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ΔΙΔΑΚΤΟΡΙΚΗ ΔΙΑΤΡΙΒΗ

Κοινωνικό κεφάλαιο και συμπεριφορές υγείας σε μαθητές της Α' Λυκείου της Δευτεροβάθμιας Εκπαίδευσης του Ν. Ηρακλείου. Ο παρεμβατικός ρόλος της Κοινωνικής Εργασίας με κοινότητα.

ΚΛΕΙΩ ΚΟΥΤΡΑ

MPH, ΚΟΙΝΩΝΙΚΗ ΛΕΙΤΟΥΡΓΟΣ

Τριμελής Συμβουλευτική Επιτροπή:

1. Α. Φιλαλήθης, Καθηγητής, Τομέα Κοινωνικής Ιατρικής, Τμήμα Ιατρικής, Παν. Κρήτης, Ηράκλειο.
2. Α. Κοκκέβη, Ομότιμη Καθηγήτρια, Ψυχιατρικής, Ιατρική Σχολή Αθηνών
3. Μ. Κούση, Καθηγήτρια, Κοινωνιολογίας, Πανεπιστήμιο Κρήτης, Ρέθυμνο.

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3η ΜΕΛΗΣ ΣΥΜΒΟΥΛΕΥΤΙΚΗ ΕΠΙΤΡΟΠΗ:

1. Α. Φιλαλήθης, Καθηγητής, Τομέα Κοινωνικής Ιατρικής, Τμήμα Ιατρικής, Παν. Κρήτης, Ηράκλειο.
2. Α. Κοκκέβη, Ομότιμη Καθηγήτρια, Ψυχιατρικής, Ιατρική Σχολή Αθηνών
3. Μ. Κούση, Καθηγήτρια, Κοινωνιολογίας, Πανεπιστήμιο Κρήτης, Ρέθυμνο

7ης ΜΕΛΗΣ ΕΞΕΤΑΣΤΙΚΗ ΕΠΙΤΡΟΠΗ:

1. Α. Φιλαλήθης, Καθηγητής, Τομέα Κοινωνικής Ιατρικής, Τμήμα Ιατρικής, Ηράκλειο, Παν. Κρήτης

2. Α. Κοκκέβη, Ομότιμη Καθηγήτρια Ψυχιατρικής, Ιατρική Σχολή Αθηνών

3. Μ. Κούση, Καθηγήτρια, Κοινωνιολογίας, Πανεπιστήμιο Κρήτης, Ρέθυμνο.

4. Μ. Κογεβίνας, Καθηγητής, Ιατρική Σχολή, Πανεπιστήμιο Κρήτης.

5. E. Kokaliari, Associate Professor, School of Social Work, Springfield College

6. Π. Μπίτσιος, Επίκουρος Καθηγητής Ψυχιατρικής, Ηράκλειο, Παν. Κρήτης.

7. Χ. Παναγιωτόπουλος, Αναπληρωτής Καθηγητής, School of Humanities, Social Sciences and Law, Nicosia University.

στο αγόρι της βροχής

& στις σταγόνες της ζωής μας

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Ευχαριστίες

Φθάνοντας σήμερα στο να γράφω τη σελίδα αυτή συνειδητοποιώ πόσο προικισμένη είμαι από κοινωνικό κεφάλαιο. Αυτό για μένα μεταφράζεται σε μοίρασμα, υποστήριξη, ενδιαφέρον, συνεργασία, εμπιστοσύνη, συμμετοχή, νοίαξιμο που ξεκινά από την πατρική μου οικογένεια, τη μητέρα, τη γιαγιά μου και τα αδέλφια μου Μίλτο και Χρήστο, επεκτείνεται σε αυτή που δημιούργησα με το Βασίλη και τα παιδιά μου αλλά και στους φίλους μου (*το δικό μου bonding social capital*). Αυτό συνεχίζει στους δασκάλους, στους πολύτιμους φοιτητές μου, στους αγαπημένους συνεργάτες μου (*το δικό μου bridging social capital*), οι οποίοι μου δίνουν τεράστια δύναμη και πλούτο μέσα από συζητήσεις, δράσεις, παρεμβάσεις, αντιστάσεις, εμπόδια αλλά και οράματα για όλα αυτά που παλεύουμε στις κοινότητες που συνεργαζόμαστε.

Ένα ιδιαίτερο ευχαριστώ οφείλω στον καθηγητή μου κ. Α. Φιλαλήθη που ήταν πάντα με τόση απλότητα κάτι παραπάνω από δάσκαλός και οδηγός. Ήταν ο άνθρωπος που μου έδωσε την ευκαιρία να κάνω αυτό το ταξίδι. Ήταν πάντα κοντά μου. Με ειλικρινές ενδιαφέρον υποστήριζε και ενθάρρυνε κάθε βήμα μου. Εξαιρετική ήταν η συμβολή, η συνεισφορά σε γνώσεις αλλά και σε εμπιστοσύνη των καθηγητριών κα Α. Κοκκέβη και κα Μ. Κούση που συμμετείχαν στην τριμελή συμβουλευτική μου επιτροπή.

Λίγο πριν κλείσει ο κύκλος της διατριβής μου, ο δρόμος μου συναντήθηκε με αυτόν της συνάδελφου, κας Ε. Κοκαλιάρη. Πραγματικά, η υποστήριξη της στην δουλειά μου, το νοίαξιμο της για τον άνθρωπο που έχει απέναντι αλλά κυρίως η απλότητα και η σεμνότητα της είναι μοναδικά χαρακτηριστικά ενός μοναδικού συναδέλφου και συνεργάτη.

Στο δύσκολο δρόμο της ανάλυσης πολλοί ήρθαν, άλλαξαν αλλά όλοι με υποστήριξαν με τις πολύτιμες γνώσεις τους. Ευχαριστώ ιδιαίτερα την κα Θ. Ρουμελιωτάκη με την οποία ξεκινήσαμε το στήσιμο της μελέτης και αφιερώσαμε πολλές ώρες προκειμένου σήμερα να έχουμε πληθώρα δεδομένων. Τον κ. Φ. Ορφανό που ήρθε και έδωσε σε κρίσιμες στιγμές τις γνώσεις του με νοίαξιμο και ενδιαφέρον ενός καλού φίλου, τον κ. Μ. Λιναρδάκη που αν και οι δρόμοι μας συναντήθηκαν αρκετά μετά, πραγματικά δεν έχω λόγια για τη συνέπεια, τη λεπτομέρεια και την αφιέρωση του στην δουλειά.

Ευγνωμοσύνη, χαρά, περηφάνια αλλά και υποχρέωση νοιώθω για το «Κέντρο Εκπαίδευσης Κοινοτικής Ανάπτυξης Τυλίσου» του τμήματος Κοινωνικής Εργασίας του Τ.Ε.Ι. Κρήτης. Νοιώθω ότι αυτά τα 15 χρόνια μεγάλωσα μαζί του, ωρίμασα, σμιλεύτηκα, εκπαιδεύτηκα αλλά και εκπαίδευσα πολλούς άλλους. Αυτό το ταξίδι το οφείλω στην καθηγήτρια μου κα Χ. Γιουλούντα, δασκάλα προς μίμηση, πνευματική μητέρα. Ο προσανατολισμός μου προς την κοινότητα και την προαγωγή υγείας ήταν δικά της σποράκια και για αυτά πάντα θα την ευγνωμονώ. Εδώ θα ήταν αδύνατον να μην αναφερθώ και στην κα Ν. Ράτσικα, που πάντα είναι κοντά μου με νοίαξιμο και ενδιαφέρον, με καλοσύνη και θετική ενέργεια. Οι φοιτητές και οι συνεργάτες μου αποτελέσαν και αποτελούν τον μοχλό για να συνεχίσω να αναζητώ οράματα και προοπτικές.

Ο άνθρωπος που με υποστήριζε στις δυσκολίες του διδακτορικού ήταν ο συνάδελφος, συνοδοιπόρος, φίλος Γ. Κριτσωτάκης. Θεωρώ ότι είναι «*ένα βήμα μπροστά*», ανοίγει δρόμο και ορίζοντες, είναι συμπληρωματικός σε εμένα και ελπίζω και εγώ σε αυτόν. Ας προσπαθήσουμε να έχουμε πολλά χρόνια δουλειάς παρέα. Οι φίλοι που με βοήθησαν ήταν η Λίνα, η Ιωάννα, η Χρυσούλα. Όλες μοναδικές, η κάθε μια για άλλους λόγους. Ένα ιδιαίτερο ευχαριστώ οφείλω στην μικρή μου, «*Λίνα σε ευχαριστώ που πάντα είσαι εκεί να με συμβουλεύεις, και κυρίως να με ακούς στα δύσκολα, να δίνεις λύσεις και υποστήριξη με όλη σου την ψυχή*». Πραγματικά σας ευχαριστώ όλους για τη συνεργασία, την υποστήριξη, την παρέα και τις αναζητήσεις…...

Με την όλη μου την ψυχή ευχαριστώ την οικογένεια μου, τον άντρα μου Βασίλη και τα παιδιά μου Χριστίνα & Νικόλα. Αυτοί είναι το λιμάνι μου, η ασφάλεια μου, το ορμητήριο μου και χωρίς αυτούς δεν θα μπορούσα τίποτα να καταφέρω. Είναι εκεί με ζεστασιά, κατανόηση και υπομονή για τις ώρες που είμαι κλεισμένη στο κουτί του υπολογιστή δουλεύοντας.

Αλλά όλα όσα εγώ σήμερα είμαι, απολαμβάνω, χαίρομαι, διεκδικώ, αναζητώ, ελπίζω ……τα οφείλω μόνο σε ένα άνθρωπο, στη μητέρα μου….

Μαρικάκι, σε ευχαριστώ που δεν με εμπόδισες να γίνω αυτό που είμαι!!

ΠΑΝΕΠΙΣΤΗΜΙΟ ΚΡΗΤΗΣ - ΤΜΗΜΑ ΙΑΤΡΙΚΗΣ

Πρόγραμμα Μεταπτυχιακών Σπουδών

ΔΗΜΟΣΙΑ ΥΓΕΙΑ & ΔΙΟΙΚΗΣΗ ΥΠΗΡΕΣΙΩΝ ΥΓΕΙΑΣ

Περίληψη Διδακτορικής Διατριβής

Τίτλος Εργασίας: Κοινωνικό κεφάλαιο και συμπεριφορές υγείας σε μαθητές της Α΄ Λυκείου της Δευτεροβάθμιας Εκπαίδευσης του Ν. Ηρακλείου. Ο παρεμβατικός ρόλος της Κοινωνικής Εργασίας με κοινότητα.

του/της: Κούτρας Κλειούς

Υπό την επίβλεψη του/των: Α. Φιλαλήθης
Α. Κοκκέβη
Μ. Κούση

Ημερομηνία: 30-06-2014

Εισαγωγή

Το κοινωνικό κεφάλαιο αποτελεί την πιο πρόσφατη προσθήκη στη λίστα σε μια σειρά κοινωνικών περιβαλλοντολογικών διαστάσεων που επηρεάζουν τις συμπεριφορές υγείας (Nieminen et al., 2013; Wakefield & Poland, 2005; Kritsotakis & Gamarnikow, 2004). Παρόλα αυτά, ενώ η ανασκόπηση της βιβλιογραφίας αναδεικνύει την επίδραση που φαίνεται να έχει το κοινωνικό κεφάλαιο στην υγεία των νέων, οι μηχανισμοί και οι δεσμοί που αυτό επιδρά είναι ακόμη ασαφείς.

Η επίδραση του κοινωνικού κεφαλαίου ιδιαίτερα στις συμπεριφορές υγείας των νέων είναι σημαντική στην κατανόηση και ανάλυση του πλαισίου μέσα στο οποίο αυτές λαμβάνουν χώρα (που, πότε, όταν, και με ποιον (Morrow, 1999). Το κοινωνικό κεφάλαιο μέσα από τις δυο διαστάσεις του, τη δομική και τη γνωστική μπορεί να αποδώσει το τι είναι αυτό που οι νέοι «κάνουν» (structural social capital) και το τι είναι αυτό που οι νέοι

«αισθάνονται» (cognitive social capital) (Islam, Merlo, Kawachi, Lindstrom, & Gerdtham, 2006). Αυτές, οι διαστάσεις θα πρέπει να λαμβάνουν υπόψην τους ποιο είναι το πολιτισμικό, κοινωνικό, οικονομικό, και πολιτικό πλαίσιο ώστε να μπορούν να τεκμηριώσουν, ποιες είναι οι διαδικασίες, που είτε περιορίζουν, είτε επιτρέπουν την εκδήλωση θετικών ή αρνητικών συμπεριφορών υγείας στους νέους. Το κοινωνικό κεφάλαιο οφείλει να ενταχθεί στην πρακτική εφαρμογή της κοινωνικής εργασίας μιας και από την επιστημολογία της βασίζεται σε στοιχεία κοινωνικού κεφαλαίου (Loeffler et al., 2004). Είναι μέγιστης σημασίας, οι κοινωνικοί λειτουργοί να προάγουν και να αναδομήσουν το κοινωνικό κεφάλαιο ως έναν από τους κοινωνικούς προσδιοριστές της υγείας (Coren, Iredale, Bywaters, Rutter, & Robinson, 2010) στις κοινότητες που παρεμβαίνουν, προτείνοντας παρεμβάσεις που θα βελτιώνουν τις συνθήκες διαβίωσης και υγείας των κοινοτήτων τους.

Σκοπός & στόχοι

Ο σκοπός της εν λόγω διατριβής είναι να διερευνήσει τη σχέση του κοινωνικού κεφαλαίου στις συμπεριφορές υγείας των μαθητών της Α΄ Λυκείου στο Νομό Ηρακλείου και να συνεισφέρει στο ρόλο που μπορεί να έχει το κοινωνικό κεφάλαιο στην προαγωγή υγείας από τη σκοπιά της Κοινωνικής Εργασίας.

Πιο συγκεκριμένα, η διατριβή στοχεύει (1) στην ψυχομετρική στάθμιση της κλίμακας του κοινωνικού κεφαλαίου των νέων στην Ελλάδα, (2) στη διεύρυνση του ρόλου που διαδραματίζει το φύλο των μαθητών στην επιρροή του κοινωνικού κεφαλαίου στην κατανάλωση αλκοόλ, (3) στη διερεύνηση της επίδρασης του κοινωνικού και οικονομικού κεφαλαίου στην κατανάλωση καπνού και άλλων προσδιοριστών της υγείας των μαθητών, (4) στο ρόλο που το κοινωνικό κεφάλαιο μπορεί να διαδραματίσει στην προαγωγή υγείας μέσα από τις παρεμβάσεις της κοινωνικής εργασίας με κοινότητα.

Μεθοδολογία

Η μεθοδολογική προσέγγιση είναι συγχρονική επιτόπια, δειγματοληπτική έρευνα (cross-sectional). Η μέθοδος συλλογής των δεδομένων είναι η στρωματοποιημένη τυχαία δειγματοληψία. Το δειγματοληπτικό πλαίσιο αποτελεί η λίστα με το σύνολο των σχολικών μονάδων της Δευτεροβάθμιας Εκπαίδευσης του Ν. Ηρακλείου (28 μονάδες).

Ο πληθυσμός αναφοράς υπολογίστηκε συνολικά σε 2.854 μαθητές. Αυτός διαρθρώνεται σε α) αγροτικό στρώμα με 9 σχολικές μονάδες και 268 μαθητές, β) αστικό με 18 σχολικές μονάδες και 1.921 μαθητές, και γ) ημιαστικό με 14 σχολικές μονάδες και 665 μαθητές.

Η συλλογή των δεδομένων πραγματοποιήθηκε σε δύο φάσεις από τον Απρίλιο έως τον Ιούνιο του 2008. Στην πρώτη φάση έγινε η πιλοτική εφαρμογή του εργαλείου (*Youth Social Capital Scale*) προκειμένου να διασφαλιστεί η αξιοπιστία των μετρήσεων. Αυτή η φάση πραγματοποιήθηκε εκτός του κυρίου δείγματος και συγκεκριμένα σε σχολεία που ανήκουν στο ημιαστικό στρώμα (Koutra et al., 2012a). Από αυτά επιλέγη τυχαία μια σχολική μονάδα (κωδ. 1753010), όπου στο σύνολο των τμημάτων της επαναλήφθηκε η μέτρηση με την πάροδο μιας εβδομάδας προκειμένου να διασφαλιστεί η αξιοπιστία του ερωτηματολογίου (test-retest reliability) (Erevnidou, Launois, Katsamouris, & Lionis, 2004).

Κατόπιν των απαραίτητων βελτιώσεων στη Youth Social Capital Scale (*YSCS*) ακολούθησε η δεύτερη φάση. Αυτή αφορούσε στη συλλογή των δεδομένων από το κύριο δείγμα της μελέτης. Από το αγροτικό στρώμα λόγω του μικρού σχετικά αριθμού των μαθητών εισήχθησαν το σύνολο των 9 σχολικών μονάδων με 268 μαθητές, ενώ από το αστικό στρώμα εισήχθησαν κατόπιν κλήρωσης 4 σχολικές μονάδες με 409 μαθητές.

Εργαλεία μέτρησης

Το αυτοσυμπληρούμενο ερωτηματολόγιο με το οποίο συλλέχθησαν τα δεδομένα αποτελεί σύνθεση των Youth Social Capital Scale (YSCS) και Health Behaviour in School-aged Children (HBSC). Άδεια για την χρήση των εργαλείων δόθηκε από τους κατασκευαστές τους κατόπιν σχετικού αιτήματος. Επίσης άδεια συλλογής από τις σχολικές μονάδες δόθηκε κατόπιν σχετικής αίτησης από το Παιδαγωγικό Ινστιτούτο του Υπουργείου Παιδείας (απόφαση: 20946/G2/20-2-2008).

Αποτελέσματα

Ψυχομετρική στάθμιση

Σχετικά με την ψυχομετρική στάθμιση που διαπραγματεύτηκε αυτή διατριβή στο πρώτο άρθρο μετρήθηκε, τόσο η εσωτερική συνοχή και κατασκευή, όσο και οι δοκιμές για συγκλίνουσα και διακρίνουσα εγκυρότητα. Η παραγοντική ανάλυση απέδωσε πέντε

παράγοντες στην κλίμακα του κοινωνικού κεφαλαίου (YSCS). Ο συνολικός Cronbach της κλίμακας κρίθηκε ικανοποιητικός (α=.771). Η παραγοντική ανάλυση έδειξε κοινά πρότυπα για πολλά ζητήματα μεταξύ της ελληνικής και της αρχικής αυστραλιανής κλίμακας (Koutra et al., 2012a).

Κατανάλωση αλκοόλ

Στο δεύτερο άρθρο της διατριβής, η κατανάλωση αλκοόλ φαίνεται αυξημένη σε κάποιους δομικούς παράγοντες του κοινωνικού κεφαλαίου. Η ανάλυση τεκμηρίωσε ότι αυτοί σχετίζονται, με αύξηση ανά μονάδα, της πιθανότητας τακτικής κατανάλωσης αλκοόλ. Ο παράγοντας «Γειτονικά δίκτυα» του κοινωνικού κεφαλαίου συσχετίστηκε θετικά με την τακτική κατανάλωση αλκοόλ στα κορίτσια του δείγματος. Αντίθετα, οι γνωστικοί παράγοντες του κοινωνικού κεφαλαίου «Ανοχή στη διαφορετικότητα» και «Αίσθημα εμπιστοσύνης και ασφάλειας» συσχετίσθηκαν με μειωμένη πιθανότητα μέθης στα κορίτσια. Το συνολικό σκορ του κοινωνικού κεφαλαίου συσχετίστηκε θετικά με την πιθανότητα της τακτικής κατανάλωσης αλκοόλ, αλλά όχι με την πιθανότητα μέθης και για τα αγόρια και για τα κορίτσια.

Κατανάλωση καπνού

Στο τρίτο άρθρο της διατριβής, το κοινωνικό και οικονομικό κεφάλαιο δε διαφοροποιήθηκαν από το φύλο του δείγματος. Αυξημένος διαπιστώθηκε μόνο ο παράγοντας του κοινωνικού κεφαλαίου «Συμμετοχή στην κοινότητα» για τα αγόρια. Οι μαθητές που αναφέρουν κακή αυτοαναφερόμενη οικονομική κατάσταση έχουν 4.71 μεγαλύτερη πιθανότητα για μειωμένη ικανοποίηση από τη ζωή (95%CI:3.00, 7.40) και 2.72 μεγαλύτερη πιθανότητα για κακή υγεία (95%CI:1.58, 4.71). Αντίθετα, δεν βρέθηκαν σημαντικές συσχετίσεις με το επίπεδο απασχόλησης των γονιών των μαθητών και το κάπνισμα και άλλων κοινωνικών προσδιοριστών της υγείας του δείγματος.

Οι μαθητές με χαμηλό επίπεδο δομικού κοινωνικού κεφαλαίου («Συμμετοχή στην κοινότητα») έχουν 0.45 μικρότερη πιθανότητα για καθημερινό κάπνισμα (95%CI:0.32, 0.95) αλλά 2.49 μεγαλύτερη πιθανότητα για κακή υγεία (95%CI:1.58, 4.71). Αντίθετα, οι μαθητές με χαμηλό γνωστικό κοινωνικό κεφάλαιο («Αισθήματα εμπιστοσύνης και ασφάλειας») έχουν μεγαλύτερη πιθανότητα για καθημερινό κάπνισμα (2.95; 95%CI:1.47, 6.04) και κακή υγεία (4.22; 95%CI:2.08, 8.56). Δεν βρέθηκε σημαντική διαφορά μεταξύ της συχνότητας

καπνίσματος και του επίπεδου κοινωνικού κεφαλαίου (21.1% versus 24.3%, αντίστοιχα $p>0.05$). Ωστόσο, σημαντικά περισσότεροι ήταν οι μαθητές με χαμηλό κοινωνικό κεφάλαιο (19.6% versus 9.6%, αντίστοιχα, $p<0.05$) και κακή υγεία (16.5% versus 6.2%, αντίστοιχα, $p<0.05$) που αναφέρουν μειωμένη ικανοποίηση από τη ζωή.

Κοινωνικό κεφάλαιο, προαγωγή υγείας και κοινωνική εργασία με κοινότητα

Αυτό το άρθρο συζητά για τα κοινά στοιχεία που μοιράζεται η μέθοδος της Κοινωνικής Εργασίας με Κοινότητα (Κ.Ε.Κ.) με το κοινωνικό κεφάλαιο και την προαγωγή υγείας. Το τέταρτο και τελευταίο άρθρο της διατριβής διαπραγματεύεται τα κοινά στοιχεία που μοιράζεται η μέθοδος της Κοινωνικής Εργασίας με Κοινότητα (Κ.Ε.Κ.) με το κοινωνικό κεφάλαιο και την προαγωγή υγείας, ώστε οι κοινωνικοί λειτουργοί να βελτιώσουν και να αναπτύξουν την πρακτική του επαγγέλματος στις κοινότητες.

Αυτό το άρθρο αποδίδει το δυναμικό ρόλο που η Κ.Ε.Κ. μπορεί να διαδραματίσει μέσα από τη στρατηγική της κοινοτικής ανάπτυξης στο κοινωνικό κεφάλαιο και στην προαγωγή υγείας. Οι κοινότητες με επιτυχή ανάπτυξη είναι πιο πιθανόν να βιώσουν συλλογικές δράσεις. Αυτές οι κοινότητες ενδέχεται να είναι περισσότερο αλληλέγγυες, υγιής, ασφαλείς και συνεργατικές. Επομένως, οι κοινωνικοί λειτουργοί προκειμένου να οδηγήσουν τις κοινότητες σε συλλογική επίλυση των όποιων δυσκολιών αντιμετωπίζουν, θα πρέπει να διερευνήσουν ποιοι είναι οι μηχανισμοί που παρέχουν κίνητρα για δράση και ποιοι είναι παράγοντες αλλά και τα εμπόδια που συνεισφέρουν ή όχι στην ανάπτυξη συλλογικών δράσεων στις κοινότητες.

Συμπεράσματα

Το κοινωνικό κεφάλαιο αποτελεί ένα σημαντικό κοινωνικό προσδιοριστή της υγείας των μαθητών. Τα αποτελέσματα της διατριβής ανέδειξαν ότι το γνωστικό και δομικό κοινωνικό κεφάλαιο φαίνεται να έχουν διαφορετικού τύπου συσχέτιση με τη συχνή κατανάλωση αλκοόλ και την ευκαιριακή μέθη, σε αγόρια και κορίτσια. Παρόμοια, το χαμηλό δομικό κοινωνικό κεφάλαιο φαίνεται να σχετίζεται προστατευτικά στην καθημερινή κατανάλωση καπνού ενώ το γνωστικό κοινωνικό κεφάλαιο, όχι.

Οι μηχανισμοί βελτίωσης του κοινωνικού κεφαλαίου των μαθητών και πως αυτοί επηρεάζουν τις συμπεριφορές υγείας τους, απαιτεί προσεκτική και λεπτομερή ανάλυση καθώς οι διαστάσεις και οι παράγοντες αυτού έχουν τόσο θετικές, όσο και αρνητικές

επιπτώσεις στην υγεία. Αυτή η τεκμηρίωση θα δώσει στους κοινωνικούς λειτουργούς σαφή εικόνα και γνώση για το ποιες στρατηγικές αλλά και βασικά στοιχεία παρέμβασης του κοινωνικού κεφαλαίου και της προαγωγή υγείας, αλληλεπιδρούν θετικά ώστε να είναι σε θέση να σχεδιάσουν και να τρέξουν παρεμβάσεις που να μεγιστοποιήσουν το κοινωνικό κεφάλαιο, προάγοντας άμεσα ή έμμεσα την υγεία των κοινοτήτων τους.

Abstract

Title: Social Capital and Health Behaviours of pupils in the 1st class of the Lyceum in Secondary Education in Heraklion Prefecture: The outreach role of Community Social Work.

by: Kleio Koutra

Supervisor: 1. A. Philalithis

2. A Kokkevi

3. A. Kousi

Date: 30-06-2014

Introduction

Social capital is one of the recent additions to the list of a number of social dimensions that affect environmental indicators and health behaviours (Wakefield & Poland 2005, Kritsotakis & Gamarnikow 2004). However, while the literature highlights the influence that social capital seems to have on the health and wellbeing of young people, mechanisms and linkages that underlie this effect is still unclear.

Aims

The aim of this thesis was to investigate the relationship of social capital with health behaviours of high school students in the prefecture of Heraklion, Crete, Greece and contribute to the understanding of the mechanisms by which social capital promotes health from the perspective of Community Social Work.

More specifically, the thesis aims to report on (1) the psychometric validation of the youth social capital scale and subscales in Greece, (2) the role the gender of the participants has when studying the influence of social capital in the frequent and heavy alcohol consumption (3) the influence of social and economic capital in the daily consumption of tobacco and other students health determinants (4) the role that social capital has in promoting health through interventions in community social work.

Methodology

The methodological approach was cross-sectional. The sampling method was stratified random sampling. The sampling frame was the list of all the Secondary Educational schools (28 units) in Prefecture of Heraklion. The population was estimated at 2,854 students. Those were studying in 9 rural schools with 268 students, 18 urban schools with 1,921 students and 14 suburban schools with 665 students.

The data collection was carried out in 2008 in two phases. The first phase was the pilot implementation of a scale (*Youth Social Capital Scale*) in order to ensure the validity and reliability of the measurements (Koutra et al., 2012a). A school unit was randomly selected (code 1753010) in which all segments were repetitively measured over a week to ensure the reliability of the questionnaire (test-retest reliability) (Erevnidou, Launois, Katsamouris, & Lionis, 2004).

After the necessary enhancements that resulted in the final version of the Youth Social Capital Scale (YSCS) data were collected from the rural and urban population. In relation to the rural stratum, due to the relative small number of students all the students were included (268 students), while in the urban strata four schools (409 students) were randomly selected.

Assessment tools

Data were collected using a self-administered questionnaire compiled from the Youth Social Capital Scale (*YSCS*) (Onyx et al., 2005) and the Health Behaviour in School-aged Children (HBSC) questionnaire developed by an international research network in collaboration with W.H.O., with participation of Greece since 1997 (E.P.I.PS.Y 2006). Permission for the use of both questionnaires was provided. The Pedagogical Institute of the Ministry of Education also provided permission for data collection (Case: 20946/G2/20-2-2008).

Results

Psychometric Validation

The validation of the scale included both internal consistency and construct, convergent and discriminant validity tests. Exploratory factor analysis yielded five social capital factors. The overall Cronbach's a coefficient was .771. Factor analysis revealed common patterns for many questions between the Greek and the original scales (Koutra et al. 2012a).

Alcohol consumption

For both boys and girls, higher score on some structural social capital subscales was associated, per unit increase, with increased likelihood of regular drinking. Neighbourhood connections were also associated with increased binge drinking in girls. Cognitive social capital subscales were associated with decreased likelihood of binge drinking in girls. For both genders, total social capital-score was positively associated with the probability of regular, but not of binge drinking.

Smoking consumption

Results for the multiple logistic analyses indicated that both low structural and cognitive social capital, and low economic perceived affluence, were significantly associated with poor health outcomes and increased smoking habits.

Health promotion, Social capital, Community social work

This article discusses about social capital, health promotion and community social work and highlights the common features, methodology and approach shared through community development so that social workers may be better equipped to improve and further develop the practice of their profession in the community. Professional social workers and their educators need to acknowledge the benefits and the advantages of working with the strategy of community development, thereby contributing to healthy communities capable of rebuilding and producing social capital.

Conclusions

Social capital is an important social determinant of students' health and well-being. The results of this study demonstrated that cognitive and structural social capital has different associations with the regular and binge drinking in boys and girls. Similarly, the

low structural social capital was related protectively to the daily tobacco consumption while cognitive social capital, did not.

Mechanisms of improving the students' social capital require careful and detailed analysis as dimensions and factors have both positive and negative effects on health.

Κεφάλαιο 1ο Εισαγωγή

Η έννοια του κοινωνικού κεφαλαίου, τις τελευταίες δεκαετίες έχει συνδεθεί σημαντικά με την πρόληψη και την προαγωγή της υγείας (Wakefield & Poland, 2005), ως ένας από τους κοινωνικούς παράγοντες της υγείας. Επίσης τελευταία, το κοινωνικό κεφαλαίο αποτελεί το πλαίσιο μελέτης των συμπεριφορών υγείας (Thorlindsson, Valdimarsdottir, & Jonsson, 2012; Prins et al., 2014). Με γνώμονα τα παραπάνω, το κοινωνικό κεφάλαιο οφείλει να ενταχθεί στην πρακτική εφαρμογή της κοινωνικής εργασίας. Η κοινωνική εργασία από την ίδρυση της, δουλεύει με στοιχεία κοινωνικού κεφαλαίου (Loeffler et al., 2004). Μάλιστα αναμένεται από τους κοινωνικούς λειτουργούς να προάγουν και να αναδομήσουν το κοινωνικό κεφάλαιο στις κοινότητες που παρεμβαίνουν, αν και στην πραγματικότητα, σπάνια αυτές οι παρεμβάσεις συζητούνται με την ορολογία και τις θεωρήσεις του κοινωνικού κεφαλαίου (Ersing & Loeffler, 2008; Muhkerjee, 2007). Σημαντικό, θεωρείται οι κοινωνικοί λειτουργοί, να αναγνωρίσουν τις δυσκολίες και την πολυπλοκότητα του κοινωνικού κεφαλαίου, αλλά και τη χρησιμότητα του στις κοινοτικές προληπτικές παρεμβάσεις.

