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Disruptive Social Capital: (Un)Healthy Socio-Spatial Interactions Among Filipino Men Living with HIV/AIDS

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Introduction

Social capital has become the vogue strategy of policy makers, nonprofit organizations, foundations, and communities to address a myriad of difficult social, economic, political, and health challenges. The concept's popularity in research and practice is due in large part to its commensurability with community-centered strategies on the one hand, and neoliberalist state retraction on the other. That is, on the one hand, social capital focuses the definition of problems and the search for solutions and policies at the community level (in contrast to individually-focused problem definitions and strategies). On the other hand, because social capital focuses on civil society solutions, it has become a central remedy for ineffective or inefficient state efforts to address poverty, environmental degradation, lack of political engagement, and health disparities across the developed and developing worlds.

But as critics have argued, the social capital rubric tends to be blind to political economic conditions, and relations of gender, race/ethnicity, and sexual identity. While we agree with these scathing critiques, we also argue in this paper that problematizing social capital and reorienting the notion may serve to enable a critical social capital approach that is useful for not only clarifying when and how social relationships define and are defined by health geographies, but also how practice may be informed. As part of this reorientation of the social capital framework, we offer what we are calling a “disruptive social capital” approach, that focuses on the instabilities and disruptions so present in the lives of marginalized, stigmatized, and excluded populations.

To develop this disruptive social capital approach, the paper proceeds in the following way. First, we outline the prevailing debates surrounding social capital, with a focus on the problematic nature of the approach. We then provide a more detailed discussion of the disruptive social capital framework, which emphasizes the instability and turbulence in resources through social networks for resource poor, marginalized, and socially excluded communities in the US. This disruptive social capital framework emerged from a qualitative analysis of interviews, conducted in 2004–2005 with 52 Filipino men living with HIV/AIDS in Los Angeles. Third, we discuss disruptive social capital and health for these Filipino men living with HIV/AIDS, which provides insights into the nature of disruption associated with HIV/AIDS, and highlights how social capital both helps individuals to access resources through their social networks, but also acts, often simultaneously, to create health denigrating

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conditions, such as heightening contacts with places and persons that enable HIV transmission, or enabling micro-level containment and social control. Finally, we conclude the paper with further questions that arise from this analysis and conceptual approach.

Social Capital Contested: Proponents and Critics

Social capital is defined as a set of emotional and material resources accessed through social interactions (Bourdieu, 1985; Coleman, 1988; Putnam, 1993), or as collective or communal action (Ostrom, 1990). The expansion of social capital, especially for communities with few economic and political resources, ideally results in positive social, economic, political, and health outcomes. Some see social capital as associational, with membership in social groups resulting in a myriad of positive social outcomes such as better governance, improved health, and expanded democracy (Putnam, 2000). Economists see social capital as a preference, as a resource much like other capital resources, or a way to address imperfect information and other market failures (van Staveren, 2003). Geographers have observed its “apparent utility in offering a ‘meso-level’ approach that can be combined flexibly with a number of development [and other] theories” and have applauded its focus on civil actors rather than the market or state alone (Radcliffe, 2004, p. 518). Though the now vast literature on social capital continues to disagree on the primary components and linkages within social capital, in general, the basic social capital model may be diagrammed in the following way:

Research on social capital by public health researchers has relied primarily on aggregate data analyses to clarify the connections between social capital (operationalized as trust in others and social organizations, and as participation in voluntary organizations; Kawachi et al., 1997) and health disparities or mortality (Pilkington, 2002). Though national level analyses have indicated few significant connections between social capital and health (Kennelly et al., 2003), studies at smaller scales and focused on specific health conditions have indicated that social capital is correlated with lower incidence of disease and illness (Holtgrave and Crosby, 2003).

One of the alluring qualities of social capital is that all communities having social relationships should have access to resources available through these relationships (that is, emotional and material support, or individual benefits), and moreover, should reap the benefits accorded to communal action when these relationships result in group activities that improve health and quality of life (that is, communal or collective goods or benefits).ⁱ Trust and reciprocal social relationships lead to cooperative behavior and associational life (leading to both community—rather than individually-focused behavior, and reinforcement of norms of cooperation in contrast to individualism). Cooperative behavior and communal action result in access to resources within communities, and relationships between communities and outside entities (e.g., government agencies, nongovernmental organizations, and other communities).ⁱⁱ The more trust and frequency in reciprocal relationships, the greater the number, types, and depth of cooperative behavior and communal action (both within communities and between communities and outside groups), in turn leading to greater and more frequent access to

ⁱPutnam (2000) defines social capital as both of these facets, individual and collective, though he aggregates individual survey data to represent groups (DeFilippis, 2002). Others in contrast focus on collective dimensions of social interaction (Ostrom, 1990).

material and emotional resources. The growth in social capital as a consequence of trusting and reciprocal relationships, expanded cooperative/communal action and associational life, and its associated increase in resources, results in improved health.ⁱⁱⁱ

Of course, the notion that social relationships promote health is not a new idea. Researchers have long argued that isolation increases individual susceptibility to physical and mental disability, and that social support has beneficial physical and mental health effects (Brownell and Shumaker, 1984; Schilling, 1987).^{iv} Social support emanates from two primary sources, personal networks^v (Fischer, 1982) and outside personal/community connections with institutions, agencies, and professionals,^{vi} which provide distinct sets of resources (Hoch and Hemmens, 1987). Social capital takes this general approach one step further by incorporating a “capacity for storage” and “mutual metamorphosis” from social capital into other types of capital (Light, 2004, pp. 146–147).

But, there have been scathing critiques offering varying explanations for social capital’s lack of effectiveness in substantially improving health and well being. Structural critiques, posited primarily by neo-marxist and feminist geographers, dispute the prevailing focus of 1990s social capital models on individuals, from conceptualization to empirical methods (DeFilippis 2002; Mayer 2003). Uneven distributions of income/wealth and unequal power relations are instead posited as the underlying forces dictating how resources are distributed and used, and consequently, social relationships, while important, are insufficient to alter existing relations of privilege and marginalization. Public health researchers critical of social capital have similarly argued that poverty (measured by absolute rather than relative income) and social inequality are more important indicators of health and well being than social capital (Lynch et al. 2000).

