Depressive Symptomatology, Exposure to Violence, and the Role of Social Capital Among African American Adolescents

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Focusing on the role of capital as both personal and social resources for adolescents, the authors examined depressive symptomatology among a sample of 10- to 18-year-old African American youths (N = 1,538). In addition to gender and age differences, adolescents exposed to threatening environments (school, neighborhood, home) reported more depressive symptoms. Social capital had a significant inverse relationship with adolescent depression; self-esteem and a social capital index were negatively related to depressive symptomatology. Furthermore, the interaction effects of gender with social capital, age with self-esteem, and age with grades were significant, indicating the presence of a buffering effect. These findings suggest the importance of interrelationships among violence exposure, capital, and well-being for adolescents.

Over the last several decades, we have witnessed a growing concentration of poverty and minority status in America’s inner cities—the ghettoization of poverty (Fitzpatrick & LaGory, 2000; Jargowsky, 1997; Wilson, 1987). This increasing isolation of the poor reflects a broader trend in society, described in Robert Putnam’s (2000) *Bowling Alone*. Putnam argued that this disconnectedness in American life has implications not only for communities but also for the physical and mental health of America’s residents. He believed that social connections are a critical form of personal and community capital affecting well-being. The absence of such connections may have dramatic significance for those already suffering from the negative consequences of poverty and inner city spatial isolation.

Youth, because of their limited mobility, may be particularly affected by the growing social and spatial isolation of the inner city. Research suggests that low-income and minority youth are at great risk for a wide range of problematic outcomes affecting their personal well-being (Aneshensel & Sucoff, 1996; Brooks-Gunn, Duncan, Klebanov, & Sealand, 1993; Compas, Connor, & Hinden, 1998; Ensminger & Juon, 1998; Fitzpatrick, 1993; Fitzpatrick & LaGory, 2000; Jessor, 1992; Kandel, 1998; Loeber, Farrington, Stouthamer-Loeber, & Van Kammen, 1998; M. D. Resnick et al., 1997). Putnam noted that well-being outcomes ranging from unhappiness and depression to suicide among youth may be a function of diminishing social capital (Putnam, 2000; Saguaro Seminar, 2000), a trend with special relevance for those living in the inner city because of its social isolation (Mitchell & LaGory, 2002).

Among the most researched topics in the general literature on well-being is the subject of depression. Our understanding of adolescent depression, more so than other forms of adolescent psychopathology, has witnessed substantial revisions in the last decade (see Cicchetti & Toth, 1998, for a comprehensive review of depression research pertaining to youth). The literature has evolved from the belief that youth do not experience depression during adolescence to the realization that not only do they experience it, there is
a marked increase in depression between childhood and adolescence, with depression often co-occurring with other disorders (Compas et al., 1998; Gled & Pine, 2002). In fact, adolescent prevalence rates for depression closely approximate those of adults, indicating that, in many cases, adult depression may have its onset in adolescence. Although estimates vary, studies tend to report rates of depression in children between 1% and 3% and rates of 1% to 8% among adolescents (Anderson & McGee, 1994; Birmaher et al., 1996; Roberts, Lewinsohn, & Seeley, 1995; Satcher, 1999).

Studies of depression for both youths and adults have documented a significant association between environmental hazards and risks (e.g., violence, poverty, social isolation) and depressive symptomatology (Birmaher et al., 1996; Deykin, Levy, & Wells, 1987; Fitzpatrick & LaGory, 2000; W. E. Hawkins, Hawkins, & Seeley, 1992; Kandel & Davies, 1986; Satcher, 1999). Although many of these studies have found a complicated set of causal relationships, as expected, participants who report greater exposure to environmental hazards report more mental health symptoms, are less socially competent, and have increased difficulty with social adaptation as they get older (Aneshensel & Sucoff, 1996).