Η κοινωνική εργασία έχει βαθιά παράδοση στην πρόληψη, και στην προαγωγή της υγείας (Siefert, 1983; Moniz, 2010). Οι κοινωνικοί λειτουργοί είναι σε θέση «να μετρήσουν το πρόβλημα, να αξιολογήσουν τη δράση, να διευρύνουν τη γνώση, και να μεταδώσουν τη γνώση για τους κοινωνικούς προσδιοριστές της υγείας, στο ευρύ κοινό» (Moniz, 2010, p.8). Αναγνωρίζοντας λοιπόν, το κοινωνικό κεφάλαιο ως έναν από τους κοινωνικούς προσδιοριστές της υγείας (Coren et al., 2010), η κοινωνική εργασία έχει τη δυνατότητα, να αξιοποιήσει αποτελεσματικά το κοινωνικό κεφάλαιο, στο σχεδιασμό και στην εφαρμογή κοινοτικών, προληπτικών, παρεμβάσεων.

1.1 Κοινωνικό κεφάλαιο

Την τελευταία δεκαετία, εντυπωσιακή είναι η αύξηση των μελετών που διαπραγματεύονται την επίδραση του κοινωνικού κεφαλαίου στην υγεία (Kawachi, Subramanian, & Kim, 2008; Poortinga, 2012; Roberts et al., 2009), αλλά και σε άλλους τομείς (Hawkins & Maurer, 2012). Ο Putnam (2001) αναφέρει ότι, από όλες τις περιοχές που έχει μελετήσει το κοινωνικό κεφάλαιο, καμία δεν είναι τόσο καλά εδραιωμένη, όσο η υγεία. Οι Kawachi and Berkman (2001) υποστηρίζουν μια θετική, προστατευτική σχέση του κοινωνικού κεφαλαίου στην υγεία του πληθυσμού. Ο Wilkinson (1996) τεκμηριώνει

την επιρροή της κοινωνικής ιεραρχίας στην υγεία, αναδεικνύοντας, οι χώρες με άνιση κοινωνική και οικονομική κατανομή εισοδήματος έχουν χειρότερη υγεία. Σειρά μελετών έχουν αναδείξει ότι το κοινωνικό κεφάλαιο εκφρασμένο από την κοινωνική συμμετοχή και κοινωνική συνοχή παράγουν καλύτερα επίπεδα υγείας (Poortinga, 2006; Snelgrove, Pikhart, & Stafford, 2009) και μειώνουν την ανισότητα στην υγεία (Marmot, 2010).

Πρόσφατα, στη βιβλιογραφία τεκμηριώνεται η θετική επίδραση των διαφορετικών μορφών του κοινωνικού κεφαλαίου (*bonding, bridging, and linking*) στην υγεία των κοινοτήτων και των γειτονιών (Poortinga, 2012). Το κοινωνικό κεφάλαιο, παρέχει όλες τις πηγές που μια κοινότητα μπορεί να αξιοποιήσει, ώστε δρώντας συλλογικά, να βελτιώσει την υγεία και την ευεξία της (Lochner, Kawachi, & Kennedy, 1999). Το κοινωνικό κεφάλαιο, μαζί με την κοινωνική συνοχή, θεωρείται ένα από τα συλλογικά στοιχεία που επηρεάζουν, τη συνολική ευημερία της κοινότητας (Eriksson, 2011).

Γενικά, το κοινωνικό κεφάλαιο με τον ένα ή τον άλλο τρόπο, αναφέρεται σε συλλογικούς δεσμούς, κανόνες, αξίες, αλληλεπιδράσεις, επίσημα και ανεπίσημα δίκτυα και οργανώσεις. Το κοινωνικό κεφάλαιο μπορεί να οριστεί ως ένας πολυδιάστατος πόρος που προέρχεται από τα κοινωνικά δίκτυα, τους δεσμούς και τις σχέσεις με άλλα άτομα, ομάδες ή κοινότητες (Hawkins, & Maurer, 2012; Koutra et al., 2012a). Στο κοινωνικό κεφάλαιο έχουν αποδοθεί πληθώρα ορισμών και προσεγγίσεων δημιουργώντας μια όχι και τόση σαφή εικόνα (Woolcock, 1998) για τον ορισμό και τη μέτρηση του (Macinko & Starfield, 2001). Στο *Πίνακα 1* παρουσιάζονται οι διαφορές, στις τρεις βασικές θεωρήσεις του κοινωνικού κεφαλαίου, και ακολουθεί η σύντομη παρουσίαση τους.

1.1.1 Κοινωνικό κεφάλαιο ως ατομικό αγαθό

Ο Γάλλος κοινωνιολόγος Bourdieu (1984) διαχώρισε την έννοια του «κεφαλαίου», σε τρεις διαφορετικές κατηγορίες, και με αυτήν τη ταξινόμηση καθόρισε τον ορισμό που απέδωσε στο κοινωνικό κεφάλαιο. Οι τρεις αυτές κατηγορίες κεφαλαίου (οικονομικό, πολιτισμικό, κοινωνικό) (Bourdieu, 1984), συνδέονται και αλληλεξαρτώνται με απώτερο σκοπό την αναπαραγωγή κυρίως, του οικονομικού κεφαλαίου. *Βασική αρχή σε αυτήν τη θεώρηση είναι ότι το κοινωνικό κεφάλαιο, θεωρείται ατομικό αγαθό*. Σύμφωνα με τον Bourdieu, «*το κοινωνικό κεφάλαιο διευκολύνει τη συμμετοχή των ατόμων, σε κοινωνικές ομάδες, και δίκτυα, με την αλληλεγγύη να είναι ισχυρή, μόνο όταν τα μέλη έχουν να αποκομίσουν οφέλη μέσα από αυτήν, την οργανωμένη δράση*» (Field 2003, p.15). Δίνει μεγαλύτερη έμφαση στους κάθετους δεσμούς

και στην αναπαραγωγή άνισων και δυνατών σχέσεων, από διαφορετικές μορφές κεφαλαίου. Εδώ, το κοινωνικό κεφάλαιο αντανακλά την αρνητική έννοια της έκφρασης «*Δεν είναι τι ξέρεις, αλλά ποιόν ξέρεις*» και αντανακλά στην πεσιμιστική άποψη, της εσωτερικής αναπαραγωγής των ισχυρών (Gauntlett, 2011).

1.1.2 Κοινωνικό κεφάλαιο ως ατομικό αγαθό αλλά με κοινωνική λειτουργία

Τη δεύτερη θεωρητική σχολή του κοινωνικού κεφαλαίου, δημιούργησε ο Αμερικανός κοινωνιολόγος, Coleman, στα τέλη του '80 (Coleman, 1987). Διέκρινε τρείς μορφές κεφαλαίου, το φυσικό, το ανθρώπινο και το κοινωνικό κεφάλαιο. Σε αυτή την προσέγγιση, το κοινωνικό κεφάλαιο περιλαμβάνει, τόσο το δίκτυο, όσο και τα αγαθά που μπορούν να διακινηθούν μέσα απ' αυτά τα κοινωνικά δίκτυα. Αρχικά, το κοινωνικό κεφάλαιο διαμορφώνεται μέσα στους κόλπους της οικογένειας και διαχέεται προς στην κοινότητα. Για αυτόν, το κοινωνικό κεφάλαιο είναι μια πολύτιμη πηγή που το άτομο αποκομίζει από τις κοινωνικές σχέσεις του (Coleman, 1988). Ενώ, λοιπόν ορίζει «*το κοινωνικό κεφάλαιο ως ατομικό αγαθό*», το βλέπει «*ως δομική κοινωνική πηγή*» (Coleman, 1994), αναδεικνύοντας στη λειτουργιά του έναν κοινωνικό χαρακτήρα (Coleman, 1994). Μέσα από την έρευνα του, ο Coleman διαπίστωσε ότι τα οφέλη του κοινωνικού κεφαλαίου διαχέονται, και είναι δυνατόν να καρπώνονται από άτομα, τα οποία, δε συντελέσαν στην ανάπτυξή του (Coleman, 1988).

1.1.3 Κοινωνικό κεφάλαιο ως κοινοτικό αγαθό

Ο Αμερικανός πολιτικός επιστήμονας, Putnam (1993; 2000) αποτελεί τον πιο δημοφιλή και διάσημο θεωρητικό της μελέτης του κοινωνικού κεφαλαίου. Ο Putnam βλέπει το κοινωνικό κεφάλαιο ως τους «*δεσμούς με την κοινότητα που με χιλιάδες τρόπους κάνουν τη ζωή μας πιο πλούσια*» (Putnam, 2001). Για τον Putnam, το κοινωνικό κεφάλαιο αποτελεί παραδοσιακά ένα δημόσιο, κοινωνικό αγαθό, προσβάσιμο σε όλους, χωρίς περιορισμούς και διακρίσεις (Woolcock, 2001). Εκεί βασίζεται και η βασική κριτική που έχει δεχθεί από τους επικριτές του, ότι στον ορισμό του, έχει αγνοήσει την ανισότητα στη δύναμη. Για αυτόν, το κοινωνικό κεφάλαιο είναι «*τα στοιχεία της κοινωνικής οργάνωσης, όπως τα δίκτυα, οι κανόνες και η εμπιστοσύνη που προάγουν το συντονισμό και τη συνεργασία για το κοινό καλό*» (Putnam 1993, p. 41). Οι βασικοί δείκτες μέτρησης του κοινωνικού κεφαλαίου σύμφωνα με τον Putnam, είναι ο εθελοντισμός στην κοινότητα, τα άτυπα δίκτυα, η κοινωνική συμμετοχή, η κοινωνική εμπιστοσύνη και η πίστη στους θεσμούς.

Πίνακα 1. Κύριες διαφορές στις τοποθετήσεις των τριών βασικών εκφραστών του κοινωνικού κεφαλαίου

Κύριοι εκφραστές κοινωνικού κεφαλαίου	*Προσέγγιση*	*Επίπεδο ανάλυσης*	*Αγαθό*	*Οφέλη*	*Κύρια σημεία*
Bourdieu Social network approach	Μαρξιστική	Μίκρο	Ατομικό	Το άτομο μέσα από την ιδιότητα μέλους μπορεί να αποκομίσει υλικά ή συμβολικά οφέλη	Στο ρόλο της δύναμης και στην ανισότητα πρόσβασης στις πηγές
Coleman Social network approach	Φιλελεύθερη	Μέσο	Ατομικό με κοινωνική λειτουργία	Το άτομο αποκομίζει από τις κοινωνικές σχέσεις του οφέλη τα οποία είναι δυνατόν να καρπωθούν και από άλλους	Στη σημασία των σχέσεων, των κοινωνικών δράσεων και των θεσμών στην κοινωνική ευημερία
Putnam Social cohesion approach	Φιλελεύθερη	Μάκρο	Κοινοτικό	Οι κοινωνικοί θεσμοί και οι ομάδες είναι αυτές που θα πρέπει να δημιουργούν την εμπιστοσύνη στους πολίτες και να τους προτρέξουν να δράσουν συλλογικά για ευρύτερο κοινό κάλο	Οι πολίτες έχουν την ίδια πιθανότητα να επωφεληθούν σε μια κοινότητα με υψηλό κοινωνικό κεφάλαιο

1.1.4 Κοινωνικό κεφάλαιο & Νέοι

Σε γενικές γραμμές, το «*κοινωνικό κεφάλαιο*» των νέων αναφέρεται στις κοινωνικές σχέσεις και την κοινωνικότητα, τα κοινωνικά δίκτυα, την κοινωνική υποστήριξη, την εμπιστοσύνη, την αμοιβαιότητα, και την πολιτική δέσμευση (Morrow, 1999). Το κοινωνικό κεφάλαιο των νέων είναι δύσκολο, περίπλοκο, και αρκετά ακαθόριστο ως έννοια. Οι τρεις κύριοι θεωρητικοί του κοινωνικού κεφαλαίου Bourdieu, Coleman και Putnam που συνοπτικά αναπτύχθηκαν παραπάνω αντιλαμβάνονται το κοινωνικό κεφάλαιο των νέων, με εντελώς διαφορετικό τρόπο (Holland, Reynolds, & Weller, 2007; Morrow, 2002). Ο Bourdieu στην ανάλυση του δεν αναφέρεται καθόλου στους νέους, ενώ η προσέγγισή του

παρέχει πολυμήχανους τρόπους, με τους οποίους πολλοί νέοι χρησιμοποιούν το κοινωνικό τους κεφάλαιο, προκειμένου ως άτομα και εντός των ομάδων τους να ξεπεράσουν τα οικονομικά τους προβλήματα (Gillies, 2005; Cockburn & Cleaver, 2009). Η αντίληψη του Coleman, για το κοινωνικό κεφάλαιο των νέων βασίζεται στη δυναμική των γονιών τους. Και τέλος, ο Putnam στηρίζει το κοινωνικό κεφάλαιο των νέων, σε τοπικά δίκτυα υποστήριξης και δράσεις συμμετοχής στα κοινά (Campbell, 2001). Οι Putnam και Coleman βλέπουν τα παιδιά, ως αποτέλεσμα του κοινωνικού κεφαλαίου, των γονιών τους στην κοινότητα. Βλέπουν τους νέους «*ως ανθρώπινο γίγνεσθαι και όχι ως ανθρώπινα όντα*" (Leonard, 2008, p. 226).

Οι νέοι είναι πιο πιθανό να συμμετέχουν σε ανεπίσημες κοινωνικές δραστηριότητες και να έχουν ευρύτερα δίκτυα κοινωνικής στήριξης από ότι οι ενήλικες (Deviren & Babb, 2005). «Κοινωνικοποιούνται μέσα στα δίκτυα των φίλων, συμμετέχουν σε τοπικές δραστηριότητες, δημιουργούν τους δικούς τους δεσμούς αλλά και τα δίκτυα για τους γονείς τους» (Edwards, Franklin, & Holland, 2003, p.12). Αυτή η γνώση, οδηγεί στην περαιτέρω κατανόηση του κοινωνικού πλαισίου μέσα στο οποίο, οι νέοι ζουν (Leeder & Dominello, 1999), την έκταση, και τη φύση των κοινωνικών δικτύων τους (οικογένεια, σχολείο, συμμαθητές) μέσα στις οποίες κοινωνικοποιούνται, και αναπτύσσουν δεσμούς (Bassani, 2007). Ως εκ τούτου, για την καλύτερη κατανόηση του κοινωνικού κεφαλαίου των νέων, απαιτείται η απόκτηση περαιτέρω γνώσεων, αναφορικά με τις εμπειρίες και τις ανησυχίες τους για τη ζωή (Onyx, Wood, Bullen, & Osburn, 2005).

Ανάλογες, των θεωρητικών προσεγγίσεων είναι και οι μορφές, τα επίπεδα μελέτης και οι διαστάσεις του κοινωνικού κεφαλαίου. Για την πληρέστερη κατανόηση του κοινωνικού κεφαλαίου, οι βασικές πτυχές αυτών των κατηγοριοποιήσεων συνοπτικά παρουσιάζονται.

1.1.5 Γνωστική και δομική διάσταση του κοινωνικού κεφαλαίου

Ξεκινώντας από τον διαχωρισμό που εισήγαγε ο Uphoff (2000), θα αναφερθούμε στη γνωστική (cognitive) και δομική (structural) διάσταση του κοινωνικού κεφαλαίου. Το γνωστικό κοινωνικό κεφάλαιο των νέων αναφέρεται σε υποκειμενικά χαρακτηριστικά, όπως, κανόνες, αξίες, στάσεις, και πεποιθήσεις, ενώ το δομικό αναφέρεται σε ορατές πλευρές της κοινωνικής οργάνωσης, όπως επίσημα (σχολείο, θρησκεία, πολιτική, αθλητισμό) και ανεπίσημα κοινωνικά δίκτυα (φίλοι, οικογένεια, γείτονες) (Baum &

Ziersch, 2003; Islam et al., 2006). Σημαντικό είναι να αναφερθεί ότι το δομικό κοινωνικό κεφάλαιο έχει οριζόντια (bonds, bridges) και κάθετη διάσταση (links).

1.1.6 Bonding, bridging and linking κοινωνικό κεφάλαιο

Ο Putnam είναι αυτός που εισήγαγε την πιο ευρέως διαδεδομένη ταξινόμηση στη συζήτηση του κοινωνικού κεφαλαίου. Αυτή η ταξινόμηση αφορά στο «*bonding*», «*bridging*», και «*linking*» κοινωνικό κεφάλαιο, που για πολλούς είναι η συνέχεια της συζήτησης των όρων «*δυνατά*» και «*αδύναμα*» δίκτυα του Granovetter (1973).

Η μελέτη του κοινωνικού κεφαλαίου των νέων, απαιτεί να διερευνηθούν και να ενισχυθούν και οι τρεις μορφές, δεσμοί, γέφυρες αυτού. Χρειάζεται συστηματικά να ενισχυθούν, οι κοινωνικές πηγές των νέων σε όλα τα επίπεδα, ώστε να μπορέσουν να επηρεάσουν θετικά την υγεία τους.

Το «*bonding*» αναφέρεται σε οριζόντιους στενούς δεσμούς ανάμεσα σε άτομα ή ομάδες με παρόμοια κοινωνικοδημογραφικά χαρακτηριστικά (Portes, 1998). Χαρακτηριστικά παραδείγματα αποτελούν, η οικογένεια, οι στενοί φίλοι, οι γείτονες. Μάλιστα κατά τη διάρκεια της εφηβείας, η επιρροή των γονέων μειώνεται, ενώ την ίδια στιγμή, εκείνη των συνομηλίκων αυξάνεται. Ο σημαντικός ρόλος που διαδραματίζουν, οι ομάδες συνομηλίκων έχει τεκμηριωθεί (Lin & Weinberg, 2014), καθώς και το αντίκτυπο που έχουν αυτές στη λήψη αποφάσεων και στις συμπεριφορές υγείας (Fletcher, 2014). Το «*bonding*» κοινωνικό κεφάλαιο έχει την τάση να ενδυναμώνει αποκλειστικές ταυτότητες και ομογενείς ομάδες (Morrow, 2004). Συχνά, αυτή η μορφή είναι μη ανεκτική στη διαφορετικότητα και στην ευρύτερη κοινωνία και δεν παράγει οφέλη συνεργασίας και εμπιστοσύνης. Αυτή η μορφή μπορεί να προκαλέσει αρνητικές επιπτώσεις στην κοινωνικοποίηση και την υγεία των νέων (Koutra et al., 2014; Portes, 1998). Έτσι, όπως συμβαίνει συχνά, στις κλειστές ομάδες των συνομηλίκων, οι νέοι μπορούν να επιλέξουν συμπεριφορές που πληρούν τις απαιτήσεις της ομάδας (π.χ. νεανικές συμμορίες, κατανάλωση ουσιών), και μπορεί να αισθάνονται υποχρέωση να συμμορφωθούν με τους κανόνες της ομάδας, ακόμη, και αν αυτή, η συμμόρφωση αντιβαίνει στο δικό τους προσωπικό καλό (Özbay, 2008).

Το «*bridging*» και το «*linking*» αναφέρεται σε δεσμούς με διαφορετικές ομάδες. Το «*bridging*» είναι πιο εξωτερικευμένο και αφορά οριζόντιες σχέσεις με άτομα διαφορετικών

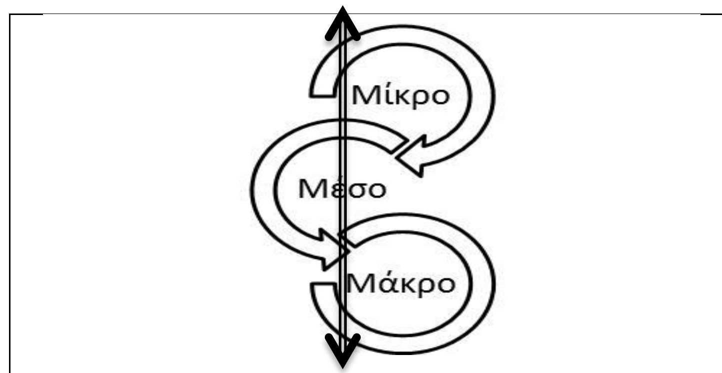
κοινωνικών ομάδων (Kim, Subramanian, & Kawachi, 2006). Για την αύξηση της κοινωνικής υποστήριξης των νέων απαιτείται το «*bridging*». Αυτό φέρνει κοντά «*επίσημους και ανεπίσημους δεσμούς με άτομα, με διαφορετικά χαρακτηριστικά και πόρους, όπου τα θέματα, αλλά και τα δίκτυα επεκτείνονται*» (Kawachi et al., 2008, p.31). Ιδιαίτερα αυτή η μορφή, θεωρείται σημαντική για την υγεία (Poortinga, 2012; Iwase et al., 2012).

Τέλος, το «*linking*» αναφέρεται σε κάθετες σχέσεις, οι οποίες βοηθούν τα άτομα, να κερδίσουν πρόσβαση, σε διαφορετικές και ευρύτερες πηγές και δομές δύναμης (Woolcock, 2001) προκειμένου να επιτύχουν κοινωνική και οικονομική ανάπτυξη. Αντίθετα, φτωχό «*linking*» συνεπάγεται ανισότητα στην οικονομία και στην ευημερία. Αυτή, η μορφή κοινωνικού κεφαλαίου είναι δυνατό να μειώσει τις ανισότητες, διότι ενθαρρύνει τα άτομα να αισθανθούν ευθύνη για τους άλλους που δεν ανήκουν, στην δική τους ομάδας (Foley & Edwards, 1999).

1.1.7 Μίκρο, μέσο και μάκρο επίπεδο ανάλυσης του κοινωνικού κεφαλαίου

Τελειώνοντας την ανάλυση των κατηγοριοποιήσεων του κοινωνικού κεφαλαίου, τα επίπεδα ανάλυσης του θα παρουσιαστούν, τα οποία επίσης διαφοροποιούνται ανάλογα τη θεωρητική σχολή και τον ορισμό του. Όπως παρατηρούμε και στην *Εικόνα 1*, τα επίπεδα μελέτης είναι κυρίως το Μίκρο, Μέσο και Μάκρο επίπεδο.

Εικόνα 1 Επίπεδα μελέτης του κοινωνικού κεφαλαίου



Έτσι, το κοινωνικό κεφάλαιο μελετάται σε ατομικό, ομαδικό και κοινοτικό ή και σε εθνικό επίπεδο (Coleman, 1988; Putnam, 1995). Σημαντική είναι η τοποθέτηση των Onyx και Bullen (2000) που υποστηρίζουν, ότι το κοινωνικό κεφάλαιο είναι τόσο ατομικό, όσο και συλλογικό αγαθό. Εντούτοις, καμία συμφωνία για το επίπεδο μελέτης και ανάλυσης

δεν έχει επιτευχθεί, επιτρέποντας στους μελετητές του, να το προσεγγίζουν ο καθένας από τη δική του σκοπιά.

Μέσα από τη βιβλιογραφική ανασκόπηση που προηγήθηκε διαπιστώνουμε, ότι οι μελετητές του κοινωνικού κεφαλαίου ανέπτυξαν διάφορους ορισμούς και θεωρήσεις από πολλά και διαφορετικά επιστημονικά πεδία με αποτέλεσμα να δημιουργείται σύγχυση στο καθορισμό της έννοιας, αλλά και μέτρησης του κοινωνικού κεφαλαίου.

1.2 Συμπεριφορές υγείας των νέων και κοινωνικό κεφάλαιο

Οι συμπεριφορές υγείας και ο τρόπος ζωής στην ενήλικη ζωή είναι σε μεγάλο βαθμό, το αποτέλεσμα της ανάπτυξης κατά τη διάρκεια της εφηβείας (Viner et al., 2012; Winstanley et al., 2008). Οι νέοι είναι ριψοκίνδυνοι. Έχουν την ανάγκη να πειραματιστούν, να δοκιμάσουν και να αποκτήσουν καινούργιες εμπειρίες, να δοκιμάσουν τα όρια τους, αλλά και τα όρια των άλλων. Όλα αυτά αποτελούν μέρος της προσπάθειάς τους να μάθουν να ρυθμίζουν μόνοι τους τη ζωή τους και να αποφασίζουν για τον εαυτό τους. Επειδή όμως στην αρχή, οι εμπειρίες τους είναι περιορισμένες, μερικές φορές και η κρίση τους είναι περιορισμένη και ο κίνδυνος που παραμονεύει μεγάλος. Αυτό, έχει εξαιρετική σημασία όταν τα επιδημιολογικά δεδομένα αναδεικνύουν, ότι η Ελλάδα κατέχει από τους υψηλότερους δείκτες τακτικών καπνιστών, ηλικίας 17-18 ετών στην Ευρώπη (Andersson et al., 2007), και είναι ανάμεσα στους υψηλότερους στην κατανάλωση αλκοόλ στην Ευρώπη (Hibell, Guttormsson, & Ahlström, 2009; Hibell et al., 2012).

Η μελέτη των συμπεριφορών υγείας στην εφηβεία είναι σημαντική για αρκετούς λόγους, και κυρίως γιατί οι όποιες επιλογές στην εφηβεία (Mackenbach et al., 2008) θα επιβαρύνουν το άτομο για όλη του τη ζωή. Οι Viner κ.α. (2012) στην ανασκόπηση τους για τους παράγοντες, που επηρεάζουν τις συμπεριφορές υγείας των νέων 10–24 ετών σε επίπεδο χωρών, πέραν των ισχυρότερων θεσμικών στοιχείων σε παγκόσμια κλίμακα (εθνικός πλούτος, εισοδηματική ανισότητα, και πρόσβαση στην εκπαίδευση), αναφέρονται στο ασφαλές και στο υποστηρικτικό οικογενειακό και σχολικό περιβάλλον, και στη ζωτικής σημασίας υποστήριξης από τους συνομηλίκους. Με άλλα λόγια πέραν των θεσμικών στοιχείων κάνουν ιδιαίτερη μνεία, στο κοινωνικό κεφάλαιο. Το κοινωνικό κεφάλαιο, απαιτείται να μελετηθεί ώστε να διερευνηθούν οι διαφορετικές οπτικές των

κοινωνικών δικτύων, τα οποία αποτελούν το κοινωνικό πλαίσιο μέσα στο οποίο διαμορφώνονται, οι όποιες συμπεριφορές υγείας (Poortinga, 2012).

Γενικά, η σημασία του κοινωνικού κεφαλαίου στην έρευνα της υγείας των νέων είχε αγνοηθεί (Goodwin & Armstrong-Esther, 2004) και ελάχιστες προ δεκαετίας είναι οι προσπάθειες μελέτης και ανάλυσης του ρόλου που διαδραματίζει το κοινωνικό κεφάλαιο στη ζωή των νέων. Το κοινωνικό κεφάλαιο και η υγεία κινούνται σήμερα πέρα από το άτομο προκειμένου να διερευνήσουν την υπόθεση ότι οι συμπεριφορές υγείας, είτε συμβάλλουν θετικά, είτε όχι στην υγεία του πληθυσμού, επηρεάζονται αρκετά ή πολύ, τόσο από τη καθημερινότητα και τις δραστηριότητες της, όσο και από τις προσωπικές αποφάσεις των νέων (Morrow, 1999). Τελευταία, εκείνοι που εργάζονται στον τομέα της δημόσιας υγείας γίνονται όλο και περισσότερο ενήμεροι, για το πώς οι νέοι συνδέονται με τα ευρύτερα κοινωνικά δίκτυα και τις κοινότητες τους και την επίδραση που έχουν αυτά στην υγεία τους (Viner et al., 2012; Koutra et al., 2014; Poortinga, 2012). Είναι αυτό που η Morrow χαρακτηριστικά αναφέρει ότι *«δεν είναι η φύση των συμπεριφορών υγείας, αλλά το πλαίσιο στο οποίο λαμβάνουν χώρα (που, πότε, όταν, και με ποιον), αυτό είναι ανάγκη να αναλυθεί»* (Morrow, 1999).

1.3 Κατανάλωση αλκοόλ και καπνού στους νέους

1.3.1 Κατανάλωση αλκοόλ

Η κατανάλωση αλκοόλ από ανηλίκους είναι συνηθισμένο φαινόμενο, σε πολλές ευρωπαϊκές και βορειοαμερικανικές χώρες (Currie et al., 2012). Στην Ελλάδα, ο επιπολασμός της συχνής κατανάλωσης αλκοόλ στην εφηβεία είναι από τους υψηλότερους στην Ευρώπη, και το ποσοστό των Ελλήνων μαθητών που έχουν καταναλώσει αλκοόλ, κατά τη διάρκεια των τελευταίων 12 μηνών (87%) και τις τελευταίες 30 ημέρες (70%) είναι κατά κανόνα υψηλότερος από εκείνον, των περισσότερων Ευρωπαϊκών χώρων (Hibell et al., 2009; Hibell et al., 2012; Arvanitidou, Tirodimos, Kyriakidis, Tsinaslanidou, & Seretopoulos, 2008; Kokkevi et al., 2007). Επιπρόσθετα, τα επεισόδια μέθης των μαθητών 15-16 ετών αυξάνονται σημαντικά, τα τελευταία χρόνια (Hibell et al., 2012).

Η κατανάλωση αλκοόλ από ανηλίκους θα έπρεπε να θεωρείται πρόβλημα δημόσιας υγείας στην Ελλάδα (Kokkevi et al., 2007) λόγω της υψηλής συσχέτισης του με πολλαπλές συμπεριφορές κινδύνου, όπως η παραβατική συμπεριφορά, οι αποτυχίες στα μαθήματα

(Tsai, Anderson, & Vaca, 2010; Koutra et al., 2012b), η πρόωρη νοσηρότητα, τα ατυχήματα και οι θάνατοι σε νεότερες ηλικίες (Möller, Dherani, Harwood, Kinsella, & Pope, 2012; Stone, Becker, Huber, & Catalano, 2012). Παρόλα, αυτά περιορισμένες είναι οι ουσιαστικές παρεμβάσεις και οι πολιτικές που έχει εφαρμόσει πραγματικά, το κράτος στο θέμα αυτό (Gefou-Madianou, Karlsson, & Sterberg, 2003).