Economist explanations for the failure of social capital center primarily on the notion that communal action (stemming from or constituting social capital) that would improve the conditions of groups is a form of market failure, and consequently, experiences the same sorts of rational non-communal incentives that plague all types of market failure. Therefore, social capital – and communal action – must be understood as part of the larger commons, prisoner dilemmas, and externalities literatures to shed light on how behavior might be changed (that is, how incentive structures might be altered) to refocus on group rather than individual benefits.

While both these explanations offer clear reasons for the ineffectiveness of social capital to fundamentally improve the lives and health of impoverished and socially excluded groups, they present an incomplete portrait of its limitations. Conceptually, the limitations may stem in part from social capital’s incommensurability with either structural or individual levels of explanation, because it is a “meso-level” notion that is most useful in combination with other

ⁱⁱSocial capital has been described in various ways: social network structure (Lin, 1999), the strength of relationships or social ties (Granovetter, 1973), and social cohesion (Kushner and Sterk, 2005). Social capital between communities and outside groups has also been argued to be extremely important as internal social relationships are insufficient for substantial quality of life improvements (DeFilippis, 2002). Social capital researchers have labeled these intra- and intergroup or community relationships in a myriad of ways: social glue and social bridges (Putnam, 1993); bonding and bridging (Gittel and Vidal, 1998); social integration and linkage (Woolcock, 1998); contract and reciprocal relations (Granovetter, 1985).

ⁱⁱⁱTo measure the extent and types of social capital, scholars have worked to develop indices and typologies of social capital (e.g., Lochner et al. 1999).

^{iv}Discussions about the lack of clarity and potential downsides of social support mirror contemporary debates about social capital (see, e.g., Schilling 1987).

^vSocial capital scholars refer to these connections as bonding relations (Gittel and Vidal, 1998). A seminal work by Fischer (1982) characterizes a personal network as being “directly involved” or having a relation with people in one of three ways: (1) “socially recognized roles with reciprocal rights and duties”, (2) being sentimental, and (3) “interaction and exchange” (p. 35).

^{vi}These networks or connections, characterized as bridging connections in the social capital literature (Gittel and Vidal, 1998), may have personal dimensions but these connections connect individuals and groups to those individuals representing organizations, agencies, or institutions (thereby implying access to resources outside personal connections, but also indicating potentially unequal power relations; Baum and Palmer, 2002).

theories of social action (Bebbington 2002, p. 801). But, perhaps what is also necessary is a rethinking of the dynamism associated with resources embedded in social networks in the lives of impoverished, marginalized, and socially excluded groups.

The structural critiques, while important in highlighting inequalities across communities at the local, regional, national, and global scales, tend to represent inequality as relatively monolithic. Powerless communities are economically marginalized and oppressed through structural inequities reinforced through and by culture and violence (Young 1990). Structure is fundamentally important in shaping the daily and life chances of impoverished, marginalized, and socially excluded groups, and consequently, is necessary in any (re)formulation of social capital aimed at material improvements in health and well being (Bebbington, 2002). But there is much variation and variety in the resources available to groups and communities over time and across place, even for those considered resource poor or marginalized by any number of measures. Some households especially in immigrant populations acquire financial and material assets over time, overcoming poverty and entering the so-called middle class (e.g., Light and Bonacich 1988; Myers and Woo 1996; Zhou 1992). Social capital has been argued as the “adaptive advantage” enabling upward mobility for young immigrants (Zhou and Bankston 1994, p. 821).

The economist explanations are important in identifying the failure of social capital as stemming from rational individual behavior, refocusing the analysis on individual incentives to take action for communal objectives. Economists have focused on social capital as a commons issue (Ostrom 1990), where group interaction leads to market failures (Olson 1965). However, there are two specific issues that make this approach insufficient to fully explain the drawbacks of social capital. First, though engaging in communal/collective action may require overcoming prisoner dilemmas situations and other market failures centered on group interaction, group action may also be intimately related to urgent circumstances that catalyze action (such as housing eviction, which suddenly interrupts the usual behavioral practices of communities). That is, urgent situations that would deny or remove substantial resources from individuals across a specific spatial area may serve as an effective motivation for collective action, overcoming in immediate ways rational thought about possible benefits that might accrue with free ridership. Second, behavioral norms that privilege individuals in favor of groups are certainly affected by cultural (as well as utilitarian) norms and values, and by temporal-spatial conditions. Some have argued for example that the social capital concept presumes, perhaps wrongly, that increasing trust and reciprocity necessarily leads to greater cooperation, that is, that social capital has a naturally increasing trajectory through time, consistently leading to more and more communal action (Boix and Posner, 1998).

Consequently, though these two sets of critiques identify vital elements about the lack of capacity of social capital to materially improve the health and well-being of communities, there is a need to explain the variability of social capital in helping some (i.e., some households getting “ahead” – Briggs 2004), while also seeming to be ineffective for others especially in terms of health (Kennelly et al. 2003). In other words, these two critiques, while important, provide only part of the story. If social capital is to remain a useful rubric for health geographers, its concepts must be made “culturally safe” (Dyck and Kearns, 1995) through the recognition and theorizing of the lived experience of impoverished, marginalized, and socially excluded groups, and the interactions with place and space must be made explicit (Macintyre et al., 2002). The framework must account for structural and institutional inequalities, not just individual and community action (Bourdieu, 1985; Mayer, 2003), and should highlight the dynamic processes inherent in reciprocal relationships (e.g., the role of trust and betrayal), cooperation and conflict, and the instability of material and emotional resources (Portes and Landolt, 1996; Takahashi, 1998).

We propose an alternative explanation for the limitations of social capital. Our disruptive social capital approach, emanating from a qualitative analysis of interviews with 52 Filipino men living with HIV/AIDS, presumes that the instability and disruptions experienced by resource poor, marginalized, and socially excluded communities constitute substantial drains and obstacles for social capital to improve health and alleviate poverty in any widespread and meaningful way. Instability and disruptions affect network interaction and resource availability across time and space, and therefore, affect different households, networks, and communities in different ways at different times in different places, conditioned by race/ethnicity, gender, class, and sexual identity. The only certainty then for social capital in resource poor, marginalized, and socially excluded communities and groups is instability in resource availability and access. But in addition to this instability, the disruptive social capital approach also highlights the ways that social networks and the resources derived through them may actually lead to worsened health and heightened risk for illness or death. This dimension of disruptive social capital is a countervailing force to the presumed health promotion facets of social networks and resources that constitute a general assumption for health researchers and practitioners.

