the research questions and hypotheses used to explore social capital on psychological well being and community mental health among young adults. The following methodological advances were discussed, firstly, a brief description on the positivism paradigm, a discussion on mixed methods approach, design, followed by an outline of the demographics, sampling, a description of the quantitative and qualitative instrumentation used in the research, an outline of how data was collected and the procedures for the statistical data procedures were outlined for the quantitative and a description of the methodology and process used to collect and analyse the qualitative data was presented. Finally, a reliability, validity and ethical considerations issue was addressed.

### **3.2 Research Paradigm**

The predominant philosophy which guided this study on how data should be collected, analysed and used was the positivism paradigm. The positivists, modernists and empiricists assert that social phenomena can be explained 'scientifically', based on regularities from the data obtained. Most researchers who take this standpoint aim “not to disturb the world they are studying: their aim, instead, is to trawl their data collecting net quietly through the social world” (Graham and Jones 1992 p.239) and use tools such as surveys or questionnaires to depict and understand the subject matter and numerical approaches to reporting and analysing the data gathered (Ward and Boeck, 2000). The paradigm was chosen to allow the researcher to observe and measure the findings in order to develop nomothetic understanding on the variants of social capital on psychological well and community mental health among young adults, the relative associations and evidence based activities, laws and policies to generate nomothetic knowledge to generate promotion of psychological well being and community mental health using community based approaches.

### **3.3 Research Approach**

In addressing the challenges inherent in the measurement and construct of social capital the current used an integrative mixed method approach; this approach entails both quantitative and qualitative processes. This represents research that involves collecting, analyzing, and interpreting quantitative and qualitative data in exploring social capital investment to

psychological well being and community mental health in a single study. Of note is that several typologies of mixed-methods research designs exist (Tashakkori & Teddlie, 2003), however, the concurrent mixed design was the typology used in this research was the typology adopted for this research. This design allows for the dual process of data collection procedures by using both quantitative and qualitative data. The data is analysed and interpreted separately, followed by the merging and data integration of both quantitative and qualitative data; this allows the researcher to draw an overall “meta-inference” about both data sets (Tashakkori & Teddlie, 2003, p. 686). The justification for collecting both quantitative and qualitative data was drawn from the conclusion that one a singular data source component was not adequate for the current research primarily looking at the variables psychological well-being and mental health was not adequate and the second method was to support the primary method.

The quantitative approach was predominantly used (Quan-qual) by using the connected contributions with the strengths of the qualitative approach used to contribute to the performance of the quantitative approach. In collecting data using the quantitative component structural factors such as the confidentiality surrounding psychological well-being where some of the sensitive issues in the survey instrument, the level of education of the participant, inconclusive survey items to elicit participants valid opinions, all impact on the quality of the data that was analysed and collected in relation to the reliability and validity of the interpretation given to the data. Guba & Lincoln (1994) further argue that “qualitative data helps to redress that imbalance by providing information that is relevant to the context. This allows for a broader overview of the phenomena under research that are not adequately measured by the quantitative framework. In support of this Sechrest and Sidani (1995, p.77) make reference to what they have termed ‘methodological pluralism’ which is of importance to current modern science as it allows for the reliability and validity of the results through triangulation on the relations between levels of social capital, psychological well-being and community mental health outcomes.

The purpose of the qualitative data was threefold. It served to enrich and extend on the findings from the quantitative data, enabled the researcher to gain a deeper understanding of the social capital construct, and was used to elucidate the strengths and challenges within each of the key communities in order to inform future intervention strategies. The findings from both the qualitative and quantitative studies were also examined interactively for occurrences of “convergence, complementarity, and discordance” (Greene, 2007, p. 157) in

order to validate the findings from each method and build upon social capital theory, therefore, it was deemed both important and necessary to employ a mixed method design in the current research in order to fully explore and explicate the influences of social capital on psychological well being and community mental health.

In summary, the use of multiple methods in research can contribute to methodological rigour (Patton, 2002) by creating synergistic research whereby the addition of a second method (i.e., quantitative or qualitative) enables the other to be more effective (Hesse-Biber & Leavy, 2011). Mixed-methods designs draw strengths from quantitative and qualitative designs, thereby minimising the limitations associated with the monomethod approach (Johnson & Onwuegbuzie, 2004). More specifically, while this research capitalised on strong statistical techniques, it is also recognised that interviewing a sample of participants provided rich insights into their experiences that are not easily captured using only quantitative methods. Therefore, using this typology of the mixed method approach allowed the results from each data collection to be compared and contrasted, with the aim of arriving at valid and well-substantiated conclusions about the phenomenon under study. In this study, quantitative data was used to test social capital theory which predicts that networks and positive relationships will either positively or negatively influence the psychological well being and community mental health for young adults, the qualitative data explored social capital features such as bonding, bridging and linking for young adults in Mpopoma.

### **3.4 Research Design**

The survey design was used for this research. The survey design describes what we see, hence reveals the actual picture of a situation through the emerging trends from the study (Leedy, 1997). The aim of the survey, with its qualitative and quantitative components, was to enable the examination of the interaction between the micro, meso and macro aspects of the construction of the social environment, in line with the concept of social capital that it cuts across the socio-ecological levels. It is important to highlight that the survey was not designed to ‘measure’ social capital, but to further the investigation of the different domains, and how these domains interact with each other in relation to psychological well-being and community mental health. More so, this design allowed for the researcher to gather original data for the purpose of describing certain perceptions, opinions attitudes and relationships and in this context the knowledge, attitudes and perceptions to psychological well being and community mental health as drawn from the research questions and hypothesis discussed in

Chapter one. The resultant outcome of this design enabled the researcher to obtain in depth information which can be used to generalise the findings of exploring investment of social capital to psychological well being and community mental health among young adults using nomothetic understanding of the phenomena to the larger population.

### **3.5 Target Population**

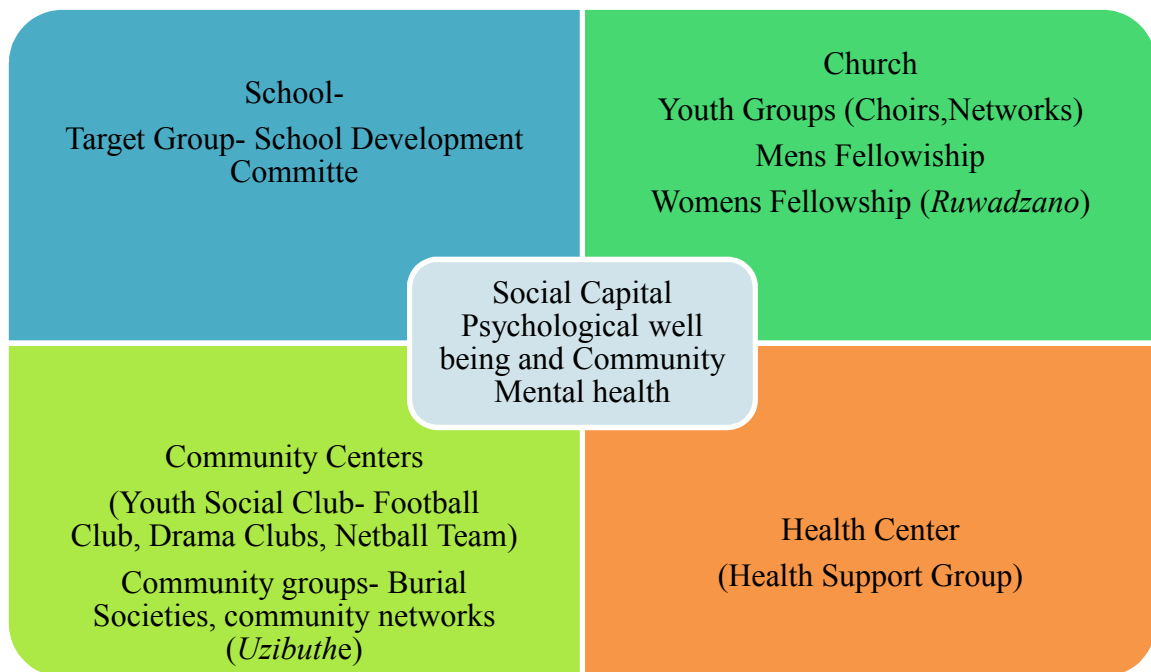
For this purposes of this study the researcher drew participants who belonged to one or more social group or network from Mpopoma Ward 9 which is part of the Bulawayo Metropolitan Province. The demography of the population was set at an age limit of 18 to 49 years. The basis of the selection of this population is that there is high prevalence and concerns on mental health issues particularly focusing on the social determinants in psychological well being and community mental health. This target population comprised of individuals with one or more common characteristics, attitudes and behaviours (homophile) despite their heterogenic characteristics, with much consideration given to the nature of social capital in that it thrives and better understood in groups or social networks. The community of Mpopoma ward 9 has schools both primary and secondary, churches, community centres and facilities which provide opportunities for networking and meeting by various social groups of the specified age group.