Independent of these negative circumstances, some youth are more resilient than others. This resiliency is fostered throughout development by a set of protective mechanisms, one of which is the individual’s social connections (Formoso, Gonzales, & Aiken, 2000). For youth, these connections, sometimes referred to as social capital, are embedded in several domains—family, school, peer group, and community. Since Durkheim’s (1897/1966) early work on suicide, the impact of social connections on mental well-being has been well documented (e.g., Lin, Dean, & Ensel, 1986; Putnam, 2000; Srole, Langer, Michael, Opler, & Thomas, 1962; Thoits, 1995). More specific to this research effort, studies have shown that children and adolescents benefited from these connections, whether through relationships with family, friends, or teachers (Dekovic, 1999; Fitzpatrick, 1997; Fitzpatrick & Boldizar, 1993; J. D. Hawkins, 1995; M. D. Resnick et al., 1997; Smith, Lizotte, Thornberry, & Krohn, 1995). However, no study, to our knowledge, has focused its exploration on the basic relationships among hazardous circumstances, social capital, and mental health among poor, minority youth.

The intention of this article is to explore depressive symptomatology in a sample of African American inner city youth, paying special attention to the following questions: (a) Does social capital really matter? Specifically, are bonding social ties important for well-being, and do they act as risk mediators or buffers in predicting depressive symptomatology among this sample of African American adolescents? (b) Do other personal forms of capital, so-called human capital (e.g., academic achievement, self-esteem), play a role in predicting depressive symptoms among adolescents? What hazardous circumstances and risks (e.g., exposure to violence) correlate with depression, and how are they related to social capital?

Unhealthy Places

Inner city areas have been characterized as “islands of risk and despair” (Fitzpatrick & LaGory, 2000, p. 121); this is descriptive of disorganized communities in which social detachment, crime, physical hazards, and stress abound (Ross, 2000; Ross & Mirowsky, 2001; Ross, Mirowsky, & Pribesh, 2001; Wilson, 1996). Andrus (1997) described the consequences of inner city residence as an “urban health penalty” (p. 2) in which persons living in high-minority, high-poverty neighborhoods share more in common with those in a third world country than they do with other residents of their own metropolitan area. This penalty—the intersection of poverty, unemployment, deteriorating housing, violence, poor nutrition, and a general erosion of service delivery—has created a deepening urban health crisis (Fitzpatrick & LaGory, 2000).

One aspect of this crisis is the urban resident’s exposure to violence. Central city residents are twice as likely to be victims of violence and three times more likely to be murdered than those living in other parts of the metropolitan statistical area (Fingerhut & Kleinman, 1990; Reiss & Roth, 1993; U.S. Department of Health and Human Services, 1999). Because of youths’ immobility, immaturity, and dependence on others, they are truly more place bound and at the mercy of these hazardous circumstances. Because these youths are place bound, the risks attached to the local landscape, along with the youths’ ties to local actors and institutions, become crucial factors in shaping their overall well-being.

Violence exposure has been linked to a wide range of mental health problems for youth, including anxiety, depression, suicide ideation, and posttraumatic stress disorder (e.g., Fitzpatrick, 1993; Fitzpatrick & Boldizar, 1993; Mazza & Reynolds, 1999; Rosenthal, 2000; Singer, Anglin, Song, & Lunghofer, 1995).
Most of this work has found that increased violence exposure has a positive, additive effect on increased mental health symptom reporting. Whether the individual is a witness, a victim, or even a perpetrator, exposure continues to be a major predictor of mental health problems among youth, particularly those characterized as low income, minority, and urban. Even as some indicators of general violence have recently declined (Bureau of Justice Statistics, 2003), juvenile crime and violent victimization continue to be significant social problems (Fields & McNamara, 2003). In addition, studies on chronic exposure to violence indicate a rise in the reporting of violence in homes, schools, and communities by youth (Fitzpatrick & LaGory, 2000; Osofsky, 2001; Osofsky & Fenichel, 1999; U.S. Department of Justice, 2001). In the hazardous urban environment, few places represent a refuge. Unfortunately, the same domains that youth look to for protection often end up being places of risk and danger. Given the current literature regarding exposure to violence, we expect to find that, regardless of type, youth reporting more exposure to violence, either as a perpetrator or as a victim, are more likely to report more depressive symptoms than their counterparts (Knox, Funk, Elliot, & Bush, 2000; Vermeiren et al., 2003).