Disruptive social capital – an alternative explanation

Disruption and instability are common features of daily life for impoverished individuals, households, and communities (Newman, 1999). We argue that social capital is defined by and defines disruption in the lives of marginalized populations through four interrelated elements: (1) limited resources and social disadvantage lead to dependence on social capital (here defined as resources available through social networks and interactions); (2) the social capital available to such populations is rife with instability and turbulence, i.e., disruption; (3) interruptions in social capital and the disruption resulting from social capital lead to searches for new social networks and new places; and (4) the tapping of new social capital leads to new health conditions and situations, but these conditions and situations are not solely positive (as social capitalists would argue) or negative, but instead constitute and are constituted by inextricable beneficial and denigrating dimensions (Figure 1). We describe these elements in more detail in this section.

Limited resources and social disadvantage

Limited resources create conditions where individuals, households, and communities face severe challenges in “getting by” much less “getting ahead” (Briggs, 2004). Economic (e.g., unemployment and poverty), social (e.g., stigmatization), and political (e.g., illegal status, such as undocumented immigration) conditions defining limited resources create significant obstacles to health and well being. Coupled with social disadvantage, for example, socio-spatial stigmatization due to HIV/AIDS diagnosis, undocumented immigrant status, etc., individuals, households, and communities, require more than their own resources to enable daily survival (Takahashi, 1997, 1998).

With limited resources and social disadvantage, disruption becomes a common facet of daily life. Disruption in daily and life routines mean that emotional and material resources are not available in stable and predictable ways. Impoverished households constantly struggle to find resources to meet their daily needs, juggling individual and communal resources that are available in given times and places (Roy et al., 2004). But disruption also impedes the capacity of networks and relationships to provide emotional and material resources, i.e., social capital. This requires that others have available (and are willing to share) the emotional and material resources needed by their network members when and where those members need (and ask) for them.

There are two elements to this uncertain and unstable resource pool and the social relationships that govern its distribution. First, emotional and material resources are available to network members in unpredictable ways. That is, resource providers should have available a variety of resources at critical moments for network members. Second, network members who need resources have to be in a congenial or at least cooperative relationship with network members who can provide resources, have to be willing to ask for these resources (that is, draw on relations of obligations and reinforce relations of reciprocity) and the resources provided by these network members have to match the needs of those who need help (Bebbington, 2002). Disruption and uncertainty make this synchronization of needs and resources difficult at best, especially for resource-poor or marginalized groups and communities.

Disrupted and disruptive social capital

Social capital has been seen by many researchers as a buffer mitigating the disruptions associated with violence, family break-up, and housing marginality often experienced by low-income populations (Morenoff et al., 2001; Rowe and Wolch, 1990; Sampson et al., 1997). But social capital itself may also be disruptive, resulting in the search for new networks and places from which resources can be accessed. Here, we outline two dimensions of social capital and disruption: disrupted social capital (where resources are interrupted) and disruptive social capital (where resources and social relationships result in change, sometimes health promoting or denigrating).

Disrupted social capital consists of the interruptions in resources available through social networks because of time-space dislocation, and the inability of and instability in the ability of networks to provide resources to their members. Disruption, as discussed in the previous section, interrupts the ability of social networks and relationships to provide for urgent or ongoing needs for resource-poor or marginalized groups and communities.

Social capital is also disruptive. Critics of the social capital rubric have argued for example that social capitalists assume “social networks [as] being normatively good things and sets of win-win relationships” (DeFilippis, 2002, p. 793). Portes (1998) in a widely cited review identified several downsides of social capital, such as exclusion, lessening of individuality and independence, and ongoing resistance to entering the social mainstream (also Portes and Landolt 1996). And as Woolcock (1998) has argued, social capital has both advantages and disadvantages, with the particular importance of either depending upon the context and circumstances. It is clear from such discussions that social capital may reduce life chances, and increase risk of illness, injury, or even death. Researchers have long noted for example the strength of social connections among gang members, drug using networks, and sexual networks (e.g., Cairns et al. 1988), where high degrees of trust are associated with unhealthy and socially unacceptable behavior. Information, material resources (money, housing, protection), and emotional support (belonging, self image) are all provided through such networks. Use of these networks for resources result in some ways in socio-spatial stability (through routinized behaviors related to the needs of the group for financial and material assets), however, the potential for disruption and negative health outcomes become pronounced over time, including incarceration, multiple stigmatized illnesses, and death by violence or disease (also Gilbert 1998).

Disruptive social capital, particularly as it relates to communal action that resists economic, political, or social marginalization or oppression, however, may enable resource redistribution and contribute to empowerment and enhanced quality of life. In terms of positive dimensions of disruptive social capital, collective or communal action may have some disruptive dimensions, if mobilization seeks resource redistribution through noncooperation, confrontation, or resistance (Piven and Cloward, 1977). Much of the literature in geography on collective action has centered on disruptive acts, such as protests and group activities aimed

at resistance or noncooperation. For example, labor struggles, anti-eviction campaigns, and other forms of resistant collective action are clear examples of effective catalyzing of social capital brings (Pulido, 2006).

Search for new networks and places

Because resource poor and socially disadvantaged individuals, households, and communities are dependent on social capital for meeting their emotional and material needs, ever present disruptions in daily life lead to searches for new social capital. The search for new social capital, however, remains focused on accepting individuals and groups, especially because these populations face stigma, exclusion, and discrimination. That is, for marginalized or stigmatized populations, because of race/ethnicity, gender, sexual identify, illness, or intersections among these, social capital will be limited to new networks and places where stigma is minimal, or where stigmatized identities do not interfere or inhibit the flow of emotional or material support.

There are also spatial dimensions to the search for new social capital. Proximity may enhance the ability of individuals to draw on particular types of available resources, such as information and in-kind services. Social capital is itself spatially defined, with social interactions taking place in familiar places (even if these familiar places are in different locations after spatial disruption, such as immigration). That is, familiar place types (such as work, bars, etc.) may indicate to individuals and groups the types of behavior and norms that permeate the locale, providing for individuals experiencing disruption an opportunity to replace former social interactions in new locations.