### **3.6. Sampling Method**

For the purpose of this research which was exploratory in nature; ‘non-probability’ sampling was chosen; the purposive sampling method in both phases (qualitative and quantitative) of the research was used. The purposive sampling technique is not just an easy ‘cop out’, trying to avoid the difficulties of accessing a representative, cross-section of people in the whole population, but rather that a focused and “handpicked sample” would contribute better to the exploration of the subject (Denscombe 2007 p.17). In purposive sampling, ‘handpicking’ specific group(s) allows for information rich cases which mean that there is a greater understanding of the phenomena being studied. The choice of ‘purposive’ sampling was informed by the literature review, own judgment as careful consideration was given to who was likely to provide the best information on social capital in relation to psychological well being and community mental health.

#### **3.6.1a Population Sampling Procedure- Quantitative Sample**

The nature of purposive sampling entails that the information gathered from the sample population is meaningful to the research process. Likewise the sampling procedure should be well informed to minimise bias. Using ecomapping, strategic locations where social capital activities and initiatives thrive were observed. From, observations of these locations specific groups were identified where purposive sampling was likely to occur as outlined in the map below;



**Figure 3.1: Purposive Sampling Participants Map**

The total sample comprised of a range of dimensions of social capital based on the cultural and network backgrounds, as well as a representative gender mix. A total of one hundred and thirty five participants were drawn from the community four outlined clusters to carry out the survey and the questionnaire was administered.

### 3.6.1b Population Sampling Procedure- Qualitative Sample

The qualitative sample consisted of a total of 10 participants. The sample was drawn from the various clusters that belonged to almost all cluster networks/social group. This was a subsample from the same communities described in the previous quantitative sample and data was collected in the form of semi structured interviews. From the survey questionnaire participants who belonged to various community groups were nominated from diverse social and cultural groups to ensure that a variety of viewpoints and circumstances were accessed during the interviews.

### **3.6.1c Population Sample**

The overall sample of this study was drawn from Mpopoma with 135 participants drawn from various community social networks. This was the sample population engaged with during the study, the age range of 18-49 years was chosen and drawn from various cultural background and networks to eliminate bias and get reliable information. The sample was factored in by the researcher considering the logistics and manageability of time frames.

### **3.7 Research Instrument**

The key guideline in the instrumentation in the research process is the development or use of an effective instrument that fulfils the acquisition of relevant information from participants for further analysis and discussion. Therefore careful consideration should be given on the choice of instrument to closely ascertain the behaviours, perceptions, attitudes and relations of social capital to psychological well being and community mental health.

#### **3.7.1a Quantitative Instrument- Questionnaire**

The research used a combination of instrumentation that have been previously tested for strong psychometric properties as well as additional scales that are specific to psychological well being and community mental health. The study utilised a standardised Social Capital Cohesion Scale (SCCS) which had a Cronbach's construct validity of .70. It incorporated scales of measures in social capital, psychological well being and community mental health (Appendix A) to assess participants' levels of social capital and how this may influence various psychosocial and well being outcomes in the community. Constructs measured by the selected instrumentation included: groups and networks; trust and solidarity; collective action and cooperation; network structure, participation in the local community; feelings of trust and safety; neighbourhood, work, friends, and family connections; and tolerance of diversity. The psychologically well being measures included a range of objective and subjective measures, including: autonomy, environmental mastery, purpose in life, personal growth and positive relations. On the other hand community mental health measures included physical and mental health, behavioural problems, drug and alcohol use, physical well-being, quality of life, and perceived safety.

#### **3.7.1b Qualitative Instrument- Semi Structured Interview**

A series of semi-structured interviews were conducted with participants drawn from the survey. The semi-structured interview gave enough flexibility for participants to illuminate important and significant areas spontaneously, it also allowed specific key areas to be targeted. In addition, the interviewer was provided with the opportunity to ask spur-of-the-moment questions resulting from information given by the interviewee/s (Magson, 2013). The semi structured interview addressed each of the research question outlined in chapter one, and built upon the quantitative study of social capital, the semi-structured interview schedule contained questions investigating what respondents' value in their proximal and distal social relationships (family, friends, neighbours, school, and community), and their involvement within their local community. To assess community strengths and weaknesses for potential intervention strategies, participants were also asked to describe their community, identify any problems, and highlight community strengths. Interviewees were also asked about the types of services operating within the community and whether or not they felt these services were adequate in addressing the psychological well being and community mental health needs.

### **3.8 Data Collection Procedures**

Research approval was sought and subsequently obtained from the Midlands State University. In addition, Bulawayo City Council Approval Process was completed with the Authority granting approval after full Council meeting approval referenced TNB/OS N6A/103 (Appendix), and permission to undertake the study within City Council facilities in Mpopoma Ward 9 was granted. After approval, potential participating institutions and participants were approached with consent and information forms were distributed by the researcher (see Appendices A and B).

The survey was carried out by the researcher at the identified locations in the community clusters as identified from the community ecomap. On data collection, participants who had not signed consent forms were excused; those who had signed consent forms were further, instructed verbally of the purpose of the study, of their voluntary and anonymous participation, and their right to withdraw at any time with lack of penalty. The survey took approximately 45 minutes to complete. All collected surveys were assigned a unique identification code to ensure the anonymity of all participants, had consent forms removed to further de-identify participants, and were safely kept by the researcher.

Collection of the qualitative data was conducted in 30 minute using a semi-structured interview format (see Appendix C) a phone digital recorder, observation and field notes were used to record participants' responses for the entirety of each interview. Participants were selected on the frequency/high number of social groups or networks, in order to acquire a diverse range of opinions and life experiences. At the beginning of each interview, participants were informed that their participation was voluntary and they could stop the interview at any interval without reason or penalty. Each participant gave their consent verbally, prior to beginning the interview. In addition to answering the prescribed set of questions, the research participants were also given the opportunity to speak of other relevant and significant issues arising from the initial set of prearranged questions. At the end of each interview, participants were asked individually if they wanted to discuss anything that may have distressed them during the discussion, and were given the details on how to contact psychosocial support services.

### **3.9 Data Presentation and Analysis Procedures**

As a consequence of using mixed method and purposive sampling techniques, the goal of this study was not to generalize but to obtain insights into the phenomenon of social capital in relation to psychological well being and community mental health. Therefore, the independent analysis and interpretation of the quantitative and qualitative data, both sets of data were examined for convergent and divergent results in order to provide a greater understanding of the phenomenon under study.

#### **3.9.1a Quantitative Analysis**

The SPSS version was used for statistical analyses. Data was presented in the form of graphs and tables. The tables and graphs gave numerical measurement about the participants understanding and relationship of social capital on psychological well being and community mental health. Various statistical analyses on the SPSS were used in a numerical way to quantify the relationship between the variables and answer the hypothesis from this analysis the researcher was left with appropriate procedures to draw conclusions from and make recommendations.

#### **3.9.1b Qualitative Analysis**

Interview digital recordings was transcribed verbatim, coding was used to analyse the qualitative data through the method of thematic analysis (Aronson, 1994). As described by



Ezzy (2002), data reduction involved four procedures: (1) open coding, an evidence-driven approach of assigning labels to meaningful sections of information were used to analyse the whole data set generated during the study; (2) axial categorisation was used to subdivide this mass of data segments according to their emergent patterns, relations, and themes; (3) interpretive summaries were produced focusing on the insights drawn from this analysis; and (4) evidence-driven commentary units were created. The latter included: (i) a key analytical point; (ii) orienting information; (iii) the evidentiary excerpt; and (iv) researcher interpretations. Initially, manual data coding was used to identify and collate major themes relating to each of the primary focused research questions. The data was then further reduced into secondary sub-themes. Secondly, the data was further analysed for emergent themes that were not associated with the initial categories. Following this, evidentiary excerpts that best represented the theme were selected for each theme and orientation information was collated.

### **3.10 Trustworthiness**

Credibility or trustworthiness of inferences made in mixed method research is often thought analogous with internal validity in quantitative designs (Paul, 2005). Krathwohl (2004) states that credibility can be enhanced by considering the plausibility of the explanations given, the quality of implementation (i.e. the design of the study appropriately addressed the initial aims and research questions of the research), convergence of evidence and explanations, and finally, a lack of other plausible explanations for the current findings. To ensure the credibility of the current research, relevant theory and previous empirical research was related to the current findings to ensure inferences were plausible and test the extent to which evidence was congruent with earlier research. In addition, variables in the quantitative component and the interview schedules in the qualitative component were designed specifically to address the prescribed hypotheses and research questions outlined in Chapter 1.

The transferability of the results, (also known as external validity in quantitative studies) is also important in determining the quality and usefulness of the results and subsequent conclusions. Lincoln and Guba (1985) argue it is imperative that the research context is made explicit to allow future researchers to make legitimate comparisons between samples and determine whether the findings generalise across various research settings. In order to address this, the present research detailed the specific age, gender, and demographics of the

qualitative participants, and provided a thorough description of the research settings in which they were situated.