Personal Capital in Resource-Poor Environments

Clearly, place matters for exposure to stressors such as violence. Nevertheless, not everyone residing in a hazardous place exhibits similar symptoms of distress. Families, friends, schools, churches, and service-based organizations all play an important role in lowering levels of stress, even in the face of high poverty, crime, and general community disorganization. This relationship is just as important for youth as it is for adults. Despite the significance of hazardous residential contexts for unfavorable outcomes among residents, some youth are more resistant or resilient to detrimental effects, whereas others are not. Why do children exposed to similar community, school, and family risk variables differentially experience and respond to those environments? Some children and adolescents living in high-risk communities are exposed to considerable environmental stressors yet manage to adapt and succeed. Even in resource-poor urban environments, youths may have assets on which they may draw for coping with stressful circumstances. These resources include a catalog of personal and social support mechanisms that help to mediate or buffer the effects of stress on well-being (Brooks-Gunn, Duncan, & Aber, 1997; Dumont & Provost, 1999; Fitzpatrick, 1997; Garvey, 1993; Werner, 1990).

In the last decade, the public health literature has explored the issue of resiliency and assets within a risk and protective factors framework. The framework conceptualizes health behavior among youth as a function of both socially determined chances and individual choices, focusing on factors that either promote or discourage health-compromising behaviors; factors exist in multiple domains and operate both at the individual and at the contextual level (Fitzpatrick & LaGory, 2000; J. D. Hawkins, Catalano, & Miller, 1992; Rolf, Masten, Cichetti, Nuechterlein, & Weintraub, 1987). This approach provides considerable insight into what (risk) factors contribute to negative behavioral outcomes for youth and, perhaps more important, what (protective) factors help to mediate or buffer these negative circumstances to minimize the impact on children and adolescents. Although the concepts of risk and protection are theoretically useful, they have not been translated into specific social and psychological variables.

In the mental health literature, two sets of resources have emerged as important in reducing negative effects on well-being—psychological and social resources (Ensel & Lin, 1991). Research on children’s mental health indicates that self-esteem is a significant psychological resource that is consistently recognized as lessening symptoms of anxiety and depression among adolescents (Bettschart, Nunez, Bolognini, & Plancherel, 1994; Dumont & Provost, 1999; Rosenbaum-Asarnow, Carlson, & Guthrie, 1987). Similarly, social support, social networks, and participation in various voluntary associations have been identified as critical social resources used by youth in coping with stressful events and circumstances.

These two forms of resources (psychological and social) can be conceptualized as aspects of an individual’s personal capital—that is, resources regularly used by individuals to enhance well-being. Viewing assets from the perspective of capital provides fresh new insights into the analysis of mental health and the coping resources available to individuals. It further addresses some of the above-mentioned shortcomings of the risk and protective factors model developed in the public health literature. Although this perspective has a long history in sociology (Bourdieu, 1984; Burt, 1997; Coleman, 1990; Portes, 1998), in the last several years, Robert Putnam
(2000) has become its major proponent. Putnam’s (2000) work suggests that humans draw on various forms of capital in social settings to produce well-being, a perspective that has much value for the exploration of mental health in the urban community. He discussed three types of capital that may benefit well-being: (a) physical capital, that is, the income and wealth that improves the individual’s level of living; (b) human capital, the personal characteristics and experiences of an individual that enhance his or her productive behavior and overall well-being; and (c) social capital, the social ties and networks that help people get by or get ahead.

From the capital perspective, psychological and social resources take on a broader meaning. Psychological resources can be viewed as an aspect of human capital (Becker, 1993; Putnam, 2000), the training, skills, talents, and personal orientation on which an individual draws in task-oriented situations. For youth, academic achievement and performance can be seen as a key aspect of human capital. Although grades have been cited as a risk factor in previous studies (e.g., J. D. Hawkins et al., 2000; G. Resnick & Burt, 1996), the present study argues, from a human capital perspective, that high academic achievement is a form of capital that promotes adaptive and productive capacity both now and in the future, thus reducing depressive symptomatology. In addition, self-esteem is a dimension of personality that orients the individual to the setting and affects his or her perception of performance. Youths who have a positive self-image are more likely to perform well in school and other social settings, and these successful social experiences are likely to promote mental well-being.

Social resources are another form of capital—social capital. Social capital was described by Putnam (2000) as a critical resource for the promotion of individual and community well-being. Social networks and voluntary association memberships bond similar people together and bridge differences between heterogeneous people in the community. Of all the consequences of social capital, perhaps the most established is the case of health and well-being (Lin, Cook, & Burt, 2001; Putnam, 2000). We anticipate that the bonding social ties that youth depend on within their family, school, and community will have a significant inverse relationship with depressive symptomatology. By taking this perspective, we suggest that social connectedness is likely to yield benefits to the individual.