Inextricability of positive and negative health impacts

But disruptive social capital need not be monolithically negative, illicit, or stigmatized by mainstream society. Perhaps one of the most problematic situations is the overlap of socially acceptable networks and resources, with networks and resources leading to illness, injury, or death. For example, individuals may connect with socially stigmatized or health denigrating networks through socially sanctioned networks. Socio-spatial overlaps between economic networks (e.g., coworkers) and health denigrating networks (e.g., smoking, drug using, anonymous sex), or between socially required contexts (e.g., school) and dangerous networks (e.g., gangs) mean that promoting social capital generally may not result in better health and quality of life, but is highly dependent on the socio-spatial context of relationships.

Further, as will be shown in the section that follows, emotional and material resources accessed through social networks may have intertwined within them heightened risk for HIV transmission or stigmatization and ostracization. Perhaps the most problematic dimension of disruptive social capital is the inextricability of health promoting and denigrating aspects of such resources (also Gilbert, 1998).

Filipino men living with HIV/AIDS in Los Angeles

Clearly, social capital, especially the material and emotional resources available through social relationships (e.g., trust, reciprocity), is vital for impoverished, marginalized, and socially excluded communities to cope with the challenges of daily survival and upward mobility. HIV/AIDS in communities of color provides a stark example of how social capital is important for dealing with the emotional, physical/medical, and social obstacles and challenges wrought by an HIV or AIDS diagnosis, especially for those individuals and households who are resource poor. But an HIV/AIDS lens also illustrates how social connections and resources (such as information) lead individuals to networks and places that elevate the potential for HIV transmission.

Qualitative data collection

Filipino men living with HIV/AIDS were recruited through an AIDS service organization that targets Asian Pacific Islanders (APIs), Asian Pacific AIDS Intervention Team (APAIT) in Los Angeles, and by having project participants contact other potential participants to inform them about the study. Although flyers were distributed and posted at various community and neighborhood settings and events, no participants were recruited using the posted email address or toll-free phone number. All participants were recruited into the project via APAIT staff conversations with potential participants and via project participants encouraging other men to participate. One explanation for this recruitment pattern was posed by APAIT staff members, who suggested that the stigma associated with HIV/AIDS in the Filipino and larger API population meant that researchers needed legitimacy and credibility (that anonymous phone numbers and web sites associated with the university did not provide). APAIT staff and community members consequently served as trustworthy individuals who could vouch for the integrity of the research team, encouraging individuals to participate in the research project.

A total of 52 Filipino men living with HIV/AIDS were interviewed, from July 2004 – August 2005. The interviews ranged in length from 25 minutes to 2 hours, and were digitally recorded with consent of the participant. Participants were usually interviewed at the APAIT office in Los Angeles, however, some participants preferred to be interviewed at their homes or at other sites (public parks, friend's home). Several of the interviews took place with other participants in the room, by request of those participants.

Following written informed consent, participants were interviewed, completed a brief demographic questionnaire, and were provided with a \$50 cash incentive. The semi-structured interviews, conducted in English,^{vii} focused on socio-cultural and political economic issues (e.g., stigma, racism, homophobia); social capital mechanisms (i.e., trust, reciprocity, and civic engagement) and resources (tangible/material and intangible/emotional support); daily/weekly/monthly routines (to identify the regular and sustained use of social capital, use of HIV prevention services, and risky/risk reduction practices); and immigration issues including the participant's immigration status. Several of the participants were somewhat uncomfortable responding to questions about their or others' immigration status, presumably because of fear that their or others' undocumented status might be disclosed to authorities. Almost all of the interviewed men indicated that they were US citizens.

The men interviewed ranged in age from 22 years to 62 years, with a mean age of 43.5 years (Table 1).^{viii} A large proportion consisted of immigrants (8 of the interviewed men were born in the US); a large proportion had lived in the US for a long period, with a mean of over 20 years. About three quarters self identified as Filipino, though about 20% reported that they were mixed race (having one Filipino parent, usually the mother). Over half of the men interviewed were currently working part or full time, and their expenditures (used as a proxy for income) during the previous month (housing/rent, food, health, transportation, and

^{vii}Non-English speaking Filipinos in Los Angeles comprise a very small proportion of the Filipino population. According to the weighted results of the 2000 Census 5% PUMS, for the Los Angeles-Long Beach PMSA (Primary Metropolitan Statistical Area), out of a total population count of 261,825 Filipinos, over 99% indicated that they spoke English, with 95% reporting that they spoke only English, spoke English very well, or spoke English well (about 5% reported that they spoke English but not well). See Steven Ruggles and Matthew Sobek et al. 2003. Integrated Public Use Microdata Series: Version 3.0, Minneapolis: Historical Census Projects, University of Minnesota, <http://beta.ipums.org/usa/index.html> (accessed 1/25/04). To compare with the 5% PUMS weighted sample results, the 100% 2000 Census population counts indicated that in Los Angeles-Long Beach, the Filipino population totaled 260,158.

^{viii}Though the age range, years in the US, and years since HIV diagnosis span a large time period, the experiences with social capital, both its positive and negative aspects, were remarkably similar for these men, especially with respect to marginalization by family and community, HIV transmission, and subsequent interaction with family and peer networks. The most significant differences among the younger, more recently diagnosed, and most recently immigrated and those who were older, lived in the US longer, and been living with HIV/AIDS for years and sometimes decades were related to receiving state disability benefits and their migration histories once they arrived in the US.

remittances) showed a very wide range from a low of \$186 to a high of \$3400, and a mean of \$972.^{ix} In terms of sexual orientation and HIV/AIDS, almost all of the men interviewed considered themselves homosexual. A large proportion (66%) had received their HIV positive/AIDS diagnosis in the City of Los Angeles, and slightly more than half of the men interviewed had received the test result at a community health clinic.

The 52 completed interviews were transcribed verbatim, and analyzed. A preliminary coding scheme was developed using existing research on social capital, and on health and HIV/AIDS in API populations and the Filipino community more specifically. This coding scheme was refined using an inductive analysis of the transcripts, focusing on types, frequency, and personal or social events related to socio-spatial disruptions and resources acquired through social interactions (Strauss and Corbin 1998).