### **3.11 Ethical Considerations**

Liamputtong (2007), emphasises that ethical considerations should not only be part of the research process, but also be considered before and after the research. The ethical considerations were not only applied to the research process, but also when choosing the methods of the research. Overall, this research adhered to the 2010 American Psychological Association Amendments of the 2002 “Ethical Principles of Psychologists and Code of Conduct”. When devising the information leaflets and consent forms for the research participants (see Appendices and ), I followed this statement and focused on the following APA (2002), general principles as an overarching point of reference,

- Principle A: Beneficence and Nonmaleficence
- Principle B: Fidelity and Responsibility
- Principle C: Integrity
- Principle D: Justice
- Principle E: Respect for People’s Rights and Dignity

#### **3.11a Informed Consent**

Information sheets were provided for participants, the information sheet (see Appendix ) meant to communicate the following:

##### **3.11ai Rights of participants**

- The commitment on behalf of the researcher to preserve anonymity
- The right to consent to be involved and to leave the research at any time during the research process
- The right to decline involvement in specific parts of the research project (such as declining to answer certain questions)

##### **3.11b Purposes of the Research**

- The purpose of the research (including aims and objectives) was communicated, in all cases, with absolute clarity by the researcher

##### **3.11c Dissemination of the Research**

- The intended use of the research was made as clear as possible in all information sheets
- Further to the provision of this information sheet, I made myself available to discuss any issues concerning the research project.

### **3.11d Confidentiality and Anonymity**

The participant's right to anonymity was preserved throughout the duration and dissemination of the project. All original data, interview materials and transcripts, consent forms and other documents that contained references to personal details were stored in secure conditions, accessed only by the researcher. The provision of consent, further confirmed in the continued discussion with participants, assumed that data could be used for the research project and for the completion of this Masters dissertation.

### **3.12 Chapter Summary**

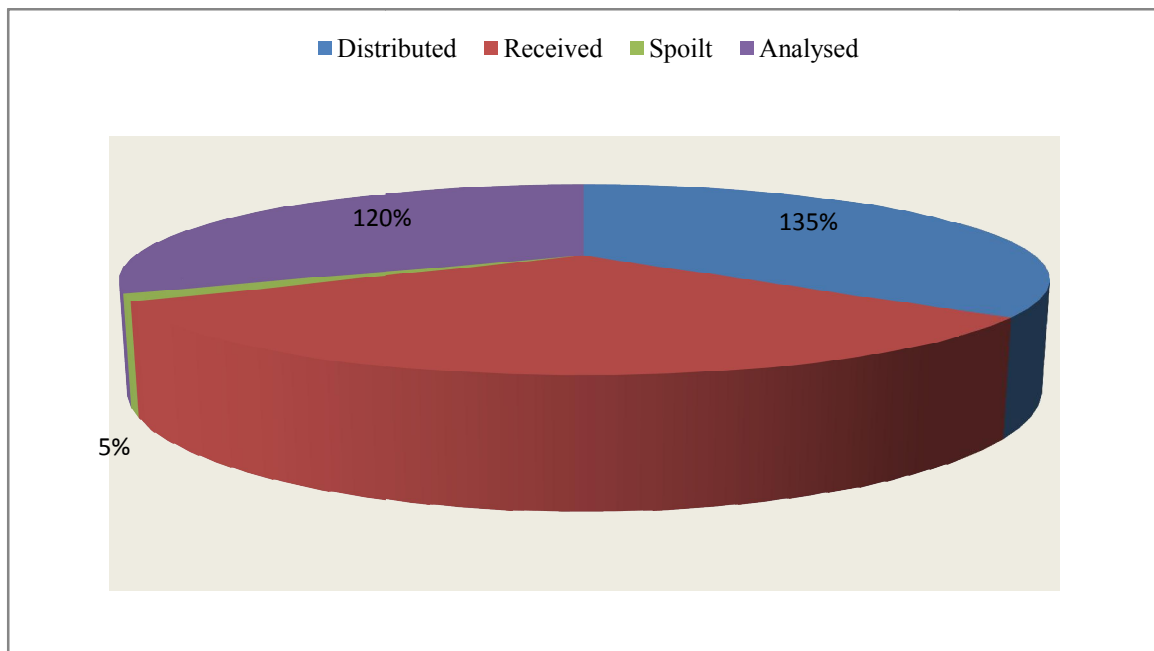
This chapter illustrated the methodology utilised to answer the hypotheses and research questions proposed for the research. A description of participant demographics and characteristics were provided, and the relevant research settings presented. The battery of quantitative instruments was described and the statistical procedures used to assess the psychometric properties of instrumentation and predictive relations of key constructs were detailed. Finally, the procedures for collecting, recording, and analysing the qualitative data were discussed. The results of all data analyses were presented in the following chapter.

## CHAPTER FOUR: DATA PRESENTATION, ANALYSIS AND INTERPRETATION

### 4.1 Introduction

This chapter presented the results of the study, analysis and interpretation of the findings from the research. The discussions in this chapter supported the proposed hypotheses and research questions, focusing on whether there is any relationship between social capital, psychological well-being and community mental health. The use of statistical tools such as graphs, tables were used to analyze the quantitative data and answer the hypothesis and quotable quotes were used to analyse and interpret the findings to validate the research questions.

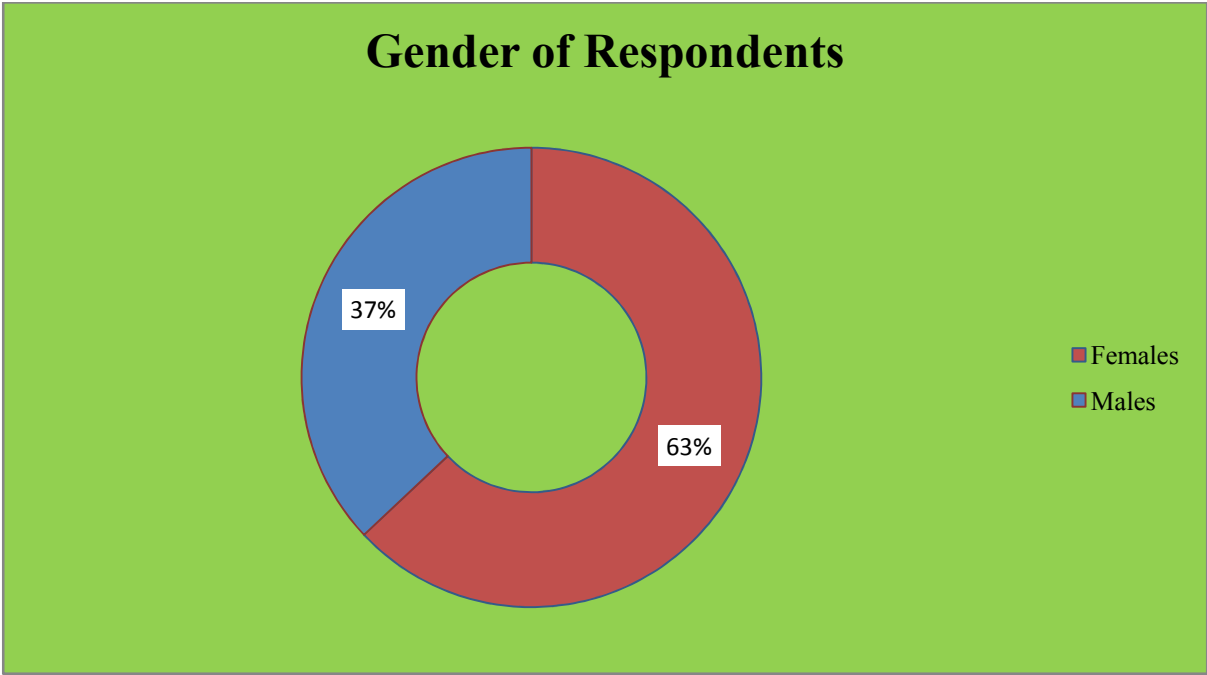
### 4.2 Response rate- Quantitative Data



**Figure 4.1 Overall response rate and analysed questionnaires**

A total number of one hundred and thirty five questionnaires were distributed among participants in different social networks in the community as outlined in Chapter 3. One hundred and twenty five questionnaires were collected; five questionnaires were removed from the survey because they were incomplete or had double responses on the same question. Questionnaires that were available for analysis and valid were hundred and twenty (Valid N= 120). The overall percentage of analyzed questionnaires from the distributed was 89%.

### 4.3 Demographic data and characteristics of respondents



Most of the respondents were women at 63% of the sample and 37% comprised of males. The density of the respondents seemed to be high among the females this could be attributed to the high levels of participation of women in networks such as School development association community networks such as *zibuthe* and support groups. Further analysis of the demographic characteristics were analysed and findings presented in the table below.