Method

Data

The sample consists of 1,538 African American middle and high school students from a single school district in central Alabama. The sample area for this study is a classic example of Jargowsky’s (1997) and Wilson’s (1987) descriptions of a high-poverty ghetto. The majority of the residents living in the school district are African American (60%); over one third (35%) are from families headed by a woman with children under the age of 18 years, and over one third are living below the poverty level (U.S. Bureau of the Census, 1993). Of the sampled students, approximately 49% were boys, and the median age of the sample was 14 years (ninth grade). The 2001–2002 average daily attendance for the middle and high schools in the system was 2,028 students. Students’ participation in the study was voluntary and yielded a response rate of approximately 76%. After institutional review board approval by the school, consent forms explaining the purpose of the health assessment were sent home by the school district office. If students chose not to participate, they were required to return the letter signed by a parent or guardian. In addition to those students who returned letters indicating that they were not to participate (less than 10%), the remaining students who did not participate likely consisted of youth who were absent, suspended, or no longer attending school in the system. Thus, it is possible that, if rates of participation had been higher, some of the problems reported in this article would actually have been higher as well.

The data were collected during the spring of 2002. The survey instrument contained questions on sociodemographics, family structure, hazardous circumstances (exposure to violence), capital (human and social), students’ attitudes toward school, students’ assessments of their relationships with teachers and parents, and depressive symptomatology. The questionnaires were self-administered under close supervision by classroom teachers. Each teacher received training and a set of instructions outlining the procedure for survey administration, confidentiality, and the proper response to questions from students. The teachers read all instructions aloud and were available to students for questions. Students filled out the questionnaires during the class period and returned them in a sealed envelope. Students’ responses were completely confidential; the students were instructed not to put their name on the instruments, and no identifying marks or numbers were used.

Measurement

Depression. Depression was measured with a shortened version of the original 20-item Center for Epidemiological Studies for Depression (CES-D) Scale designed to index affective depressive symptoms (Radloff, 1977). The version used in the present study has eight items with individual responses to each item ranging from 0 (less than 1 day) to 3 (5 to 7 days; M = 5.1, SD = 5.2). The eight questions focus
mostly on the depressive affect domain of the CES-D. In addition to asking students whether they felt sad, lonely, or fearful, other questions asked students whether they had difficulty sleeping, trouble getting along with others, and so forth. The formal properties of the original CES-D have been amply demonstrated with very high coefficients of internal consistency when the scale is administered to adolescents (Allgood-Merten, Lewinsohn, & Hops, 1990; Avison & McAlpine, 1992; Garrison, Addy, Jackson, McKeown, & Waller, 1991; Prescott et al., 1998; M. D. Resnick et al., 1991; Roberts et al., 1995; Schoenbach, Kaplan, Wagner, Grimson, & Miller, 1983). Among our sample of students, the brief CES-D was reliable, with a Cronbach’s alpha of .85. We weighted the brief CES-D, for comparison purposes, by a factor of 2.5 (the number of original CES-D items divided by the number of brief version items; i.e., 20/8 = 2.5). This weighting provides a basis for comparison with other samples in which the full CES-D was used to assess adolescent depression. The new, weighted CES-D had a mean of 13.96 and a standard deviation of 12.65.

Several caveats are necessary concerning the use of the brief CES-D. First, because the measure only assesses the frequency of symptoms, not the severity, we consider our sample of students to be on some continuum of depressive symptom reporting rather than in specific categories that correspond to degrees of clinical depression. Second, our measure is a self-reported assessment of feelings that students reported over a 2-week period. Thus, we are not in a position to report clinical diagnoses. In addition, we acknowledge the weakness of self-reported assessments generally in determining mental health status, particularly among adolescents. Finally, although the full CES-D was the most desirable to use in the current study, we were somewhat constrained by the length of the questionnaire and the single class period of approximately 45 min. Other studies facing time constraints have adopted brief versions of the CES-D and have had considerable success, yielding valid and reliable responses. It should be noted, though, that, in the majority of cases, those responses were from the student's self. Answers range from 1 to 7. SD = 1.6, SD = 1.5). The index was reliable, with a Cronbach’s alpha of .68. In both cases, we expect that increased reporting of exposure to violence will be related to increased levels of depressive symptom reporting.