Πληθώρα μελετών έχουν τεκμηριώσει ότι οι συνομήλικοι, οι γονείς, οι περιβαλλοντικοί και οι γενετικοί παράγοντες είναι προάγγελοι της κατανάλωσης αλκοόλ στην εφηβεία (Richter, Leppin, & Gabhainn, 2006; Nunez-Smith, et al., 2010; Hanewinkel, et al., 2012; Bobakova et al., 2012; Tornay et al., 2013), αν και οι συσχετίσεις αυτές διαφέρουν από χώρα σε χώρα, και εξαρτώνται ιδιαίτερα, από το φύλο των ερευνώμενων.

Το φύλο των μαθητών αναδεικνύεται σημαντικός παράγοντας κινδύνου. Γενικότερα, υπάρχει η τάση, τα αγόρια να αναφέρουν υψηλότερα ποσοστά κατανάλωσης αλκοόλ από ότι τα κορίτσια (Hibell et al., 2012). Οι φυλετικές κατασκευές και προσδοκίες (Landrine, Bardwell, & Dean, 1988), οι κοινωνικοί ρόλοι και οι σχέσεις (Schinke, Fang, & Cole, 2008) μπορεί να λειτουργήσουν, άλλοτε προστατευτικά και άλλοτε όχι, στην κατανάλωση αλκοόλ. Η διαδικασία της κοινωνικοποίησης απαιτεί από τα κορίτσια να μειώσουν, ενώ από τα αγόρια να διατηρήσουν ή χειρότερα να αυξήσουν την κατανάλωση αλκοόλ (Billet, 2011; Schulte, Ramo, & Brown, 2009).

1.3.2 Κατανάλωση καπνού

Το κάπνισμα έχει συνέπειες σε όλη τη ζωή των εφήβων. Οι καπνιστικές συνήθειες των μαθητών Γυμνασίου (ηλικίας 17.5±1.3 ετών) στην Ελλάδα, δεν έχουν αλλάξει την τελευταία δεκαετία. Ο επιπολασμός του καπνίσματος (32.6% αγόρια, 26.7% κορίτσια, 29.6% σύνολο) και η ετήσια κατά κεφαλήν κατανάλωση στη χώρα είναι υψηλή (Sichletidis, Chloros, Tsiotsios, & Spyratos, 2006). Η Ελλάδα έχει να ανταπεξέλθει σε μια «πανδημία καπνίσματος», δεδομένου ότι έχει το υψηλότερο ποσοστό τακτικών καπνιστών ηλικίας 17-18 ετών στην Ευρώπη (41%) (Andersson et al., 2007). Στοιχεία από τη *GYTS* (Παγκόσμια Έρευνα για το κάπνισμα των Νέων), αναφέρουν ότι το 32,2% των μαθητών 13-15 ετών στην Ελλάδα έχουν καπνίσει και σχεδόν ένας στους τέσσερις άρχισαν το κάπνισμα, πριν από την ηλικία των δέκα ετών (Kyrlesi et al., 2007).

Το κάπνισμα και η μύηση στο κάπνισμα στους εφήβους αφορά στην αλληλεπίδραση μεταξύ των μικροσυστημάτων που ανήκει ο έφηβος, όπως, η οικογένεια, το σχολείο, οι συνομήλικοι, και των εξωγενών μακροσυστημάτων, όπως η γειτονιά και η κοινότητα (DiNapoli, 2009; Ennet et al., 2010). Επίσης σχετίζεται με μια σειρά παραγόντων κινδύνου, όπως, η καπνιστική συνήθεια γονέων και αδελφών (Rachiotis et al., 2008), το χαμηλό κοινωνικοοικονομικό επίπεδο (Tewolde, Ferguson, & Benson, 2007), οι συνθήκες εμπορίας καπνού (Gilpin, White, Messer, & Pierceet, 2007), η έλλειψη αντικαπνιστικών νόμων και κανόνων (Siegel, Albers, Cheng, Biener, & Rigotti, 2005), οι διαφημίσεις στην τηλεόραση (Titus-Ernstoff, Dalton, Adachi-Mejia, Longacre, & Beach, 2008), και οι έξοδοι με φίλους που καπνίζουν τα βράδια (Kokkevi et al., 2007). Μελέτη χρησιμοποιώντας δεδομένα από 26 ευρωπαϊκές χώρες (*ESPAD*) εκτίμησε ότι, η αύξηση ενός μαθητή που καπνίζει οδηγεί σε αυξημένη πιθανότητα ο «*μέσος*» μαθητής της τάξης, να καπνίζει (McVicar, 2011).

1.4 Κατανάλωση αλκοόλ και καπνού στους νέους και κοινωνικό κεφάλαιο

Η συσχέτιση κοινωνικού κεφαλαίου και κατανάλωσης αλκοόλ και καπνού δεν έχουν μελετηθεί εκτενώς, σε πληθυσμούς εφήβων (Winstanley et al., 2008). Έτσι και η επίδραση του κοινωνικού κεφαλαίου στις συμπεριφορές κίνδυνου των νέων, δεν είναι ακόμη πλήρως κατανοητή.

1.4.1 Αλκοόλ

Οι Morgan και Haglund (2009) αναφέρουν ότι η κατανάλωση αλκοόλ συνδέεται στενά με κοινωνικές και πολιτισμικές νόρμες. Οι Bryden, Roberts, Petticrew, & McKee (2013) στην ανασκόπηση τους για την επίδραση των κοινωνικό-διαρθρωτικών παραγόντων, βρήκαν ότι η στέρηση, η φτώχεια, το εισόδημα, η ανεργία, η κοινωνική αναταραχή και η εγκληματικότητα σχετίζονται με την κατανάλωση αλκοόλ των νέων. Παράλληλα, τεκμηρίωσαν μια προστατευτική επίδραση του κοινωνικού κεφαλαίου και της κοινοτικής υποστήριξης στην κατανάλωση αλκοόλ σε εφηβικούς και μαθητικούς πληθυσμούς (Bryden et al., 2013).

Η ευκαιριακή μέθη, σε εφήβους ηλικίας 12-18 ετών, δεν βρέθηκε να έχει σημαντική συσχέτιση με το κοινωνικό κεφάλαιο, μέσα από την κοινωνική εμπιστοσύνη και την κοινωνική συμμετοχή, σε μελέτη επιπολασμού σε πόλη, στη νότια ακτή της Σουηδίας (Lundborg, 2005). Ο Takakura (2011) αναφέρει, ότι η εμπιστοσύνη και η ασφάλεια

σχετίζονται με χαμηλότερη πιθανότητα κατανάλωσης αλκοόλ σε 3248 μαθητών, ηλικίας 15-18 ετών στην Ιαπωνία. Στην ίδια κατεύθυνση κινείται και η μελέτη των Wray-Lake κ.α (2012), με δεδομένα 33-ετών στις Ηνωμένες Πολιτείες (1976-2008), να αναφέρουν ότι οι κοινοτικοί δεσμοί και η κοινωνική εμπιστοσύνη συνδέονται με χαμηλότερη κατανάλωση αλκοόλ σε μαθητές Γυμνασίου.

Όμως, αυτή η προστατευτική επίδραση δεν είναι συνεπής στη βιβλιογραφία. Συγχρονικά στοιχεία σε μελέτη για το αλκοόλ σε αμερικάνικο κολέγιο, διαπίστωσαν ότι η συμμετοχή και ο εθελοντισμός στην κοινότητα, αυξάνει την πιθανότητα ελαφριάς κατανάλωση, αλλά, μειώνει την πιθανότητα της ευκαιριακής μέθης σε ένα εθνικά αντιπροσωπευτικό δείγμα, 17.592 νεαρών ενηλίκων. Τέλος, μελέτη σε 7.097 παιδιά ηλικίας 11, 13 και 15 ετών για την κοινωνική συμμετοχή και τα προβλήματα συμπεριφοράς των εφήβων, έδειξε ότι όσο οι έφηβοι μεγαλώνουν, και το ποσοστό της κοινωνικής συμμετοχής τους αυξάνει, αυξάνει και η ποσότητα αλκοόλ που καταναλώνουν (Vieno, Nation, Perkins, & Santinello, 2007).

1.4.2 Κάπνισμα

Αυξανόμενος είναι ο αριθμός των μελετών που έχει ερευνήσει τη σχέση μεταξύ του καπνίσματος των ανηλίκων και του κοινωνικού κεφαλαίου, τη τελευταία πενταετία. Το ατομικό επίπεδο κοινωνικής εμπιστοσύνης και συμμετοχής μεταξύ των μαθητών σχετίζεται αρνητικά με το κάπνισμα, αναδεικνύοντας την προστατευτική επίδραση του κοινωνικού κεφαλαίου (Lundborg, 2005; Takakura, 2011). Παρομοίως, το κοινωνικό κεφάλαιο από την άποψη της συμμετοχής σε δραστηριότητες που σχετίζονται με τα οργανωμένα σύνολα που βοηθούν τα παιδιά να αναπτύξουν δεξιότητες, επέδρασε προστατευτικά στο κάπνισμα των εφήβων, σε γειτονιές υψηλού κινδύνου (Xue, Zimmerman, & Caidweli, 2007). Επίσης, οι εξωσχολικές δραστηριότητες, όπως τα ομαδικά αθλήματα επέδρασαν προστατευτικά στην πρόληψη του καπνίσματος σε ανηλίκους (Adachi-Mejia, Carlos, Berke, Tanski, & Sargent, 2012; Zambon et al., 2010). Η Curran (2007) μετρώντας το κοινωνικό κεφάλαιο μέσω της οικογενειακής συνεκτικότητας, υποστήριξης, και εμπιστοσύνης, τεκμηρίωσε προστατευτικό ρόλο στη χρήση ουσιών των εφήβων.

Στην ίδια κατεύθυνση είναι η μελέτη H.B.S.C. σε μαθητές ηλικίας 15 ετών που ανέδειξε ότι το αίσθημα της ασφάλειας και «*του ανήκειν*» στη γειτονιά και στην κοινότητα, είχε μεγαλύτερη επίδραση στη μείωση των συμπεριφορών κινδύνου, από ότι η οικογένεια,

προτείνοντας ότι οι θεσμικές πτυχές οργάνωσης της ζωής των νέων δρουν προστατευτικά στην υγεία τους (Viner et al., 2012; Brooks, Magnusson, Spencer, & Morgan, 2012). Έρευνα σε 781 συμμετέχοντες, για την αποτίμηση της σχέσης του κοινωνικού κεφαλαίου στο κάπνισμα σε τέσσερις γειτονιές χαμηλού εισοδήματος στο Σαντιάγκο, διατύπωσε ότι το αίσθημα εμπιστοσύνης των νέων στην γειτονιά επηρέασε αντιστρόφως ανάλογα τις καπνιστικές συμπεριφορές τους (Sapag et al. 2010).

Αντιθέτως, οι Kawachi και Berkman (2001) αναφέρουν μια όχι και τόσο προστατευτική επίδραση στο κάπνισμα των μαθητών. Στο ίδιο μήκος, κινείται και έρευνα στην Σουηδία, με μια όχι και τόσο ισχυρή συσχέτιση κοινωνικού κεφαλαίου και κατανάλωσης καπνού (Lindstrom, Moghaddassi, Bolin, Lindgren, & Merlo, 2003). Ισχυρές ενδείξεις, ότι η γειτονιά έχει σημαντικές συνέπειες στην υγεία και στην ποιότητα ζωής των νέων έχουν καταγραφεί. Μελέτη της H.B.S.C. σε 80 σχολεία της Μ. Βρετανίας ανέδειξε ότι το κοινωνικό κεφάλαιο που μετράται ως χαμηλό «*αίσθημα του ανήκειν*» στην οικογένεια, και στη γειτονιά και με μη συμμετοχή σε εξωσχολικές ομάδες είχε ανεξάρτητες επιδράσεις στο κάπνισμα (Morgan, & Haglund, 2009). Οι Rojas και Carlson (2006) τεκμηρίωσαν ότι όταν το «*bonding*» κοινωνικό κεφάλαιο που αποτελείται από τη γειτονιά και τους φίλους αυξηθεί, περισσότεροι μαθητές θα κινδυνεύουν με αυξημένη κατανάλωση καπνού και αλκοόλ. Παρομοίως, ο Capriano (2004) ανέδειξε ότι η αυξημένη κοινωνική στήριξη από τη γειτονιά σχετίζεται με αυξημένη καθημερινή κατανάλωση καπνού και αλκοόλ, επιβεβαιώνοντας τη θεωρία του Bourdieu, ότι το κοινωνικό κεφάλαιο παράγει θετικά και αρνητικά αποτελέσματα (Kawachi et al., 2008).

1.5 Κενό που καλύπτει η διατριβή

1.5.1 Κοινωνικό κεφάλαιο και Συμπεριφορές υγείας

Η διατριβή σχετικά με τις συμπεριφορές υγείας προσπαθεί να συνεισφέρει στα ασυνεπή αποτελέσματα της σχέσης κοινωνικού κεφαλαίου και της συχνής κατανάλωση αλκοόλ και καπνού αλλά και της ευκαιριακής μέθης στην εφηβεία. Ιδιαίτερη βαρύτητα δόθηκε στη λεπτομερή ανάλυση, αλλά και στην επίδραση σειρά κοινωνικοδημογραφικών παραγόντων, προκειμένου να διασφαλιστεί η αξιοπιστία των αποτελεσμάτων.

Αναμφισβήτητα είναι σημαντικό να μελετηθεί το κοινωνικό κεφάλαιο στο ελλαδικό χώρο, διότι η Μεσόγειος, η Ελλάδα, η Κρήτη συνθέτουν ένα διαφορετικό κοινωνικό και

πολιτισμικό περιβάλλον, από εκείνο των χωρών της Βόρειας Ευρώπης, Αμερικής και Αυστραλίας. Μεγάλη έμφαση δόθηκε στην προσαρμογή της κλίμακας του κοινωνικού κεφαλαίου, ώστε να μετρά πραγματικά το κοινωνικό κεφάλαιο των νέων στην Ελλάδα. Μάλιστα, η επιλογή της κλίμακας *YSCS* αποτέλεσε μια εξαιρετική επιλογή που έδωσε στη μελέτη τη δυνατότητα να μελετήσει πολλούς παράγοντες, μορφές και διαστάσεις, του κοινωνικού κεφαλαίου. Αυτό, θεωρήθηκε σημαντικό γιατί κάλυψε το κενό πληθώρας μελετών που χωρίς την πολιτισμική προσαρμογή των εργαλείων μέτρησης, μελετούν το κοινωνικό κεφάλαιο και μάλιστα επιλέγοντας μία ή δύο ερωτήσεις για να το αξιολογήσουν, μην καταφέρνοντας να αποτυπώσουν σε βάθος, όλες τις διαστάσεις του. Με σιγουριά, η πιο προσεκτική αξιοποίηση και αξιολόγηση των εργαλείων μέτρησης θα ήταν μια λύση στην σύγχυση που προκαλούν όλα τα διφορούμενα αποτελέσματα των μελετών.

Τέλος, η διατριβή συνεισφέρει στη βιβλιογραφία εξετάζοντας δύο μορφές κεφαλαίου, το οικονομικό, και το κοινωνικό, που σπάνια, έχουν μελετηθεί σε πληθυσμούς εφήβων και στην επίδραση αυτών στο κάπνισμα και σε άλλους παράγοντες της υγείας στην νοτιοανατολική Μεσόγειο.

Συνοψίζοντας, η διατριβή αναδεικνύει ότι το κοινωνικό κεφάλαιο μπορεί να συνεισφέρει στην καλύτερη κατανόηση και γνώση του κοινωνικού πλαισίου μέσα στο οποίο, τα αγόρια και τα κορίτσια στην εφηβεία υιοθετούν συμπεριφορές κινδύνου ή όχι, και αναδεικνύει την αναγκαιότητα ανάπτυξης στοχευμένων προληπτικών παρεμβάσεων.

1.5.2 Κοινωνική εργασία

Αυτή η διατριβή συνεισφέρει στη γνώση και στη συζήτηση που οι κοινωνικοί λειτουργοί οφείλουν να έχουν, στο ρόλο που το κοινωνικό κεφαλαίο διαδραματίζει στην υγεία. Επίσης, η διατριβή μέσα από το θεωρητικό μοντέλο που προτείνει στο κεφάλαιο έξι, δίνει τη δυνατότητα στους κοινωνικούς λειτουργούς να αναγνωρίσουν τα οφέλη και τα πλεονεκτήματα, του να δουλεύουν με την στρατηγική της κοινοτικής ανάπτυξης, συνεισφέροντας σε κοινότητες υγιείς, ικανές να αναδομήσουν και να προάγουν κοινωνικό κεφάλαιο.

Η εκπαίδευση των κοινωνικών λειτουργών θα πρέπει να κάνει στροφή στην κοινότητα και να δώσει την δυνατότητα στη μέθοδο της Κ.Ε.Κ. να ετοιμάσει τους

μελλοντικούς επαγγελματίες, ώστε να είναι σε θέση να ανταπεξέλθουν σε ένα συνεχώς μεταβαλλόμενο και πολύπλοκο κοινωνικό περιβάλλον, με νέα εργαλεία και διεπιστημονικές συνεργασίες. Συνεργασίες και εργαλεία με άλλα επιστημονικά πεδία όπως, της κοινωνικής επιδημιολογίας, της νοσηλευτικής, της ιατρικής, της γεωγραφίας (με την χρήση χαρτών GIS) που θα εμπλουτίσουν τη γνώση των κοινωνικών λειτουργών από άλλη σκοπιά.

Το ζητούμενο είναι οι αυριανοί κοινωνικοί λειτουργοί, να έχουν την καλύτερη δυνατή γνώση των κοινοτικών αναγκών, αλλά και των πηγών, δυνάμεων και κοινωνικού κεφαλαίου προκειμένου να είναι σε θέση να προτείνουν εύστοχες παρεμβάσεις, που θα βελτιώνουν τις συνθήκες διαβίωσης και υγείας των κοινοτήτων τους.

1.6 Σκοπός και σημασία της προτεινόμενης ερευνητικής εργασίας

Ο σκοπός της διατριβής είναι η διερεύνηση των πτυχών του κοινωνικού κεφαλαίου που επιδρούν στις συμπεριφορές υγείας των μαθητών της Δευτεροβάθμιας Εκπαίδευσης στο Νομό Ηρακλείου.

Πιο συγκεκριμένα, η μελέτη στοχεύει στο:

(1) να μειώσει το κενό στη μελέτη του κοινωνικού κεφαλαίου των νέων στην Ελλάδα αλλά και να συνεισφέρει στη συζήτηση σε διεθνές επίπεδο,

(2) να περιγράψει την ψυχομετρική στάθμιση της *YSCS* και να καθορίσει τους παράγοντες στην ελληνική πραγματικότητα,

(3) να διερευνήσει το ρόλο του φύλου των μαθητών στη σχέση του κοινωνικού κεφαλαίου με τις συμπεριφορές υγείας των μαθητών (αλκοόλ και κάπνισμα),

(4) να διερευνήσει τη σχέση φύλου, τόπου διαμονής και αυτοαναφερόμενης οικονομικής κατάστασης και κοινωνικού κεφαλαίου στις συμπεριφορές υγείας των μαθητών,

(5) να συζητήσει για τα κοινά που μοιράζεται η μέθοδος της κοινωνικής εργασίας με κοινότητα, με το κοινωνικό κεφάλαιο και την προαγωγή υγείας, προκειμένου να δώσει τη δυνατότητα στους κοινωνικούς λειτουργούς, να βελτιώσουν και αναπτύξουν περαιτέρω την πρακτική του επαγγέλματος στη κοινότητα.

1.7 Μεθοδολογία

Αυτή είναι μια επιτόπια, δειγματοληπτική, συγχρονική έρευνα (cross-sectional). Ο πληθυσμός αναφοράς υπολογίστηκε από το αρχείο της Δευτεροβάθμιας Εκπαίδευσης. Η μέθοδος συλλογής των δεδομένων είναι η στρωματοποιημένη τυχαία δειγματοληψία. Στρώματα ορίστηκαν σύμφωνα με την Εθνική Στατιστική Υπηρεσία, το αστικό (50.00 και άνω κάτοικοι), το ημιαστικό (2.000 -50.000 κάτοικοι) και το αγροτικό (έως 2.000 κάτοικοι).

Το δειγματοληπτικό πλαίσιο αποτέλεσε η λίστα με το σύνολο των σχολικών μονάδων της Δευτεροβάθμιας Εκπαίδευσης του Ν. Ηρακλείου. Δειγματοληπτική μονάδα είναι η σχολική μονάδα. Από το σύνολο των σχολικών μονάδων της Δευτεροβάθμιας Εκπαίδευσης του Ν. Ηρακλείου (42) εξαιρέθηκαν τα εσπερινά λύκεια (2) λόγω του ότι διέφεραν σημαντικά τα κοινωνικοδημογραφικά χαρακτηριστικά των μαθητών. Από το σύνολο των σχολικών μονάδων επιλέχθηκαν μόνο οι μαθητές της Α΄ Λυκείου, λόγω του ότι οι μαθητές της Β' και Γ' Λυκείου έχουν αυξημένες σχολικές υποχρεώσεις, το οποίο θα διαφοροποιούσε σημαντικά τις μετρήσεις του κοινωνικού κεφαλαίου.

1.7.1 Δειγματοληψία

Ο πληθυσμός αναφοράς υπολογίστηκε σε 2.854 μαθητές. Αναλυτικά, στο αγροτικό στρώμα ανήκουν 9 σχολικές μονάδες με 268 μαθητές, στο αστικό 18 σχολικές μονάδες με 1.921 μαθητές, και στο ημιαστικό 14 σχολικές μονάδες με 665 μαθητές. Κατόπιν κλήρωσης με τυχαίο και συστηματικό τρόπο κληρώθηκαν για την πιλοτική μελέτη από το ημιαστικό στρώμα 5 σχολικές μονάδες (222 μαθητές).

Για το κύριο δείγμα, λόγω του μικρού σχετικά αριθμού των μαθητών συμπεριλήφθηκε το σύνολο του αγροτικού στρώματος (268 μαθητές). Αναφορικά με το αστικό στρώμα κληρώθηκαν οι 4 από τις 18 σχολικές μονάδες με απλή τυχαία δειγματοληψία (409 μαθητές).

Η συλλογή των δεδομένων πραγματοποιήθηκε σε δύο φάσεις. Την πρώτη φάση αποτέλεσε η πιλοτική εφαρμογή της κλίμακας (*YSCS- Youth Social Capital Scale*), προκειμένου να διασφαλιστεί η αξιοπιστία των μετρήσεων. Η πιλοτική εφαρμογή πραγματοποιήθηκε εκτός κυρίου δείγματος και συγκεκριμένα σε σχολεία που ανήκαν στο ημιαστικό στρώμα. Από αυτά επιλέγει τυχαία μια σχολική μονάδα (κωδ. 1753010), όπου στο σύνολο των τμημάτων της επαναλήφθηκε η μέτρηση με την πάροδο μιας εβδομάδας,

προκειμένου να διασφαλιστεί η αξιοπιστία της κλίμακας (test-retest reliability). Κατόπιν των απαραίτητων βελτιώσεων στη κλίμακα *YSCS* πραγματοποιήθηκε η δεύτερη φάση που αφορούσε στη συλλογή των κύριων δεδομένων από το κύριο δείγμα.

1.7.2 Εργαλεία μέτρησης

Το μέσο συλλογής των δεδομένων είναι το ερωτηματολόγιο. Για τις ανάγκες αυτής της μελέτης χρησιμοποιήθηκαν δύο εργαλεία.

α) Η Youth Social Capital Scale (YSCS) αναπτύχτηκε για να μετρά το ατομικό κοινωνικό κεφάλαιο των νέων 12 έως 20 ετών (Onyx et al., 2005). Για την παρούσα μελέτη, η κλίμακα έχει περάσει τη διαδικασία μετάφρασης και πολιτισμικής προσαρμογής σύμφωνα με τις αρχές καλής πρακτικής των Wild et al. (2005), ενώ παράλληλα πραγματοποιήθηκε η ψυχομετρική στάθμιση της κλίμακας στην Ελλάδα (Koutra et al., 2012a).

Η κλίμακα μετρά το κοινωνικό κεφάλαιο των νέων μέσα από πέντε διαστάσεις: α) τη συμμετοχή στην κοινότητα, β) τα γειτονικά δίκτυα, γ) οι φίλοι και οι γνωστοί δ) το αίσθημα της εμπιστοσύνης και ασφάλειας και ε) η ανοχή στη διαφορετικότητα. Το σύνολο των σταδίων μετάφρασης και πολιτισμικής προσαρμογής θα βρείτε στο έκτο άρθρο, στον κατάλογο των δημοσιεύσεων της διατριβής που είναι υπό δημοσίευση.

β) Το Health Behaviour in School-aged Children (H.B.S.C.) είναι ένα σταθμισμένο ερωτηματολόγιο που αναπτύχθηκε από ένα διεθνές ερευνητικό δίκτυο με τη συνεργασία του Π.Ο.Υ. με τη Ελλάδα να συμμετέχει σε αυτό από το 1997. Οι συμπεριφορές υγείας (κάπνισμα, αλκοόλ), η θετική υγεία, η κοινωνική ανισότητα, η οικογενειακή δομή και η επίδραση των συνομήλικων μετρηθήκαν με το H.B.S.C. (Ε.Π.Ι.Ψ.Υ, 2006). Άδεια και ερωτηματολόγια για τη χρήση χορηγήθηκε από την επιστημονικά υπεύθυνη για την Ελλάδα, η οποία είναι μέλος της τριμελής συμβουλευτικής επιτροπής, αυτή της διατριβής.

1.7.3 Χρονική διάρκεια και χρηματοδότηση

Τα ερωτηματολόγια είναι αυτοσυμπληρούμενα και ανώνυμα προκειμένου να διασφαλιστεί το απόρρητο των απαντήσεων των μαθητών. Ο χρόνος συμπλήρωσης του ερωτηματολογίου είναι 20 λεπτά. Κατόπιν αίτησης στο Υπουργείο Εθν. Παιδείας και Θρησκευμάτων για τη διεξαγωγής έρευνας στις σχολικές μονάδες του Νομού Ηρακλείου χορηγήθηκε στην ερευνήτρια στις 20-2-2008 με αριθ. Πρωτ. 20946/Γ2, η απαραίτητη

έγκριση μετά τη γνωμοδότηση του Τμήματος Ερευνών, Τεκμηρίωσης και Εκπαιδευτικής Τεχνολογίας του Παιδαγωγικού Ινστιτούτου. Η έρευνα διεξήχθη το 2008. Κανένας φορέας δεν χρηματοδότησε την έρευνα.

Κεφάλαιο 2ο Ψυχομετρική στάθμιση κοινωνικού κεφαλαίου

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Psychometric Validation of the Youth Social Capital Scale in Greece

Kleio Koutra[1], Philippos Orfanos[2], Theano Roumeliotaki[3], George Kritsotakis[4], Anna Kokkevi[5], and Anastasios Philalithis[6]

Abstract

Objectives: This article describes the psychometric validation of the Youth Social Capital scale (YSCS) in 16- to 17-year-old students living in rural and urban areas in Crete, Greece. Methods: Sampling was performed among 27 secondary education units of Heraklion Prefecture. The self-reported questionnaire was answered by 692 participants (response rate 96.3%). The validation of the scale included both internal consistency and construct, convergent and discriminant validity tests. Results: Exploratory factor analysis yielded five social capital factors. The overall Cronbach's α was coefficient .771. Factor analysis revealed common patterns for many questions between the Greek and the original scales. Conclusions: This article supports the validity of the YSCS for assessing the social context of young individuals in Greece.

Keywords

adolescents, methodology, factor analysis, reliability study, construct validity

Social capital appears to be a multidimensional resource derived from one's social networks, ties, and relations with other people and groups or communities. Social capitals' key elements of trust, reciprocity, and mutuality are integral to health and social work practice (Aghabakhshi & Gregor, 2007). In fact social work has a long tradition of using social capital interventions (Loeffler et al., 2004). Social workers focus on individuals', organizations', and communities' ties, networks, and interdependencies (Jordan, 2003). Thus, it is a natural fit for social capital practice and research. Although social workers are expected to promote, rebuild, and sustain social capital in the communities they work and intervene, seldom are these interventions discussed in terms of social capital (Ersing & Loeffler, 2008). This limits social work's contribution to the development of social capital theory. Thus, a paradigm change is needed to fully recognize the usefulness of social capital at the micro, mezzo, and macro practice level.

One pillar of this paradigm shift may be the development and validation of social capital measurement tools by social workers (Cheung & Kam, 2010). This will aid to evaluate the social capital effects of our interventions by assessing its effectiveness on favorable outcomes, and especially in health and well-being (Healy & Hampshire, 2002).

Various studies document a strong association between social capital, health and well-being, and adult health (Kawachi, Subramanian, & Kim, 2008; Kritsotakis & Gamarnikow, 2004). In youth, empirical research indicates that social capital may be a predictor of positive as well as negative outcomes (Wright, 2006). High levels of social capital in youth have been positively associated with academic performance (Coleman, 1988), prosperity, (Parcel & Dufur, 2001) subjective notion of health (Khawaja, Abdulrahim, Soweid, & Karam, 2006; Von dem Knesebeck, Dragano, & Siegrist, 2005), access to formal and informal caregiving systems (Boyce, Davies, Gallupe, & Shelley, 2008), promotion of successful youth development (Fustenburg & Hughes, 1995) and mental health (Boyd, Hayes, Wilson, & Beasly-Smith, 2008). In a research of five European countries and Canada, participation in clubs was supportive of healthy lifestyles for adolescents. However, political and youth groups had negative effects on smoking and drinking (Zambon et al., 2010).

Social capital has come under a fair amount of criticism. This criticism can mainly be attributed to the fact that a commonly accepted definition has yet to be found (Macinko & Starfield, 2001) and that measurement methods vary according

[1] Department of Social Work, Technological Educational Institute of Crete, Heraklion, Crete, Greece
[2] Department of Hygiene, Epidemiology and Medical Statistics, University of Athens, Athens, Greece
[3] Department of Social Medicine, University of Crete, Heraklion, Crete, Greece
[4] Nursing Department, Technological Educational Institute of Crete, Heraklion, Crete, Greece
[5] Department of Psychiatry, Athens University Medical School, Athens, Greece
[6] Faculty of Medicine, University of Crete, Heraklion, Crete, Greece

Corresponding Author:
Kleio Koutra, Department of Social Work, Technological Educational Institute of Crete, Heraklion, Crete 71301, Greece
Email: kkoutra@staff.teicrete.gr

to the theoretical approach (Kritsotakis, Koutis, Maiovis, & Philalithis, 2009; Lochner, Kawachi, & Kennedy, 1999). Main theorists of social capital have been criticized for seeing children as passive recipients of parental social capital rather than active producers who are capable of generating and articulating their own construction of self and society (Holland, Reynolds, & Weller, 2007; Morrow, 2002).