Characteristic	Frequency	N-Valid	%
<b>Age of participants</b>			
18-24 years	20	120	17
25–30 years	31	120	26
31–36 years	59	120	49
37–49 years	10	120	8

The frequencies shown above show that from the respondents 49 % were aged between the ages of 31 to 36 years, this age band proved to be more proactive in social networks. From the sample the purposively sampled interview participants had the following characteristics as outlined in the table below:

Participant	Age	Sex	Marital Status	Average number of Networks
A	27	F	Married	4

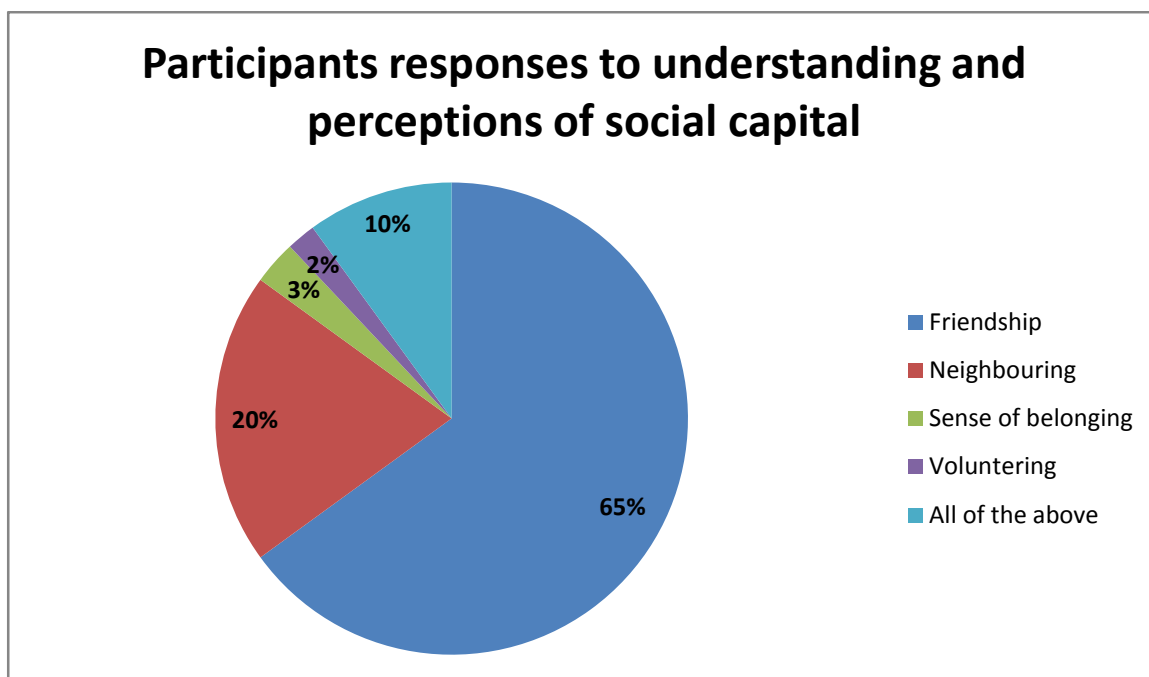
<b>B</b>	39	F	Married	3
<b>C</b>	20	F	Married	4
<b>D</b>	28	M	Married	4
<b>E</b>	33	F	Married	3
<b>F</b>	22	F	Married	4
<b>G</b>	36	M	Married	4
<b>H</b>	36	M	Married	4
<b>I</b>	42	F	Married	3
<b>J</b>	18	F	Single	3

**Table 3 Qualitative Sample  $n=10$**

#### 4.4 Results

The results of the study are outlined below as per the set research questions

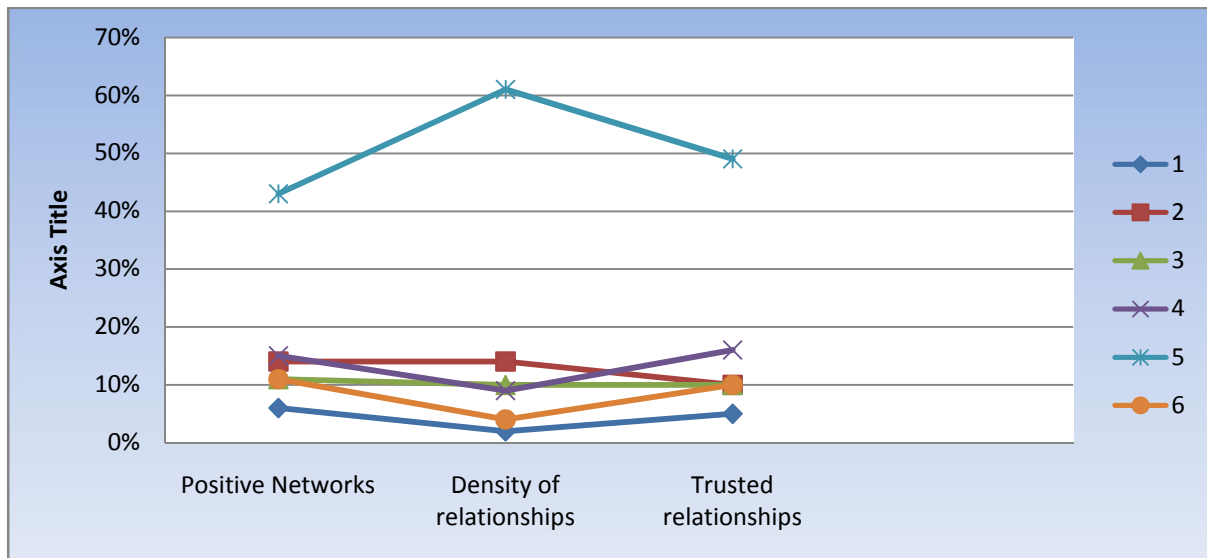
##### 4.4.1 Research Question: Perception and understanding of Social capital.



In general most of the respondents seemed to relate social capital with friendship as 65% of the respondents believed that it is all about friendship, 20% perceived it to be related with neighbourliness, 10% believed it was all inclusive of friendship, neighbourliness, sense of community and volunteering, 3% related it to sense of community and 2% related it to volunteering. From the data gathered there is no single 'correct' definition of social capital as a concept. Definitions of 'social capital' will vary not only depending upon the understanding

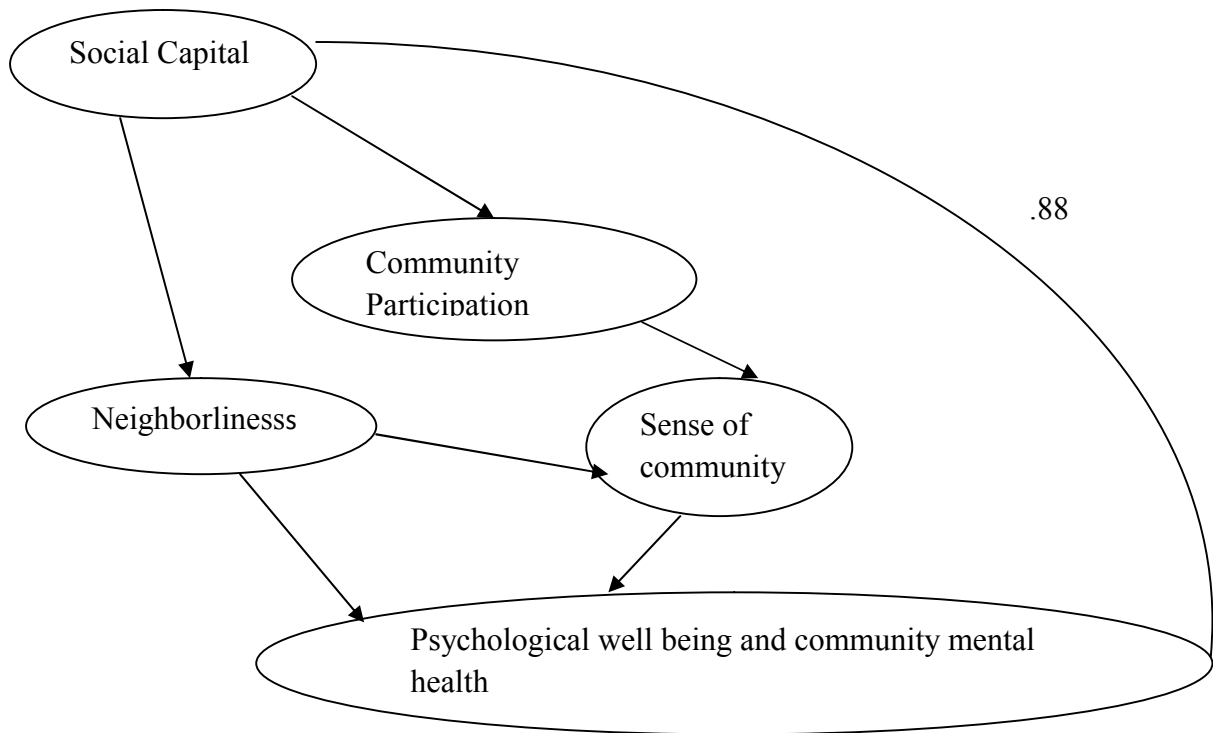
of the individual being asked, but also on account of differences in age and level of education. Whilst recognising that social capital is subjective and an inconclusive subject particularly looking at understanding psychological well being and community mental health the elasticity of the construct was acceptable as this study focused on dynamic processes and proxy features of social capital. The implication of this result is that within our communities there is an understanding of social capital and presence of networks as seen by 100% response to social capital proxy answers. More so from the qualitative data analysis the following overarching themes on perceptions and understanding of social capital came out.