Human capital. Human capital involves the personal resources (capacity, knowledge, and demeanor) that persons bring to bear in task-oriented situations. In exploring the link between human capital and depression, we examine self-esteem. We measured self-esteem using Rosenberg’s (1965, 1979) 10-item Self-Esteem Scale. These 10 items ask students questions pertaining to how they perceive themselves. Answers range from 1 = strongly agree to 4 = strongly disagree. Higher scores indicate greater self-esteem among the students (M = 32.1, SD = 5.1). The self-esteem variable in this sample of students was reliable, with a Cronbach’s alpha of .76.

A second human capital variable used in the analysis was the subjective reporting by students of the grades “they mostly get in school,” ranging from 1 = mostly Ds and Fs to 7 = mostly As. Academic performance has been noted as an indicator of a personal resource—important in the development of resiliency and coping strategies, particularly in the face of hazardous environments.

Social capital. In addition to inner resources and capacities that constitute human capital, capital is also a product of social relationships that occur at the family, school, and community levels (Coleman, 1990; Lin et al., 2001; Portes, 1998; Putnam, 2000). These supportive relationships act as critical assets fostering competence, promoting successful development, and building resiliency in youth. Forms of social capital, in part, are expected to mediate or buffer negative effects of hazardous environments and, despite...
exposure to debilitating circumstances, help individuals to adapt and succeed (Mitchell & LaGory, 2002). These multilevel factors should mediate or buffer exposure to violence and, through either individual or structural means, promote positive development among children and adolescents. In the current study, we examine forms of social capital in the family, school, and church community.

We created a multidimensional index of social capital that combines six ordinal level variables. One is how often the family shares an evening meal together, with categories ranging from $0 = \text{never}$ to $4 = \text{all of the time}$. This variable continues to be recognized as a critical indicator of connectedness within the family unit, and, even where parental presence is limited, many youth view a time set aside to share a meal as extremely important. A second variable is how often during the week an adult is present when the student comes home from school, with categories ranging again from $0 = \text{never}$ to $4 = \text{all of the time}$. Another family domain variable is how often the adolescent talks to his or her parents about personal problems, with categories ranging from $0 = \text{never}$ to $4 = \text{all of the time}$.

Another set of variables used to create the social capital index are at the school level. Youth spend a great deal of time in their school, and that community institution can be a crucial link to the general success they experience during this critical phase of development. In particular, students who are able to identify someone in the school who cares for them or pays attention to them may be less at risk for experience negative health outcomes. We used a variable that asked the student, “Is there someone at school who cares about you and what happens to you?” Besides self-reporting of attitudes about school and teachers, students were asked how often they talked to their teachers about their personal problems. A final variable that we used to create the social capital index is how often students attend church or religious functions. Again, the ordinal variable has four categories, ranging from $0 = \text{never}$ to $4 = \text{attend all the time (every week)}$.

The analyses focus primarily on the cross-sectional relationships among sociodemographics, exposure to violence, capital (human and social), and depressive symptomatology. Although we know that cross-sectional data limit our ability to formally test causal hypotheses, they nevertheless provide an important assessment of the interrelationships among these factors and their association with depressive symptoms among African American middle and senior high school students. Such data also limit our ability to analyze more complex interrelationships among the variables in the model, such as the interplay between human and social capital (i.e., academic performance and self-esteem, on the one hand, and social relationships, on the other). Additionally, we note that several independent variables used in the regression analyses are not interval-level variables but rather combinations of ordinal-level variables. Thus, we exercise some caution in the interpretation of the findings in light of this limitation. Finally, the data for the analysis are based on youths’ subjective accounts. Although we cannot assess the importance of this subjective reporting, there is growing evidence that self-report measures of adolescent behaviors are reliable and valid (Brener, Collins, Kann, Warren, & Williams, 1995).

Results

Table 1 presents the descriptive statistics and Pearson correlations for sociodemographic, exposure to violence, and capital (human and social) variables. The mean CES-D for this group of African American adolescents was 13.49. This average is higher than is typically reported in general adolescent population studies (e.g., Birmaher et al., 1996; Lewinsohn, Hops, Roberts, Seeley, & Andrews, 1993) as well as some studies of depression among African American youth (Doerfler, Felner, Rowlison, Raley, & Evans, 1988; Roberts, Roberts, & Chen, 1997; Siegel, Aneshensel, Taub, Cantwell, & Driscoll, 1998). Given the already stressful circumstances to which these youth find themselves exposed, it is not surprising that their symptom levels were elevated.