Limited resources and social disadvantage

The socio-spatial disruptions associated with immigration (unfamiliar neighborhoods, disconnections from former employers and friends, and need for material and emotional resources to transition to new neighborhoods and ways of life) were eased by the resources available particularly through parents, siblings, and close friends (including information about employment and access to informal economic revenue generating activities). Immigration for 44 of these men was generally enabled by petitioning by one of their family members, usually a parent, though some married US citizens and others were undocumented.

Upon arrival to Southern California (sometimes by way of San Francisco, Seattle, or other US cities), about three-quarters of the immigrant Filipino men were immediately connected to employment or revenue generating opportunities through family members, working at banks, as hairdressers, and in other service sector positions (administration, drafting). Human capital, such as college degrees, tended to not be transferable from the Philippines to the US labor market, and consequently, about one third worked in the informal economy, particularly those who worked as hair dressers, often providing services to neighbors and family members in their or their clients' homes. Some of those who did not have family connections to employment remained unemployed for long periods before finding entry level employment through temporary employment agencies.

Almost all of these men lived with their parents or other members of their families (especially siblings or cousins) or friends upon arrival to Southern California. Socially sanctioned activities for those living with their families included family celebrations and gatherings, work/school, and church (many of these men were, and remain, regular churchgoers). Several of these men had been married in the Philippines or had female partners for a time, and a handful had children. The regularizing activities of work/school, family activities, and church provided stabilizing economic and social frames on the lives of these men shortly following immigration to the US.

Disrupted and disruptive social capital

But family life whether with parents and siblings, or girlfriends or wives, even with these regularizing activities and places, also had disruptive dimensions, particularly concerning the gay identities of these men. Parents, families, and the wider community tended not to be supportive of gay identity or activities, with many openly condemning or criticizing gay individuals or homosexuality. Consequently, in the midst of the seeming stability created by the material resources (e.g., jobs, housing, money) available through family and friends, almost

^{ix}The wide range in expenditures (used here as a proxy for income) was due to some of the men receiving disability benefits and living in subsidized housing, and others working and paying for private sector housing.

all of the men led what they termed “underground” or “down” lives, did not disclose their gay identity as many were uncertain or conflicted about their homosexuality, and often abused substances (e.g., cocaine, crystal meth, alcohol). The “underground” or “down” part of their lives consisted of sneaking out of the house, and cruising alone or with other gay men, sometimes Filipino, sometimes other ethnicities, at clubs, circuit parties, and other locations where gay men were known to congregate (including public parks, bookstores, department stores, bath houses).

So it was a constant underground kind of thing, which was, you know, horrible on my part because it, you know, I’m putting myself at risk of these things. Um, as far as, not telling my parents where I was going, coming home and telling them to leave me alone. Really just trying, you know, trying to avoid them as much as possible because I didn’t want them to know about my lifestyle. [232946, Filipino male, 22 years old, immigrant, lived in US 18 years, diagnosed with HIV in 2001]

Anonymity permeated public sex behaviors and environments, and provided for some a level of acceptance and independence lacking in their family-centered lives, and for a handful of the men, even a relative feeling of safety (compared to bringing potential partners to their homes, even if they did not live with their families).

I didn’t care [about having anonymous sex].... I was independent. ... Because, meeting all these boys and, having sex and, nobody, no parents around. [232925, Filipino male, 34 years old, immigrant, lived in US 25 years, diagnosed in 1999]

...in the bathhouses, it’s more safer. You know, when you talk about the policemen or something like that. But the only thing you, you have to prevent to, is the disease, the HIV because I think most of, I think HIV you can get it anywhere. ... Not only in bathhouses. Because you know if you’re going to bring it to your house, sometimes it’s hard to bring anybody in the house because, of uh, you know uh, they may kill you or they may, you know. You never know, you know. And also I respect, the house, you know. Especially, you know, uh, because of the, that’s the place I live. ... I think better be in the bathhouse or in the hotel. [232929, Filipino male, 52 years old, immigrant, lived in US 35 years, diagnosed in 2001]

HIV diagnosis constituted a severe socio-spatial disruption for all of these men, changing their self-images, networks and regular social interaction patterns, and the places they lived, worked, and recreated. These changes were often severe and unhealthy, especially in the period immediately following HIV testing and diagnosis. Romantic relationships dissolved, family relationships underwent sometimes positive, but often negative shifts, work was disrupted or ended, friendships often changed (some relationships intensified, others ended), participation in collective action became much more uncertain (many did not want to be paraded in public, some became quite committed to promoting HIV prevention, and stigma in the API community meant a high degree of hiding of the condition even within households).

About three quarters of the men sought an HIV test because they were feeling abnormally ill. Many saw themselves as physically healthy individuals, so shortness of breath, non-healing wounds, and other severe physical symptoms led them to clinics, physicians, or emergency rooms. Most did not believe or refused to consider that HIV might be the cause of their physical ailments, and all recounted devastation and trauma at hearing the news that they were HIV positive, or for a handful, that they were diagnosed with AIDS. Following the results of the HIV test, these men reported a variety of responses, but in general, the transition period from HIV/AIDS diagnosis to living with HIV/AIDS was frequently described as chaotic. Many turned to cocaine, heroin, and crystal meth to try to cope with hopelessness, severe depression, and what they believed was imminent death.

I started doing heavy drugs [after I received my HIV positive test result]. ... I wanted to kill myself. ... I was doing, excessive amount of, not just crystal, I was doing, you know, I mean, I tried heroin, I tried, um, PCP. I tried, smoking crack. I tried, primos. I tried hydroglass, crank, peanut butter crystal, paint crystal. I tried uh, mushrooms. I tried uh, angel dust. I tried, oh, every drug, you name it. Acid. ... *(And um, was there anyone that you, you feel, you felt like you could turn to during this time?)* Um, no. I didn't feel that I, I didn't feel comfortable, where, you know, I didn't feel comfortable going to, any of the group. No. *(And um, did you, talk to your, your therapist? About this? After when you got your results?)* Um, yeah, but it was, like, too shocking for me. I didn't want to, talk to anybody after. Because I had to, rethink my life. So I wanted to be left alone. [232949, Filipino male, 32 years old, immigrant, lived in US 20 years, diagnosed in 1995]

Search for new networks and places

Prior to their HIV diagnoses, when these men initially moved out of their parents'/families' house, about half moved to more central urban areas, some very far from the neighborhoods where their family and friends had situated their lives. Not surprisingly, those who lived with friends, primarily in groups (e.g., fraternity brothers, acquaintances met through clubs), lived with different social norms and acceptable behaviors than those who lived with their families. For a small handful of these men, these groups provided much needed social support, acceptance, and role models.