#### 4.4.2 Research Question: Social Capital, association between psychological well-being and community mental health outcomes



The percentages responses shown above shows that most of the respondents had high scores in relationships and network density total a total of 60% had high levels of . Similarly because of the relationship shared relationship had 61% of the respondents scored low and this was further reflected in the trusted relationships component with about 49% also finding it difficult to be warm and concerned with others. This clearly shows that there is a relationship of positive relations with social capital as most of the respondents scored high. More so the stronger levels of sense of community identified particularly from the community networks showed greater outcomes of psychological well being among the participants because they had greater density of networks. These greater densities resultantly

became expressive of social capital pathways which showed greater correlations on psychological well being and community mental health.



The correlation variable pathways are explained in the table below

Variables	r	N	P
Community participation	.74	120	0.001
Neighborliness	.86	120	0.001
Sense of community	.78	120	0.001
Social capital on Psychological well-being and community mental health	.88	120	0.001

**Table 4.3 Correlation of Social capital on psychological well-being and community mental health**

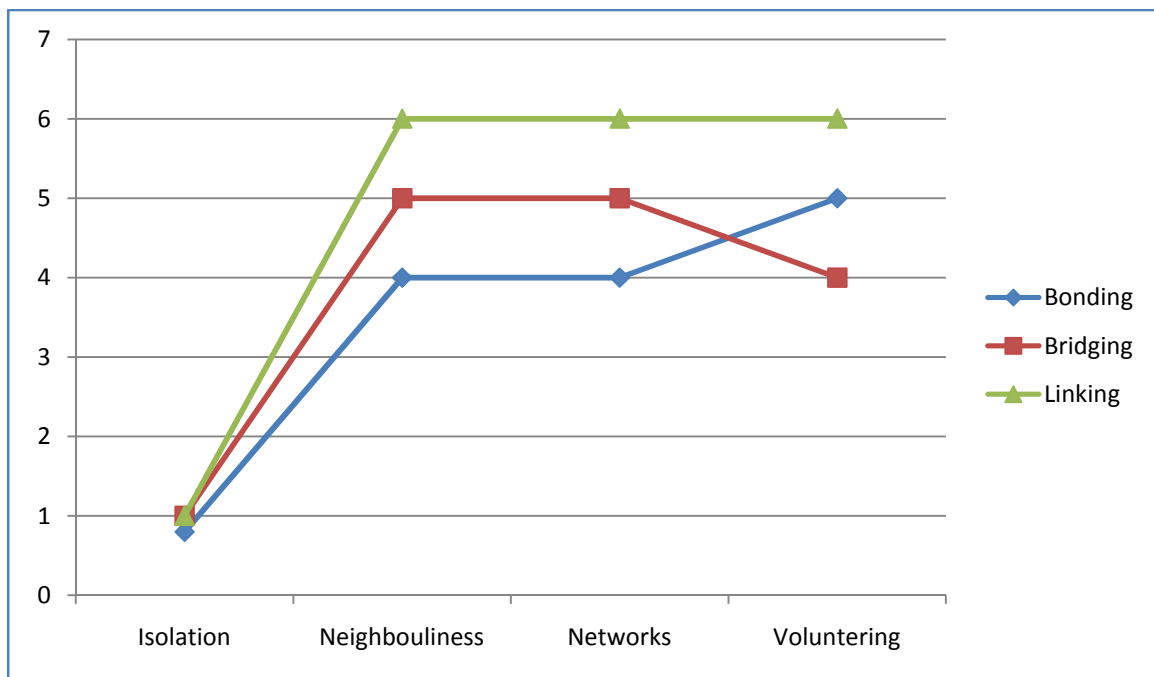
With regard to the above table the correlation coefficient between social capital and psychological well-being (P= 0.001) was positive at 0.88, the positive result was a result of the strong presence of the variables in social capital such as sense of community, social



support and participation these variables strongly influenced participants psychological well being, therefore, this shows that there is a direct relationship between social capital and psychological well-being.

**4.4.2a Hypothesis H<sub>1</sub> Social capital has an effect psychological well-being and community mental health among**

The hypotheses that has been raised in the research was shown to prove that social capital has an effect on psychological well-being and mental health.



**Network density in relation to psychological well being and community mental health**

The graph above illustrates the relation of and effect of how networking or psychological capital impacts on psychological well-being, with all relations from neighbouring networking and volunteering scoring high on psychological well- being.

**4.3 RQ3: Enhancing Social Capital: Strategies for Psychological well being and Community Mental Health**

Participants strongly agreed on the need for strategies or activities that promote psychological well-being and mental health. From the qualitative data collected most respondents related with these activities and strategies to promote psychological well-being and mental health.

**4.3a Social support**

Participants believed that networking had a stronger impact on social support one participant related that;

*“I always feel better when we come and meet as a social support group as this always lifts my spirits on the weekend”*

The participant strongly felt that the network helped them to get by and they always looked towards the coming of the meeting on a weekend. This shows the relation between social capital and community mental health, and the nature of meeting proposed was support group.

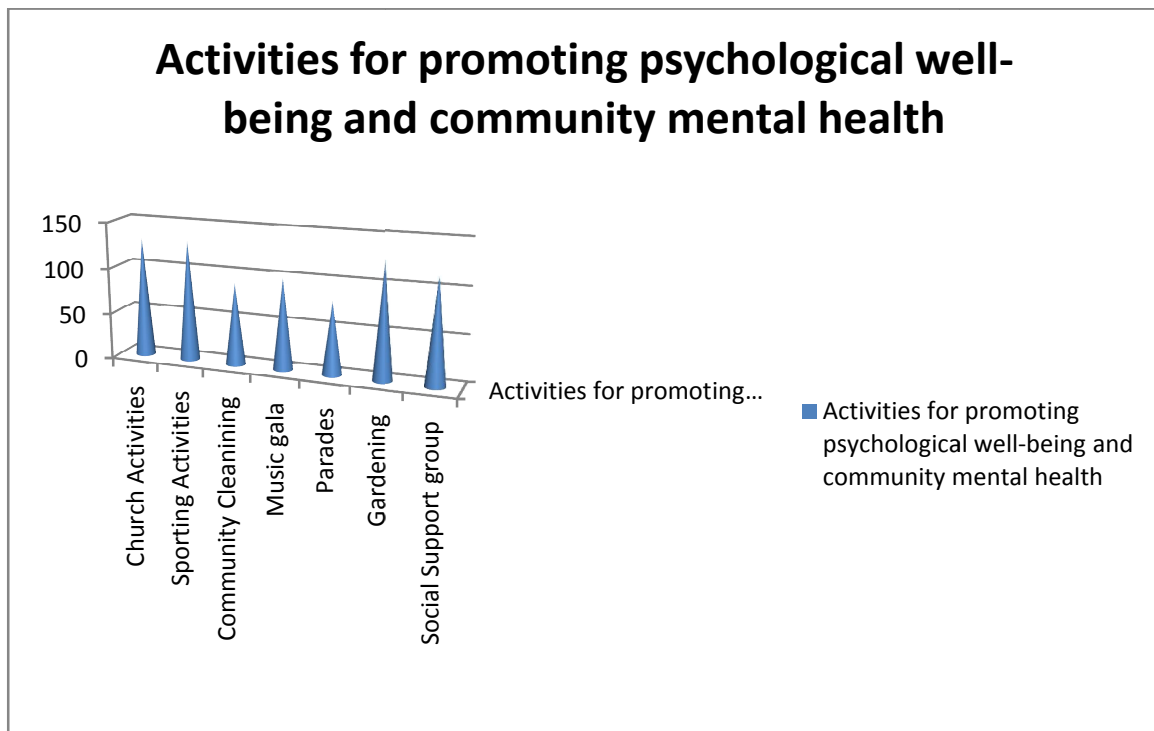
#### **4.3b Communitarianism**

Participants also identified with the concept of Communitarianism as they related with potlucks. One participant said

*Our church potluck activity helps to bring and share anything that we have this helps to share and when you give you feel knowing that you have something that you give.*

So potluck activities proved to be of benefit to the psychological well-being and community mental health.

In the overall the participants seemed to have an understanding on the activities that can be used to promote psychological well-being and community mental health as outlined by the graph below;



Most of the participants related with sporting activities and church activities leading the pack in some of the activities or strategies that can be used to promote psychological well-being and mental health.

#### **4.4 Chapter Summary**

This chapter focused on the results, findings of the research. It sought to quantify and validate the research questions and hypotheses. The results indicated a strong association and correlation from social capital with psychological well being and community mental health. the result indicate the plausibility and the feasibility of promoting mental health across the ecological levels of the community, as the results discussed show that there is a high level of understanding of social capital, that it is associated with quality of life, psychological well-being and community mental health, more so the presentation that the various opportunities and strategies provide for an opportunity to raise psychological well-being and community mental health and for low level psychological interventions.