The correlations provide important preliminary information regarding the interrelationships among violence exposure, capital, and well-being in youth. Both exposure variables were significantly ($p < .01$) related to CES-D scores, which suggests that greater exposure to violence and violent circumstances is associated with increased depressive symptom reporting. Clearly, self-esteem had a strong correlation with depressive symptomatology; the social capital index also had a significant negative association with CES-D symptoms. All these relationships were significant at the .01 level. Likewise, the hazardous circumstances and exposure to violence variables consistently had inverse, in some cases significant, relationships with the capital variables. Youth who reported more exposure to violence had lower grades and self-esteem, and youth with lower capital also reported more exposure to violence, either as a perpetrator or as a victim.

Table 2 presents a series of regressions examining the effects of sociodemographic, exposure to violence, and capital (human and social) variables on depressive symptom reporting among this sample of African American adolescents. Blocks of variables were entered in succession; the intention is to examine not only the independent effects of each of the variables but also the significance of groups of variables and the role they play in predicting depressive symptomatology. In addition, we are interested in whether capital (both human and social) plays a mediating or buffering role, thus, by either mecha-
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<td>.060*</td>
<td>-.160**</td>
<td>-.023</td>
<td>-.043**</td>
<td>.083**</td>
<td>-.050*</td>
<td>--</td>
<td></td>
</tr>
<tr>
<td>15. Friends in gangs</td>
<td>.032</td>
<td>-.208**</td>
<td>.171**</td>
<td>.181**</td>
<td>.127**</td>
<td>.114**</td>
<td>.207**</td>
<td>-.056*</td>
<td>-.138**</td>
<td>-.074**</td>
<td>.065*</td>
<td>-.044**</td>
<td>.396**</td>
<td>--</td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>12.68</td>
<td>0.52</td>
<td>13.98</td>
<td>0.47</td>
<td>0.42</td>
<td>0.96</td>
<td>1.55</td>
<td>16.47</td>
<td>4.17</td>
<td>2.51</td>
<td>1.58</td>
<td>0.71</td>
<td>0.86</td>
<td>0.11</td>
<td>0.38</td>
</tr>
<tr>
<td>SD</td>
<td>13.06</td>
<td>0.50</td>
<td>2.34</td>
<td>0.98</td>
<td>0.82</td>
<td>1.32</td>
<td>1.45</td>
<td>3.29</td>
<td>1.61</td>
<td>1.26</td>
<td>1.02</td>
<td>1.04</td>
<td>0.35</td>
<td>0.31</td>
<td>0.49</td>
</tr>
</tbody>
</table>

Note. N = 1,538. CES-D = Center for Epidemiological Studies Depression Scale.
* p < .05, one-tailed.  ** p < .01, one-tailed.
nism, reducing the negative effects of exposure to violence on the reporting of depressive symptoms.

The sociodemographic variables were entered first. As expected, gender was significant \((p < .01)\); girls reported more symptoms than boys. Age was also significant, in that older adolescents reported more symptoms. The second block of variables involved exposure to violence. When we controlled for gender and age, the block of exposure variables was significant, increasing the explained variation in depressive symptomatology by more than 10%. The victim exposure variable was significant at the .01 level. Both variables operated in the expected positive direction, with increased frequency of exposure increasing depressive symptomatology. Nevertheless, the perpetrator variable (weapon carrying, fighting, and bullying) did not have a significant impact on depressive symptomatology.

Human and social capital variables were added in a third block. Both exposure variables remain unchanged. Self-esteem had a significant and large inverse relationship with depressive symptom reporting; youth with higher self-esteem reported fewer depression symptoms. The relationship between the social capital index and depression was in the expected inverse direction and significant \((p < .05)\); students who scored higher on the social capital index reported lower levels of depressive symptoms. Twenty percent of the variation in adolescent self-reported depressive symptoms was accounted for by the sociodemographic, exposure to violence, and social capital variables. Each successive block of variables was significant and increased the explained variation in the overall model. In addition, an inspection of the regression coefficients and their change or lack of change in subsequent equations suggested no evidence to support a mediation hypothesis.

