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Access to occupational networks and ethnic variation of depressive symptoms in young adults in Sweden

Alexander Miething [a, b, *], Mikael Rostila [b], Jens Rydgren [a]

[a] Department of Sociology, Stockholm University, SE-106 91 Stockholm, Sweden
[b] Centre for Health Equity Studies (CHESS), Stockholm University, Karolinska Institutet, SE-106 91 Stockholm, Sweden

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ABSTRACT

Social capital research has recognized the relevance of occupational network contacts for individuals' life chances and status attainment, and found distinct associations dependent on ethnic background. A still fairly unexplored area is the health implications of occupational networks. The current approach thus seeks to study the relationship between access to occupational social capital and depressive symptoms in early adulthood, and to examine whether the associations differ between persons with native Swedish parents and those with parents born in Iran and the former Yugoslavia.

The two-wave panel comprised 19- and 23-year-old Swedish citizens whose parents were born in either Sweden, Iran or the former Yugoslavia. The composition of respondents' occupational networks contacts was measured with a so-called position generator. Depressive symptoms were assessed with a two-item depression screener. A population-averaged model was used to estimate the associations between depressive symptoms and access to occupational contact networks.

Similar levels of depressive symptoms in respondents with parents born in Sweden and Yugoslavia were contrasted by a notably higher prevalence of these conditions in those with an Iranian background. After socioeconomic conditions were adjusted for, regression analysis showed that the propensity for depressive symptoms in women with an Iranian background increased with a higher number of manual class contacts, and decreased for men and women with Iranian parents with a higher number of prestigious occupational connections. The respective associations in persons with native Swedish parents and parents from the former Yugoslavia are partly reversed.

Access to occupational contact networks, but also perceived ethnic identity, explained a large portion of the ethnic variation in depression. Mainly the group with an Iranian background seems to benefit from prestigious occupational contacts. Among those with an Iranian background, social status concerns and expected marginalization in manual class occupations may have contributed to their propensity for depressive symptoms.

1. Introduction

Psychological complaints and depressive symptoms in adolescence constitute a burden of global extent (Gore et al., 2011; Patel et al., 2007; Thapar et al., 2012), and represent the most prevalent health problem among youths in Sweden (Hagquist, 2010; Wiklund et al., 2012). Previous research has shown that these types of complaints are more widespread among women (Nolen-Hoeksema, 2001; Piccinelli, 2000) and affect immigrants to a larger extent than natives (Hjern, 2012), but also vary notably between different ethnic groups (Sundquist et al., 2000; Tinghög et al., 2007). While stressors associated with migration and acculturation experiences have been linked to poor mental health in first-generation immigrants (Bhugra, 2004; Porter and Haslam, 2005), findings for descendants of immigrants are less consistent. Previous studies referring to the Swedish case have found considerable intergroup variation in mental health, but still poorer mental health in individuals with foreign-born parents compared to the native population (Gilliver et al., 2014; Leão et al., 2005). It has been previously held that descendants of immigrants – though they did not go through the stressful process of migration – may

* Corresponding author. Department of Sociology, Stockholm University, SE-106 91 Stockholm, Sweden.
E-mail addresses: alexander.miething@sociology.su.se (A. Miething), mikael.rostila@chess.su.se (M. Rostila), jens.rydgren@sociology.su.se (J. Rydgren).

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nevertheless share their parents' experience of social exclusion, acculturation difficulties, and socioeconomic disadvantages in the receiving country (Heath et al., 2008; Mood et al., 2016). Detrimental conditions in school and on the labor market, sociocultural differences, encounters with discrimination, and distinct health behaviors may contribute to the persistent health disadvantages of people with a foreign background (Leão et al., 2005; Sieberer et al., 2012).

Research on the social determinants of mental health has recognized social capital as a potentially important support mechanism (Almedom, 2005; De Silva et al., 2005). Ambiguities in defining, measuring and operationalizing social capital have led to ongoing debate as to how it translates into health (Moore and Kawachi, 2017; Rostila, 2011a; Szreter and Woolcock, 2004). In general, access to a broad range of social capital is believed to improve health (Moore and Kawachi, 2017). However, dependent on contextual conditions, social capital can function socially exclusively and inclusively, and thus result in negative and positive effects (Szreter and Woolcock, 2004). Moreover, comparative studies have found distinct health implications of social capital in individuals of foreign and non-foreign origin (Lorant et al., 2016). Relative to their credentials and socioeconomic conditions, people with an immigrant background encounter more difficulties than non-foreign people do (Kelly and Hedman, 2016), and are thus expected to receive greater health returns from social capital.