## **CHAPTER FIVE DISCUSSION, CONCLUSION AND RECOMMEDATIONS**

### **5.1 Introduction**

This final chapter discussed the results reported in chapter four in detail. It presented the results in a generalised manner and made particular reference to how they dovetail to existing theoretically perspective, interpretations and whether they agree with published literature. More so it sought to relate theory to the practical implications as related by the conclusions from the findings, recommendations for future research and suggestions for policy implementation on investing in social capital for psychological well being and community mental health among young adults.

### **5.2 Discussion of results**

The results were discussed in relation to the research questions and hypothesis as the purpose of this study was to ascertain and evaluate how social capital may be utilised to promote, raise awareness on psychological well being and community mental health. The objectives of the study were to assess participants understanding and perceptions of social capital, establish and evaluate strategies to promote psychological well being and community mental health among young adults. The main research question for the study, of how social capital is relevant to psychological well being and community mental health among young adults and the hypothesis used for the study  $H_1$  proposed that social capital has an effect on psychological well being and community mental health among young adults and that there is a significant correlation ( $r = 1$ ).

A mixed methods research design was used the reason being that a meta inference of combined data sets was helpful in the study as it helped to show pathways to associations and activities for enabling social capital to promote psychological well being and community mental health. The construct validity of the Social Capital Cohesion scale (SCCS) was adopted for this study which had Cronbach's internal consistency reliability greater than, or equal to, the minimum research requirement of .70. Furthermore, the inter correlations of the SCCS subscales were ranging between (.74 and .80); family social capital .87, peer social capital .82, neighbourhood social capital .89, community social capital .70 and community belonging .78 and community isolation at .74 all these were at 0.01 significant level. The obtained values suggest that probability of individual item responses on the various subscales on social capital were consistently the same with the total responses.

### 5.2.1 RQ1- Perception and understanding of social capital

RQ1 had suggested and sought to find the level of understanding among the research participants. This was intentional intended to bring participants to the fore of co-creation of knowledge as the researcher did not want to prescribe terms but was keen on participants understanding and perceptions on social capital.

The results in the previous chapter indicated a strong understanding of social capital. In looking at the results shown in the previous chapter it is clear that most of the respondents had knowledge and understanding of the variables of Social capital as prescribed by social capital theories. Aldrich and Meyer (2014), quoted, Louis Hanifan who identified social capital as good will, fellowship, mutual sympathy, and social intercourse among a group of individuals and families who make up a social unit. They further make reference to Bourdieu definition of social capital as the aggregate of the actual or potential resources that are linked to possession of a durable network of more or less institutionalized relationships of mutual acquaintance or recognition. Lin further tied social capital to networks of relationships, defining it as resources embedded in one's social networks, resources that can be accessed or mobilized through ties in the networks (Lin, 2001). In relation to the understanding and perceptions of social capital the results showed a clear indication of the relationship of the variables of social capital across the academic breadth and discourse.

Relatively, the participants used vernacular terms such as *sahwira, shamwari, omakhelwane, umgane*, and the “we” ness is spelled out by most participants was similar to the study carried out by Moloji 2011 in South Africa on an Exploration of Group Dynamics in “Stokvels” and its Implications on the Members’ Mental Health and Psychological Well-Being. From the study names of networks such as *Masisizane* and *Siyazama*, when loosely translated, mean “together, we try to assist and help one another”, proved that stokvels promote the spirit of sisterhood in females and brotherhood among males as embraced in the Zulu idiom, “*Umuntu, ngumuntu ngabantu*”. Overall responses from participants were central to this concept and were in sync with social capital discourse from previous researches as one of four types of capital, along with economic, cultural, and symbolic, that collectively determine social life trajectories focusing on the participation in groups and networks, as they both have individual, collective outcomes and the social structures could be actualised into concrete resources for use by individuals (Coleman, 1998). Therefore in analyzing the results of the research conducted at Mpopoma-Bulawayo, they showed that there was an understanding of

social capital among participants and the implication of this is the understanding of the importance of networks and how they relate psychological well being and community mental health.

### **5.2.2 RQ2- Social Capital, association between psychological well-being and community mental health outcomes**

The current study findings indicated that there is an association between psychological well being and community mental health both negative and positive. The correlation is high and positive this has been shown by the statistical findings that showed that individuals who were high scorers in the survey questionnaire health outcomes. The outcomes of this research are uniform with the findings of Magson (2013) who stated that for mental health outcomes, in general, it can be concluded that the more isolated one feels from their community, the more likely they are to suffer from depression, anxiety, and stress, and the more social capital one has within the family the less likely they are to experience these same symptoms.

In addition Lee, Chung and Park (2016) on their study in South Korea examined the intertwined relationships among three closely related concepts—social networks, social capital, and social support and their role in the well-being of college students. Their research findings found that social support was positively related to both indicators of subjective well-being and sense of belonging. In addition, social capital, offline bonding, was positively associated with social support and well-being measures, suggesting the value of resources that are accessible from face-to-face connections with those in close-knit, embedded relationships. In the current study, among various characteristics of social capital, personal network density had a positive and significant association with perceived social support. Through social connections, people obtain various forms of resources, including emotional and informational support. Results suggest that people who are embedded in a dense network of close connections perceived themselves as receiving more support. When those who surround an individual are connected to one another, such a close circle of connections can provide the feeling of intimacy and belonging and facilitate the exchange of social support (Lee, Chung and Park 2016).

Further analyses by Magson (2013) revealed that higher levels of family and community social capital significantly predict positive health practices, improve life satisfaction, and act as a buffer against inactivity amongst the adolescents and further revealed that in general, social capital was associated with decreased levels of risk-taking behaviours in adolescents.

In contrast, isolation from the community resulted in increased risk taking activities among teenagers. Furthermore, a higher level of social capital was associated with improved living conditions, and greater social capital amongst neighbours resulted in greater participation in community activities. Kawachi and Berkman (2001) further found an association between social ties and mental health is securely established, to the maintenance or improvement of psychological wellbeing.

The above section has demonstrated that a number of interesting findings relating to social capital psychological well being and community mental health. It was shown above and beyond the close proximal relationships among family and peers, the strongest predictor of a psychological well being and community mental health. This association was evident regardless of gender. Additionally, it was found that social capital was a positive predictor of psychological well being and community mental health, therefore from this research study all levels of social capital exerted a positive influence over participants' psychological well being and community mental health.

### **5.2.3 RQ3- Strategies for psychological well being and community mental health**

The results in this investigation presented in Chapter four and show that there are broad and wide initiatives that can be carried out to enhance psychological well being and community mental health. These results are in line with the studies carried out by previous researchers, Kawachi and Berkman (2001) describes several pathways through which participation in social networks can affect psychological well-being. Behaviours such as regular exercise may, in turn, exert a salutary influence on mental health. Integration in a social network may also directly produce positive psychological states, including a sense of purpose, belonging, and security, as well as recognition of self-worth. These positive psychological states, in turn, may benefit mental health because of increased motivation for self-care (e.g., regular exercise, moderation of alcohol intake), as well as the modulation of the neuroendocrine response to stress. Finally, location in the broader social structure (e.g., participation in community organizations, involvement in social networks, and immersion in intimate relationships) enhances the likelihood of accessing various forms of support, which in turn protect against distress. Examples of such resources include access to health-relevant information or receipt of informal health care that could prevent a minor ailment from progressing into a more serious psychiatric disorder. It is also important to recognize that many life events traditionally conceptualized are actually breaks in social ties, for example,

divorce, deaths of loved ones. In coming with interventions the design, duration, timing, and types of social support intervention, such that interventions are aimed to increase levels of perceived emotional support, others to augment informational support or instrumental support (Kawachi and Berkman, 2001). This has been noted by Kawachi and Berkman in Derose and Varda (2009) identified three ways that social capital could affect individual health at the neighbourhood level, namely, by influencing (a) health-related behaviours through more rapid diffusion of health information, which fosters healthy norms of behaviour or exerts social control over deviant behaviour; (b) access to local services and amenities, for example, transportation, community health clinics, and recreational facilities; and (c) psychosocial processes (e.g., providing affective support and acting as the source of self-esteem and mutual respect).

In addition, Magson (2013) in their study drew the different approaches and programs implemented by the schools, the council, and other non-government organisations in order to try and address the challenges evident in these disadvantaged communities. Within the schooling context, curriculum and disciplinary policy were revised to suit the needs of the students whilst providing them with a sense of justice and worth. Staff also encouraged parental participation in the school's social events and parental courses to facilitate social interaction among other community members. Within the community context the council organised community wide events and urged all residents to participate regardless of culture or religion. Other organisations within the community assisted local residents in finding employment, provided help and guidance to neighbourhood youth. Community residents, businesses, and educational institutions offered financial assistance to subsidise educational costs for those in need.

### **5.3 Conclusions**

In understanding the indigenous knowledge of participants allows for the participatory and co creation of knowledge and for the development of sustainable programmes that people relate and to which they identify. The various terminology used by the participants is a clear indication that participatory research is an effective tool to the creation of knowledge.