See, my fraternity brothers, they're like, my huge, huge, huge, support system. They were my family basically, outside my family. I needed that. I needed someone to identify with. I didn't have, like all my years of growing up, I didn't have anybody to look up to or, even, identify with. Everybody else, my brother was looking up to my dad. I mean, you know, if I had a sister, I'm sure she would be looking up to my mom. I had nobody, like I didn't know who was gay in my family. I didn't know, I didn't have any gay relatives. I didn't have any gay friends to talk to about my issues. So then when I finally met, like this community that was so positive, I mean, they weren't, like, my other friends that were in [California city] who were like sleeping with people, doing drugs and drinking. They were like really cool people who were doing community service, who were, you know, really working to make, the gay life happen, basically. Not like, not like the bad side of gay life. But the good side, like they weren't promiscuous or anything. [232946, Filipino male, 22 years old, immigrant, lived in US 18 years, diagnosed with HIV in 2001]

For most of the other men, however, their new roommates, co-workers, and friends tended to encourage riskier life styles and behaviors with respect to HIV transmission. In essence, the support networks available to many of these men, that accepted and encouraged their gay identities or homosexual practices, also tended to coincide with networks, places, and behaviors that put these men at high risk for HIV transmission. They were able to obtain illicit drugs (many times at no cost) and regularly became drunk or high at these cruising sites, clubs, and circuit parties. These activities constituted regularizing interactions at familiar places, associated with anonymous sexual contacts (some indicating that they preferred Asian, especially Filipino partners, others avoiding Filipino male partners), substance abuse, and socializing. Close friends and confidants tended to be those individuals who could both understand and accept the men's gay identity, but also tended to be individuals who were drug users/dealers, or who frequented anonymous sex environments.

(And um, why would you, why did you see him as someone that close?) Cuz I was, able to talk to him. Like I didn't have to hide myself. I was free to talk to him about, everything. Uh, we shared the same hobbies, boys, sex, crystal meth. *(So if you ever*

needed anything, was, was he someone you would turn to?) Yeah. [232925, Filipino male, 34 years old, immigrant, lived in US 25 years, diagnosed in 1999]

Social disruptions, such as romantic break-ups or moving away from family, friends, and familiar places, often led these men to seek new but relatively familiar environments of gay bars, clubs, and parties. Even if they chose to live in places without friends and/or family nearby, the familiarity of the club and party scene enabled them to engage with other gay men, providing them with a set of familiar routines and gay-friendly environments even if the people and places themselves were different. The familiar routines and environments (though distinct places) of gay clubs, cruising sites, and circuit parties provided a sense of stability, though these routines and sites also created conditions where the risk of HIV transmission was heightened.

Uh, no, I didn't know anyone [when I moved to a state in the southeastern US], but, but I kind of like wanted to work there on my own too, and start like, new, a new life. But then again, it didn't happen that way. I ended up like knowing all the people in bars and clubs. Even managers. [232935, Filipino male, 49 years old, immigrant, lived in US 28 years, diagnosed in 1986]

(And then after you, you guys, uh, broke up?) Split. (Uh, what'd you do? How did you get back into, the social scene?) I went back to the bar scene. [232930, Filipino male, 53 years old, immigrant, lived in US 30 years, diagnosed in 1999]

Inextricability of positive and negative health

the problematic of social capital is most clear in the inextricable nature of the positive/supportive and negative/ostracizing/unhealthy dimensions of social relationships. Two examples from the interviews with these Filipino men exemplify this inextricability, particularly after these men received their HIV/AIDS diagnoses: (1) family interactions; and (2) peer networks and support groups.

Family interactions—There were many positive changes in social interaction that emerged after HIV diagnosis. Support from family often coincided with chronic illnesses experienced by other family members; cancer was often seen as a bridge between these men and their HIV positive/AIDS condition and a family member coping with a cancer diagnosis. Other men indicated that their HIV diagnosis overcame barriers to communication with their family about their gay identity.

Uh, at that time also, my dad was diagnosed with cancer. And, me and my dad was talking and you know, and fighting with the, and my mom realized that my dad was crying over the phone. And, that's how she knew, that uh, that I have uh, oh, everything they think at the time is AIDS that, you know, you're going to die soon. I said no, it doesn't, it's not that way. ... And we became more closer after I was, I became more closer to my father. [232935, Filipino male, 49 years old, immigrant, lived in US 28 years, diagnosed in 1986]

(Were you, did you feel comfortable bringing them [gay friends], home to like, family parties as your friends?) Uh, not, after I was diagnosed. Before I was diagnosed, no. (You didn't bring them home? As friends?) No. (But after you were diagnosed, you felt comfortable?) Right. [232923, Filipino male, 39 years old, immigrant, lived in US 23 years, diagnosed in 1995]

However, intertwined with supportive behavior from family members, for example, providing housing, food, and inclusion at family gatherings, there were also micro-level socio-spatial containment actions that served to reinforce stigma and emphasize social difference. Almost all of the men reported that once their families were informed about their HIV positive status,

family members would engage in ostracizing behavior meant presumably to protect the HIV negative family members from HIV transmission, such as bleaching the plates and utensils used by these men or providing them with separate plates of food and utensils. A few of these men tried to educate their families about HIV transmission, with some more successful than others. One man reported that because his family (he lived with his sibling and her family) continued to bleach the plates he ate from, he asked that the family use disposable plates [232939], while others decided to disengage themselves from frequent family interactions.