Young people are more likely to participate in informal social activities and to have larger social support networks than adults (Deviren & Babb, 2005). They are "socialised in friendship networks, participate in local activities, generate their own connections and make links for their parents" (Edwards, Franklin, & Holland, 2003, p.12). This knowledge enables further understanding of the social framework within which they live (Leeder & Dominello, 1999), the extent and nature of their social networks, and the ways and the communities (family, school, peers) in which they are socialized and develop ties (Bassani, 2007). Therefore, to better understand the social capital of youth, we must first gain further insight into their experiences and concerns regarding life (Onyx, Wood, Bullen, & Osburn, 2005; Panelli, 2002). For example, further insight is required into the role played by peer groups within the prism of social capital (Bassani, 2007).

Youth bonding social capital refers to inward-looking bonds, focusing on relationships and networks of trust and reciprocity that reinforce ties within groups (Portes, 1998). These may provoke some negative, effects in socialization and health. Thus, as is often the case within exclusive peer groups, young people may choose behaviors that meet the requirements of the group (e.g., youth gangs), and they may feel obliged to conform to its rules even if it is not in their own best interest to do so (Özbay, 2008).

Social capital of young people has mainly been measured using quantitative methods (Almgrena, Magaratib, & Mogford, 2009; Boyce et al., 2008; Drukker, Kaplan, Schneiders, Feron, & Os van, 2006; Özbay, 2008; Winstanley et al., 2008) and to a lesser extent using qualitative methods (Denner, Kirby, Coyle, & Brindid, 2001; Morrow, 2002). One of the tools used is the Youth Social Capital scale (YSCS) which was developed in Australia (Onyx et al., 2005) and is the adapted counterpart of that used for adults (Onyx & Bullen, 2000). The adult version has been cognitively and psychometrically tested in Greece (Kritsotakis, Antoniadou, Koutra, Koutis, & Philalithis, 2010; Kritsotakis, Koutis, Alegakis, & Philalithis, 2008). It is one of the few practical and reliable instruments to measure both bonding and bridging social capital (Harpham, Grant, & Thomas, 2002). In Greece, no research aiming at identifying the social capital of young people has been carried out (Chtouris, Zissi, Papanis, & Rontos, 2006).

The present study attempts to diminish this gap, since most efforts have deliberately focused on adults and avoided the issue of social capital and youth. The aims of this article are to describe the psychometric validation of the YSCS, establish the factor dimensions of the Greek version of the scale, and compare findings with those obtained from the original Australian study.

Methods

Participant Characteristics

The study population consisted of 2,189 secondary education students living in rural, semi-urban, or urban regions of the Prefecture of Heraklion, Crete. The methodology and results presented in this article is part of a greater study focused on the role of social capital to youth health behaviors. Using a cross-sectional design, only first grade students were chosen to participate in the study. In Greece, the elementary level is 6 years of school, and 12 years of schooling are needed prior to attend a university or a technical college. The minimum compulsory education is 9 years.

Sampling Procedures

The sampling frame was the Prefecture of Heraklion which is one of the four prefectures of Crete, Greece. It is the most densely populated and financial developed Cretan Prefecture (297 inhabitants/sq.mile; Office for Greek National Statistics, 2001). Farmlands are situated in the central and the northern parts of the island. The mountains dominate the rest of the prefecture including the south.

Rural and urban strata were based on data of the Greek Statistical Authority. Rural strata were villages with up to 2,000 inhabitants and urban strata towns over 50,000 citizens. The 27 secondary school units of the Prefecture of Heraklion comprised the sample units. In the strata of rural regions there were 9 school units with 323 students, and in the stratum of urban region there were 18 units with 1,548 students according to the Secondary Education Administration Office of the Prefecture of Heraklion. It was decided to include the whole rural stratum in the study, due to the small number of students, whereas from the urban stratum four school units were selected (512 students). The sampling ratio for the urban stratum was estimated at 0.331. Data were collected from April 2008 through June 2008.

Of the 835 students enrolled in the selected classes, in total 708 completed the questionnaire (day absences) and the response rate was 96.3%. The study sample was further reduced due to subject misclassification (11 students who attended "urban" schools but lived in rural areas) and due to missing information (5 uncompleted questionnaires). The final number of students included in the analyses was 692. Individuals with missing data in one or more sociodemographic variables were excluded from the descriptive and correlation analyses but not from the main analysis of factor extraction. Missing data ranged from 3 to 8 cases for the following variables: body mass index (BMI; 8 cases), district of residence (5 cases), number of siblings (3 cases), family type (3 cases), and income (3 cases).

Written ethical permission was granted from the Greek Pedagogical Institute and the Ministry of National Education and

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Religious Affairs (20946/G2/20-2-2008) and by the schoolmaster of each selected school. Students were informed during their classes about the aims of the study and the anonymity of their responses and were entitled to decide whether to participate in the study or not. Those who chose not to take part waited in the school yard. Students completed the YSCS-G during a school hour under the instructions of the researcher. Average completion time of the scale was estimated to be 20 minutes.

Measures

Sociodemographic data. For sociodemographic data collection, the Health Behaviour in School-Aged Children (HBSC) was used (Research Institute of Mental Health, 2005), in which Greece is one of the participating countries from 1997 until now. HBSC is a self-administered questionnaire consisted of 11 sections and 90 questions. Five sections were used for this study and part of those are presented here. Those sections were (a) You (demographic characteristics), (b) Health and my life (self-reported health, BMI, life satisfaction, and sexual behavior), (c) My relations, (d) My family (family type: single parent, tight, and extensive. "Tight family" consisted of only parents and children, while "extensive" included all grandparents living at home), and (e) Physical behavior and health (smoking, drinking, and drug use). Self-reported financial status was measured by a single question, "How well off do you think your family is?"

Social capital. The YSCS was developed to measure the individual social capital of youth aged 12 to 20 years old (Onyx et al., 2005). It is a self-administered questionnaire consisting of 34 questions in seven factors: (A) Participation in the community, (B) Youth social agency, (C) Trust and safety, (D) Neighborhood connections, (E) Family and friends, (F) Friends, and (G) Moral principles. All items are answered on a 4-point Likert-type scale. Higher score indicates more social capital. A summary score of ratings of all social capital items may be calculated.

Translation and cultural adaptation. To translate the YSCS in Greek, a 9-step approach of the Principles of Good Practice for the Translation and Cultural Adaptation was applied (Wild et al., 2005). According to this approach, the questionnaire was forward translated by two independent professional translators. Then, the first author compared and combined those translations and the outcome of this conciliation was back translated to English. The original and the back translated questionnaire were compared in order to identify the possible inconsistencies. The next step in this process was cognitive validation in order to evaluate the understanding of the instrument (Karabenick & Woolley, 2006). To assure cultural relevance of the cognitive debriefing results in relation to the original version, review of Cognitive Debriefing Results and Finalization followed (data not shown).

Statistics

Factor analysis. The Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy and the Bartlett's test of Sphericity were initially employed to determine the appropriateness of the data set for factor analysis (Kline, 1993; Malhotra, 1996). High values (>.5) in KMO indicate that the factor analysis is appropriate. Factor analysis using the correlation matrix was conducted to extract potential underlying dimensions that influence social capital in young people. To identify the number of factors the eigenvalue of >1.0 was used as the primary criterion. However, since this approach usually leads to the retention of many factors hardly interpretable and with variables loading high in more than one factor, the scree test and interpretability criteria were used. Varimax and promax rotation methods were applied to help in the simplification of factors' interpretation. Items with factor loadings >.30 were considered important contributors to a factor and played the key role for the interpretation and labelling of the construct they loaded on (Hair, Anderson, Tatham, & Black, 1998). Solutions deriving factors with less than 3 items with loading >.30 were disregarded.

Reliability and construct validity. Reliability and validity were investigated as main psychometric properties. The Cronbach's α coefficient was used as an index of internal consistency for each extracted factor using as criterion the lenient cutoff of .60, which is common in exploratory factor analysis to retain an item in an "acceptable" scale (Cronbach, 1951). Construct validity (both convergent and discriminant) were implemented to examine whether the items converge to the construct. In brief, corrected total correlations between the item score and the scores obtained from all extracted constructs were computed; the higher the correlation the more likely to obtain adequate convergent validity, and, the lower the correlation of an item's score with the scores of the other constructs the more likely to obtain adequate discriminant validity. Items with a corrected item-total correlation of less than .20 were dropped. Moreover, scale-discriminant validity was tested using the α coefficient (Ware & Gandek, 1998).

Association of social capital dimensions and sociodemographic characteristics. New variables reflecting the retained factors were subsequently produced using either (a) all item, by summing the standardized values of the items weighted by their absolute scoring coefficients or (b) those items that best define each factor—that is, items with the highest factor loadings—by adding their scores. Thus, each individual received two scores (one from option a and one from option b) for each construct retained, and the higher the score the more likely to be socially capitalized toward the corresponding dimension, irrespective of the option. Pearson correlations were applied among the retained factors and partial correlation coefficients were obtained for each of these factors with a series of sociodemographic and lifestyle characteristics (gender, district of residence, self-reported BMI, place of birth, number of siblings,

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family type, parents' socioeconomic status [SES], and income) controlling for gender and district of residence.

All statistical analyses were performed using the SPSS (SPSS 15.0 for Windows, 2006) and Stata (Stata/SE 11.0 for Windows, 2010; Stata Corporation, Lakeway Drive, College Station, Texas) statistical packages.

Results

Demographics Characteristics

A total of 692 students completed the surveys questionnaire (Table 1). As shown in Table 1, the sample consisted of 306 males and 386 females. The average age of the participants was 16.1 years (SD = .55). Boys had a higher BMI when compared to girls. The majority of them were born in Greece (95.4%). Irrespective of gender, the participants were living mainly in urban (or semi-urban) areas, in a "tight" type of family (although this percentage was higher for girls) with a satisfactory self-reported income status. Almost two third of the sample had both of their parents working. Most participants had siblings (either one or more), but the percentage of "only child" student was higher in boys.

Item Analysis and Data Adequacy for Factor Analysis

The overall KMO measure for the 31 items initially analyzed was .786 much higher than the cutoff of .5. However, the measure of sampling adequacy for Q28 "If you had an argument with a teacher or your employer, would you get mediation (that is another person to help work out your differences)?" was .479 (<.5), thus indicating that this item may not fit well with the other items. Its corrected item-total correlation was .036, which is much lower when compared to the item-total correlations of the rest 30 items. Therefore, this question was dropped from further analyses. The re-computed KMO measure for the final 30 items negligibly changed (.791) and the Bartlett's test of Sphericity verified that the interitem correlations were sufficient ($\chi^2 = 3233.8$; $df = 435$, $p < .0001$). The overall α coefficient was satisfactory (.771) and the item-total correlations ranged from .22 to .49 ($p < .05$), indicating that each of them contributed to the total score (Table 2). The final column in Table 2 indicates that the majority of the students responded favorably to most of the items (more than one third in 22 of the 30 items).

Factor Solution

Since there was no a priori assumption or suggestion for an orthogonal pattern, that is, the underlying factors to be unrelated, the oblique (promax) rotation was initially applied. The correlations among the extracted factors after oblique rotation were generally low (the majority being less than .20), thus indicating the use of an orthogonal rotation (data not shown). In order to obtain independent factors measuring different dimensions, principal components extraction method with varimax rotation was performed. Eight factors were found to have eigenvalues >1. The examination of eigenvalues, the scree test, and the fact that the solution led to ambiguous factors with some of them having less than three components indicated the retention of 5–7 factors (data not shown). Analyses were then carried out for 5, 6, and 7 factors and the results were contrasted. The 7-factor solution provided 4 factors with 3 items only and low α coefficients and was therefore rejected. The 6- and 5-factor solutions proved to be quite satisfactory in terms of interpretability, with the latter performing better in terms of simplification (that is, conceptual suitability with questions fitting better in the factors in this set) and having higher α coefficients when compared to the former.

Table 3 presents the questions that best define the five extracted factors in the Greek sample, as well as, the respective factors that loaded on in the original Australian youth analysis. The factor loadings of the 30 items on the Greek factors are also listed. Only two items (Q22 and Q5) loaded >.30 on more than one factors but were included in the factor in which they had the highest absolute scoring coefficient. Using as template the factors extracted in the original Australian study (Onyx et al., 2005), factor labels were chosen accordingly. The strongest factor (factor 1), almost identical to factor 2 of the Onyx study (only Q15 was not included), was labelled "participation in community" equivalently.

The second factor was in essence a combination of Factors 1 ("family and friends") and 6 ("friends") of the original study, indicating that these two factors represent a homogeneous component in the Greek sample. Only items Q23 (Q34 had already been dropped from the analyses) of the first Onyx factor and Q19 of the sixth Onyx factor did not load on this Greek factor. Based also on Q2, Q22, and Q30, which also loaded heavily, this Greek factor was labelled as "friends and acquaintances."

Factor 3 almost identical to Factor 4 of the Onyx study (only Q15 did not load) was labelled "neighborhood connections."

Factor 4 was unlike any factor of the original scale and included items that loaded on 4 out of the 7 factors identified by Onyx: Q8 and Q14, that is the overall original Factor 5 ("trust and safety"), Q17 and Q33 from original Factor 7 ("youth social agency"), Q23 from original Factor 1 ("family and friends"), and Q19 from original Factor 6 ("friends"). However, since all items that loaded on this Greek factor (except possibly Q17) appeared to concern a sense of feeling safe and having trust, it was labelled similarly as "trust and safety". Finally, three of the four items included in Factor 5 had loaded on Factor 3 in the original scale ("moral principles"). In spite of that, Factor 5 was labelled "tolerance to diversity" as its items meaning referred to tolerance.

Generally, factor analysis revealed common patterns for many questions between the Greek and the original scales: 20 out of the 30 items loaded on factors with quite similar interpretation and only 1 item (Q29) did not load on any of the factors having negligible absolute scoring coefficients (<.1).

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Table 1. Characteristics of the Study Participants in the Greek Sample[a]

	Total N = 692		Boys n = 306		Girls n = 386		
Characteristics	M	SD	M	SD	M	SD	P Value
Age in years	16.1	.55	16.2	.65	16.1	.44	<.001
Weight[b] in kg	64	13.20	71.5	14.00	57.9	8.67	<.001
Height[b] in m	1.7	.09	1.76	.07	1.65	.06	<.001
BMI,[b] kg/m^2	22.1	3.52	23.1	3.89	21.3	2.98	<.001
	n	%	n	%	n	%	
Age groups							.014
16–17	666	96.2	288	94.1	378	97.9	
Other (13–21)	26	3.8	18	5.9	8	2.1	
Born in Greece							.100
No	32	4.6	19	6.2	13	3.4	
Yes	660	95.4	287	93.8	373	96.6	
District of residence[b]							.755
Urban/semi-urban	402	58.5	175	57.8	227	59.1	
Rural	285	41.5	128	42.2	157	40.9	
Max number of siblings[b]							.013
2+ Siblings	305	44.3	130	42.8	175	45.5	
1 Sibling	336	48.8	143	47.0	193	50.1	
Only child	48	7.0	31	10.2	17	4.4	
Family type[b]							.001
Single parent	80	11.6	39	12.8	41	10.7	
Tight	476	69.1	188	61.8	288	74.8	
Extensive/other	133	19.3	77	25.4	56	14.6	
Family income status[b,c]							.334
Not good	138	20.0	65	21.2	73	19.1	
Good +	551	80.0	241	78.8	310	80.9	
Family's SES							
Both work	442	63.9	193	63.1	249	64.5	.750
Only one or none works[d]	250	36.1	113	37.0	137	35.5	

Note: SES = socioeconomic status.
[a] P Values refer to gender differences: Mann–Whitney nonparametric test for continuous variables; chi-square or Fisher exact tests for categorical variables.
[b] Missing values were excluded.
[c] This variable is based on self-reported responses on a 10-scale variable (cutoff used is 7).
[d] Father or mother either do not work or have died or unknown.

Reliability

The five factors accounted for the 38.3% of the total variance which could be considered low but the factors extracted were quite reasonable in terms of conceptual suitability (data not shown). The loss in explained variance from the 6-factor solution was negligible (4.5%; total variance explained for the 6-factor solution was 42.8%). In the original Australian study on adults, the percentage of total variance explained for the 8-factor solution was 49.3% (Onyx & Bullen, 2000) comparable to the Greek youth initial 8-factor solution (49.7%). The 41.1% for the 6-factor solution in the Greek general population (Kritsotakis et al., 2008) was similar to the 6-factor solution of our results.

The α coefficients for the first three Greek factors were .730, .643, and .708 respectively, all higher than the threshold of .60 for an acceptable reliability (Table 4). Removing any of the items in these three factors did not lead to an improvement in the factor reliability, indicating adequate internal consistency. Factor 5 had initially an α of .534, but the corrected item-total correlation for item Q5 was substantially low (<.20), indicating that this item fitted poorly in the corresponding construct and it was therefore dropped from the factor. The new α improved to .572, quite close to .60. Factor 4 labeled as "trust and safety" did not perform well with an α of .530. It was kept however, because the questions included in this factor inferred a conceptual suitability and supported the psychometric strength of the whole scale, and because in no other factor solution did we manage to get a higher α coefficient than this solution.

Construct Validity

Item-scale convergent validity was tested through the internally corrected item-total correlations (data not shown). The convergent validity was satisfactory for factors "participation in community," "neighborhood connections", "tolerance to diversity", and "friends and acquaintances" (in the latter only two items had correlations slightly lower than .30). Only the

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Table 2. The General Social Capital Factor and Questions Finally Used in the Greek Sample

	Descriptives				
Question	*M*	*SD*	Item Total[a]	Corrected Item Total[b]	% of Subjects Responding 3 or 4
1. Have you ever joined a local action? (e.g., a demonstration or a protest concerning the improvement of living conditions in your neighborhood/area).	1.460	.712	.36	.30	7.7
2. Do you feel important that you count between your coetaneous in school or the wider community that you live in?	2.909	.760	.32	.24	71.7
3. Can people with different lifestyles be part of your community? (e.g., from another country, with other religion, or different dressing codes).	2.922	.921	.29	.21	65.6
4. Have you ever picked up other people's rubbish in a public place?[c]	–	–	–	–	–
5. Some say that by helping others you help yourself in the long run. Do you agree?	3.087	822	30	22	77.5
6. Do you feel valued by friends and peers?	3.275	.695	.33	.27	87.9
7. Do you help out a local group as a volunteer?[c]	–	–	–	–	–
8. Do you feel safe walking down your neighborhood after dark?	3.447	.775	.22	.14	90.2
9. Within your group of friends are there people from a different country, speaking another language with different religion or customs?	1.965	1.099	.25	.14	29.5
10. Do your friends hustle to help you whenever you may need them?	3.510	.644	.34	.28	94.7
11. Have you ever been involved in organizing a youth event or youth project in the community? (e.g., speech, music concert, theatrical group, Chorus, music band).	2.295	1.218	.49	.39	41.2
12. If you needed to would you ask a neighbor for a favor?	2.319	1.039	.47	.38	37.4
13. Have you attended a local community event in the past 6 months? (e.g., live music, community celebration, sport event).	2.536	1.163	.44	.34	50.3
14. Does your area have a reputation for being a safe place?	2.734	.848	.29	.21	61.7
15. Are you an active member in a sports club, youth club, cultural club, or religious group, etc.?	2.319	1.241	.43	.32	49.1
16. Have you visited a neighbor in the past week?	2.192	1.172	.43	.32	32.4
17. Is life worth living?	3.610	.694	.27	.21	93.6
18. In the past week how many phone conversations have you had with friends?	2.932	1.006	.35	.26	68.3
19. Does your local community feel like home?	2.999	.975	.48	.40	68.4
20. Over the weekends do you use to go out with friends for lunch/ dinner/coffee of a drink?	3.043	1.071	.28	.17	69.1
21. In the last 3 years have you been part of a project for which a big part of your area/community needed to cooperate? (e.g., tree planting, cleaning, fund raising).	1.464	.718	.42	.36	6.9
22. When you go shopping in your local area are you likely to run into friends and acquaintances?	2.988	.953	.47	.39	68.8
23. Do you agree that in general people are trustworthy?	2.040	.752	.22	.15	22.5
24. If you need information to make a life decision do you know where to find that information? (e.g., further studies, health, sexual issues, personal problems).	3.163	.754	.33	.26	85.7
25. Do you enjoy living between people with different customs, lifestyle, language, or ethnicity?	2.530	.929	.26	.17	46.7
26. In the past month have you spoken to a neighbor?	3.198	1.042	.44	.35	71.4
27. Are you on a management committee or organizing committee for any local group or organization? (e.g., school council, local council, sports club).	1.646	.847	.46	.39	14.3
28. If you had an argument with a teacher or your employee would you get mediation? (that is another person to help work out your differences).[c]	1.816	.838	–	–	–

(continued)

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Table 2 (continued)

Question	Descriptives M	Descriptives SD	Item Total[a]	Corrected Item Total[b]	% of Subjects Responding 3 or 4
29. How many people did you talk with yesterday not counting your classmates at school?	2.971	.885	.40	.32	64.0
30. If you disagree with what everyone else agreed on would you feel free to speak out?	3.215	.881	.34	.26	79.2
31. Have you attended a local youth, community event in the past 3 months? (e.g., ball, speech, festival, sports event, protest).	1.814	.860	.49	.42	14.9
32. Have you ever been part of a project to organize a new service in your area? (e.g., youth club, local council, film club, theatrical group, local newspaper etc.)	1.412	.721	.39	.32	8.4
33. If a stranger someone different moves into your street would he or she be accepted by the neighbors?	2.984	.696	.24	.18	82.5
34. How many people would you contact in a week using Internet chat, e-mail, or phone SMS?[c]	–	–	–	–	–
Overall score	78.980	9.900	$\alpha^d = .771$		

Note: [a] Correlation of item with overall score (sum of all 30 variables used)
[b] Correlation of item with overall score excluding the item (corrected for overlap; sum of the remaining 29 variables used)
[c] Questions 4 and 7 were excluded since they were considered irrelevant for the sample of Greek students. Question 28 was dropped due to its small (<.5) measure of sampling adequacy (MSA), indicating poor fit with the structure of the other variables for factor analysis. Question 34 was misinterpreted and confused with Question 18 causing high percentage of missing values.
[d] Cronbach's α for the 30 items that were finally used.

fourth factor labeled as "trust and safety" did not perform well with four out of its six items having correlations <.30.

For those items with inadequate convergent validity, we tested whether they were related better to a factor other than the one they belonged to. No scaling failure occurred in any of these items except possibly Q17 which appeared to be equally correlated with the "friends and acquaintances" factor ($r = .24$ almost equal to its corrected item-total correlation with Factor 4 of $r = .25$). The findings supported satisfactory discriminant validity.

To further examine the discriminant validity, the α coefficients of the extracted factors were compared to the corresponding between-factor Pearson correlations (Table 4). The low correlations between the factors when compared to the respective α coefficients signify adequate scale-discriminant validity and it can be assumed that each factor is measuring a different dimension.

Individuals' Characteristics Related to Social Capital

Table 5 shows the partial correlation coefficients of each of the five extracted factors (as obtained from both options a and b) with a series of sociodemographic and lifestyle variables after controlling for gender and district of residence. District of residence is associated with all social capital dimensions, although the magnitude of association is attenuated when using the option b (items that best define each factor) for "friends and acquaintances" and "tolerance to diversity" factors. More specifically, living in rural areas is positively associated with "participation in community," "neighborhood connections," and "trust and safety" and inversely associated with "friends and acquaintances" and "tolerance to diversity." Moreover, boys seem to score higher in "participation in community," "trust and safety," and "tolerance and diversity" than girls. Family income is positively associated with "friends and acquaintances" and "trust and safety," while family's SES is positively associated with "neighborhood connections" and negatively associated with "tolerance and diversity."

Discussion and Applications to Social Work

This study presents the psychometric validation of the YSCS in Greece (YSCS-G). The overall results show that it is a reliable and valid tool to measure social capital among young students. Although, there is some variation in the performance of individual items and the scales, the overall evaluation suggests that it includes relevant items, which young people can relate to and that it is easy to complete.

Factor analysis produced five social capital subscales based on 30 items instead of the original 34. Interestingly, the main components of social capital are represented in those factors. YSCS-G measures both cognitive and structural components of social capital. Cognitive social capital, which refers to trust and reciprocity, is measured through the "trust and safety" factor. Structural social capital, which refers to collective action and group membership through horizontal organizations and networks, is perfectly fitted with the "participation in community" factor. The tool also taps, to some extent, the two out of three forms of social capital: bonding through "friends and acquaintances" and bridging through relationships to people of a different social identity through "tolerance to diversity."

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Table 3. Factor Loadings for the Final Five Extracted Independent Factors in the Greek Sample

Item	Participation in Community	Friends and Acquaintances	Neighborhood Connections	Trust and Safety	Tolerance and Diversity	Original YSCS[a]
27	.65	.06	.02	.11	−.08	Participation in community
32	.61	−.01	.00	.04	.09	Participation in community
15	.61	.10	−.09	.08	−.05	Neighborhood connections
31	.60	.14	.10	.01	.13	Participation in community
21	.58	−.02	.22	.03	−.01	Participation in community
13	.55	.03	.11	.10	−.02	Participation in community
11	.55	.14	.14	−.01	.14	Participation in community
1	.51	.00	.09	−.02	.08	Participation in community
6.	−.04	.60	.01	.30	−.07	Friends
20	.09	.59	−.11	−.13	−.07	Family and friends
10	.02	.57	.03	.23	−.07	Friends
22	.13	.55	.34	−.03	.03	Youth social agency
2	.15	.51	−.10	.09	−.05	Moral principles
30	−.02	.49	.09	.00	.25	Moral principles
18	.16	.42	.11	−.17	.07	Family and friends
24	−.03	.38	.20	.21	.08	Family and friends
26	.06	.11	.75	.06	.11	Neighborhood connections
12	.21	.01	.75	.05	.02	Neighborhood connections
16	.16	.00	.72	.06	−.02	Neighborhood connections
14	.12	−.08	.04	.68	−.05	Trust and safety
19	.11	.18	.28	.57	.09	Friends
23	.03	.03	−.02	.50	.07	Family and friends
17	−.01	.33	−.10	.46	.04	Youth social agency
33	−.01	.08	.01	.45	.17	Youth social agency
8	.10	−.03	.12	.35	−.19	Trust and safety
25	.01	−.01	.02	.09	.76	Moral principles
3	.04	.04	.03	.10	.75	Moral principles
9	.26	−.15	.04	−.09	.51	Youth social agency
5	.02	.33	.01	.08	.39	Moral principles
Items below did not load on any factor						
29	.27	.24	.25	.11	−.14	Youth social agency

[a] Items that best define each of the seven factors extracted on the original scale of Onyx, Wood, Bullen, and Osburn (2005).

Although different when compared to the 7-factor solution of the original study, the 5-factor solution is considered conceptually suitable at identifying simple factors with explicit interpretation. It was proved to be better than the 6- and 7-factor solutions leading to profound and interpretable factors.

Theoretically, we could assume that the dimensions for social capital are independent and therefore an orthogonal rotation is appropriate. Nevertheless, several analyses were applied using combinations of different statistical methods, such as 5-, 6-, or 7-factor solutions, either with orthogonal or with oblique rotations, and either with principal components or with principal axis factoring extraction methods. The "participation in community," "neighborhood connections," and "tolerance to diversity" dimensions were identified in all cases, irrespective of the methodology applied, reflecting the strength and importance of these dimensions in the Greek youth sample (although the latter had an α coefficient <.60). The differences in extracted factors among the several solutions and methods applied referred to the items composing Factors 2 and 4. However, the two (remaining) factors ("friends and acquaintances" and "trust and safety") derived from the 5-factor solution had larger α coefficients and quite explicit interpretation when compared to the factors extracted from higher factor solutions.

The present study provides evidence for common dimensions of social capital in young people in Greece with those identified in the original youth study (Onyx et al., 2005). Dimensions like "participation in community," "neighborhood connections," and "friends and acquaintances" (as a combination of two original factors) were also identified and were the strongest in terms of percentage of explained variance and α coefficients. The "tolerance to diversity" dimension was also replicated with only moderate variations in the items included. The only factor that was quite different from those extracted in the original study was the fourth, although it included the original Factor 5 referring to "trust and safety" as a whole. However, the rest of the items composing this factor support our decision to keep the same label as that of the original Factor 5. The only original factor that could not be replicated in the Greek sample was the "youth social agency," the items of which were distributed in three Greek factors. This comes as no surprise as the questions had a similar distribution in the Greek adult version (Kritsotakis et al., 2008). The

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Table 4. Pearson Correlation Coefficients Among the Extracted Social Capital Factors in the Greek Sample

	Participation in Community	Friends and Acquaintances	Neighborhood Connections	Trust and Safety	Tolerance to Diversity	Cronbach's α
Participation in community	1	.22[1]	.30[1]	.19[1]	.15[a]	.730
Friends and acquaintances		1	.18[1]	.27[1]	.05	.643
Neighborhood connections			1	.19[1]	.09[b]	.708
Trust and safety				1	.08[b]	.530
Tolerance and diversity					1	.572

Note: The correlations between the factors emerge by adding the scores for the best questions (highest loadings) that define each factor
[a] Statistically significant correlation at the .001 level of significance.
[b] Statistically significant correlation at the .05 level of significance.

Table 5. Partial Correlations Coefficients for Each of the Extracted Factors With a Series of Sociodemographic Variables After Controlling for Gender and District of Residence

	Participation in Community		Friends and Acquaintances		Neighbor-hood Connections		Trust and Safety		Tolerance to Diversity		General Factor
	C1	C2	C1	C2	C1	C2	C1	C2	C1	C2	C3
Gender[a]	−.12[c]	−.07[c]	.07	.01	.03	.03	−.17[c]	−.20[c]	.27[c]	.12[c]	−.05
District of residence[b]	.24[c]	.27[c]	−.14[c]	−.05	.29[c]	.28[c]	.17[c]	.18[c]	−.12[c]	−.05	.22[c]
Born in Greece	.02	.04	.03	.01	−.03	−.02	.10	.08[c]	−.19[c]	−.21[c]	−.01
BMI	.01	.00	−.04	−.03	.07	.06	−.07	−.07	.01	.02	−.01
Max number of siblings	−.07	−.05	.10[c]	.12[c]	−.01	−.02	.03	.06	.06	.03	.04
Family type	−.01	.01	.04	.04	.07	.07	.07	.07	.03	.01	.07
Family income status	.04	.06	.23[c]	.24[c]	.00	.04	.16[c]	.19	−.06	−.04	.18[c]
Family's SES	−.05	−.02	−.02	−.05	.08[c]	.08[c]	.02	.00	−.08[c]	−.11[c]	−.04

Note: SES = socioeconomic status; C1 = The factor variables (social capital factors) emerge by summing the standardised values of all 30 items weighted by their absolute scoring coefficients; C2 = The factor variables (social capital factors) emerge by adding the scores for the best questions (highest loadings) that define each factor; C3 = The general factor emerges by summing the scores for all 30 questions used in the analyses. Missing values are omitted in each bivariate correlation.
[a] Controlling only for district of residence.
[b] Controlling only for gender.
[c] Statistically significant correlation at the .05 level of significance.

psychometric tests revealed adequate internal consistency with acceptable α coefficients (except for one extracted factor) and satisfactory construct validity (both convergent and discriminant) based on the item-total correlations.