The findings clearly showed that social capital can exert a positive influence on psychological well being and community mental health. Overall social capital was shown to have the most powerful influence over psychological well being and community mental health.



The activation of social capital is important and key to the use of social capital for positive outcomes. In terms of activation there are various strategies that can be used to ensure that positive psychological well being and community mental health are achieved.

In addressing the treatment gap and understanding that the single pronged approach to psychological well being is not conclusive. Therefore, activating social capital is ideal and using the interventions that are derived from the strategies may be able to improve psychological well and community mental health literacy. More so activating social capital enables a holistic approach to health and well being as it allows for the understanding of social determinants of psychological well being and community mental health. The holistic approach will further allow for increase in mental health literacy, removal of stigma (shame), improve overall quality of life, increase referral pathways as social prescription becomes part of that pathway and acts as a buffer against negative psychological outcomes across the ecological mediating community structures.

#### **5.4 Recommendations**

In accordance with findings in this research the following are recommendations have been made;

- i) Participatory action research should be the core and drive the designing and implementation of intervention programs.
- ii) Community and individual capital should be activated, by allowing awareness raising, and training of gate keepers in the community in psychological well being and community mental health.
- iii) Policies and activities that promote social capital to be increased across all levels in the community and refining the approach to effective intervention. At the same time, research and interventions on social capital must take greater cognizance of networks in the broader social structure.
- iv) Community based approaches, low psychosocial interventions for example, Psychological first aid, and strategies promoting psychological well being, community mental health should be cascaded to all ecological levels in the community

#### **5.5 Chapter Summary**

In summary, the above section has shown that social capital, all levels of social capital and its variables are positively associated with positive psychological well being and community mental health. Its main emphasis was to discuss the research findings from the questionnaires in relation to the relevant literature review. It gives conclusions of the research and meaningful recommendations based on the statistical analysis which found that there is a correlation between social capital psychological well-being and community mental health. Therefore, recommendations and suggestions arising from this research were centred on the research findings to direct intervention strategies and policies to address the limitations of the medical approach to community based approaches to psychological well being and community mental health.

## References

- Cardemil, E.V., Reivich, K.J., & Seligman, M.E.P. (2002). The prevention of depressive symptoms in low-income minority middle school students. *Prevention and Treatment*, 5(1) Article D8.
- D'Angelo, E.J., Llerena-Quinn, R., Shapiro, R., Colon, F., Gallagher, K., and Beardslee, W.R. (2009). Adaptation of the preventive intervention program for depression for use with Latino families. *Family Process*, 48(2), 269-291.
- group dynamics: a critical evaluation of an experiential programme* (pp. 31-38).
- Kawachi, I. & Berkman, L. F. (2001) Social ties and mental health. *Journal of Urban Health*, 78, 458-467.
- Kennedy, B. P., Lochner, K., et al (1997) Social capital, income inequality, and mortality. *American Journal of Public Health*, 87, 1491-1498.
- Kingston, S., Mitchell, R., Florin, P., & Stevenson, J. (1999). Sense of community in neighbourhoods as a multi-level construct. *Journal of Community Psychology*, 27, 681-694.
- Korpela, K.M. (1989). Place-identity as a product of environmental self-regulation. *Journal of Environmental Psychology*, 9, 241-256.
- Leighton, A.H. (1982) *Caring for Mentally Ill People: Psychological and Social Barriers in Historical Context*. New York: Cambridge University Press.
- Lewis, G. & Booth, M. (1994) Are cities bad for your mental health? *Psychological Medicine*, 24, 913-916.
- Lochner, K., Kawachi, I. & Kennedy, B. P. (1999) Social capital: a guide to its measurement. *Health and Place*, 5, 259-270.
- London: Pearson Professional Ltd.
- Long, D.A., & Perkins, D.D. (2003). Confirmatory factor analysis of the Sense of Community Index and development of a Brief SCI. *Journal of Community Psychology*, 31, 279-296.
- Lynch, J.W., Davey Smith, G., Kaplan, G. A., et al (2000) Income inequality and mortality: importance to health of individual income, psychosocial environment, or material conditions. *BMJ*, 320, 1200-1204.
- McMillan, D.W., & Chavis, D.M. (1986). Sense of community: A definition and theory. *Journal of Community Psychology*, 14, 6-23.
- Oxford University Press.
- Perkins, D.D., Brown, B.B., & Taylor, R.B. (1996). The ecology of empowerment: Predicting participation in community organizations. *Journal of Social Issues*, 52, 85-110.

Perkins, D.D., Florin, P., Rich, R.C., Wandersman, A., & Chavis, D.M. ~1990!. Participation and the social and physical environment of residential blocks: Crime and community context.

Peterson, N. A. & Zimmerman, M. (2004). Beyond the Individual: Toward a Nomological Network of Organizational Empowerment. *American Journal of Community Psychology*, vol. 34 (1/2),129:297.

Reber, A. S., & Reber, E. S. (2001). The Penguin dictionary of psychology (3rd ed.).In M. Visser & L. Routledge (Eds), *Substance abuse and psychological well-being of South African adolescents* (pp. 595-615). Brooklyn: University of Pretoria.

Reed, M. T. (1992). Group techniques. In H. Cook, & H. Matheson (Eds), *Teaching*

Ryan, R. M., & Deci, E. L. (2001). On happiness and human potentials: A review of research on hedonic and eudaimonic well-being. In Q. M. Temane, & M. P. Wissing, (Eds), *The role of spirituality as a mediator for psychological well-being across different contexts*. (pp. 582-597). South Africa: Unisa Press.

Schlebusch, L. (2000). *Mind Shift: Stress Management and your Health*. South Africa: University of Natal Press.

Seedat, M., Duncan, N., & Lazarus, S. (2001). *Community Psychology*, Cape Town:

Seedat, M., Mackenzie, S., & Stevens, G. (2004). Trends and redress in community psychology during 10 years of democracy (1994-2003): A journal based perspective.

Seedat, Maton, K. I. (2008). Empowering Community Settings: Agents of Individual Development, Community Betterment, and Positive Social Change. *American Journal of Community Psychology*, 41, 4:21.

*South African Journal of Psychology*, 34, 595-612.



## Appendix A: Quantitative Instrument

### Survey

#### Purpose

The purpose of this survey is to help to find out your thoughts on social capital, psychological well being and community mental health in your community. Your participation in the study is voluntary and you can withdraw from the study at any time. Not participating in the study will not affect your relationship with anyone or any organisation.

This is not a test. There are no right or wrong answers and everybody will have different answers. Just make sure that your answers show what you really understand and think about social capital, your psychological well being and community mental health. I will read the questions aloud to you and explain how to answer each one. This is not a trick. It is just that this type of survey needs to ask questions in slightly different ways. Just answer them in a way that shows what you really understand.

Your answers will only be seen by the researcher and will not be shown to anyone in your community. The researcher will remove the consent form you sign below and store this separately. The researcher will not report the names of participants in the study.

#### ***Before signing this form you should read the attached project information sheet***

- Please read carefully the points made below and follow the instruction given only if you consent to take part in this project.
- I have had the study explained to me and I understand my involvement in it.
- I have read the project information sheet and have discussed the details with the researcher.
- I understand that I can leave the study at any time. I therefore agree to take part in the above study as described in the Project Information Sheet.

#### Participant Consent

#### **Participant Consent Form to Participate in Research Study**

Name.....(Pseudo name accepted)

Age.....

I agree to participate in the study

Signature.....

Date.....

How long have you lived in this community

1-5 years

6-10 years

11-20years

21-30years

More than 30years

#### **People in Your Life**

We would now like to know about the people in your life and type of relationships you have with your friends, family, neighbours and your local community. Please write your answers on the line provided. If there is more than one answer to chose from, please circle the option that most closely indicates your situation. **1**

**Including yourself, how many members in your immediate family?**

**(E.g. your Parents, Brothers & Sisters)**

*Please write here \_\_\_\_\_*

**2**

**Would you have contact with one or more of these immediate family members:**

1 Every Day

2 Weekly

3 Fortnightly

4 Every 3 weeks

5 Monthly

6 Less than monthly

**6**

**Approximately how many of your neighbours do you know:**

1 All of them

2 Most of them

3 Not many of them

4 None of them

**7**

**Would you speak with one or more of these neighbours:**

1 Every Day

2 Weekly

3 Fortnightly

4 Every 3 weeks

5 Monthly

6 Less than monthly

**Section 4 – Social Trust**

In the following section, we would like to know how much trust you have in your family, friends and neighbours, and how willing you are to help each other out if the need arises. The following questions ask how much you agree or disagree with the each of the statements below. Please show your answer by circling the number that best reflects how you feel.