Uh, you know at first I noticed that, um, you know, she [my mother], she was careful as far as sharing utensils with me. But, um, I had to tell her, you know, you know, that, don't get the HIV, from sharing utensils and all that stuff. And, you know, one time I was hurt because she was trying, to separate, you know, I knew and you know, she was washing the dishes and she separated my utensils and my dishes and, and I asked her what, why are you trying to separate it? You know. Oh, just for our protection. And I said, you know, you don't get HIV from, you know, sharing utensils. [232932, Filipino male, 40 years old, immigrant, lived in US 15 years, diagnosed in 1990] Yeah. You know when, when, when I was going to the place, and, they [my brother and his family] invited me, oh, I have my own plate. I have to, have my own plate. My ... spoon and fork, and my cup. And my cups, you know? And it was so, how do you call that? ... And I get, I, I got tired of that. Then I started not going to their place. I said why would I go there because they, I tried to, to teach them, about HIV but they, they have, uh, they, didn't have, this effort to, learn about HIV. So I started not going. I, I stopped going to my brother's place cuz I'm tired of like, I can, I can have a really nice dinner and lunch in my place, you know? [232926, Filipino male, 49 years old, immigrant, lived in US 7 years, diagnosed in 1998]

Peer networks and support groups

Support from and trust in friends was often defined as not disclosing the men's conditions to others, talking frequently and regularly, and keeping these men from abusing drugs, alcohol, or engaging in other risky behaviors. Supportive relationships provided stability and a positive alternative to the more familiar places and networks linked to drugs, alcohol, and anonymous sex.

Now [my life now], it's, it's getting, better. It's much better. It's not so chaotic. ... I, try to uh, hang out with positive people, you know. There's one, couple of friends that I visit almost daily basis, you know. And, and I've tried to do the right thing you know. Even when I want to go cruise, you know, just to, get on the bus, you know, Silverlake or bookstore, it's just like, oh, that's so embedded, embedded in my damn brain, you know. To go cruising in the gay area. It's just, sicko, you know. I'm 32 and I'm getting tired of, you know, going to the bookstore and that's where all the gay men cruise at the bookstore. It's just, it's so repetition, just, it's like a turn off to me now, you know. Maybe I'm getting older. [232949, Filipino male, 32 years old, immigrant, lived in US 20 years, diagnosed in 1995]

In addition, many of the men were committed to providing emotional and material support to other API men who become HIV positive/AIDS diagnosed, especially in terms of finding social support and navigating the social service delivery system. About one-fifth of the men, who were in recovery, served as sponsors or contacts for others (APIs and non-APIs) who faced crisis situations or who were experiencing relapse in terms of substance use. In such situations, these men, usually as volunteers though some were paid staff, provided an emotional anchor for many experiencing similar kinds of substance abuse, mental health, and physical health challenges.

They'll call me at two o'clock in the morning to say they're craving crystal meth. Uh, then I had to, have to talk to them. Talk them out of it or, people call me. Oh, I relapsed, can you help me go through a drug rehab? I drive there and, pick them up, drop them off. I don't have food to eat. I said come over, you know. I'll give them the food or whatever. (*How often do you, do you, have people, asking you for help?*) Well, every Friday, people call me to take them. That's every Friday, like today, I have to do it too. I have to, take people to, crystal meth meetings. I would go to the drug, uh, drug recovery house. I would take, four people. Take them there, take them back. (*So would you consider that, volunteer work or is that?*) No. I would consider that, being of service. [232925, Filipino male, 34 years old, immigrant, lived in US 25 years, diagnosed in 1999]

And so, yeah. I would say, that I, I, gladly provide that [HIV prevention] information and then if I get a sense that, uh, some of my friends are carrying out risky behaviors, then you know, they know I'll [laughs] jump on their case. Yeah. Yeah, as a friend. You know, it's like I'm not going to, I'm not gonna be moralistic about it. Because for me, I've lived, as many years as I have, there's not too many things I haven't done. So whatever they tell me is not going to be really surprising. ... You know in that regard, um, so what's different also [about my life now after being diagnosed with HIV]? Um, I think, being able to be, a positive role model. In both senses, you know. Someone positive and as a positive role model, in terms of, how do you live with this disease. [232927, Filipino male, 58 years old, US born, diagnosed in 1989]

However, though attendance at API support groups for people living with HIV/AIDS was helpful in terms of regularizing interaction with others facing similar circumstances, emotional ties to support group members also led to sadness and depression as members died.

Peers, yeah. I've seen a lot of people die. You know, in my eyes. In front of my eyes, actually. You know. [232936, Filipino male, 40 years old, immigrant, lived in US 18 years, diagnosed in 1993]

So he's at that point where a lot of his cohorts are starting to become sick or they died off already. And so, um, friendship, is one of those things that's, the hardest to develop. [232927, Filipino male, 58 years old, US born, diagnosed in 1989]

Perhaps as a consequence of this probable disruption in their social network, about one-fifth of these men chose to interact with support groups in cautious and minimal ways. Moreover, there was distrust, jealousy, and conflict within API social networks centered on HIV/AIDS. Consequently, the provision of and accessing emotional support through social interaction remained complex after life for these men became more stable. That is, being HIV positive/AIDS diagnosed did not erase individual conflicts or distrust for these men, and as the network of individuals was rather small, many of these men tended to know one another, creating overlapping networks with supportive and sometimes not so supportive dimensions.

We [the API support group members] have a picnic. And I am the one who's bring the, some of the food. ... I think I'm, I think I'm bringing all, I'm bringing, I'm bringing all the food. ... I, I'm not, cooking them, I'm just bringing them, to make them happy. Even, even the, even the guys that I don't like. I'm feeding them because ... it's like give and take. [232930, Filipino male, 53 years old, immigrant, lived in US 30 years, diagnosed in 1999]

About one-half of these men felt that they could not or would not speak to friends about their HIV positive test result, because of embarrassment or fear of disclosure to other members of the social network. Many isolated themselves from their friends and family, especially because of concerns about "back-stabbing" and gossiping, but also because of difficulty in asking for help. Prior to their discussing their conditions with their families, many believed that their

friends and family might have suspected that HIV or AIDS might be a possibility. A diagnosis of pneumonia along with possible gay identity provided a sort of social code that signified HIV positive or AIDS diagnosis to family or friends, with some of the men disclosing to their families their HIV positive status as families came to the hospital to help care for them when they became acutely ill.