A significant contribution of this article is that youth social capital is a complex concept. Its different components (cognitive and structural) and types (bonding, bridging, and linking) have different associations with certain group characteristics (gender, locality, and income). These should be explored independently to effectively guide our everyday practice.

From the correlation analyses, it was evident that there were gender differences in social capital. Girls seem to have lower "participation in community" and "trust and safety" while they scored higher in "tolerance to diversity." Our findings are in agreement with Dallago et al. (2009): they found strong gender differences on how 15-year-old students from 13 countries perceive their local neighborhood area (place attachment, social capital, and safety). Girls had a weaker bond with the local area where they lived, perceived their neighbors as less connected, and felt less safe than boys. Hofferth and Iceland (1998) have also documented that it is more possible to have supportive networks and strong patterns of giving in rural regions than in urban settings. In the present study, the place of residence holds an important role in the formation of social capital, but it cannot be compared with the original validation as it was focused only on rural regions.

Social work can play an important role in youth social capital building through planning and managing comprehensive empowerment activities at the community level. Social capital may facilitate collaboration, trust, belonging, and membership. Previous collaboration experience is a key predictor of current levels of trust. Priority must be placed on understanding and promoting positive developmental features of adolescent extracurricular activities, social clubs such as community groups

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(e.g., youth clubs), service-focused groups (e.g., interaction), and school leadership groups (e.g., student council). These environments may foster intrapersonal and interpersonal assets and community resources.

Among the advantages of this study were its large sample size; the use of standardized procedures for the translation process of the original questionnaire; the high response rate of the study, the implementation of several combinations of statistical methods, and the consistency occurred irrespective of method (three standard factors were identified by any of the methods applied); and the investigation of several variables with potential predictive importance for the strongest social capital dimensions (as extracted from factor analysis).

Limitations of the study were the nonrepresentative sample of the Greek student population as it referred only to the island of Crete, and the dropping of a number of items throughout the analysis (Q4, Q5, Q7, Q28, and Q29). Possible explanations for the exclusion of these items may be their irrelevance with the Greek sample when compared to the Australian one or, to a minor extent, the variation in the statistical methods (although we have used varimax rotation like the original study). Another limitation was the inadequate α coefficient for factor "trust and safety" (<.60). The reason for this may be that for the Greek sample, questions need to be added or modified in order to capture this dimension. However, no information on α coefficients was available in the original study in order to compare values and the level of internal consistency. Finally, it was not feasible to assess test–retest reliability due to logistical constraints and the luck of a data for the participants from another point in time.

In conclusion, the study provides evidence that YSCS-G is a valid and reliable tool to assess the social context of young educated individuals in rural and urban settings and that the Social Capital (SC) measurement tools should be validated in each new cultural setting in which they are used. Understanding the need for and the process of conducting a psychometric validity study is important for social work researchers. Social work practitioners are obligated to critically review measures and methodology significant issues they use in their research. The scale has a potential use as an assessment tool, an intervention planning strategy, and an outcome measure enabling social workers and health professionals to gain further insight and to better understand how Greek students develop their social capital and their socialization process. Future research will help to increase the efficacy of collaborative processes as well as our understanding of social capital's broader benefits. This knowledge can be used to plan a number of community interventions in various important life domains of young people such as relationships, community participation, collaboration, health, education, employment, and use of leisure time.

Authors' Note

Kleio Koutra, Department of Social Work, Technological Educational Institute of Crete, Heraklion, Crete, Greece. Contact: kkoutra@staff.teicrete.gr.

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Social capital and regular alcohol use and binge drinking in adolescence: A cross-sectional study in Greece

Kleio Koutra[1], George Kritsotakis[2], Philippos Orfanos[3], Nikoleta Ratsika[4], Anna Kokkevi[5], & Anastas Philalithis[6]

[1]*Department of Social Work, Technological Educational Institute of Crete, Heraklion, Crete, Greece,* [2]*Department of Nursing, Technological Educational Institute of Crete, Heraklion, Crete, Greece,* [3]*Department of Hygiene, Epidemiology and Medical Statistics, Medical School, University of Athens, Athens, Greece,* [4]*Department of Social Work, Technological Educational Institute of Crete, Heraklion, Crete, Greece,* [5]*Department of Psychiatry, Athens University Medical School, Eginition Hospital, Athens, Greece, and* [6]*Faculty of Medicine, University of Crete, Heraklion, Crete, Greece*

Aims: The purpose of this study is to examine the gender-specific associations of different dimensions of individual-level social capital with regular alcohol consumption and binge drinking in 16–17 years old adolescents in Crete, Greece.
Methods: Of the 835 randomly selected students, 708 completed the Youth Social Capital Scale and the Health Behaviours in School-aged Children (HBSC) questionnaire from April through June 2008 and 650 (92%) were included in this analysis. The outcome of interest was regular alcohol use and binge drinking. A gender specific backward stepwise logistic multivariate regression was performed adjusted for potential confounders.
Findings: For both boys and girls, higher score on some structural social capital subscales was associated, per unit increase, with increased likelihood of regular drinking. Neighbourhood connections were also associated with increased binge drinking in girls. Cognitive social capital subscales were associated with decreased likelihood of binge drinking in girls. For both genders, total social capital-score was positively associated with the probability of regular, but not of binge drinking.
Conclusions: Cognitive and structural social capital dimensions have different patterns of association with regular and binge alcohol use in adolescent boys and girls. Social capital's dimensions should receive greater emphasis for the design of effective preventive interventions in adolescence, particularly in the light of an increasing prevalence of alcohol consumption in modern societies.

INTRODUCTION

Underage alcohol consumption is very common in many European and North American countries (Currie et al., 2012). In Greece, the prevalence of frequent alcohol consumption in adolescence is among the highest in Europe and the proportion of Greek students who have consumed alcohol during the past 12 months (87%) and the past 30 d (70%) is typically higher than that of most European countries (Arvanitidou, Tirodimos, Kyriakidis, Tsinaslanidou, & Seretopoulos, 2007; Hibell et al., 2012; Hibell, Guttormsson, & Ahlström, 2009; Kokkevi et al., 2007). In addition, heavy episodic drinking among 15–16 years old students increased significantly in recent years (Hibell et al., 2012).

Adult men usually exceed women in typical drinking frequency, in average alcohol consumption, in rates of heavy drinking episodes and in adverse drinking consequences, although the gender gap is narrowing in some countries (Keyes, Li, & Hasin, 2011; Wilsnack, Vogeltanz, Wilsnack, & Harris, 2000). Similar trends can be noted for adolescent boys and girls, although in some countries the above-mentioned averages and rates are almost equal between boys and girls and in some cases girls outnumber boys

Correspondence: Kleio Koutra, Master of Public Health (MPH), BA of Social Work, Department of Social Work, Technological Educational Institute of Crete, Estauromenos, P.O. 1939, 710 04, Heraklion, Crete, Greece. Tel: +30 2810379527. Fax: +30 2810379522. E-mail: kkoutra@staff.teicrete.gr

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(Hibell et al., 2012; Schulte, Ramo, & Brown, 2009). In Greece, boys reported higher percentages of adverse alcohol consumption more often than girls (Hibell et al., 2012). Underage alcohol consumption should, thus, be considered a public health concern in Greece (Kokkevi et al., 2007) due to its high associations with multiple health risk behaviours, delinquent behaviour and academic underachievement, (Koutra et al., 2012a; Tsai, Anderson, & Vaca, 2010) and its contribution to premature morbidity, injuries and deaths at younger ages (Möller, Dherani, Harwood, Kinsella, & Pope, 2012; Stone, Becker, Huber, & Catalano, 2012).

Previous studies have shown that individual, peer, parental, environmental and genetic factors are predictors of alcohol consumption and binge drinking in adolescence (Bobakova et al., 2012; Hanewinkel et al., 2012; Nunez-Smith et al., 2010; Richter, Leppin, & Gabhainn, 2006; Sanchez, Locatelli, Noto, & Martins, 2013; Tornay et al., 2013) although the associations vary across countries and depend on the gender of the participants. Gender is related to alcohol consumption for a number of reasons. Gender-specific constructs and expectations (Landrine, Bardwell, & Dean, 1988) and social roles and relationships (Schinke, Fang, & Cole, 2008) can serve to guard protectively or not the likelihood of drinking. The socialization process demands for girls to reduce or stop alcohol consumption while boys are taught to maintain or increase it (Schulte et al., 2009).

Morgan and Haglund (2009) stated that "as alcohol consumption is closely connected to societal and cultural norms, it is not surprising that the influence of community-level factors, social networks and social capital in shaping adolescents' alcohol consumption is an issue of growing attention in current public health agenda" (p. 1). However, the effect of social capital on the formation of health risk behaviours in adolescents has yet to be fully understood.

Social capital refers to elements of social organization such as social networks, participation in associations, feelings of safety, trust and reciprocity all of which facilitate collective action (Kawachi, Subramanian, & Kim, 2008; Kritsotakis & Gamarnikow, 2004). There is an inconsistency regarding the conceptualization of social capital, with two main theoretical perspectives, as Kawachi et al. (2008) stated: the communitarian (or normative or consensual) paradigm proposed by Putnam (2000) and the individualistic (or relational or conflict paradigm) proposed by Bourdieu (1983/1986) In the first approach, social capital is a societal construct measured at the ecological level and it is emphasized as the features of social organization (networks, norms, reciprocity, social cohesion and social trust) that facilitate collective action. In Bourdieu's view, social capital is the actual or potential resources at the individual level that are linked mainly to durable social networks. In this individualistic approach social capital is measured by assessing the individual's perceptions of the social environment and their actual networks (De Silva, McKenzie, Harpham, & Huttly, 2005).

A prominent distinction is made between cognitive and structural features of social capital. Cognitive social capital measures what people feel (e.g. fear, trust, reciprocity) whereas, structural social capital measures what people actually do in their social environments (e.g. volunteerism, participation) (Kawachi et al., 2008).

Youth social capital is a complicated notion that is poorly defined despite the fact that it enables further understanding of the social framework within which adolescents live, the extent and nature of their social networks, the communities in which they are socialized and develop ties as well as the ways they do it (Bassani, 2007; Leeder & Dominello, 1999). Bourdieu does not mention young people in his analysis of social capital although it is his approach that provides resourceful ways in which many young people use their social capital to overcome economic constraints, as individuals and within groups (Cockburn & Cleaver, 2009; Gillies, 2005). Putnam, on the other side, mainly perceives children as the result of their parents' social capital in the community, according to Leonard (2008) "as human becomings rather than human beings" (p. 226).

Bryden, Roberts, Petticrew, and McKee (2013) reviewed the relevant evidence and reported inconclusive results on the influence of socio-structural factors such as deprivation, poverty, income, unemployment, social disorder and crime on alcohol use. However, they reported some indication of a protective effect of social capital, community supportiveness, and community attachment on alcohol use in adolescent and student populations (Bryden et al., 2013). Nevertheless, this protective effect is not consistent across literature.

Binge drinking in adolescents aged 12–18 years old had no significant associations with individual-level social capital in terms of generalized trust and social participation in a cross-sectional study in a medium-sized town on the south coast of Sweden (Lundborg, 2005). Takakura (2011) reported that individual-level trust and safety was associated with lower likelihood of alcohol consumption among 3248 students aged 15–18 years old in the Prefecture of Okinawa, Japan. Along these lines, Wray-Lake et al. (2012) using data from a 33-years ongoing United States nationally representative survey (1976–2008), reported that community attachment, social trust and social responsibility were all associated with lower alcohol use among high school seniors. Cross-sectional data from the US College Alcohol Study, found that community participation and volunteerism increased the likelihood of light drinking but decreased the likelihood of binge drinking in a nationally representative survey of 17,592 young adults aged 18 to 26 years enrolled at 140 four-year colleges, a result of definite public health interest (Weitzman & Kawachi, 2000). A study of 7097 children aged 11, 13 and 15 years old assessed the

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links between civic participation and adolescent behaviour problems. It showed that as adolescents get older, the participation rate increases and so does alcohol consumption. The study also confirmed the importance of comparing results according to gender as boys differentiated from girls (Vieno, Nation, Perkins, & Santinello, 2007).

This inconsistency in the outcomes of the associations urge for a more detailed gender-specific exploration of the associations of different social capital dimensions in relation to regular and binge alcohol consumption in adolescence. This is of definite importance in the Greek context, because the Mediterranean social environment is different from that of the Northern European countries. The inconsistencies may be explained by differences in the cultural context, the social capital dimension, the outcome measures used and gender. Consequently, in the present study we explored the gender-specific role of social capital on regular and binge alcohol consumption among adolescents in Crete, Greece.

METHODS

Participants

The target population consisted of first grade secondary school students living in rural and urban regions in the Prefecture of Heraklion, Crete (Hellenic Statistical Authority, www.statistics.gr). Crete is the fifth largest island of the Mediterranean with the highest rates of population increase among all European Regions (OECD, 2005). A random sampling design was adopted with the Prefecture of Heraklion as the sampling frame. Nearly half of the secondary schools were randomly selected ($n = 17$) and all first-grade students (16+ years old) attending the selected schools were chosen to comprise the study sample, that is, 835 students. A total of 708 students participated (85%, as a consequence of student absences) by completing a self-administered questionnaire assessing socioeconomic, demographic, and behavioural information and social capital. Sixteen students did not fully complete the questionnaire on social capital and therefore excluded from subsequent analyses. Details on the sampling procedures have been previously described (Koutra et al., 2012b). From the remaining 692 individuals, 42 were excluded from the present analysis due to missing values on one or more variables of interest. The final sample included 650 students, 291 boys and 359 girls (78% of the original study sample). When comparing the characteristics between those included (650) and those excluded (42), there were no significant differences. The mean values in social capital factors did not differ, apart from the factor ''tolerance to diversity'' ($p = 0.030$) (data not shown).

Data collection

Data were collected during April to June 2008. Ethical permission was granted by the relevant committee of the Greek Pedagogical Institute (decision number: 20946/G2/20-2-2008) and by the schoolmaster of each participating school. Students received written and oral information about the aim of the study and the anonymity of their responses. They were provided with the necessary instructions by the principal researcher, while the teacher waited outside the classroom (Koutra et al., 2012b).

Measures

Alcohol consumption

The Health Behaviours in School-aged Children (HBSC) instrument was used to collect information on alcohol consumption and other variables. The HBSC is a standardized questionnaire developed by an international research network in collaboration with the World Health Organization Regional Office for Europe and has been previously used in Greece (Currie et al., 2011; Koller et al., 2009). The questionnaire, despite a number of constraints, has been recognized as an important tool for cross-national comparisons of high quality data (Roberts et al., 2007).

In this study, we used two dichotomous variables to reflect students' alcohol consumption: (a) regular drinking and (b) binge drinking. The regular drinking was measured by asking ''at present how often do you drink any alcoholic drink''. Responses were rated on a 5-point scale (1 = every day; 2 = every week; 3 = every month; 4 = rarely; 5 = never). Students who reported drinking on a daily or weekly basis (1, 2) were categorized as regular drinkers when compared to those drinking on a monthly of less basis (3, 4, 5); (Morgan & Haglund, 2009). Binge drinking was measured by asking ''Have you ever had so much alcohol that you were really drunk?'' Responses were rated on a 5-point scale (1 = no, never; 2 = yes, once; 3 = yes, 2–3 times; 4 = yes, 4–10 times; 5 = more than 10 times). Students who reported having been drunk at least two or three times in a lifetime were categorized as binge drinkers (Bauman & Phongsavan, 1999; Vieno, Gini, & Santinello, 2011) when compared to those having been drunk once or never. The cut-off point to dichotomize the variables was based both on the categorizations found in current literature and on the distribution of our data.

Social capital

The Youth Social Capital Scale (YSCS, Onyx, Wood, Bullen, & Osburn, 2005) has been psychometrically adapted in Greek (Koutra et al., 2012b) comprising a general social capital factor (total SC-score), as well as five subscales representing different social capital dimensions: ''participation in the community'', ''friends or acquaintances'', ''neighbourhood connections'', ''trust and safety'', and ''tolerance to diversity'' (Koutra et al., 2012b). Social capital is measured by adding the scores of the questions (4-point scale-variables) that best defined each factor. Higher scores in each of these subscales reflect higher social capital

(Koutra et al., 2012b). The extracted factors represent cognitive (e.g. ''trust and safety'': Does your area have a reputation for being a safe place?, ''tolerance to diversity'': Do you enjoy living between people with different customs, lifestyle, language, or ethnicity?) and structural components of social capital (e.g. ''neighbourhood connections'': In the past month have you spoken to a neighbour?, ''participation in community'': Ever joined a local action?) (Koutra et al., 2012b).

Potential predictor variables

Information on several socio-economic, demographic and anthropometric variables was further collected via the HBSC instrument. Among these were age, country of birth, parents' birthplace, district of residence, parental occupation based on the British Registrar General's social classification of occupations (OPCS, 1991; Richter et al., 2006) and type of family. Moreover, variables indicating the student's perception for the quality of life and their health status were explored as proxies for co-morbidities (depression/anxiety) due to the absence of relevant data. Other included variables were: sexual activity and smoking status; student's belief/perception of having friends who smoke or consume alcohol; students' perception of family's financial status and satisfaction from family relationships. Finally, information on body perception, self-reported body mass index, use of illicit drugs (hashish, marijuana, etc.), victim of bullying and number of siblings were further considered.

Strategy for analyses

To investigate the associations of alcohol consumption with social capital, gender-specific logistic regression models were performed using regular and binge drinking as dependent variables. Initially, the interactions between district of residence and other potential confounders with social capital factors on alcohol consumption were tested and found to be statistically non-significant at the 5% level of significance. A multivariate analysis was performed including all five social capital factors (mutually adjusted) controlling for potential confounders using a stepwise logistic regression through the application of a backward elimination procedure: each model started by including all variables as independent (potential predictors) and eliminated one variable at a time with the highest p-value, using as significance level of removal $p = 0.100$. The final gender-specific logistic regression models extracted from the backward elimination procedure included, in addition to the five social capital factors, those variables that were found to be significantly associated with regular drinking or binge drinking (based on the aforementioned significance level of removal) in more than one of the several models performed. These potential confounders were: district of residence (urban versus rural), smoking status (never smoke or only experimented versus smoke at least once a week), sexually active (no versus yes) and the two variables indicating belief/perception of whether they had friends who smoke or who consume alcohol (both were classified in five categories: none; few; some; most; and all friends, and were used as ordered variables). The aforementioned models were also fitted using total SC-score as dependent variable. To take into account the potential effect of cluster sampling, the reported 95% confidence intervals (95%CI) were calculated based on robust standard errors. All statistical analyses were performed using the SPSS statistical package (SPSS 18.0; SPSS Inc., Chicago, IL).

RESULTS

The general characteristics of the 650 students and the scores for the social capital dimensions are presented in Table I. The majority of the students were born in Greece (95.5%). In the social capital factors, there were generally no differences between boys and girls in ''participation in the community'', ''friends or acquaintances'' and ''neighbourhood connections'', while boys reported feeling more safe (''trust and safety'', $p < 0.001$), but less tolerant to diversity ($p < 0.001$). The proportions of both regular (52.2%) and binge (32.6%) drinkers among boys were generally twice as much that of girls (20.1% and 18.1%, respectively).

Irrespective of gender, the proportions of regular and binge drinkers were substantially higher among smokers when compared to non-smokers ($p < 0.001$). Both regular alcohol consumption and binge drinking was more common among students who had the belief that many of their friends smoke and/or consume alcohol. The proportion of binge drinking was higher in rural areas when compared to the urban ones, but only among boys ($p < 0.001$) (data not shown).

The gender-specific associations between regular drinking and binge drinking with SC after adjusting for several confounders are presented in Table II (for the social capital subscales) and Table III (for the total SC-score). Boys reporting higher participation in the community (structural social capital) were more likely to be regular drinkers (adjusted OR 1.09 95%CI 1.02–1.17). Among girls, a higher score in the ''neighbourhood connections'' (adjusted OR 1.13 95%CI 1.00–1.27) and ''participation and community'' factors (both structural social capital subscales) was associated with an increased likelihood of regular drinking (although marginally not significant for the latter in the adjusted models).

Among girls, those scoring higher in ''trust and safety'' and ''tolerance to diversity'' factors (cognitive social capital) were consistently found to be less likely binge drinking drinkers (adjusted OR for ''trust and safety'': 0.80, 95%CI 0.69–0.93; adjusted OR for ''diversity'': 0.83, 95%CI 0.71–0.97).

For both genders, total SC-score was positively associated with the probability of regular drinking

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Table I. General characteristics of the study sample of 650 adolescents in Crete, Greece.

	Boys (n = 291)		Girls (n = 359)	
	Mean	SD	Mean	SD
Social capital factors[a]				
Total SC-score (28 items)	73.6	9.3	72.5	9.2
Participation in community (8 items)	15.3	4.4	14.7	4.6
Friends or acquaintances (8 items)	25.0	3.7	25.1	3.6
Neighbourhood connections (3 items)	7.6	2.6	7.8	2.5
Trust and safety (6 items)	18.6	2.5	17.3	2.4
Tolerance to diversity (3 items)	7.2	2.2	7.7	2.1
Body mass index (kg/m^2)	23.0	3.6	21.3	3.0
Number of siblings	1.6	1.2	1.7	1.1
Satisfaction from family relationships[b]	8.3	1.9	8.2	1.9
Perceived financial status[b]	6.8	1.8	7.0	1.7
Quality of life[b]	7.5	1.7	7.3	1.8
	n	%	n	%
Age				
16 years old	243	83.5	339	94.4
17 years old	32	11.0	14	3.9
18+ years old	16	5.5	6	1.7
Regular drinking[c]				
No	139	47.8	287	79.9
Yes	152	52.2	72	20.1
Binge drinking[d]				
No	196	67.4	294	81.9
Yes	95	32.6	65	18.1
District of residence				
Urban	170	58.4	213	59.3
Rural	121	41.6	146	40.7
Country of birth				
Other	17	5.8	12	3.3
Greece	274	94.2	347	96.7
Parents' birthplace				
Other[e]	28	9.6	20	5.6
Greece	263	90.4	339	94.4
Parental occupation[f]				
High	87	29.9	108	30.1
Medium	71	24.4	86	24.0
Low	128	44.0	158	44.0
Not specified	5	1.7	7	1.9
Family type				
Single parent	37	12.7	37	10.3
Both parents / extended	242	83.2	315	87.7
Other	12	4.1	7	2.0
Perceived health				
Very good	148	50.9	152	42.3
Good	108	37.1	151	42.1
Average/bad	35	12.0	56	15.6
Body perception				
Slim/underweight	60	20.6	47	13.1
Normal	150	51.6	168	46.8
Overweight	81	27.8	144	40.1
Victim of bullying				
Never	134	46.0	193	53.8
A couple of times	84	28.9	97	27.0

(continued)

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Table I. Continued.

	Boys (n = 291)		Girls (n = 359)	
	Mean	SD	Mean	SD
2–3 times a month	34	11.7	19	5.3
Once every week	18	6.2	19	5.3
More than once every week	21	7.2	31	8.6
Use of illicit drugs[g]				
No	248	85.2	333	92.8
Yes	43	14.8	26	7.2
Smoking status				
Never smoked or only experimented	235	80.8	301	83.8
Smoke at least once/week	56	19.2	58	16.2
Sexual activity				
No	126	43.3	280	78.0
Yes	165	56.7	79	22.0
Belief/perception of prevalence of smoking among friends				
None	48	16.5	70	19.5
Few	72	24.7	113	31.5
Some	78	26.8	75	20.9
Most	71	24.4	90	25.1
All	22	7.6	11	3.0
Belief/perception of prevalence of alcohol drinking among friends				
None	10	3.4	26	7.2
Few	61	21.0	95	26.5
Some	70	24.1	91	25.4
Most	92	31.6	119	33.1
All	58	19.9	28	7.8

[a]Variables reflecting Social Capital factors emerged by adding the scores for the best questions (4-point scale-variables) that defined each factor (highest loadings) (Koutra et al., 2012b).
[b]These variables are based on a 10-point scale (1 = lowest level … 10 = highest level) of self-reported responses.
[c]Regular drinking was defined as drinking on a daily or weekly basis compared to non-drinking (monthly or less).
[d]Binge drinking was defined to include those students who reported drunkenness 2–3 times or more in a lifetime, when compared to those having been drunk once or never.
[e]Either one or both parents were not born in Greece.
[f]Based on the British Registrar General's social classification of occupations (OPCS, 1991; Richter et al., 2006).
[g]Illicit drug users were defined those individuals who reported substance use at least once a month (hashish, marijuana or other substances).

(boys: adjusted OR 1.04 95%CI 1.01–1.07; girls: adjusted OR 1.04 95%CI 1.00–1.07). Associations with binge drinking were not statistically significant.

DISCUSSION

In this cross-sectional study, we explored the gender-specific associations of regular alcohol consumption and binge drinking with cognitive and structural dimensions of social capital in a sample of 650 adolescents in Greece. For both boys and girls, higher score on some structural social capital subscales was

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Table II. Logistic regression (mutually adjusted gender-specific odds ratios) for the association of regular and binge drinking with social capital subscales in adolescents in Crete, Greece.

	Boys						Girls					
	Regular drinking[a]			Binge drinking[b]			Regular drinking[a]			Binge drinking[b]		
	(daily/weekly versus monthly/rarely/never)			(got drunk $\geq$2–3 times versus once/never			(daily/weekly versus monthly/rarely/never)			(got drunk $\geq$2–3 times versus once/never		
	OR	(95%CI)	*p*	OR	(95%CI)	*p*	OR	(95%CI)	*p*	OR	(95%CI)	*p*
N of cases / total		152 / 291			95 / 291			72 / 359			65 / 359	
Participation in community	**1.09**	1.02 to 1.17	**0.011**	1.00	0.93 to 1.08	0.958	1.07	1.00 to 1.14	0.057	0.98	0.91 to 1.05	0.540
Friends or acquaintances	1.05	0.96 to 1.15	0.250	1.09	0.98 to 1.21	0.116	1.01	0.93 to 1.11	0.769	1.08	0.97 to 1.20	0.161
Neighbourhood connections	1.02	0.91 to 1.14	0.767	0.95	0.84 to 1.07	0.408	**1.13**	1.00 to 1.27	**0.044**	1.13	1.00 to 1.28	0.052
Trust and safety	0.91	0.80 to 1.03	0.146	0.91	0.81 to 1.03	0.141	0.97	0.85 to 1.11	0.650	**0.80**	0.69 to 0.93	**0.003**
Tolerance to diversity	1.06	0.93 to 1.21	0.398	0.98	0.85 to 1.12	0.717	0.95	0.83 to 1.09	0.474	**0.83**	0.71 to 0.97	**0.016**
Smoking status												
Never smoked/only experimented	ref			ref			Ref			ref		
Smoke at least once/week	2.32	0.97 to 5.54	0.058	**5.28**	2.35 to 11.85	**<0.001**	**2.46**	1.07 to 5.65	**0.033**	1.14	0.49 to 2.68	0.759
District of residence												
Urban	ref			ref			Ref			ref		
Rural	0.87	0.48 to 1.59	0.654	**4.59**	2.33 to 9.04	**<0.001**	0.74	0.38 to 1.45	0.377	1.16	0.55 to 2.43	0.702
Sexual activity												
No	ref			ref			Ref			ref		
Yes	1.48	0.83 to 2.66	0.188	**2.22**	1.14 to 4.30	**0.019**	1.54	0.75 to 3.16	0.239	1.89	0.90 to 3.98	0.092
Friends who smoke[c]	1.13	0.85 to 1.50	0.414	1.19	0.88 to 1.61	0.268	1.00	0.70 to 1.42	0.982	**2.29**	1.53 to 3.44	**<0.001**
Friends who drink alcohol[d]	**2.31**	1.71 to 3.11	**<0.001**	1.34	0.99 to 1.82	0.056	**2.40**	1.64 to 3.51	**<0.001**	1.15	0.77 to 1.71	0.499

The bold values indicate statistical significance at the 5% level of significance.
[a]Regular drinking was defined as drinking on a daily or weekly basis compared to non-drinking (monthly or less).
[b]Binge drinking was defined to include those students who reported drunkenness two to three times or more in a lifetime, when compared to those having been drunk once or never.
[c]Belief/perception of prevalence of smoking among friends (ordered in 5 categories: none, few, some, most, all).
[d]Belief/perception of prevalence of alcohol drinking among friends (ordered in 5 categories: none, few, some, most, all).

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Table III. Logistic regression (mutually adjusted gender-specific odds ratios) for the association of regular and binge drinking with the total social capital score in adolescents in Crete, Greece.

	Boys						Girls					
	Regular drinking[a]			Binge drinking[b]			Regular drinking[a]			Binge drinking[b]		
	(daily/weekly versus monthly/rarely/never)			(got drunk ≥two to three times versus once/never			(daily/weekly versus monthly/rarely/never)			(got drunk ≥two to three times versus once/never		
	OR	(95%CI)	*p*	OR	(95%CI)	*p*	OR	(95%CI)	*p*	OR	(95%CI)	*p*
N of cases / total		152 / 291			95 / 291			72 / 359			65 / 359	
Total SC score	**1.04**	1.01 to 1.07	**0.015**	0.99	0.96 to 1.03	0.788	**1.04**	1.00 to 1.07	**0.040**	0.98	0.95 to 1.01	0.215
Smoking status												
Never smoked/only experimented	ref			ref			ref			ref		
Smoke at least once/week	2.23	0.95 to 5.21	0.065	**5.41**	2.43 to 12.04	**<0.001**	**2.70**	1.20 to 6.07	**0.016**	1.42	0.64 to 3.16	0.391
District of residence												
Urban	ref			ref			ref			ref		
Rural	0.88	0.50 to 1.53	0.640	**3.95**	2.13 to 7.32	**<0.001**	0.86	0.45 to 1.62	0.634	0.94	0.49 to 1.79	0.851
Sexual activity												
No	ref			ref			ref			ref		
Yes	1.59	0.90 to 2.81	0.114	**2.49**	1.29 to 4.82	**0.007**	1.45	0.71 to 2.96	0.309	1.70	0.80 to 3.62	0.167
Friends who smoke[c]	1.16	0.87 to 1.55	0.303	1.23	0.90 to 1.66	0.189	1.00	0.70 to 1.42	0.989	**2.20**	1.46 to 3.34	**<0.001**
Friends who drink alcohol[d]	**2.27**	1.71 to 3.02	**<0.001**	**1.40**	1.04 to 1.89	**0.028**	2.40	1.65 to 3.50	**<0.001**	1.20	0.78 to 1.83	0.406

The bold values indicate statistical significance at the 5% level of significance.
[a]Regular drinking was defined as drinking on a daily or weekly basis compared to non-drinking (monthly or less).
[b]Binge drinking was defined to include those students who reported drunkenness two to three times or more in a lifetime, when compared to those having been drunk once or never.
[c]Belief/perception of prevalence of smoking among friends (ordered in 5 categories: none, few, some, most, all).
[d]Belief/perception of prevalence of alcohol drinking among friends (ordered in 5 categories: none, few, some, most, all).

associated, per unit increase, with increased likelihood of regular drinking (For boys: Participation in the community; for girls: Neighbourhood connections). Neighbourhood connections were also associated with increased binge drinking in girls (adjusted OR 1.13 95%CI 1.00–1.28). Cognitive social capital subscales ''Tolerance to diversity'' and ''Trust and safety'' were associated with binge drinking in girls in a protective way (adjusted OR 0.83 95%CI 0.71–0.97; adjusted OR 0.80 95%CI 0.69–0.93, respectively). No such a significant health protecting or damaging association was established for boys. For both genders, total SC-score was positively associated with the probability of regular, but not of binge drinking.