Because human and social capital variables remained significant, it was important to test a buffering hypothesis. Thus, the final part of the analysis involves an examination of interaction effects between the major structural variables (gender and age) and the human and social capital variables. A fourth and final block of variables included three interaction terms. We tested for the significance of all possible interaction terms, using an \(F\) test criterion \((\Delta R^2)\), and included the Gender \(\times\) Social Capital, Age \(\times\) Self-Esteem, and Age \(\times\) Grades interactions in this fourth block. Entering the block of interaction effects slightly increased the explained variation in depressive symptom reporting. When these interaction terms were included, the additive effects of the capital variables became less significant. These results suggest that capital could play the role of a buffering agent for particular segments of youth. For example, whereas girls generally report higher depressive symptoms, those with high levels of social capital report fewer symptoms. Similarly, although age tends

### Table 2

*Ordinary Least Squares (Unstandardized/Standardized Coefficients) Regression Models Predicting Depressive Symptomatology Among African American Adolescents*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(B) (\beta)</td>
<td>(B) (\beta)</td>
<td>(B) (\beta)</td>
<td>(B) (\beta)</td>
</tr>
<tr>
<td><strong>Sociodemographics</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender (female = 1)</td>
<td>2.25** .091</td>
<td>4.63** .125</td>
<td>3.33** .134</td>
<td>8.19** .330</td>
</tr>
<tr>
<td>Age</td>
<td>0.38* .066</td>
<td>0.31 .054</td>
<td>0.41* .070</td>
<td>1.55** .270</td>
</tr>
<tr>
<td><strong>Exposure to violence</strong></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Violence perpetrator</td>
<td>0.00 .001</td>
<td>0.01 .006</td>
<td>0.01 .011</td>
<td></td>
</tr>
<tr>
<td>Violence victim</td>
<td>1.79** .336</td>
<td>1.45** .272</td>
<td>1.44** .271</td>
<td></td>
</tr>
<tr>
<td><strong>Capital (human and social)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-esteem</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-0.71** -.284</td>
<td>0.28 .111</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grades</td>
<td>0.21 .030</td>
<td>-3.35** -.245</td>
<td></td>
<td></td>
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<tr>
<td>Social capital index</td>
<td>-0.18* -.070</td>
<td>0.01 .005</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Interactions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender (\times) Social Capital Index</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age (\times) Self-Esteem</td>
<td></td>
<td></td>
<td></td>
<td>-0.38** -.225</td>
</tr>
<tr>
<td>Age (\times) Grades</td>
<td></td>
<td></td>
<td></td>
<td>-0.585</td>
</tr>
<tr>
<td>Constant</td>
<td>7.38 3.11</td>
<td>7.39 8.37</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(R^2)</td>
<td>.02 .12*</td>
<td>.20*</td>
<td>.23*</td>
<td></td>
</tr>
</tbody>
</table>

*Note. \(N = 1,538\).*

*\(a R^2\) change is based on a hierarchical \(F\) test of significance \((p < .001)\).*

*\(p < .05\), one-tailed. **\(p < .01\), one-tailed.
to be directly related to depression, older adolescents experiencing high levels of capital report fewer symptoms. Finally, whereas grades are inversely related to depression, age interacts with grades such that younger persons with lower grades are particularly affected, reporting a greater number of depressive symptoms.

Discussion

The major focus of this article has been to examine the applicability of a capital perspective for understanding the well-being of African American middle and high school students in an inner city community. Using a sample of 1,538 mostly low-income, African American students, the model does a reasonable job in predicting depressive symptomatology. The results underscore important aspects of the hazards faced by inner city youth and the resources available to them. Although the resources examined in this article are primarily relational, they nevertheless highlight the importance of social connectedness for adolescent well-being.

As expected, there are significant sociodemographic differences in symptom self-reporting among adolescents. The higher levels of depression for adolescent girls may be due, in part, to their greater emotional maturity. They are not only more aware of their emotions but also more likely to discuss their feelings with others. The link between gender and depression, coupled with the finding that older adolescents tend to report more symptoms, has important implications for the design of interventions.