In what follows, social capital is understood as individuals' accumulated resources that are embedded in their social relationships and released through social interactions (Bourdieu, 1986). Less an individual characteristic, social capital is an ecological feature that emerges from social ties (Lochner et al., 1999). It can further be disaggregated into cognitive and structural components (Harpham et al., 2002; McKenzie et al., 2002). Cognitive social capital plays a salutary role, through supportive social ties and interpersonal social relationships, for a person's mental health and well-being. Perceptions of trust, reciprocity, sharing, and emotional support are essential ingredients of cognitive social capital, and are only accessible through social ties (Harpham et al., 2002). They serve as resources that facilitate stress resistance and coping capability, and thus reduce one's susceptibility to mental ill-health (Thoits, 2011). Whereas cognitive social capital is commonly framed as “bonding” social capital, which intensifies existing network support, in contrast “bridging” structural social capital denotes the potential opportunities offered by social networks (De Silva et al., 2005; Rostila, 2011b). The access to structural positions mobilizes social resources that are embedded in individuals' social networks (Song and Lin, 2009). The roles, behaviors, practices, and knowledge attached to certain occupational positions assemble what Lin and Dumin (1986) term “instrumental action”, and may improve individuals' labor market and career opportunities (Granovetter, 1973). Individuals' access to extensive occupational networks has been affirmed to enhance status attainment (Lin, 1999), and is particularly advantageous in late adolescence when school-leavers enter the labor market or begin higher education (Hällsten et al., 2017a).

In order to sample individuals' access to structural positions, Lin and Dumin (1986) proposed the so-called position generator to map the hierarchical ordering of occupational positions within individuals' social networks. Previous implementations of position generator instruments have found convincing support for the mental health impacts of social network resources and occupational contacts beyond the effects of social support (Bassett and Moore, 2013; Song and Lin, 2009; Verhaeghe and Tampubolon, 2012). Several mechanisms have been pointed out as evoking the association between access to occupational contacts and health: a higher quantity and diversity of occupational contacts is assumed to provide a greater variety of health information than a network comprising only a small number of occupations (Umberson and Montez, 2010). Further, behavioral aspects linked to others' occupational habitus and prestige, but also social monitoring, modeling, and comparison, may operate as mechanisms that exert influences on health (Thoits, 2011). In addition, network members' resources are believed to reinforce individuals' identification, self-esteem, and perception of status positions, which in turn could have positive effects on mental health (Song and Lin, 2009). In general, individuals' access to higher positions in the occupational hierarchy, and likewise more prestigious positions, are expected to render better mental health returns than positions with lower status or prestige (Lin, 2000).

As reversed causation and selection processes possibly contribute to the association between social capital and mental health (Giordano and Lindström, 2015), they may also obscure the mediating role of occupational contacts in the association between ethnic background and depression. For example, persons with psychological disorders (e.g. depression) may have difficulties developing and maintaining relationships with others who hold strategically important positions. Similar to the notion that the health implications of social capital are context-dependent (Szreter and Woolcock, 2004), immigrant background is also a potentially relevant factor to consider when examining the associations with health. For example, ethnic homophily – the often observed principle of bonding social capital that describes the tendency to interact with similar others – has shown to predict better health in natives, but has revealed adverse health effects for immigrants (Rostila, 2010). Accordingly, homophily may function as a mediator that structures the distribution and acquisition of material and non-material resources relevant for health. For ethnic minorities in less powerful and socially disadvantaged conditions ethnic, homophily likely constrains the quality and quantity of health-related resources.

Sweden represents an interesting context for exploring ethnic differences in depression, and the mediating role of occupational networks in this association. Labor immigrants and refugees contributed to a comparably high share of foreign-born residents in Sweden (about 16% in 2016 (OECD, 2016)). Similar to other countries, in particular persons with refugee background and their children have limited contact opportunities and face more challenges to integrate in the labor market compared to the native (Swedish) population (Bevelander and Pendakur, 2014; Hällsten et al., 2017b).

Descendants of Iranian and Yugoslavian immigrants, who constitute some of the largest populations with a foreign background in Sweden, may exemplify relevant groups for exploring the relationship between occupational social capital and depressive symptoms. While Yugoslav immigrants are the largest European group of foreign origin outside the Nordic states in Sweden, Iranian immigrants represent the second largest non-European group (of foreign origin). The first large wave of Iranian immigrants came to Sweden as refugees in the wake of the Islamic revolution in 1979, and belonged to the well-educated middle class in Iran. Their educational level was considerably higher than that of Iranians who fled to Sweden during the 1980s after the war between Iran and Iraq, and of Iranian Kurds who came to Sweden in the 1990s. The first wave of Yugoslavian immigrants arrived in Sweden in the 1960s and 1970s, and were mostly low-skilled and recruited for manufacturing jobs (Jonsson, 2007). The socioeconomic profile of Yugoslavian labor force immigrants coming to Sweden in the 1960s and 1970s was more homogeneous than that of Yugoslavian civil war refugees who arrived in Sweden in the 1990s. As socioeconomic credentials regulate how social capital is distributed and structured, access to social capital likely varies by ethnic origin,