In contrast to our results, participation in different school or community-based organizations in 12–17-years-old US adolescents was found to prevent individuals from alcohol consumption and dependency (Winstanley et al., 2008). Nevertheless, the fact that social connectedness and participation is related to alcohol consumption in our sample comes as no surprise. Social participation, via social influence and social comparison, tends to encourage the dominant social norms (Ferlander, 2007). Skog (1991) reported that socially active individuals drink more in cultures, a contention that has been verified, among other countries, in Italy, Russia and Poland (Buonanno & Vanin, 2007; Jukkala, Mäkinen, Kislitsyna, Ferlander, & Vågerö, 2008; Pavlova, Silbereisen, & Sijko, 2013). This result comes in confirmation of Bourdieu's ideas that individuals use a highly valued behaviour as a means to claim and to reinforce their position in social hierarchies (Lunnay, Ward, & Borlagdan, 2011). Thus, regular alcohol consumption might be means for adolescents to strengthen their position within their social groups and may explain the positive association of total SC-score with regular drinking for both genders.

The inconsistent findings regarding alcohol consumption and participation in the community may be explained by placing the participatory activities in the relevant context and distinguishing among different types of clubs/ associations/ organizations. Adolescents' social participation does not imply the same level of adult supervision. This notion is supported by Zambon, Morgan, and Vereecken (2010) from data derived from a 2005–2006 World Health Organization collaborative study. He concluded that participation in voluntary services and sport clubs promoted positive health behaviours including non-adherence to alcohol consumption among 15 years old adolescents, but participation in political and youth groups was related to increased alcohol consumption (Zambon et al., 2010).

The observed associations of the ''neighbourhood connections'' subscale with both regular alcohol consumption and binge drinking among girls, but not among boys, fits within the Cretan culture, in which boys are expected to be more independent, while girls are expected to socialize around their home and neighbourhood, especially in rural areas (Ratsika, 2012). It is what Billet (2011) stated that ''social constructions and the perception of the appropriate gender behaviour have an important role in the way in which youths participate in structured and unstructured activities''(p. 79).

Capriano (2004) suggested that increased neighbourhood social support was positively associated with everyday alcohol consumption. In contrast with the previous results, Winstanley et al. (2008) in USA and Åslund and Nilsson (2013) in Sweden reported that secondary school students in neighbourhoods with low social capital and greater neighbour disorganization were at increased odds of alcohol consumption. It seems plausible that both low and high neighbourhood and community social capital may be associated with increased risk for health damaging behaviours, albeit with a different underlying pathway: in low social capital communities alcohol consumption is an manifestation of the lack of social control and lower community reinforcements of desired behaviours (Åslund & Nilsson, 2013), whereas in high social capital communities, it is a method of socialization.

Takakura (2011) reported that the likelihood of alcohol consumption increased 1.5 times among girls with a low level of trust and safety among 3248 students aged 15–18-years-old in the Prefecture of Okinawa, Japan. Mirroring their results, in this study, girls feeling less safe within their neighbourhood or community were more likely to be alcohol consumers. An explanation for the inverse association between individual-level trust and alcohol use may be that girls are generally more fearful or distrustful to hang out in their local community or neighbourhood than boys (Morrow, 2001) and are aware of this as their parents fear more for the safety of their daughters than their sons. Girls may be subject to stressors that boys aren't and are more likely to adopt unhealthy coping behaviours when facing stress (Lundborg, 2005).

The percentage of boys reporting alcohol consumption was twofold that of girls, a finding generally substantiated by several studies (Andersson et al., 2007; Hibell et al., 2012; Simons-Morton et al., 2009). In the present study, alcohol consumption was found to be more common among students who reported having many friends who consume alcohol or smoke, confirming the significant peer influence of friends with health-risk behaviours suggested in a cross-sectional survey of 14- to 19-year-old students living in an agricultural area of Crete (Koutra et al., 2012a).

Although our findings provide some useful insights on the different associations between social capital and regular alcohol consumption and binge drinking, they come with the limitations shared by all cross-sectional analyses: in the absence of time sequences, the evaluation of causal associations is not possible. Nevertheless, the direction of the association implied in the present analysis can be considered plausible.

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Our data are also prone to recall and social desirability bias, again a common limitation when using self-administered questionnaires. We attempted to limit these biases by using standardized questionnaires to collect information on social capital, alcohol consumption and other socio-economic and demographic variables. Our data come only from the prefecture of Heraklion, Crete, and this may raise some concerns about their generalizability. However, data from other studies support that in terms of adolescent's health behaviours in Heraklion, there are no major departures from the national means (University Research Institute of Mental Health, 2012). Strengths of the present study are the relatively large sample size, the satisfactory response rate, the use of two standardized self-administered questionnaires, the use of varied social capital measures, the gender-specific associations and the investigation of several variables with potential confounding importance.

In conclusion, structural social capital may increase the likelihood of light to moderate drinking in boys and girls, and, marginally, the likelihood of binge drinking in girls. At the same time, cognitive social capital is associated with decreased likelihood of binge drinking in girls. The results support the significance of social capital theory to a better understanding of how boys and girls in adolescence adopt health damaging or health promoting behaviours and can provide further insights for the development of gender-specific preventive interventions for underage alcohol consumption. Social capital should receive a greater emphasis for the design of effective public health interventions, particularly in the light of an increasing prevalence of alcohol consumption in adolescence. Nevertheless, future research should employ a longitudinal design to explore the possible effects of social capital in regular alcohol use and binge drinking during adolescence and distinguish among different types of participatory activities.

Declaration of interest: The authors report no conflicts of interest.

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Koutra, K., Kritsotakis, G., Linardakis, M., Ratsika, N., Kokkevi, A., & Philalithis, A. (2014).

Social capital, perceived affluence and parents occupation to smoking and other health determinants among secondary students in a Mediterranean region: a cross sectional study.

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Social capital and economic perceived affluence associations with smoking and other health determinants among students in a Mediterranean region: a cross sectional study.

BACKGROUND

Smoking is among the risk-related behaviors taken up by many adolescents with lifelong consequences. According to WHO/Europe, smoking is a leading risk factor of preventable morbidity and mortality, causing approximately 1.6 million deaths in Europe alone. Only 20% of regular smokers manage to quit smoking and their addiction starts during adolescence implying that tobacco dependence is a "pediatric disease" (Global Youth Tobacco Survey Collaborative Group, 2002).

This is especially relevant for Greece: high school students (aged 17.5±1.3 years) smoking habits have not changed over the last decade as both the prevalence of smoking (32.6% in boys; 26.7% in girls; 29.6% in total) and the annual per capita consumption are high (Sichletidis, Chloros, Tsiotsios, & Spyratos, 2009). Greece faces a smoking pandemic as it has the highest prevalence of regular smokers aged 17-18 years old in Europe (41%) (Andersson et al., 2007). Data from the Global Youth Tobacco Survey reported that 32.2% of 13–15 year old youths in Greece have smoked and almost one in four of them had started smoking before the age of ten while 16.2% reported being current users of tobacco products (Kyrlesi et al., 2007).

Smoking and smoking initiation among adolescents involves an interaction between proximal microsystems, family, school, peer, and a more distal exosystem such as the neighborhood and community (Ennet et al., 2010). It is associated with a wide range of risk factors such as: parental and sibling smoking (Rachiotis et al., 2008), low socio-economic status (Tewolde, Ferguson, Benson, 2007) living with a single parent (Griesbach, Amos, Currie, 2003), exposure to tobacco marketing (Gilpin, White, Messer, Pierce et, 2007), lack of anti-smoking laws and regulations (Siegel, Albers, Cheng, Biener, Rigotti, 2005), depiction of smoking on television and other media (Titus-Ernstoff, Dalton, Adachi-Mejia, Longacre, Beach, 2008), and going out most evenings and having many friends who smoke (Kokkevi et al., 2007).

Causal linkages between economic and social factors, and health-related behaviors have been established while rarely has the importance of both has been analysed in relation to health at the individual level (Ahnquist,

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Wamala, Lindstrom, 2012), especially in adolescent population. A vast literature has shown an association between socioeconomic position mostly been defined as occupational status, education or income and health behaviors (Linstrom, 2008). Tewolde et al. (2007) using data from the National Population Health Survey about smoking behavior among young people in Canada, found that youths in poorer health, who come from a single-parent family and from a lower income bracket are also more likely to be smokers. In addition, a study of 995 middle school students in Nanjing, China found a strong association between smoking and gender, low family SES, low school performance, low parental monitoring, peer and family smoking, and approval of smoking from parents and friends (Li, Mao, Stanton, Zhao, 2010). Additionally a growing body of evidence showed that the social environment (mainly focused on the concepts of social support and social capital) plays an important role in influencing health-related behaviors.

In general, youth "social capital" refers to social relationships and sociability, social networks, social support, trust, reciprocity, community, and civic engagement (Morrow, 1999). Studying youth social capital requires exploration of both its cognitive and structural dimensions, as well as its three types, specifically, bonding, bridging and linking social capital (Kawachi, Subramanian, Kim, 2008). Cognitive social capital refers to subjective features like norms, values, attitudes and beliefs, while structural components refer to externally observable aspects of social organization like formal (school, religion, politics, sports) and informal (friends, family, neighbors) social networks, or patterns of civic engagement (Islam, Merlo, Kawachi, Lindstrom, & Gerdtham, 2006). Regarding the different social capital types, bonding social capital refers to the interrelationships that strengthen links within same groups, bridging social capital establishes bridges between different groups and linking social capital establishes vertical links to power and decision-making authorities. The above distinctions do not imply that each of its components or types or levels of analyses, produce positive social capital (Kawachi et al. 2008) or have a positive effect on health.

Lately, a growing number of studies have investigated associations of adolescents' smoking behavior and social capital, mainly through social participation, trust, friends and neighborhood of residence. Individual-level generalized trust and social participation among adolescent students, boys and girl alike, was negatively associated with smoking and drinking, a protective social capital effect (Lundborg 2005; Takakura 2011).

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Similarly, social capital in terms of participation in pro-social activities (i.e. activities associated with organized groups that help children develop skills) has a protective effect on smoking among adolescents in high-risk neighborhoods (Xue, Zimmerman, Caidweli, 2007). Extracurricular activities, such as team sports participation, are also associated with preventing youth smoking (Adachi-Mejia, Carlos, Berke, Tanski, Sargent, 2012; Zambon, Morgan, Vereecken, 2010; Curran, 2007).

Most studies used different measurement instruments of social capital, nevertheless a report of Pevalin and Rose (2003) using data from the first nine annual waves of the British Household Panel Survey (BHPS) found that low contact with friends is associated with a lower likelihood of smoking. This is a finding with broad acceptance and documentation in the literature. Some of the studies that have highlighted the positive influence of friends and siblings who smoke are Urberg, Degirmencioglu, and Pilgrim(1997), Tewolde et al. (2007) and Harakeh, Engels, Vermulst, De Vries, and Scholte (2006).

Strong evidence, that the context of a young person's neighborhood has important consequences for a young person's health and quality of life, has been recorded (Sampson, Morenoff, Earls, 1999). The Health Behavior School Aged Children (HBSC) study in 80 schools in England has shown that social capital measured as low, that family and neighborhood sense of belonging and non-involvement in school clubs had independent effects for smoking (Morgan & Haglund 2009). Data from the HBSC study on 15-year-old students revealed that feelings of safety and belonging in neighborhood and community settings, had a greater role in reducing risk behavior compared with that of the family, and suggests that contextual aspects of young people's lives act protectively to their health (Brooks et al. 2012). Similarly, Sampson et al. (1999) argued that neighbors who are willing to exert social control over unhealthy behaviors, such as adolescent smoking, might exert an important role in prevention.

On the contrary, Rojas and Carlson, (2006) found that as the bonding social capital, composed from the neighborhood and friends, increased, the more students are at risk from consuming tobacco. Smoking by peers, namely bonding social capital, is considered one of the strongest risk factors, as adolescents are more likely to smoke when their friends are smoking (Buller et al., 2003). According to Capriano (2004) increased social

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support from the neighborhood means increased consumption of tobacco confirming Bourdieu's' view by whom social capital generates positive and negative outcomes (as cited in Kawachi et al., 2008). Research on 781 participants evaluating the association between social capital and tobacco use in four low-income neighborhoods in Santiago, Chile, found that trust in neighbors was also significantly inversely associated with smoking and with the number of cigarettes smoked (Sapag et al., 2010). Kawachi and Berkman (2000) stated that the neighborhood has a positive rather than a protective effect on students smoking. All previous findings have generally demonstrated that increased social capital for all youth is an ultimate goal. Nevertheless, the how and from where does social capital develop, is an important research issue (Laser & Leibowitz, 2009).

AIM OF STUDY

To the authors' knowledge, there are no studies that have analyse associations of economic perceived affluence and social capital (5 factors, structural and cognitive, overall score social capital) on self-reported health, life satisfaction and current smoking behavior in a large secondary student's population in a southeastern Mediterranean population. An explorative empirical approach adopted and especially the potential differential associations of social capital and self-perceived affluence and parents occupation among genders and localities were explored (Healy, Haynes, Hampshire, 2006).

We hypothesized that: 1) lack of social capital and self-perceived affluence and parents' occupation will contribute to high smoking behavior and poor health outcomes, and 2) social capital factors and dimensions would be associated differently with student smoking behavior and other health behaviors, 3) the associations between social and economic capital will vary by gender (b/g).

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Method

Participants

The study design was cross-sectional. The total study population consists of 2189 first year secondary school students living in rural and urban areas of the Prefecture of Heraklion, Crete, based on information provided by the Hellenic Statistical Authority (www.statistics.gr). In Greece, one has to attend nine years of compulsory education, while a total of 12 years of schooling is required prior to attending university.

Sample

A random sampling design was adopted taking into account the Prefecture of Heraklion as the sampling frame. Almost half of the secondary schools were randomly selected (n=17) and all first-grade students attending the selected schools were chosen to comprise the study sample, that is, 835 students. Considering the daily absences, 708 students finally participated (85%) by completing a questionnaire composed of socioeconomic, demographic, health behavioral and social capital items. Five questionnaires were excluded from the present analyses due to missing values on one or more variables of interest. The final sample included 703 students, 312 boys and 391 girls (84.2% of the original study sample). Details on the sampling procedures have been previously described (Koutra et al., 2012).

Procedures and Ethics

Data was collected during the period from April to June, 2008. Written permission was granted by the Ethical committee of the Greek Pedagogical Institute (decision number: 20946/G2/20-2-2008), and by the schoolmaster of each participating school, and the study was conducted according to the Helsinki declaration. Students received written and oral information about the aim of the study and the anonymity of their responses. They were provided with the necessary instructions by the principal researcher, while the teacher waited outside the classroom (Koutra et al, 2012).

Assessment of variables

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Outcome variables

The HBSC survey instrument is a standard questionnaire developed by an international research network in collaboration with the WHO Regional Office for Europe (Currie et al., 2010) and has been previously used on Greek data (Currie et al., 2010; Koller et al., 2009). It includes a number of sections, one being health determinants. In our analyses self-reported life satisfaction, self-related health and smoking behavior were used.

Self-reported life satisfaction. In this study students' self-reported life satisfaction was assessed with the validated in several studies Cantrill ladder (Currie et al., 2008). Respondents were asked to indicate where on the ladder they "… feel standing at the moment", with the top of the ladder (10) indicating the best possible life … and the bottom (0) representing the worst possible life". For the analyses, student responses were classified as expressing "normal-high" life satisfaction (categories 6–10) versus "low" (categories 0–5).

Self-related health. Self-related health was answering the question "Would you say your health is…?" giving four response alternatives (very good, good, fair, and bad). The question was categorized for the analyses as very good, good/fair, and bad (Kawachi et al. 2008; Poortinga, 2006).

Smoking. Smoking consumption was measured by answering the question "Have you ever smoked?", with two possible responses: yes or no, categorized as, current smoker or non-smokers (Mackay & Eriksen, 2002). Furthermore, the frequency of smoking was requested with the following responses: every day; at least once a week, but not every day; less than once a week; I do not smoke, categorized as, daily smokers; intermittent smokers (once or less/week); ex-smokers; non-smokers, respectively.

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Main determinants

Economic capital

Economic capital expressed from *self-reported perceived affluence and fathers/mothers employment status* were also assessed via HBSC (Currie et al., 2010).

Perceived affluence. A 10-point scale-variable ranging from 1 (lowest level) to 10 (highest level) were included indicating the student's perception of the family's financial status. Students were asked to indicate where on the

ladder they "... feel standing at the moment", with the top of the ladder (10) indicating the best economic status. For the analyses students responses were classified as expressing "low" (categories 0–5) versus "normal-high" family financial status (categories 6-10) (Currie et al., 2008).

Employment status of fathers' and mothers'. Fathers/Mothers employment status was measured by asking "What is your fathers'/mothers' occupation?". Respondents answers were summed up in two categories ranging from inactive (e.g. student, maternity leave) and unemployed, to employed.

Social capital

The Youth Social Capital Scale (YSCS) was developed to measure the individual social capital of people aged 12 to 20 years old (Onyx, Wood, Bullen, Osburn, 2005). It has been culturally adapted and psychometrically validated (Koutra *et al.*, 2012). Five subscales ("Participation in Community", "Friends and Acquaintances", "Neighborhood Connections", "Safety and Trust", "Tolerance and Diversity") representing different social capital factors and comprising a general social capital factor (overall SC-score). Social capital subscales were produced to quantitatively explore each of the social capital dimensions by adding the scores of the questions that best define each factor, based on a 4-point scale. The higher the score, the more likely a student was to have higher social capital (Koutra et al., 2012).

Explanatory variables

Several socio-demographic variables as well as possible confounders also assessed via HBSC (Currie *et al.*, 2010). These were gender (boy; girl), age (16; 17; 18 years old), district of residence (rural; urban- semi urban) country of birth (Greece; other), parents' birthplace (Greece; other), and family type (in four categories: "single parent"; "tight family"; "single family"; "extensive family" and "other").

Statistical analyses

Data analyzed using the SPSS software (IBM SPSS Statistics for Windows, Version 21.0. Armonk, NY: IBM Corp). Distributions of the descriptive characteristics of the study sample of students estimated according to genders as well. Between genders, a comparison was also made of the levels of economic capital, social capital,

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smoking and health determinants using chi-square test and analyses of variance (heterogeneity tested by Levene test).

Multiple logistic regression analyses was used to examine the relationship between the economic capital and students' smoking, life satisfaction, and self-reported health, while the control parameters were the gender, age, district of residence, country of birth, parents' birthplace, and family type. Additionally, and with the same regression method, were estimated the odds ratios (OR) for being a current smoker versus being a non-smoker, for each social capital factor separately and for all factors being mutually adjusted and for health determinants of life satisfaction and self-reported health. As control parameters were used the gender, age, district of residence, country of birth, parents' birthplace, and family type.

RESULTS

The socio-demographic characteristics of the students are presented in Table 1. A total of 703 students (312 boys and 391 girls) completed the survey questionnaires. The participants aged 16 years old; 57.9% lived mainly in semi-urban and urban areas; 92.7% were born in Greece, and so were their parents. The majority of the students (69.0%) grew up in a tight family type.

Table 2 presents the gender-specific bivariate levels of economic (perceived affluence; employment status of fathers' and mothers') and social capital (five factors and overall score) and smoking and health determinants variables (life satisfaction; self-rated health). Specifically, mean values, standard deviations and correlation coefficients for variables included in the analyses are presented. However, significant gender differences were not found. Only two factors of social capital were differentiated from gender. Higher mean levels were found in boys than girls in factor of "*Participation in Community*" (15.4 vs 14.6, respectively, p=0.031) and lower in "*Tolerance and Diversity*" (10.3 vs 10.7, respectively, p=0.013).

The results of the multiple logistic regression analyses of the relationship between the economic capital and students' smoking, life satisfaction and self-reported health are shown in Table 3. The findings showed that those who have poor self-reported economic status (low perceived affluence) have 4.71 higher odds ratio for low life satisfaction (95%CI: 3.00, 7.40), 1.53 higher odds for good health (95%CI: 1.01, 2.32) and 2.72 higher

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odds for fair/bad health (95%CI: 1.58, 4.71). The parents' employment status had no significant impact on the assessment variables of the study.

Table 4 shows adjusted odds ratios for being a daily smoker versus being a non-smoker, for each social capital factor separately and for all factors being mutually adjusted and for health determinants of life satisfaction and self-reported health. The results showed that those who have low/normal social capital ("Participation in community") in relation to those with high, have 0.55 lower likelihood (odds) for daily smoking (95%CI: 0.32, 0.95) but 2.49 higher odds for fair/bad health (95%CI: 1.28, 4.86). Conversely, students' with low/normal social capital ('Safety and trust") in relation to those with high, have higher odds for daily smoking (OR: 2.98; 95% CI: 1.47, 6.04) or fair/bad health (OR: 4.22; 95% CI: 2.08, 8.56). Students with low/normal overall score of social capital have higher odds for low life satisfaction (OR: 2.13; 95% CI: 1.22, 3.73); good (OR: 1.59; 95% CI: 1.10, 2.32); and fair/ bad self-rated health (OR: 3.18; 95% CI: 160, 6.32).

Finally, we estimated the frequencies of students' smoking behavior, life satisfaction and self-rated health in low/normal and high Social Capital levels (Figure 1) and according 95% CI. Low/normal and high Social Capital had no significant difference in the smoking frequency of students (21.1% vs 24.3%, respectively, $p>0.05$). However, were found more students with low/normal Social Capital in relation to counterparts with low life satisfaction (19.6% versus 9.6%, respectively, $p<0.05$) or having fair/bad health (16.5% versus 6.2%, respectively, $p<0.05$).

DISCUSSION

This study examined the role of individual social and economic capital on self-reported health, life satisfaction and smoking behavior in a sample of secondary school students in a Mediterranean region of Greece. We assessed five different social capital factors and social capital overall score and perceived affluence to better understand diverse social and economic influences that form smoking and other health determinants in adolescence. Our study failed to fully confirm the developing literature that supports a protective effect of social capital on smoking (Li, Horner, Delva, 2012). Verifying partly our first research hypothesis social and economic capital had both negative and positive relations with students' smoking behavior and health

determinants. Results suggest the value of structural and cognitive social capital dimensions in research on student smoking and health determinants. While all social capital factors and overall score were implicated in student smoking and health determinants, the "Community participation" (structural social capital) and the "Trust and safety" (cognitive social capital) were primarily implicated, with findings suggesting the need for consideration of the multiple social contexts student live and interact confirming our second research hypothesis. It was found that student's economic capital were more likely to be statistical significant involved in health determinants than smoking behavior of our sample. In general, the study did not identify significant gender differences in the predictors of student smoking and health. Only two of the social capital factors, expressing bridging social capital, where influenced by gender, which partially confirmed our third hypothesis. Finally, the life satisfaction found to decrease in more students with low level of social capital and bad health.

In our sample study, it is reported that 21.9% smoke at least one cigarette daily. The prevalence of those who reported having smoked one or more days during the last 30 days was detected 12.5% in the Global Youth Tobacco Survey conducted in Greece among 6378 middle-school students in 2004-2005 (Rachiotis et al., 2008). On the other hand, a study ten years before in Northern Greece reported that 29.6% out of 9,276 high-school students were smokers (Sichletidis et al., 2009). Accordingly, it can be assumed that the smoking habits of high school students in Greece have increased since the last decade. A significant element, especially when the prevalence of smoking among Greek high school students been reported as higher than that of other developed countries like Hungary, Slovakia, United Kingdom, and the USA (Sichletidis et al. 2009).

The higher prevalence of smoking in boys compared to girls is in line with a number of reported findings (Levin, Dundas, Miller, McCartney, 2014; Takakura, 2011; Giannakopoulos, Tzavara, Dimitrakaki, Kolaitis, Rotsika, Tountas, 2010), although in our study no statistical significant relation was found. In gender-specific bivariate analyses, a number of social and economic capital variables and health determinant variables were examined, but generally no gender statistical differences were found. Only bridging social capital, expressed by students who join organizations in the community, which connect them to people of a different social identity (Koutra et al., 2012; Chuang & Chuang, 2008), partially supports the hypothesis that the effects of social capital differ by gender. Boys seem to participate more in the community settings while girls are more tolerant to

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diversity. Boys are expected to be more independent and participate in a number of extracurricular activities interacting and connecting with a group of individuals. Cretan boys are socially accepted to walk around the community and participate in local activities and events; providing them a sense of belonging within and beyond the local community. A well documented result that this study didn't support was that girls are at a higher risk for poor general health perception and low life-satisfaction (Ravens-Sieberer et al., 2009; Cavallo et al., 2006).

This study supported that student's low perceived affluence is related to low life satisfaction and good to fair/bad self-reported health, but surprisingly not related to students smoking habits. Our findings differ from those of Tewolde et al. (2007) and Li et al. (2011) that found a relatively strong influence of students' low satisfaction and smoking. With respect to the self-rated health, the HBSC study, among Scottish 15-year-olds 'feeling healthy' was unrelated both to (father's) social class and to family affluence scale (Mullan & Currie, 2000). Multi variation was observed between countries in self-rated health and father's social class among 15-year-olds students in the HBSC study (Mullan & Currie, 2000). The findings were mixed; in some, weak relationships was observed, while in others quite strong relationships. Our results thus confirm the findings from other international studies, such as the 2005/2006 HBSC (Ravens-Sieberer et al., 2009) and KIDSCREEN surveys (Erhart et al., 2009), while student's low perceived affluence related to low life satisfaction.

When assessing the five social capital factors, "Participation in community" had a significant positive association in contrary with "Safety and trust" that had a negative relation with student's current smoking after adjusting for a number of possible confounders. The more the students participate in community organizations and events (structural social capital) the more they seem to smoke. This result resembles the results from Child and Adolescent Behaviors in Long-term Evolution (CABLE) project; that participating in social organizations outside school was a risk factor for being a consistent smoker (Chen, Wu, Chang, Yen, 2014). Given the high prevalence of smoking in the Greek population; more than 40% of adults are smokers; students smoking is not considered to be a disgraceful or a problematic behavior because most of the people are familiar with it or actually smoke (Vardavas & Kafatos, 2007). It is what Capriano (2008) suggested that the health damaging neighborhood effect is being promoted through participation in local neighborhood networks. This suggested

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what Sapag et al (2010) pointed out that if local social norms support smoking as part of daily social interaction that might encourage more smoking. The most plausible explanation for these findings is that when students are attached to their community, they are in fact, attached with its safe or unsafe and healthy or unhealthy norms and behaviors, like smoking.

This study suggests evidence of a harmful association between cognitive social capital ("Safety and Trust") and smoking behavior. The more unsafe the students feel the more they smoke. This finding is consistent with the findings from a study evaluating the association of social capital with tobacco use in 78 participants from four low-income neighborhoods in Santiago, Chile, concluded that trust in neighbors was inversely associated with smoking (Sapag et al., 2010). In contrast, higher levels of trust and safety, indicating higher social capital, were related to a lower smoking probability (Siahpush et al., 2006). Similarly, neighborhood safety and positive perceptions of the local area were associated with low substance use and abuse (Kirby, Van der Sluijs, Inchley, 2008; Lundborg, 2005).).

Our results showed that different features of social capital were associated with student's bad self-reported health. Low structural social capital pertaining to behaviors (e.g. membership in associations; participation in community) was associated with student's bad self-rated health. Low participation means less links across different groups and teams that do not necessarily share similar social identities, resulting in lower bridging social capital. The key to improving health is having access outside their social groups (Kawachi et al., 2008). This finding is in accordance with a study exploring social capital relation with adolescent's subjective health and wellbeing in New Zealand (Aminzadeh et al., 2013). Similarly, low cognitive social capital referring to what people feel (e.g. trust, reciprocity, safety), was associated with student's bad self-rated health. An explanation might be that when people are afraid of going out, an indication of a low sense of social trust in the community, are more common to report poor health ((Kawachi & Kennedy, 1999). It was what Poortinga (2006) supported that it's not social capital that automatically lead to a better health but it's what social capital creates. It creates more trusting, socially active individuals who feel more capable to engage with others (Poortinga, 2006).

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Finally, the findings presented here suggest that a lower overall score of social and economic capital predict poorer self-reported health status and life satisfaction in students. The results of the present study are in line with previous research in adult populations ((Kawachi & Kennedy, 1999). The self-perceived economic status in the HBSC cross-national findings (Currie et al. 2008) are in accordance with ours as the socioeconomic inequalities in life satisfaction existed for students across all countries. In contrast to ours come the results of a longitudinal study aimed to collective and individual determinants of health-related quality of life of young people. Socio-economic deprivation and social capital were both non-statistical associated with children's general health and satisfaction (Drukker, Kaplan, Feron, van Os, 2003).

An Important Field in Social Work

A large body of research shows that adolescent smoking remains a significant social and public health problem. This is why community health workers, as social workers, nurses', doctors' etc. need to identify all aspects of adolescent tobacco use. Social capital may provide a better understanding in identifying social connections that are –or are not– protective to student smoking. Organizations at all levels need to cooperate and act in order to improve the health of adolescents, which is a key area for public health research, the health care system, but also the educational system and politics.

From all social work methods, the community one, through its assessment practices, gives particularly attention to community and environmental factors (Holland, Burgess, Grogan-Kaylor, Delva, 2010). The community in this study is identified as one of the major risk factors for students' tobacco consumption that social worker's need to focus on. The micro local level is considered as a significant framework in preventing, addressing, and solving social health problems, as tobacco use is. Additionally, a community social worker using social capital theory for assessing the students' social connections, has a better understanding which connections' are protective or not to tobacco consumption. And as such community social workers through the ecological model, consider multiple individual and contextual factors, which assist them to intervene and evaluate procedures, (Russell, Champika, Wagoner, Dawson, 2008) by balancing demands (risk factors) and support (protective factors). Families, schools, community organizations, policy makers, social services,

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businesses, local community agencies, the media, health agencies, and law enforcement are diverse part of the problem which actively involved in influencing both individual behavior and community norms.