**Disagree**

**Neutral**

**Agree**

**Strongly Agree**

1	I always trust my family	1	2	3	4	5
---	--------------------------	---	---	---	---	---

2	I believe my friends always look out for me	1	2	3	4	5
3	I attend school/community events (school fete, fair)	1	2	3	4	5
4	If I see rubbish in my community I pick it up	1	2	3	4	5
5	I trust my family to look after me	1	2	3	4	5
6	My friends are always happy to help me when I need it	1	2	3	4	5
7	I can ask my neighbours for a favour	1	2	3	4	5
8	People in my school work together	1	2	3	4	5



	to improve the school/co mmunity					
9	My neighbou rs come over and spend time with me	1	2	3	4	5
10	I am always available to help my friends	1	2	3	4	5
11	I believe my neighbou rs would comfort me if I was upset	1	2	3	4	5
12	My neighbou rs are trustwort hy	1	2	3	4	5
13	I like to help my family anyway I can	1	2	3	4	5
14	If I dropped my purse or wallet in my	1	2	3	4	5

	neighbour hood, someone will return it to me with nothing missing						
15	People living outside of my community think it is a nice place to live	1	2	3	4		
	<b>Disagree</b>	<b>Disagree</b>	<b>Neutral</b>	<b>Agree</b>	<b>Strongly Agree</b>		
16	I can trust the police in my area	1	2	3	4	5	
17	Most people in my school are honest	1	2	3	4	5	
18	My neighbour s could depend on me if they are in trouble	1	2	3	4	5	
19	I can depend on my family	1	2	3	4	5	

	when I am upset					
20	When a family member is sick, I always try to help out	1	2	3	4	5
21	I trust my family to do what is best for me	1	2	3	4	5
22	My family always try to help me	1	2	3	4	5
23	I do things to help my local community	1	2	3	4	5
24	I comfort my family members when they are upset	1	2	3	4	5
25	I believe my neighbours always look out for me	1	2	3	4	5

26	When I am sick, my family helps me out	1	2	3	4	5
27	I am always happy to help my family	1	2	3	4	5
28	I trust my school to do what is best for me	1	2	3	4	5
29	People who live elsewhere think it would be nice to live in my community	1	2	3	4	5
30	I trust my friends to stand by me	1	2	3	4	5
31	The other students at my school are trustworthy	1	2	3	4	5
32	If my neighbours are	1	2	3	4	5

		1	2	3	4	5
Disagree		<b>Disagree</b>	<b>Neutral</b>	<b>Agree</b>		<b>Strongly Agree</b>
33	sick , I am happy to help them out I believe my family will always be there for me					
34	My neighbourhood has a good reputation					
35	I trust my neighbours enough to tell them my private thoughts					
36	My friends can depend on me when they are upset					
37	When me or a family member is sick, my					

	neighbour s help out					
38	I trust my friends with my secrets	1	2	3	4	5
39	I depend on my friends when I am upset	1	2	3	4	5
40	I can tell my family anything	1	2	3	4	5
41	I trust the teachers at my school	1	2	3	4	5
42	I support my friends whenever they need it	1	2	3	4	5
43	I can tell my best friend anything	1	2	3	4	5
44	My neighbour s would help us in an emergenc y	1	2	3	4	5
45	I feel most	1	2	3	4	5

people in  
my  
communi  
ty can be  
trusted



## Appendix C- Semi Structured Interview Schedules

1. Tell me about what it is like living in your community?
2. Tell me about what kind of people live in your community?
3. What are the things you like best about your community?
  - a. What do you like about the street/neighbourhood that you live in?
4. What would you like to see change in your community?
  - a. Is there anything that can be done about it?
  - b. If we were going to make this community better, what might we do?
5. Can you think of anything that has worked really well in this community (prompt for projects, community activities etc)
6. What are the challenges in this community?
  - a. Are there any local services that try to address these challenges? How do they do it?
7. How would you describe the trust between people living in this community?
8. How would you describe the levels of support amongst people living in this community?

### People

9. Tell me about the most important person in your life.
  - a. How often do you see/speak to them?
  - b. What kinds of things do you do together?
  - c. How do they help/support you?

d. How do you feel when you are with them?

### Change

10. Can you think of a time when you have done something in your *school* to change things?

11. Can you think of a time when you have done something in your *community* to change things?

### School

12. Tell me about this school.

a. What is it like to go here / teach here?

b. What are the people like?

13. What are the things you like best about this school?

14. What are the challenges that this school faces?

15. What would you like to see change about this school?





**Midlands State University**  
Established 2000

*Our Hands, Our Minds, Our Destiny*

## **Appendix D: Participant Information Sheet**

Faculty of Social Sciences,  
Department of Psychology,  
P. Bag 9055 Senga,  
Gweru, Zimbabwe.

Dear Participant

### **Research Project:**

### **Exploring social capital, an investment to psychological well-being and community mental health among young adults in Mpopoma- Bulawayo**

We invite you to take part in a community research project that is being conducted by;

Name: Sibanda Theresi  
Student Number: R123660Z  
Contact Number: 0778758491  
Email: [santinho.sibanda@gmail.com](mailto:santinho.sibanda@gmail.com)  
Academic Supervisor: Prof P Mudhovozi

Who is a Master's of Science Community Psychology student at Midlands State University. This is an academic research. The purpose of the research is to explore how social relations and networks may play a positive role in building positive psychological well-being and community mental health drawing from existing community networks. This is of particular interest as there is a wide treatment gap in Mental Health and lack of Community based interventions that can be used to promote positive well-being and increase quality of life in the communities.

Your participation involves completing a survey at school that takes about 45 minutes. The survey asks questions about a range of things including, the needs of the community, health, self-concept, and friendships and networks. Some selected participants will also be asked to discuss their answers in a 30 minute semi structured interview with the researcher that will be recorded. Participation in this study is voluntary. There will be no adverse consequences if you do not wish to participate and you can withdraw from the study at any time. Information provided in this study by individuals will not be given to others. Any results that are reported in research reports will be presented in group form, without identifying individuals. The data will be kept in a safe file, accessible only to the researchers in this study although the data may be further analysed by research supervisors.

The research has been approved by the Department of Psychology and the Bulawayo City Council.

We do hope you are interested in participating in this academic project.

Sincerely,

Sibanda Theresi (R123660Z)

**NOTE:** If you have any complaints or reservations about the ethical conduct of this research, you may contact the Midlands State University- Psychology Department. Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.

*Our hands*

*Our minds*

*Our destiny*

MEMORANDUM OF AGREEMENT FOR RESEARCH STUDENTS

MEMORANDUM OF AGREEMENT made between the City of Bulawayo (hereinafter referred to as Council) of the one part and Mr/Ms/Mrs SIBANDA THERESA (Full names)

ID Number 08-736654 MB hereinafter referred to as "researcher" of the other part.

Student Number R123660Z

Contact Address 54-1694 P.O. MPOBOMA BULAWAYO

Telephone/Mobile number 09-404185 0778758491

Name of Educational Institution MIDLANDS STATE UNIVERSITY

Faculty SOCIAL SCIENCES

Department PSYCHOLOGY

Date of Submission for the Executive Summary Copy

This agreement witness that:

1. The Researcher agrees not to divulge any information which he/she gains as a result of his/her research at Council department/s.
2. The Researcher agrees to indemnify the Council against any injury that may occur to her/him during the Course of the research with the Council.
3. The Researcher will submit a copy of his/her research findings, including the executive summary upon completion of the project to the Council.
4. The Researcher agrees that all costs relating to the research project will be met by him/her and Council has no obligation in this regard.

Signed by the researcher this 24 day of FEBRUARY 2017

As witness

1. [Signature]

2. \_\_\_\_\_

[Signature]

Researcher

Signed on behalf of Council this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_

1. \_\_\_\_\_

2. \_\_\_\_\_

Council official

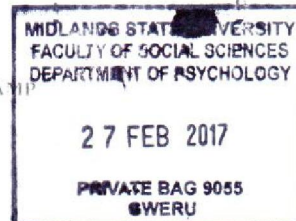
Educational institution

- ❖ The Education institution Agrees without failure that their students submit a copy of the executive summary of their research findings to Council upon completion of their research study.

Signed on behalf of the institution

[Signature]

SCHOOL STAMP





**FACULTY OF SOCIAL SCIENCES: DEPARTMENT OF PSYCHOLOGY**

**SUPERVISOR- STUDENT AUDIT SHEET**

<b>DATE</b>	<b>TOPIC DISCUSSED</b>	<b>COMMENT</b>	<b>STUDENT'S SIGNATURE</b>	<b>SUPERVISOR'S SIGNATURE</b>
08 May 2017	Research Proposal	Rework		
15 May 2017	Research Proposal	Proceed		
22 May 2017	Chapter 1	Rework		
30 May	Chapter 1	Proceed		
12 June 2017	Chapter 2	Rework		
30 June 2017	Chapter 2	Proceed		
10 July 2017	Chapter 3	Rework		
25 July 2017	Chapter 3	Proceed		
11 August 2017	Chapter 4	Rework		
21 August 2017	Chapter 4	Proceed		
12 September 2017	Chapter 5	Rework		
18 September 2017	Chapter 5	Proceed		
01 October 2017	First Draft	Proceed		
07 October 2017	Second Draft	Proceed		
13 October 2017	Final Draft	Submission to department		

STUDENT'S SIGNATURE .....

SUPERVISOR'S SIGNATURE .....