Keeping youth insulated from the negative effects of hazardous circumstances is a daunting task for both parents and teachers in the inner city (Weist, Freedman, Paskewitz, Proescher, & Flaherty, 1995). The inner city is clearly an unhealthy place for the young, yielding a distinct health penalty. Nevertheless, these results suggest important forms of capital (human and social) that can be leveled at these risks. From an individual perspective, self-esteem is unquestionably a critical asset that adolescents can draw on in attempting to navigate these risky circumstances (Dumont & Provost, 1999). It is surprising that grades did not exhibit an independent effect, although they did interact with age to influence depressive symptom reporting. Our research suggests that human capital matters and is a critical resource that youth can effectively use in managing the hazards of inner city life.

In addition, social capital makes a critical contribution to the quality of life for poor, minority youth. Sharing a meal with one’s family, talking with one’s parents about one’s personal problems, and having one’s parents around generally are significant forms of social capital (Formoso et al., 2000); the more supportive the parental environment was, the fewer depressive symptoms participants experienced. What is important about this finding is that it provides parents with a very direct and manageable strategy for improving their child’s well-being—they must make themselves available. Although this can be challenging, particularly in a low-income environment in which both parents are working, only one parent is present, or one parent is working multiple jobs, it highlights an important aspect of parenting and its role in predicting negative outcomes among adolescents. This availability may be particularly difficult to achieve for the working poor, who may have to put in long hours to support the family economically (Ackerman, D’Eramo, Umlyn, Schultz, & Izard, 2001).

The school variables that are part of this index are also important; just as other studies have shown (e.g., M. D. Resnick et al., 1997), these aspects (levels) of a youth’s environment are significant for determining adaptation and developmental outcomes. School and other institutions play a vital role in helping youth develop resiliency while protecting them from negative environments. To this end, feeling connected to school and community is an important aspect of successful maturation (Jessor, 1993). In addition to providing structure and control, schools and communities protect resident youth by helping them feel connected, building their self-esteem, and giving them a role to play in their own development. Thus, maintaining relationships with people at school and having someone there the youth can rely on or who cares about them can be crucial to youth at this age as they navigate an often hazardous, risk-filled environment.

It is notable that the blocked regression indicates the absence of a mediating role for both human and social capital. Capital, in both forms, matters for the quality of life of inner city youth. Its contribution, however, is not as a mediator of risky circumstances. This suggests that although capital can inoculate youth from hazardous environments, the inoculation reduces symptoms without eliminating all of the negative health consequences of the presenting condition. Our research indicates support for a buffering hypothesis similar to that found by Wheaton (1983, 1985), suggesting that protective factors (social support) work selectively in reducing negative behavioral outcomes. In particular, social capital does not
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seem to be as effective for boys in reducing the negative consequences of inner city residence. Likewise, the consequences of limited human capital (poor grades for younger adolescents) are intensified.

Given the previously mentioned limitations of the current research, further research is necessary to more fully understand the relationships between various forms of capital and mental health among inner city, minority youth. The measurement of the capital variables, both human and social, also requires further development. More comprehensive social capital measures for the three relational domains should be explored. In addition, an examination of well-being outcomes other than depressive symptomatology may provide a more comprehensive understanding of the dynamics of mental and physical health among inner city youth. Given the cross-sectional nature of the data, further research is necessary to establish the causal relationships among hazard, capital, and mental distress. In addition, it may be useful to consider the possibility of respecification of the causal relationships (i.e., reverse causal sequencing in the case of exposure to hazards and capital).

The implications of our findings are significant in several ways. To date, few studies have examined the applicability of an assets-based framework to psychosocial outcomes, particularly depressive symptomatology among low-income, African American adolescents. Although we have not made a definitive test of the framework, our analysis provides important insight into the relationship among hazards, capital, and well-being for adolescents. These data show that significant mental health differences exist between boys and girls; those who are connected to family, peers, and school versus those who are disconnected; and those with higher self-esteem and grades versus those with lower levels of human capital. Finally, although we know that depression is a diagnosable and treatable disease, it is often undetected among adolescents. Because of a reluctance to report symptoms or to formally seek care, youth remain a difficult population to treat. Still, more training for parents, teachers, clinicians, and community workers in the recognition of signs and symptoms of depression will allow for the development of more effective clinical and nonclinical strategies to address the issues and treatment of symptoms of depression.

References


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