As social capital distinguish all those relevant systems, networks, and relationships must be taken into account in planning multiple-approach and implementing well-conceived interventions and programs. Community needs and strengths could help practitioners involve community partners at the earliest stages of the project, helping to define research objectives and having input into how the project will be designed and organized, in order to become an effective youth smoking-prevention action. Social work is a natural home for prevention (Council on Social Work Education, 2009) and should demonstrate respect to empower communities to initiate their own ways to address needs, they themselves identify. Interventions attempting to reduce substance behavior among students needs to see the multi dimensions of the world, the eco-systems around them (Noyori-Corbett & Moon 2010).

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LIMITATIONS & STRENGTHS

Although our findings provide some useful insights on the different associations between social and economic capital and smoking and health, they come with the limitations shared by all cross-sectional analyses: its design makes difficult to establish cause–effect associations between social and economic capital and health behaviors. The study sample is non-representative of the country's student population. However, data from other studies support that, in terms of students health behaviors in Heraklion, there are no major departures from the national means (University Research Institute of Mental Health, 2011). Strengths of the present study are the relatively large sample size, the satisfactory response rate, the use of two standardized self-administered tools, the use of varied social capital measures, the social and economic capital associations and the investigation of several variables with potential confounding importance.

CONCLUSION

Our results call for a more thorough examination of the relations different factors and components of social capital might have on health behaviors in dissimilar social contexts. Social capital could give additional knowledge to social work practitioners about the factors influencing or not student's smoking and health

determinants. Students with high participation rate in community and unsafe feelings have higher possibility to smoke and report bad health while student's report low perceived of affluence have higher possibility of bad health.

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Table 1

Descriptive characteristics of the study sample of 703 Cretan (Greek) adolescents.

		n	%
Gender	*boys/girls*	312/391	44.4/55.6
Age, *years*	*16*	634	90.2
	17	50	7.1
	18	19	1.5
District of residence	*rural*	294	42.1
	urban, semi urban	405	57.9
Country of birth	*Greece*	671	95.4
	other	32	4.6
Parents' birthplace	*Greece*	652	92.7
	at least one	25	3.6
	none	26	3.7
Family type	*single*	83	11.9
	tight	483	69.0
	extensive	114	16.3
	other	20	2.1

Chi-square tests were done between genders. Boys had higher age status than girls (p=0.001).

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Table 2

Comparisons of levels in economic capital, social capital, smoking and health determinants between genders of the 703 Cretan (Greek) adolescents

			Boys *n* 312	Girls *n* 391	*p*-value
Capital	**Economic**				
	perceived affluence	*normal, high*	242 (77.6) [a]	313 (80.7)	0.348
		low	70 (22.4)	75 (19.3)	
	employment status of fathers'	*employed*	291 (93.3)	363 (93.1)	0.920
		inactive (e.g. student, maternity leave), unemployed	21 (6.7)	27 (6.9)	
	employment status of mothers'	*employed*	206 (66.0)	265 (68.1)	0.572
		inactive (e.g. student, maternity leave), unemployed	106 (34.0)	124 (31.9)	
	Social	*Participation in Community*	15.4±4.4 [b]	14.6±4.6	0.031
		Friends and Acquaintances	23.4±3.4	23.7±3.1	0.293
		Neighborhood Connections	7.6±2.7	7.8±2.5	0.478
		Safety and Trust	15.8±2.4	16.0±2.2	0.245
		Tolerance and Diversity	10.3±2.0	10.7±2.1	0.013
		Overall score	72.4±9.5	72.7±8.9	0.707
Smoking and health determinants	**Smoking**	*current smokers*	77 (24.7)	77 (19.7)	0.119
		non smokers	235 (75.3)	314 (80.3)	
		daily smokers	53 (17.0)	44 (11.3)	0.185
		intermittent smokers (once or less/week)	24 (7.7)	33 (8.4)	
		ex-smokers	72 (23.1)	98 (25.1)	
		non smokers	163 (52.2)	216 (55.2)	

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Life satisfaction	*normal, high*	266 (85.8)	312 (80.6)	0.085
	low	44 (14.2)	75 (19.4)	
Self rated health	*very good*	157 (50.3)	168 (43.0)	
	good	115 (36.9)	165 (42.2)	0.151
	fair, bad	40 (12.8)	58 (14.8)	

[a]Values are n (%).
[b]Values are means ± standard deviations.
Chi-square test and analysis of variance (heterogeneity was tested by Levene test).

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Table 3
Adjusted odds ratios and 95% confidence intervals of having low economic capital in relation to smoking and health determinants of the 703 Cretan (Greek) adolescents.

		Economic capital		
		perceived affluence	**employment status of fathers'**	**employment status of mothers'**
		low versus normal, high	*inactive (e.g. student, maternity leave), unemployed versus employed*	
			Odds ratio (95%CIs)	
Smoking	*non smokers*	1.00	1.00	1.00
	current smokers	0.94 (0.59, 1.49)	0.68 (0.30, 1.52)	0.99 (0.66, 1.48)
	non smokers	1.00	1.00	1.00
	ex-smokers	1.53 (0.98, 2.37)	1.14 (0.56, 2.31)	0.90 (0.60, 1.33)
	intermittent smokers (once or less/week)	0.55 (0.22, 1.35)	-	1.39 (0.74, 2.58)
	daily smokers	1.43 (0.82, 2.51)	1.09 (0.45, 2.67)	0.82 (0.49, 1.37)
Life satisfaction	*normal, high*	1.00	1.00	1.00
	low	4.71 (3.00, 7.40) [a]	1.24 (0.57, 2.69)	0.63 (0.40, 1.02)
Self rated health	*very good*	1.00	1.00	1.00
	good	1.53 (1.01, 2.32) [b]	1.27 (0.65, 2.51)	1.18 (0.83, 1.68)
	fair, bad	2.72 (1.58, 4.71) [a]	1.76 (0.73, 4.22)	1.40 (0.85, 2.31)

95%CIs, 95% confidence intervals.
Multiple logistic regression analysis was done. As control parameters were used: gender, age, district of residence, country of birth, parents' birthplace and family type. [a] $p<0.001$, [b] $p<0.05$.

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Table 4

Adjusted odds ratios and 95% confidence intervals of having low social capital in relation to smoking and health determinants of the 703 Cretan (Greek) adolescents

		Social capital					
		Participation in Community	Friends and Acquaintances	Neighborhood Connections	Safety and Trust	Tolerance and Diversity	Overall score
		low-normal capital **versus** *high* [a]					
		Odds ratio (95%CIs)					
Smoking	*non smokers*	1.00	1.00	1.00	1.00	1.00	1.00
	current smokers	0.68 (0.45, 1.05)	0.85 (0.56, 1.29)	0.63 (0.41, 0.96) [c]	1.86 (1.15, 3.00) [c]	0.97 (0.63, 1.50)	0.77 (0.51, 1.18)
	non smokers	1.00	1.00	1.00	1.00	1.00	1.00
	ex-smokers	0.61 (0.40, 0.93) [c]	0.59 (0.39, 0.90) [c]	0.88 (0.57, 1.36)	1.00 (0.66, 1.52)	1.11 (0.72, 1.72)	0.83 (0.54, 1.26)
	intermittent smokers (once or less/week)	0.61 (0.31, 1.18)	0.77 (0.40, 1.47)	0.94 (0.46, 1.93)	1.03 (0.54, 1.97)	0.86 (0.46, 1.63)	0.57 (0.30, 1.05)
	daily smokers	0.55 (0.32, 0.95) [c]	0.68 (0.40, 1.16)	0.45 (0.26, 0.76) [c]	2.98 (1.47, 6.04) [c]	1.12 (0.64, 1.96)	0.90 (0.52, 1.58)
Life satisfaction	*normal, high*	1.00	1.00	1.00	1.00	1.00	1.00
	low	1.30 (0.78, 2.16)	1.81 (1.06, 3.08) [c]	1.02 (0.63, 1.65)	1.64 (0.98, 2.76)	1.80 (1.06, 3.04) [c]	2.13 (1.22, 3.73) [c]
Self rated health	*very good*	1.00	1.00	1.00	1.00	1.00	1.00
	good	1.21 (0.83, 1.76)	1.58 (1.08, 2.31) [c]	1.06 (0.73, 1.55)	2.03 (1.39, 2.96) [b]	1.09 (0.75, 1.59)	1.59 (1.10, 2.32) [c]
	fair, bad	2.49 (1.28, 4.86) [c]	1.75 (0.99, 3.09)	1.35 (0.75, 2.43)	4.22 (2.08, 8.56) [b]	1.43 (0.80, 2.58)	3.18 (1.60, 6.32) [b]

95%CIs, 95% confidence intervals.

[a] Low-normal social capital was determined as having score <75% of specific gender-age percentiles.

Multiple logistic regression analysis was done. As control parameters were used: gender, age, district of residence, country of birth, parents' birthplace and family type. [b] $p \leq 0.001$, [c] $p \leq 0.05$.

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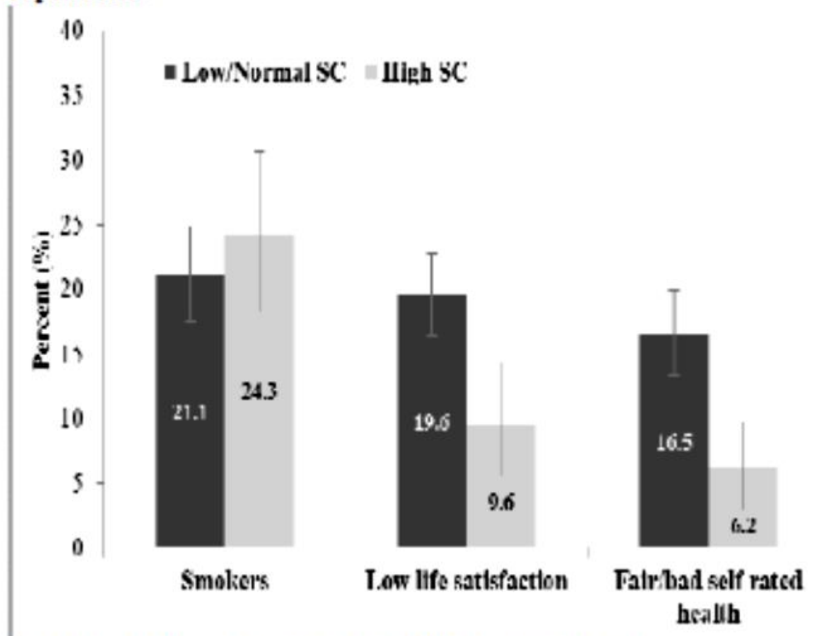
Figure 1
Frequencies of adolescents in smoking habit, life satisfaction and health status in low/normal and high Social Capital levels.



Bars "I" show the 95% confidence intervals (estimated by bootstrap techniques).

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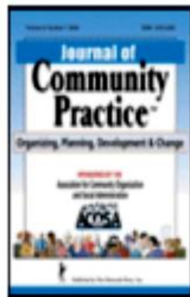
Κεφάλαιο 5ο Παρεμβατικός ρόλος της Κοινωνικής εργασίας με κοινότητα

Koutra, K., (2014).

Community development: A common field of work to Social capital, Health Promotion and Community Social Work practice.

(*Submitted to Journal of Community Practice*).

Journal of Community Practice



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Community development: A common field of work to Social Capital, Health Promotion and Community Social Work

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Running head: SOCIAL CAPITAL, HEALTH PROMOTION AND COMMUNITY SOCIAL WORK.

Abstract

The 21st century is making a turn towards community development and the value of community social work. Professional social workers, but especially their educators need to acknowledge the benefits and the advantages of working with the strategy of community development, thereby contributing to healthy communities capable of rebuilding and producing social capital. This article discusses about social capital, health promotion and community social work and highlights the common features, methodology and approach shared through community development so that social workers may better equipped to improve and further develop the practice of their profession in the community.

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Keywords: social capital, health promotion, community social work

Community development: A common field of work to Social Capital, Health Promotion and Community Social Work.

The meaning of social capital in the last decades has been strongly connected to the prevention and health promotion (Wakefield & Poland, 2005). Considering this, social capital needs to be part of the education and practice of social work. The role of social work is to recognize the difficulties and the complexity of social capital and give the chance to its professional members to recognize its utility to the community prevention interventions. Since its foundation, social work deals with data of social capital (Loeffler et al., 2004) and moreover, social workers are expected to promote and reconstruct social capital in the communities they intervene although reality has shown that these interventions are rarely discussed with the terminology and theories of social capital (Ersing & Loeffler, 2008; Muhkerjee, 2007).

Social work has a long-standing tradition in prevention and health promotion (Siefert, 1983; Moniz 2010). Social workers are responsible for 'measuring the problems, evaluating the actions, furthering knowledge, developing a trained staff for the social determinants of health and passing on the knowledge for the social determinants of health to the public'(WHO, 2008, p. 6). Teaching social workers and mainly students about the effect of social capital as one of the social determinants of health (Coren, Iredale, Bywaters, Rutter & Robinson, 2010) and giving them the opportunity to acquire real experiences inside the communities due to the planning and application of preventive interventions, social work has the capability as a profession, to play an active role in both the knowledge and appliance of social capital.

This article, discusses the common features shared in the method of community social work, social capital and health promotion, in order to give social workers the opportunity to improve and further develop the practice of their profession in the community, to the next level.

SOCIAL CAPITAL, HEALTH PROMOTION AND COMMUNITY SOCIAL WORK

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Running head: SOCIAL CAPITAL, HEALTH PROMOTION AND COMMUNITY SOCIAL WORK.

What could the connection between community social work, social capital and promotion of health be? To be able to teach social workers about social capital and its effect on the prosperity of a community, we need to give them a clear image and knowledge about which strategies and basic elements of intervention of social capital and health promotion are able to connect with the practice of community social work. This way, the social workers will be capable of social planning and running interventions that magnify social capital, by directly or indirectly promoting their community's health.

Social capital.

The meaning of social capital is relatively new in the field of health (Harpham et al., 2002). Harper (1999) claims that social capital can act by preventing the consequences of social stress, and result in a feeling of well-being. Putnam (2001) mentions that of all fields that have been studied by social capital, none has been so well established as health and well-being. Wilkinson (1996) refers to the influence of the social hierarchy on health. Countries with unequal social and financial distribution of income tend to have worse health than countries with a more just distribution. McKenzie et al. (2002) claim that, social capital is considered to be a protective factor of psychological health. On the other hand, Kawachi and Berkman (2001) claim that there is a positive and protective relationship between the social capital of a country and the health of its population.

Social capital can provide all the sources a community can evaluate to improve its health and prosperity through collective actions (Lochner, Kawachi, Kennedy, 1999). Either way, social capital may facilitate collaboration, trust, belonging, and membership. Previous collaboration experience is a key predictor of current levels of trust (Koutra et al. 2012). Many definitions and approaches have been given to this, creating an unclear image about the definition and its measurement. Despite the fact that the reference to the various theories of social capital is beyond the goals of this article, in order to support the next discussion and interpretation, it was considered important for a brief reference to be made to its three representatives. Their differences are presented in Table 1.

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Social capital as individual asset. The French sociologist Bourdieu (1984) separated the meaning of 'capital' in to three different categories and in doing this, gives sorting gave a complete definition of social capital. The three forms of 'capital' are those of the economical, cultural and social (Field, 2003) forms that are connected and depend on each other with a view to mainly reproducing economic capital. The basic principle in this theory is that social capital is considered an individual commodity. According to Bourdieu, 'social capital makes the participation of people in social groups and networks more easy and with a strong solidarity only when the members have both something material and symbolic to gain through this organized participation and action' (Field 2003, p.15). He places greater emphasis on the vertical bonds and the reproduction of uneven and strong relationships by different forms of capital. Here social capital reflects the negative meaning of the expression, 'it is not what you know, but who you know' and the pessimistic view of the inner reproduction of the strong (Gauntlett, 2011).

Social capital as an individual asset but with a social function. The second theoretical school of social capital was created in the late 80s and early 90s, by the American sociologist James Coleman (Coleman, 1987, 1994). He discerned three forms of capital, natural, human and social capital. In this approach, social capital includes the networks and the commodities that can be moved through those networks. At first social capital takes form inside the family and evolves towards the community with a series of parameters. In his view social capital is a valuable source from which an individual benefits through social relations (Coleman 1988, p.98). While he defines "social capital as an individual asset" he treats its structure "as a structural social source" (Coleman 1994, p.302) designating a social character in its function (Field, 2003, p.23). Through his research, came to the conclusion that the benefits of social capital are pervaded and exploited by individuals which were not part of its development (Coleman 1988, p.116).

Social capital as a community asset. The American political scientist Robert Putnam (1993, 2000) is the most popular and famous theorist of the study of social capital. Putnam treats social capital like 'the bonds with the community that can make our lives richer in a thousand ways' (Putnam, 2001, p.vi). For Putnam social capital is

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traditionally a public, social asset that can be accessed by everyone without restrictions and discriminations (Woolcock, 2001). This is where the basic criticism has been based, in the fact that in his definition, he ignores the inequality of power. In his view, social capital comprises the elements of social organization, such as networks, rules and trust that develop the coordination and collaboration for the common good (Putnam, 1993a, p.41). According to Putnam the basic measurement indicators of social capital are: social networks (especially voluntary associations), social values (especially trust) and moral obligations and norms.

What is more, Putnam (2000, p.19) introduced bonding, bringing and linking social capital which are the most widespread forms of social capital conversation and are considered by many as the continuity of the conversation of terms: strong and weak networks of Granovetter (1973). Bonding social capital refers to the tight horizontal bonds between individuals or groups that share similar sociodemographic characteristics. Typical examples are family, close friends, neighbors. Inequality in power and weak social solidarity are connected with the lack of bonding social capital (Putnam, 2000, p. 2-24). This form has the tendency to reinforce exclusive identities and homogeneous groups. It is often intolerant to diversity and does not generate benefits of collaboration and trust for society. On the other hand, bringing and linking social capital refer to bonds with different groups. Bringing social capital is more externalized and deals with horizontal relationships of individuals that come from different groups such as, voluntary organizations that are based on a common interest and are above the heterogeneous differences of nationality, religion, employment and socioeconomic status (Hope et al., 2007). These 'bridges' compose important vehicles for the economic and social development of the society (World Bank, 2001). Linking social capital refers to vertical relationships which help the individuals gain access to different and broader sources of power. Social and economic development is the goal in this form of social capital. A 'poor' linking social capital follows on inequality in economy and wellbeing. This form of social capital is able to reduce the inequalities because of its encouragement towards individuals to feel responsible for others beyond their own group (Foley & Edwards, 1999).

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Therefore, social capital along with social cohesion is considered one of the collective elements that influence a community in general (Eriksson, 2011). Social capital can be interpreted as a resource, which is based on collective action and it is likely to have positive results on a broader economic and social scale (Blume & Sack, 2006). From the three main exponents of social capital, we come to the conclusion that Putnam's theory gives a community prospect to social capital. Community development is regarded as a key-strategy for the theory of (Kassahun, 2010) that has been most exploited in the research of health, community prosperity and development. He claims that even individuals that do not possess evolved social networks, will gain from their living in communities with high social capital (Putnam, 2000).

Health promotion.

According to the 'Bangkok Charter for Health Promotion in a Globalized World' health promotion is '*the process of enabling people to increase control over their health and its determinants, and thereby improve their health. It is a core function of public health and contributes to the work of tackling communicable and non-communicable diseases and other threats to health*' (WHO, 2009, p. 29). The acknowledgement, that health is influenced and constitutes a parameter of social, political, and environmental factors, has led health promotion to the pursuit of new strategies. The pattern of health promotion according to W.H.O. reflects on seven key-principles: *Empowerment, Participative, Holistic, Intersectoral, Equitable, Sustainable, Multi-strategy* (Rootman, 2001). Participative and Empowerment specifically compose the most stable and powerful reference points and the first is considered a prerequisite of the second in the vision of W.H.O. for health promotion.

Health promotion develops in three areas, health services, community and education. The area of community includes both space and place and the nature of human relations and interactions. Lately, it has become essential for health promotion to be developed and have practical application in the community (Mittlemark, 1999) since the profile, the frequency of risk factors or, on the other hand protective factors can differ significantly from one community and time period to the other, since communities evolve and change (Hawkins, Shapiro & Fagan,

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2010). It is what Coulton (2005, p. 74) claims 'the community is a means of change, goal of change or framework of change'. Poland, Green and Rootman (2000) introduce two approaches of promotion of health on a community level: community based and the community development (Table 2).

The community based approach focuses on health behavior and lifestyle while community development focuses on tracing, developing and increasing the existent sources and forces of the community. The community development approach refers to the empowering of individuals and communities, to the enhancing of the advantages of communities, to the identification of a problem by the community itself, to social justice and to the professionals that are a source of workforce of the community (Poland et al., 2000).

Community development in public health is defined as "*the procedure of organizing and/or the support of different groups of a community so as to pin down their health issues, to plan and act with strategies of social change and through this action, to gain confidence and strength to make decisions* "(Labonte, 1993, p. 237). So community development is a procedure of social capital development. Of all the other health promotion strategies as identified in the Ottawa Charter, community development is the one which internalizes and works with three of the most important elements of contemporary promotion of health such as, participation, empowerment and collective action (WHO, 1986; Bracht, 1990). According to the previous quote, 'empowerment' which is in the heart of the procedure according to the Ottawa Charter for Health Promotion (WHO, 1986), plays a central part in the promotion of health.

Empowerment as a concept was developed by the social service of Solomon (1976), according to whom empowerment is 'the process by which people increase power on the personal, interpersonal, political, and economic levels in order to take action to gain more control over the conditions of their lives' (Boehm & Staples, 2004, p.270). The values of the profession of social work such as, empowerment, cultural competence, self-management, human relations, rights, dignity and social justice are recognized and honored by public health, so the social workers can be considered significantly effective in their community interventions (Spencer, Gunter, & Palmisano, 2010). Social work and public health have shared the concept of social justice and the mutual goal of

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improving the quality of life, health and prosperity of a community (Hooyman, Schwanke, Yesner, 1980; Poole, 1995) for over a hundred years.

The promotion of health is like a natural home for social workers (Siefert, 1983) since the values and philosophy of social work in general, such as 'Consider people within their social environment' (Hendricks & Rudich, 2000, Australian Association of Social Workers, 2010; Rogge & Cox, 2001) and 'Work with people's strengths' help professionals remain on the right path. As a profession, social work is at the forefront in the first line of protecting and improving the social conditions that influence health and the equality of health in a negative way (Moniz, 2010). Social work educates its students in health promotion through ecological models (Roskin, 1980) with a focus on the individual inside their environment, by giving a holistic approach to the difficulties faced by the individual.

Prevention and health promotion are considered some of the good points of intervention and education in social work through undertaking leading and organizing roles (Hawkins et al., 2010). Social workers that work in the community can cope with the demands of modern politices and practical needs of health promotion and possess the necessary training to take or, even better, to give the community such an active role. Social workers trained in the community are called upon, to design and make interventions in order to make desired social changes depending on the needs of the community. What is more, community development is a key-ability in the practice of social work that must take part in most of its interventions (Mendes, 2009). The executives in community development aim on making the community able to track its own problems and suggest solutions to them (WHO 1986, p. 2). Because of the emphasis it places on the procedure, this strategy requires professionals to work together with the community and not only for its own benefit (Mitchell, 1999). Through participatory procedures and with a down-to up approach, the community is supported so as to have skills and abilities and establish those health policies that seem most fit. Basic principles are participation and empowerment.

One program that is based on the strategy of community development by placing great emphasis on collaboration and empowerment, and which corresponds to many of the above parameters, is 'The Communities

That Care' (Hawkins & Catalano, 1992). The program was based on a widespread collaboration of key-individuals, community organizations and their leaders that acted in a collective manner in order to implement and promote prevention strategies (Hawkins et al., 2010). It brought together the youth, parents, schools, community organizations and local government services so as to promote the health and prosperity of young people. Arthur et al. (2010, p.2) mentions that 'The Communities That Care' process provides a structure for engaging community stakeholders; a process for establishing a shared community vision regarding the healthy development of young people; data collection and reporting tools for assessing the prevalence of risk and protection; processes for prioritizing risk and protective factors for community action; and tools for matching prioritized risk and protective factors with tested and effective preventive interventions'.

Community Social Work.

According to National Association of Social Workers (NASW) Code of Ethics the primary goal and principles of social work are '*..to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty. A historic and defining feature of social work is the profession's focus on individual well-being in a social context and the well-being of society. Fundamental to social work is the attention paid to the environmental forces that create, contribute to, and address problems in living*' (NASW, 1996, p. 1). By examining the above statement, one can ascertain the macro perspective of social work. Community social work is one of the methods of social work that make social work discernible from other sciences because of its focus on the great social issues of society (Glisson, 1994) and on environmental factors.

Therefore, a need emerges, for the social workers in the community to be more familiar with traditional models of intervention in community practice. Community social work practice reflects the needs of this article on the three models of intervention in the community, Rothmans's classic typology (locality or community development, social planning, and social action) (Rothman, 2001), since this particular typology is the basis of most training programs in community social work (Thomas, O' Conor & Netting, 2011), but also because several

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professional social workers are familiar with this particular model. Rothman (2008), has recently renamed his classic typology to 'Community Capacity Development, Planning and Policy Practice, and Social Advocacy', showing nine dimensions of community intervention. The conceptual model he proposes represents a triptych of strategies that can all interact with each other in a 3 X 3 cross-tab diagram and analyze and classify the condition in the community in order to accomplish the desired changes. These are : Capacity-Centered Development (Planned Capacity Development and Identity Activism), Rationalistic Planning (Participatory Planning and Policy Advocacy) and finally Social Action (Solidarity Organizing and Social Reformal), that are analyzed by Rothman (2008).

Rothman's change in classic typology was mandatory due to the fact that the conditions of the community, the degree of the population's maturity for change and the power of the community frequently require professionals to take on a great number of roles, making the mixed use of strategies (Thomas et al., 2011) imperative. Through a series of parameters, each one of the strategies is trying to bring about changes based on its own path and perspective with greater ampleness and choices (Rothman, 2008) compared to the past. To conclude, we will refer to the basic points of its strategies.

Community Capacity Development focuses on the empowerment and the collaboration of the communities that are affected by a problem or a situation, in order for communities to work collectively along with their own collective forces, and be in position to solve them and organize their future by having knowledge and skills. Community Capacity Development focuses on the development of social abilities through the empowerment of individuals and communities to act for their own gain (Table 3). In the center, there is community participation, consensus, share and the learning (Rothman, 2008). As a strategy, its focus is people-oriented, thus focusing on targets of procedure and on empowerment techniques. The community plays an active part of the problem-solving procedure. The community executive as an assistant, coordinator, animator and consensus intervention strategist tries to solve the remaining issues with the community.

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Planning/Policy is based on empiric and scientific facts. It is, from the top/down approach, in which communities, as service receivers, enjoy the benefits experts design for them without their active participation. It includes all the stages of planning and implementing an intervention or providing services for the solution of the community's problems. The settlement of serious social issues like alcohol consumption by underage people (below 18 years old), violence, poverty, unemployment are project targets for this particular strategy. The community executive, as researcher-designer, empirically collects evidence about the problem and then plans programs and services to solve this problem. With guidance and planning, the community is led from the top, to decide what is best for each situation it deals with. However, no matter how well rationalized a planning and a design is, there will always be twists and issues that have been miscalculated.

Finally, Social Advocacy involves pressure groups from inside out who take on the responsibility for defending the rights of the entire community based on the principles of social equality and justice (Rothman, 2008). The advocacy and protest tactics play a central role in the settlement of the community's problems. The ones with power and authority are not willing to lose sources and privileges. Here, the community executive as an advocator-negotiator tries to solve the conflicting interests of the groups of a society in benefit of those affected by poverty and by social exclusion.

In Greece, the training and practice of community social work is very limited. What dominates in the curricula of the faculties is case social work, which is in agreement with the general tendency of education in social work all over the world (Mendes, 2009; Hill, Ferguson & Erickson, 2010). As a result, the training of social workers does not focus, in particular, on knowledge and tools that target prevention policies and promotion of health at a community level as well as to the development and preservation of social capital (Ersing & Loeffler, 2008). Social workers have to understand and accept that social interventions are more effective than clinical individual interventions in covering social needs (Mendes, 2009; Coulton, 2005; Whelan, Swallow, Peschar & Dunne, 2002; Filliponi, 2011).

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The Community Development Educational Center (C.D.E.C) is a lab that is part of the Social Work faculty of the Technological Educational Institute of Crete where based on the above acknowledgment, trains about fifty students per semester in community social work. Over the last decade, community social work education and practice has been developed enough within the field based training this lab supervises, giving the opportunity to students to develop a series of methods, tools and techniques and to practice their abilities in the real world. In spite of the given opportunities for education in the field and the holistic-community based approach on studying the problems of individuals, of groups and organizations, the denial of students to follow a program of training in the community is still considered one of the major difficulties.

With reference to actions-interventions and the C.D.E.C. programs, characteristic examples can be found in a series of studies on the community profile in rural areas according to Seippel's model (Seippel, 1974), in the measurement of social capital on urban and rural communities as regards the community, the household and the organizations, in the cultural adaptation for providing health and welfare services (Koutra, Eulampidou, Roumeliotaki, Koutis & Philalithis, 2008), in the planning of preventive interventions for the reduction of alcohol consumption by young people (Koutra, Oikonomou, Andreadaki, Ntavaloumi, 2012), in the steps taken towards improving the health of women residing in rural communities by calling informal community networks into action (Koutra, Katsapi, Providou, Kritsotaki, 2012; Koutra, Kirou, Ratsika, 2010), and finally in the reorganization of health and social welfare services for the elderly and caregivers in rural communities (Koutra, Pelekidou, Kirou, Prokopakis & Ratsika, 2010) by using a series of methods ranging from action research to GIS mapping and social epidemiology for the recoding of health needs and services.

All the above were fields and opportunities aimed at offering the students of social work the necessary knowledge, training and insight into the issues of Rothman's model before choosing one of the strategies or a combination of them for their interventions. The model of community development is the one that mainly dominates. That model is in agreement with the grater context of the country because of the organization of social protection and care structures mainly in the public sector (Stathopoulos, 1993). On the other hand, depending on

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the problem, the available sources of influence and the interactions that are developed, do not exclude but rather encourage the combined or even better the mixed use of models, predominantly the dipole of community development and social planning.