But some of my other friends, I'm very embarrassed. Yeah, that uh, you know, that I have AIDS. They know, but, because I, I don't mind it, I don't mind it. I'm like my friend, that who lives, my other friend C. that he doesn't want to do that he is uh HIV. He just telling that he is, only got, pneumonia. ... I know I understood that if you're gay and you have pneumonia, it's understood that you have AIDS, you know. [232929, Filipino male, 52 years old, immigrant, lived in US 35 years, diagnosed in 2001]

In addition, HIV diagnosis did not necessarily bring abrupt disconnections from networks associated with circuit parties, clubs, or substance abuse. About one-third of the men reported that they disconnected from their "druggie friends" and stopped looking at web sites associated with risky behavior.

I hang out more, a lot, at sober places. Or where, you know, I hang out with sober friends, it's a simple life. Because before it was chaotic. Now I just want, I'd rather be home. [232925, Filipino male, 34 years old, immigrant, lived in US 25 years, diagnosed in 1999]

About one-fifth reported a more moderated disconnection from their former associates, web sites, and places where they used to congregate prior to their HIV test, for example, reporting that they still went to circuit parties but that they did not consume alcohol or use drugs. A handful reported still engaging in risky behaviors, such as substance use and unsafe sex following HIV diagnosis, and a few suggested that social interaction was more difficult for them now that they were sober.

After the present time? I'm still doing it [cocaine]. But, not compared to some of my friends. They're doing it everyday. They spend hundred and thousands. Me, not like that. It's only like, cuz we're, when I do that, as long as you do it in, control, you control it and in the right, uh, way, you feel more, it, it lessen the, the burden of, the burden you're carrying, the problems. [232933, Filipino male, 50 years old, immigrant, lived in US 18 years, diagnosed in 1992]

Conclusion

This paper has argued that clarifying, using, and expanding social capital in impoverished, marginalized, and socially excluded communities to improve health requires an understanding of the disruptive as well as the supportive and cooperative elements of social relationships in specific time-space situations. Disruption may not only influence the ways that social relationships form and are sustained, but may also be effective means for acquiring resources and improving health. But as this paper has shown, clarification is needed to better understand how disruption centrally defines social capital's role in health and well-being. The qualitative analysis highlighted the complex ways that social networks, resources, and group interaction contribute to capacity to deal with HIV/AIDS diagnosis, but also in enabling high risk behavior in places where HIV transmission is likely to occur.

To summarize, the conceptual framework emanating from the qualitative analysis of interviews with Filipino men living with HIV/AIDS in Los Angeles indicated several important dimensions about the central role of disruption in social capital. First, social capital has both positive and negative dimensions (with respect to health promotion and quality of life), that is,

disruption is both cause and effect in terms of explaining behavior that is generally viewed as health denigrating. Second, as social networks and the resources available through them become disrupted, individuals and groups that experience marginalization and social disadvantage (in this case, stigmatization associated with sexual identity and HIV/AIDS), seek accepting networks/places that often put them at risk of illness/death, but provide relative acceptance and support (the acceptance and support denied them because of their marginalization and social disadvantage). Third, to enhance health and well-being, such individuals are often asked to separate themselves from “negative” individuals and places. This is for example the typical approach advocated for substance users, who are asked to disconnect themselves from their networks of “using” partners, friends, and acquaintances. But, in separating themselves, these individuals may seek familiar and similar places and networks in new locations. In other words, separating from previous networks of support, even if they supported typically defined negative health behaviors, creates need for new socio-spatial networks and routines that do not rely on such social capital. This is difficult, and often, not sustainable because of a lack of networks and resources that might replace those that are deemed inappropriate and unhealthy.

The analysis focused on one intersection among race/ethnicity, gender, and sexual identity (Filipino, men, homosexuality), and how disruption might be used to highlight the vagaries of social capital. To better understand the complex nature of healthy and unhealthy social and spatial interactions, future research should emphasize disruption in social relationships, conceptualizing sudden changes in social relationships, conflict and resistance, and how larger societal dimensions influence individual and community level interactions (i.e., conflict may be an effective means of relationship formation and resource acquisition in particular social contexts). The gendered, racial/ethnic, and class dimensions of disruption in and by social capital must be clarified as part of this future research agenda.

Research should clarify the formation, dismantling, and sustainability of social capital for strategic purposes (i.e., dismantling some social networks may not always be negative, but their replacement becomes quite problematic). Researchers should work to better understand how varying types of disruption may lead to improved health and well being. The qualitative interviews showed that there are spatially overlapping networks associated with economic, social, political, health quality and potentially with degraded health and well-being. This suggests that there is a need to clarify social network change over time (shrinkage/expansion), resource availability change (limits on some resources, expansion in other resources, and need for synchronizing resource availability and need), the health promoting/denigrating dimensions of social capital (especially what can be done to disentangle the networks and resources leading to illness, injury, and death from those promoting health and well-being), and the spatial characteristics that facilitate and regularize these social interactions.

Through such research and practice, geographers and practitioners will better understand the complex nature of social capital, and how resources through social networks might best be tapped for improving quality of life for society’s most marginalized.

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Figure 1.
Disruptive Social Capital – Conceptual Model

Table 1

Sociodemographic and HIV/AIDS characteristics of interviewed Filipino men living with HIV/AIDS

Variable	Mean or %	Standard Deviation	Range
Age (N=51)	43.5 years	10.8 years	22–62 years
Years since immigrated to US (N=39; 8 were born in US)	20.2 years	8.7 years	0–37 years
Monthly expenditures (N=47)	\$ 972	\$ 702	\$186 – \$3400
Years since HIV positive/AIDS diagnosis (N=46)	9.4 years	5.5 years	0–21 years
Race/Ethnicity (N=48)	77% Filipino; 21% Mixed Race/Ethnicity		
Employed? (N=49)	51% employed; Mean hours worked per week (N=25) = 34		
Sexual Orientation (N=50)	96% homosexual (sex only with men); 4% bisexual		
City Received HIV Test Result (N=47)	66% Los Angeles, 17% in city in Los Angeles County, 6% in New York City, 4% in Orange County, 4% in San Francisco		
Facility Where HIV Tested (N=44)	52% community health clinic, 25% private physician, 23% public health department		