COMMUNITY DEVELOPMENT- A WAY FOR MUTUAL ACTION

To sum up, everything that has been mentioned has led us to the result that there is a basic point which is able to give a common field of work, methodology and approach to community social work, with social capital and with health promotion as it was analyzed in this article. This point is the strategy of social development. The connection is presented in Figure 1.

Mizrahi and Davis (2008, p.379) mention that 'Community development's primary objective of improving the living standard of marginalized groups is compatible with the historical mission of social work'. Community development is highly compatible with the macro practice of social work, while, according to Rothman (2008), the latter can indeed play an important role in it by promoting changes for individuals and their communities (Tan, 2009) and be very effective since it focuses on the reason that causes the problem than the symptom the individual shows (Filliponi, 2011).

The acceptance that the community is of paramount importance on the lives of the people, automatically leads to the need of having knowledge, skills and abilities in community practice as professional social workers (Hardcastle, Powers & Wenocur, 2004). IASSW (2001) places work in the community as the prevailing tendency for the future of social work. The 21st century is making a turn towards community development and the value of community social work according to Kirst-Ashman & Hull (2009). The methods of social work are closely linked to community development (Barclay,1982; Tan, 2009) since it is considered by some as the birth of social work (Social Work Speaks, 2012), while this relationship has been questioned by others due to the traditional attachment of social work to the 'individual', the symptom and to psychoanalytic theories.

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Those in favor of community development claim that the 'needs' of the individuals can only be dealt with in a wide scale on social, political structures and social networks (Mendes, 2009). Goldsworthy (2002, p.2) mentions that community development creates communities in contrast with the casework which focuses on creating individuals. Besides, the philosophy of 'Consider people in their environment'(Rogge & Cox, 2001) and the principle of social justice that social work advocates inevitably lead to more collectively-oriented interventions on all levels. This clearly integrates community development in the key-strategies of the social work interventions that aim at scheduled changes of social environment through empowerment practices.

Apart from sharing a mutual philosophy of intervention and action in the community, community development and social work also share basic concepts and principles like collective action, empowerment and collaboration. Long term occupation, intervention and action in participatory, empowering and collaborative relationships of community social work, places it at an advantage on applied science, which play an important part in 'how' and 'why' communities can change (Coulton, 2010) having as a given that communities are above all, places of social interaction and therefore of social capital. The assessment of community development elements by social workers is of vital importance for the understanding of the relationship social capital can play in promoting health.

Through the components of community development, collective action, empowerment and collaboration, the professional social worker evaluates, enhances, structures, organizes and implements interventions, designs and actions in order to support a group of people or a community in creating the bonds and relationships (meaning social capital), which will enable them to handle important problems and issues in their lives. Collective action is a key-point for social workers that work with Rothman's model of local/community development. Collective action aims at social change which reduces unequal powers and accomplishes the notion of mutual affairs that can only be solved collectively. This can take on multi-leveled and various forms, from institutional interventions to coordination of actions. Usually, people that live in a community either have a mutual interest, when they feel that

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they face a great threat or they have a great opportunity to come together in order to deal with these common issues or problems (Checkoway, 1997).

Collective action is closely connected with social capital. Even though it is usually presented as one of its dimensions, it is better if collective action is considered a result or an indicator of the existence of social capital, as is the case with social trust and solidarity (Yokoyama & Ishida, 2006). Various researchers have pondered over the positive relationship between collective action and social capital despite the variations in their studies (Krishna & Uphoff, 1999; Grootaert et al., 1999). The only certain thing is that collective action cannot be achieved without participation in organizations and networks, a will for collaboration, trust, empowerment and social interaction (Grootaert et al., 2003). Therefore, through participation, which constitutes the structural dimension of social capital in the community, meaning the various forms of social organization (local organizations, groups, clubs), the inhabitants have the opportunity to express themselves on issues that concern them. In turn, participation then promotes trust and social solidarity which compose the cognitive dimension of social capital and, along with the representational participation of the inhabitants in the decision-making process, leads to the demand of redistribution of power (Iatridis, 1999). Participation in organizations, the number, the kind, the form of organizations, the forms of participation and in general the networks, the social structures and membership have a positive impact on the prosperity and health of the inhabitants of the community, even though that is not panacea. Kawachi, Kennedy, Lochner, and Prothrow-Stith (1997) and Kawachi, Kennedy, and Wilkinson (1999) confirmed an inverse relationship between participation in volunteer groups, the causes and the mortality rates, even after the adaptation for income differences between countries and even individual level.

As regards to health promotion, by evaluating the principles and values of community development mentioned above, social workers are like they work within their natural environment, in their roots, since either way, all social work interventions have to do with health. By acknowledging that the economic, social and political environment influences the health or the morbidity of the population, social work has the opportunity, to encourage people of a community to work closely together, through the strategy of community development. In collaboration

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with the community, the social worker traces and evaluates the formal and informal community networks to promote the health of the community. Studies have established that communities with a good level of health care manage to handle their affairs better and have increased levels of social participation and trust (Stafford et al., 2004).

With the community development, social workers estimate the community health needs expressing the holistic character and the interactions of these needs with other sectors and needs (Smith, 1989). Though ongoing collaboration with the community and its relevant services, agencies, actively motivated social groups and by using methods such as action-research, social workers try to deal with the community's needs by encouraging promoting dialogue in the community with those who decide for more accessible and suitable health services. The basic principle of social workers in this model is to recognize that the people of a community are themselves experts in their own health problems and in the situations they have to deal with, so they have the right to be active participants in whatever decisions concern them. It is what Rothman advocates, that no matter how guiding or not is the part of a community executive to support a community to follow the right path, the final decision will always belong to the community itself.

CONCLUSION

This article has attempted to describe the dynamic part that community social work can play through the strategy of community development in social capital and in health promotion. Communities with a successful development are more likely to experience collective actions. These communities may be more cohesive, safe and collaborative. Therefore, in order to lead the communities to a collective solution of the problems they face, social workers should determine which mechanisms provide motives for actions and what factors, obstacles and limitations contribute to or hinder the development of collective actions in communities.

Therefore, it is obvious and reasonable that social workers must enter a procedure of collecting a wide range of aspects and forms of social capital in order to have a clear image of the factors that determine or prevent

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the development of social capital in a community. When referring to a wide range of forms of social capital (horizontal/vertical, bonding/ bridging/ linking, structural/ cognitive) we must careful, not only in the selection but in the interpretation of this information, because many different factors such as the cultural, social, economic and political environment as well as issues of power and authority, distribution of services and favouring some groups at the expense others, by official agencies all influence the usefulness of social capital in community development and health.

It is time social workers contributed to the knowledge and conversation referring to the influence of social capital in the promotion of health. It is also high social workers acknowledged the benefits and the advantages of working with the strategy of community development, thus contributing to healthy communities capable of rebuilding and producing social capital. The education of social workers should evolve and expand its horizons by using tools from other scientific fields while placing greater emphasis on its practice within the community so that it may prepare future professionals to cope with the ever-changing and complex social environment. Geography, i.e spatially informed research (GIS) and methods borrowed from the field of epidemiology, should enter the curricula of social work in Greece in order to enrich the knowledge of social workers about the social problems from another perspective. What is asked is that the social workers of tomorrow have the best possible knowledge of the community needs, sources, powers and social capital so that they may better suggest correct interventions that will improve the conditions of life and health in their communities.

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Table 1

Basic differences of the three main theorists of social capital

Main social capital theorists	*Perspective*	*Level of analysis*	*Asset*	*Benefits*	*Main points*
Bourdieu Social network approach	Marxist	Micro	Individual	Individuals can gain material or cultural benefits through membership	Persistence of social class and other entrenched forms of inequality
Coleman Social network approach	Liberal	Meso	Individual with social function	Individuals gain benefits through their social relationships and networks which can also be enjoyed by others	The importance of social relationships, social action and social welfare institutions.
Putnam Social cohesion approach	Liberal	Macro	Collective	Social institutions and groups are responsible for creating social trust and urging people to act collectively for the common good	Citizens have the same chance of benefiting in a community with high social capital

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Table 2

Health promotion approaches

HEALTH PROMOTION		
Health services	*Community*	*Education*
Physical space		*Human relationships*
	APROACHES	
Community based		*Community development*

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Table 3

Community Capacity Development (Rothman, 2008)

Leadership development	**Participation**
Social integration or solidarity	**Empowerment**

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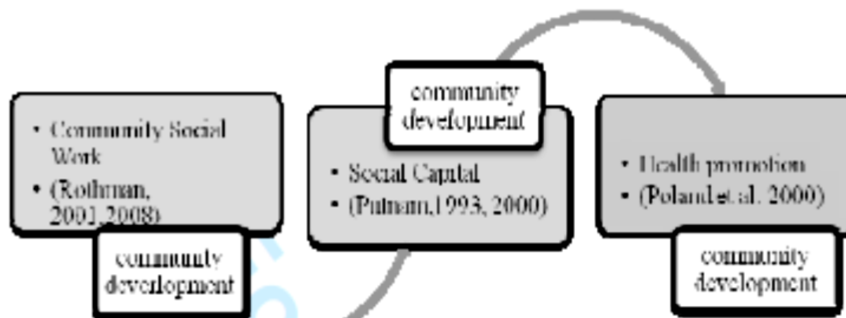
Figure 1 Community Development- a way for mutual action



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Κεφάλαιο 6ο Σύνοψη

6.1 Κύρια ευρήματα της διατριβής

6.1.1 Πρώτη δημοσίευση

Η πρώτη δημοσίευση ανέδειξε ότι η *YSCS* είναι μια έγκυρη και αξιόπιστη κλίμακα για την αποτίμηση του κοινωνικού κεφαλαίου των νέων σε αγροτικές και αστικές περιοχές στον Ελλαδικό χώρο. Αναδείχθηκε, η αναγκαιότητα τα εργαλεία μέτρησης του κοινωνικού κεφαλαίου να προσαρμόζονται στο εκάστοτε πολιτισμικό περιβάλλον. Αναδείχθηκε, η αναγκαιότητα της διαδικασίας διενέργειας της ψυχομετρικής εγκυρότητας από τους ερευνητές της κοινωνικής εργασίας και η υποχρέωση τους, κριτικά να εξετάζουν μέτρα και μεθοδολογίες για σημαντικά ζητήματα πριν την εφαρμογή τους.

Η *YSCS* έχει τη δυνατότητα να χρησιμοποιηθεί ως εργαλείο μέτρησης, ως μέσο αξιολόγησης, ως μέσο σχεδιασμού παρέμβασης και ως μέσο έκβασης από τους κοινωνικούς λειτουργούς προκειμένου να αποκτήσουν περαιτέρω γνώσεις και κατανόηση για το πώς οι νέοι μπορούν να αναπτύξουν το κοινωνικό τους κεφάλαιο προς όφελός τους. Η μελλοντική έρευνα θα μπορούσε να στοχεύσει στο να αυξήσει την αποτελεσματικότητα των συνεργατικών διαδικασιών, καθώς και στην κατανόηση των ευρύτερων ωφελειών του κοινωνικού κεφαλαίου. Αυτή η γνώση θα συνέβαλε ουσιαστικά στο σχεδιασμό σειρά κοινοτικών παρεμβάσεων σε διάφορους σημαντικούς τομείς της ζωής των νέων, όπως η συμμετοχή στην κοινότητα, η συνεργασία, η υγεία, η εκπαίδευση, η απασχόληση και η αξιοποίηση του ελεύθερου χρόνου.

6.1.2 Δεύτερη δημοσίευση

Η δεύτερη δημοσίευση της διατριβής ανέδειξε ότι το δομικό κοινωνικό κεφάλαιο (*τι κάνουν και που συμμετέχουν οι μαθητές*) σχετίζεται με την αύξηση της τακτικής κατανάλωσης αλκοόλ σε αγόρια και κορίτσια, και, οριακά, με τα περιστατικά μέθης στα κορίτσια. Παράλληλα, το γνωστικό κοινωνικό κεφάλαιο (*τι οι μαθητές αισθάνονται*) σχετίζεται με τη μειωμένη πιθανότητα ευκαιριακής μέθης στα κορίτσια. Σε αντίθεση, το συνολικό κοινωνικό κεφάλαιο σχετίζεται επιβαρυντικά με την τακτική κατανάλωση για το σύνολο του δείγματος.

Η μελέτη υποστηρίζει τη σημασία της μέτρησης του κοινωνικού κεφαλαίου. Το κοινωνικό κεφάλαιο μπορεί να συνεισφέρει στην καλύτερη κατανόηση και γνώση του

πλαισίου στο οποίο, τα αγόρια και τα κορίτσια στην εφηβεία υιοθετούν συμπεριφορές κινδύνου ή όχι, και στην ανάπτυξη προληπτικών παρεμβάσεων. Για το σχεδιασμό αποτελεσματικών παρεμβάσεων απαιτείται μεγαλύτερη εστίαση στο κοινωνικό κεφάλαιο, ιδίως όταν μιλάμε για σημαντικά ζητήματα δημόσιας υγείας όπως η κατανάλωση αλκοόλ από ανηλίκους. Προτείνονται διαχρονικές έρευνες προκειμένου να διερευνηθούν σε βάθος οι επιπτώσεις του κοινωνικού κεφαλαίου στην κατανάλωση οινοπνεύματος κατά τη διάρκεια της εφηβείας. Τέλος, κριτικής σημασίας είναι η μελέτη και η διερεύνηση των συνθηκών και των μορφών κοινωνικής συμμετοχής των νέων.

6.1.3 Τρίτη δημοσίευση

Η τρίτη δημοσίευση ανέδειξε ότι τόσο το κοινωνικό, όσο και το οικονομικό κεφάλαιο έχουν και θετική και αρνητική επίδραση στο κάπνισμα και σε άλλες μετρήσεις για την υγεία των μαθητών. Ιδιαίτερη μνεία γίνετε για το δομικό και γνωστικό κοινωνικό κεφάλαιο μιας και η «*Συμμετοχή στην κοινότητα*» & «Δίκτυα γειτονιάς» (δομικό κοινωνικό κεφάλαιο) και τα «*Αισθήματα εμπιστοσύνης και ασφάλειας*» (γνωστικό κοινωνικό κεφάλαιο) πρωτίστως σχετίζονται με την καπνιστική συμπεριφορά των μαθητών. Τα ευρήματα, αναδεικνύουν ότι το κοινωνικό περιβάλλον που οι νέοι ζουν και αλληλεπιδρούν διαδραματίζει σημαντικό ρόλο στην υγεία τους. Το οικονομικό κεφάλαιο αναδείχθηκε από τη μελέτη ότι κυρίως σχετίζεται με κακή αυτοαναφερόμενη υγεία αλλά όχι με αυξημένη κατανάλωση καπνού. Τέλος, η ικανοποίηση από τη ζωή φαίνεται μειωμένη κυρίως στους μαθητές με χαμηλό κοινωνικό κεφάλαιο και κακή αυτοαναφερόμενη υγεία.

Τα αποτελέσματα και εδώ επιβάλουν μια λεπτομερή εξέταση της σχέσης των διαφορετικών παραγόντων και διαστάσεων του κοινωνικού κεφαλαίου. Το κοινωνικό κεφάλαιο μπορεί να δώσει πρόσθετες γνώσεις στους κοινωνικούς λειτουργούς για τους παράγοντες που επηρεάζουν ή όχι το κάπνισμα. Αυτούς τους παράγοντες δύναται να αξιοποιήσουν και να μελετήσουν οι κοινωνικοί λειτουργοί, προκειμένου να σχεδιάσουν κατάλληλες παρεμβάσεις για το περιορισμό των παραγόντων κινδύνων στην υγεία των μαθητών.

6.1.4 Τέταρτη δημοσίευση

Το τέταρτο άρθρο προβάλει τη δυναμική που η Κοινωνική Εργασία με Κοινότητα (Κ.Ε.Κ.) μπορεί να παίξει μέσα από τη στρατηγική της κοινοτικής ανάπτυξης σε υγιής και πλούσιες σε κοινωνικό κεφάλαιο κοινότητες. Μέσα από αυτήν τη θεωρητική αποτύπωση συνδέθηκαν όλα τα μέρη αυτής τη διατριβής. Υποστηρίχθηκε ότι οι κοινωνικοί λειτουργοί είναι σε θέση να συλλέξουν πληροφορίες για ένα ευρύ φάσμα θεμάτων και μορφών κοινωνικού κεφαλαίου, προκειμένου να έχουν μια σαφή εικόνα των παραγόντων που καθορίζουν ή εμποδίζουν την προαγωγή της υγείας στην κοινότητα. Η θεωρητική ανασκόπηση αυτού του άρθρου προτείνει την προσεκτική και λεπτομερή επιλογή αλλά και ερμηνεία των εν λόγω πληροφοριών, καθώς πολλοί διαφορετικοί πολιτιστικοί, κοινωνικοί, οικονομικοί, πολιτικοί παράγοντες επηρεάσουν την αξία του κοινωνικού κεφαλαίου στην ανάπτυξη και την υγεία της κοινότητας.

Οι κοινωνικοί λειτουργοί απαιτείται να συμβάλουν στη συζήτηση για την επίδραση του κοινωνικού κεφαλαίου στην προαγωγή της υγείας. Απαιτείται, οι κοινωνικοί λειτουργοί του αύριο να έχουν την καλύτερη δυνατή γνώση των αναγκών και των πηγών της κοινότητας, έτσι ώστε συμμετέχοντας σε διεπιστημονικές ομάδες να είναι σε θέση να προτείνουν παρεμβάσεις που θα βελτιώνουν τις συνθήκες ζωής και υγείας των κοινοτήτων τους.

6.2 Αδύνατα και δυνατά σημεία της μελέτης

Η παρούσα διδακτορική διατριβή έχει τους περιορισμούς που μοιράζονται όλες οι συγχρονικές μελέτες. Εν τη απουσία της συνέχειας στο χρόνο, η αξιολόγηση σε βάθος των αλληλεπιδράσεων δεν είναι δυνατή. Παρόλα αυτά, η κατεύθυνση της αλληλεπίδρασης με την παρούσα ανάλυση θεωρείται εύλογη.

Λόγω της αυτοσυμπλήρωσης των ερωτηματολογίων, τα δεδομένα της μελέτης είναι επιρρεπή στην κοινωνική σκοπιμότητα. Ο περιορισμός αυτή της τάσης έγινε με τη χρήση τυποποιημένων κλιμάκων για τη συλλογή των σχετικών δεδομένων.

Τα δεδομένα της μελέτης προέρχονται μόνο από το νομό Ηρακλείου, Κρήτης και αυτό μπορεί να δημιουργήσει κενά σχετικά με τη δυνατότητα γενίκευσης των αποτελεσμάτων. Ωστόσο, τα στοιχεία από άλλες μελέτες υποστηρίζουν ότι αναφορικά με τις συμπεριφορές υγείας των εφήβων στο Ηράκλειο, δεν υπάρχουν σημαντικές αποκλίσεις από τα εθνικά δεδομένα.

Δυνατά σημεία της παρούσας μελέτης είναι το σχετικά μεγάλο μέγεθος του δείγματος, το ικανοποιητικό ποσοστό ανταπόκρισης του πληθυσμού, η χρήση δύο σταθμισμένων και πολιτισμικά προσαρμοσμένων αυτοσυμπληρούμενων ερωτηματολόγιων, η αξιοποίηση διάφορων μορφών και διαστάσεων κοινωνικού κεφαλαίου, η διερεύνηση της σημασίας του φύλου και η στάθμιση σειρά συγχυτικών παραγόντων.

6.3 Συμπέρασμα

Αυτή η διατριβή ανέδειξε την αξία του κοινωνικού κεφαλαίου ως έναν από τους κοινωνικούς προσδιοριστές της υγείας των μαθητών. Η διατριβή ανέδειξε πότε το κοινωνικό κεφάλαιο των μαθητών σχετίζεται προστατευτικά και πότε όχι, με τις συμπεριφορές υγείας. Το αυξημένο γνωστικό κοινωνικό κεφάλαιο λειτούργησε προστατευτικά στις περιπτώσεις τακτικής κατανάλωσης αλκοόλ, καπνού και άλλων παραμέτρων υγείας των μαθητών. Το υψηλό δομικό κοινωνικό κεφάλαιο είχε προστατευτική επίδραση στην κατανάλωση καπνού και στην υγεία των μαθητών. Το συνολικό κοινωνικό κεφάλαιο και ιδιαίτερα, η δομική του διάσταση είχε αρνητική επίδραση, με αύξηση στην τακτική κατανάλωση αλκοόλ των μαθητών. Οπότε, συμπερασματικά καταλήγουμε ότι το κοινωνικό κεφάλαιο είναι ένα νόμισμα με δύο όψεις, έχει την καλή και κακή πλευρά του, και σίγουρα απαιτείται ακριβής ανάλυση προκειμένου, να αξιοποιηθεί προς όφελος της υγείας των εκάστοτε πληθυσμών παρέμβασης.

Η συμμετοχή στη ζωή της κοινότητας, αποτυπώθηκε στη μελέτη ότι είναι ένας από τους σημαντικούς παράγοντες που επηρεάζουν την υγεία των μαθητών. Το μίκρο-τοπικό επίπεδο, θεωρείται σημαντικό πλαίσιο πρόληψης, παρέμβασης και επίλυσης των συμπεριφορών υγείας. Η έρευνα αποδεικνύει ότι το κάπνισμα και το αλκοόλ εξακολουθούν να αποτελούν σημαντικά κοινωνικά και δημόσιας υγείας προβλήματα. Με γνώμονα αυτό, οι επαγγελματίες υγείας στη κοινότητα, όπως οι κοινωνικοί λειτουργοί, νοσηλευτές, γιατροί κλπ. μέσα από διεπιστημονικές συνεργασίες, θα πρέπει να προσδιορίσουν όλες τις πτυχές των συμπεριφορών υγείας των νέων.

Το κοινωνικό κεφάλαιο μπορεί να παρέχει την κατανόηση, στο ποιοι δεσμοί είναι ή δεν είναι προστατευτικοί στις συμπεριφορές υγείας των μαθητών. Οι οργανώσεις σε όλα τα επίπεδα θα πρέπει να συνεργαστούν και να δράσουν ώστε να βελτιώσουν την υγεία των

νέων. Οικογένεια, σχολείο, οργανώσεις της κοινότητας, φορείς χάραξης πολιτικής, κοινωνικές υπηρεσίες, επιχειρήσεις, τοπικές κοινοτικές οργανώσεις, μέσα μαζικής ενημέρωσης, υπηρεσίες υγείας είναι οι πολλαπλές πλευρές του προβλήματος που αλληλεπιδρούν, τόσο με την ατομική συμπεριφορά, όσο και με τους κοινοτικούς κανόνες και νόρμες.

Τέλος, αυτή η διατριβή προσπάθησε μεταξύ άλλων να τεκμηριώσει πόσο στενά συνδεμένα είναι η κοινωνική εργασία με κοινότητα και το κοινωνικό κεφάλαιο. Η κοινότητα αποτελεί σημαντικό μέρος της ζωή των ανθρώπων, και μπορεί να ειπωθεί ότι είναι άμεσα συνδεδεμένη με τις γνώσεις, τις δεξιότητες, και τις ικανότητες, της πρακτικής της κοινωνικής εργασίας με κοινότητα (Κ.Ε.Κ.). Παράλληλα, η αποτίμηση των στοιχείων της στρατηγικής της κοινοτικής ανάπτυξης από τους κοινωνικούς λειτουργούς είναι ζωτικής σημασίας για την κατανόηση της σχέσης που μπορεί να διαδραματίσει το κοινωνικό κεφάλαιο στην προαγωγή της υγείας. Μέσα από τις συνιστώσες της κοινοτικής ανάπτυξης, τη συλλογική δράση, την ενδυνάμωση και τη συνεργασία, οι κοινωνικοί λειτουργοί αξιολογούν, ενισχύουν, τις δομές, τις οργανώνεις και υλοποιούν παρεμβάσεις, σχέδια και δράσεις, ώστε να υποστηρίξουν μια ομάδα ανθρώπων ή μια κοινότητα να δημιουργήσουν δεσμούς και σχέσεις δηλ. κοινωνικό κεφάλαιο.

Η διατριβή προτείνει ένα μοντέλο δουλειάς μέσα από τη στρατηγική της κοινοτικής ανάπτυξης που μπορεί να δώσει τη δυνατότητα στους κοινωνικούς λειτουργούς να εκτιμήσουν τον ολιστικό χαρακτήρα των αναγκών υγείας και την αλληλεπίδραση αυτών των αναγκών, με άλλες ανάγκες. Η βασική αρχή στο προτεινόμενο μοντέλο δουλειάς είναι ότι οι μαθητές θα πρέπει να μετουσιωθούν σε ενεργά υποκείμενα. Οι μαθητές είναι γνώστες των συμπεριφορών υγείας τους, άρα δικαιούνται να είναι μέρος και της βελτίωσης αυτών, μέρος της λύσης. Μέρος της λύσης δεν είναι μόνο οι μαθητές, αλλά και όλα τα μίκρο και μέσο συστήματα που τους περιτριγυρίζουν όπως γονείς, φίλοι, συνομήλικοι, οικογένεια, συγγενείς, γειτονιά, σχολείο, δάσκαλοι, κοινότητα, *όλοι αποτελούν ενεργά μέρη της λύσης,* των όποιων προβλημάτων. *Όλοι, αυτοί, είναι το κοινωνικό κεφάλαιο μιας κοινότητας, το κοινωνικό κεφαλαίο των νέων.* Οπότε, όσοι σχεδιάζουμε παρεμβάσεις για τους όποιους πληθυσμούς, *απαιτείται να δουλεύουμε μαζί τους, δίπλα τους, συνεργατικά γιατί σίγουρα ξέρουν κάτι που εμείς, δεν ξέρουμε.*

«*Την πραγματικότητα της καθημερινότητα τους*».

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Ερευνητικό Πανεπιστημιακό Ινστιτούτο Ψυχικής Υγιεινής (Ε.Π.Ι.Ψ.Υ) (2005). Παγκόσμια έρευνα για την υγεία των μαθητών *Παγκόσμια Οργάνωση Υγεία (Π.Ο.Υ.) και Ερευνητικό Πρόγραμμα (HBSC).*

Παράρτημα

Σύντομο βιογραφικό σημείωμα της υποψήφιας

Personal information

Full name: Koutra Kleio, E-mail: kkoutra@staff.teicrete.gr

Website: 1. Google scholar; 2. gr.linkedin.com/pub/kleio-koutra-mph-bsw/63/ 96a /14b/

Academic information

School: School of Health & Social Welfare, Department: Social Work

Courses

- Needs Assessment and Social Planning,
- Community Work and Intervention Methods
- Multicultural Social Work
- Elderly and disabled individuals: social work interventions
- Practice Learning and Practicum
- Dissertation thesis supervision

Studies

- *2007- today*: PhDc, University of Crete, Faculty of Medicine. Dissertation thesis: "***Social capital and health behaviors in high school students at the Prefecture of Heraklion. Community Social Work interventional role***".
- 2005. Master in Public Health, Medical Faculty, University of Crete. Master thesis: "***The subjective perception of health and satisfaction of health services by immigrant mothers in a municipality of Crete***".
- *1996.* BSW, Dep. of Social Work, TEI of Crete

Research interests

- Community development,
- Community Social Work,
- Social Capital,

- Health Promotion,
- Prevention in community level,
- Ageing,
- Immigration,
- Social determinants of health

Publications during the past 5 years

- Koutra, K., Kritsotakis, G., Orfanos, P., Ratsika, N., Kokkevi, A., & Philalithis, T. (2014). Social capital and regular and binge alcohol use in adolescence: a cross sectional study in Greece. *Drugs: Education, Prevention & Policy Journal* (accepted) (IF: 0, 0595)
- Papanikolaou M, Chatzikosma T., Koutra K. (2011) Bullying at School: The role of family. *Procedia - Social and Behavioral Sciences* 29, 433 – 442.
- Prokopakis, E., Ratsika, N., Koutra, K., Papadakaki, M., Pelekidou, L., Chliaoutakis, J. Three decades of migration to Greece. Assessing the attitudes of the local population in the capital of Crete. International Journal of Social Work (submitted).
- Koutra K, Orfanos P., Roumeliotaki Th., Kritsotakis G, Kokkevi A, Philalithis A. (2012). Psychometric validation of the Youth Social Capital scale in Greece. Research on Social Work Practice, 22(3):333 – 343. (IF: 1.130)
- Prokopakis, M., Koutra K., Oikonomou, K. (2011). The social capital of immigrant pupils attending primary schools in the city of Heraklion. Modern Society, Education and Mental Health Journal *4: 129-154.*
- Koutra K, Papadobassilaki K, Kalpoutzaki P, Kargatzi M, Roumeliotaki T, Koukouli S. (2012). Adolescent drinking, academic achievement and leisure time use by Secondary Education students living in a rural region of Crete. *Health and Social Care in Community* 18(3):249-256, (IF: 1.008)
- Kritsotakis, G., Antoniadou, E., Koutra K, Koutis A., Philalithis, A. (2010). Cognitive Validation of the Social Capital Questionnaire in Greece. NOSILEFTIKI 49(3): 274–285
- Koutra, K., Pelekidou, L., Kirou, J., Prokopakis, M., & Ratsika, N. (2010). The social work interventional role in the evaluation of home-care services for the elderly and

their caregivers in a rural semi-mountainous community. Paralalis, S. (eds) The Dimensions of Social Work in Greece and Cyprus. Collective volume.

- Koutra K, Eulampidou H, Roumeliotaki T, Koutis A, Philalithis A. The subjective perceptions of health of immigrant mothers. *Arch Hellen Med*. (2010) (IF: 0, 0595)

Additional information

- Translation and cultural adaptation of the Social Capital Assessment Tool (SO.C.A.T.) of the Social Department of World Bank Development for the Local Community Development Lab. Theoretical SO.C.A.T. connection with the study community by Seippel model (Mrs. K. Koutra holds the permission by its manufacturers).

Participation in funded research projects

- Coordinator in Life-Long-Learning Program GRUNDTVIG "Innovations in Mature Adult Learning" (Duration 24months, 31-8-2013 to 31-7-2015, No: 2013-1-PL1-GRU06-38771 3).
- Participation in the Life-Long-Learning Program GRUNDTVIG Multilateral 'Evaluation for the Professional Development of Adult education Staff "EDUEVAL" (2014)
- Participation in the Intercultural Training Program of the Public Employees Uniform decentralized administrative units dealing with third-country nationals legally residing in Greece (2012).
- Participation in the "Epidemiologic profiling, health needs assessment and health education intervention in the rural population of Crete, Greece". Arximedes III
- Participation in the «The process of transition from youth to adulthood. A study on young people of Crete» Arximedes III
- Participation in the «Social capital and other sociodemographic and environmental factors that predict health behaviors change young adults: A 36 month cohort study». Arximedes III.
- Participation in the «Cultural Passages" (2010).
- Participation in the Life-Long-Learning Program GRUNDTVIG, 'Active ageing & Pre-retirement counseling' (2010).