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Ethnicity and nativity status as determinants of perceived social support: Testing the concept of familism

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ABSTRACT

Research has demonstrated a protective effect of social support on health. Social support is most often treated as an independent variable. However, as with disease risk factors, which are not randomly distributed, health-promoting resources such as social support are also systematically patterned. For example, in the USA, family support is thought to be high among Latinos, Mexican Americans in particular. Using data from the Project on Human Development in Chicago Neighborhoods, we explored the relationships between ethnicity/nativity status, socioeconomic status (SES) and perceived social support from family and friends. We also assessed the role of retention of culture—measured as primary language spoken at home—on social support. Finally, we tested whether SES moderated the relationship between ethnicity/nativity status and social support. Foreign and US-born Latinos, most notably, foreign-born Mexicans, reported higher family support compared to non-Latino whites. Primary language spoken at home seems to account for the relationship between ethnicity/nativity and familial social support. Mexican-born and US-born Latino immigrants reported lower social support from family at higher levels of SES. Each ethnic minority group reported lower perception of friend support compared to non-Latino whites. There was a strong SES gradient in subjective support from friends with higher support reported among those with higher SES. This study provides evidence for the notion that Latinos in the USA, specifically foreign-born Mexicans, may rely on family ties for support more than do non-Latino whites. Findings also help identify ethnicity/nativity status, primary language spoken and SES as determinants of social support. Specifically, the higher familial social support found among Latino immigrants may be due to retention of culture. Effect modification by SES suggests that Latinos of lower and higher SES may differ with regard to the traditionally-held value of *familism*.

Introduction

Epidemiologic research has consistently demonstrated a link between social networks/social support and outcomes ranging from mental health to mortality (Berkman & Glass, 2000; House, Umberson, & Landis, 1988; Kawachi & Berkman, 2001). The association between lack of social ties and poor mental health has been especially well-established (Bassuk, Glass, & Berkman, 1999; Berkman, Melchior, Chastang, Niedhammer, Leclerc, & Goldberg, 2004; Cacioppo et al., 2002; Hamrick, Cohen, & Rodriguez, 2002; Kawachi & Berkman, 2001). According to Seeman (1996), the data on mental health outcomes have consistently demonstrated the generally protective effects of being socially integrated and conversely, the deleterious effects of social isolation.

Compared to the large and well-established body of literature on social support and its association with health, the conceptualization and operationalization of social support is often inconsistent across and within disciplines (Turner & Marino, 1994). For example, the debate of whether actual receipt of support or subjective evaluation of support is what matters for health continues today (Berkman & Glass, 2000; House et al., 1988; Turner & Marino, 1994). While both may be important to health through different mechanisms, the vast majority of studies have found that perceived social support is more strongly associated with health than received support (House, 1981; Pearlin, 2000; Seeman, 1996). A further debate in the literature surrounds whether social support impacts health through "main" or "buffering" effects (Kawachi & Berkman, 2001; Thoits, 2000; Turner, 1999; Turner & Marino, 1994). The "main effects" theory suggests that social support is relevant to health in all circumstances, regardless of whether significant stress is present (Kawachi & Berkman, 2001; Thoits, 2000; Turner, 1999; Turner & Marino, 1994). Accordingly, social support is directly

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beneficial and absence or dearth of this resource is detrimental to health (Kawachi & Berkman, 2001; Seeman, 1996; Turner, 1999). In contrast, the "buffering hypothesis" argues that social support primarily benefits health by mediating or buffering the deleterious effects of stress (Turner & Marino, 1994). Cobb, (1976) further asserted that social support is essentially a moderator of stress (Cassel, 1976; Turner, 1999; Vega & Miranda, 1985). According to Kawachi and Berkman (2001), the perception of available social support can mitigate the response to stress and ultimately prevent a cascade of subsequent adverse reactions.

Despite the extensive scholarship on how inequalities in disease risk arise, we know little about how social support varies across population subgroups (House, 1981; House et al., 1988; Turner & Marino, 1994). It is well known that health and disease are not randomly distributed, rather they are socially patterned such that certain groups are more or less likely to be affected by disease relative to others (Berkman & Kawachi, 2000). Membership in socially defined groups often dictates differential exposure to stressors which have noxious effects on health (Eaton & Muntaner, 2000; Pearlin, 2000; Thoits, 2000; Turner & Marino, 1994). Similar to the social patterning in exposure to health-damaging factors, there is reason to assume that variation in the availability of health-promoting resources such as social support is also systematically shaped by a group's social status or ranking (Turner & Marino, 1994).

Gaps in the literature

The literature on social support during the past decade has treated it almost exclusively as an independent, mediating or moderating variable. However, because social support is regarded as an independent predictor of health, we must also focus our attention on the factors that give rise to social networks and social support (House et al., 1988). House et al. (1988) similarly argued that for research, practice and policy reasons, social support must be investigated as a dependent variable (House et al., 1988). In order to develop interventions that are conducive to health, we must illuminate structural conditions that engender resources such as social support (Turner & Marino, 1994). This sentiment was closely echoed by Berkman and Glass (2000) in their call to focus on the context and structural basis that facilitate the exchange of social support. Because access to health-promoting resources such as education often varies across socially defined groups, it follows that access to social support as a health-advancing resource is also differentially distributed (Berkman & Glass, 2000; Lin & Peek, 1999; Turner & Marino, 1994).

While most researchers have focused on how gender, marital status and age are related to the provision and receipt of social support, fewer have turned their attention to differences in social support across racial/ethnic groups, immigrant, and socioeconomic status (SES) (Bassuk et al., 1999; Berkman & Glass, 2000; House et al., 1988; Seeman, 1996; Turner, 1999; Turner, Grankel, & Levin, 1983; Turner & Marino, 1994). Studies have suggested that disadvantaged social groups such as racial/ethnic minority may rely on informal sources of support such as kin because economic and social barriers restrict their access to more formal sources of social assistance (Landale, Orpesa, & Bradatan, 2006). Latinos are one such example. Studies of social support among Latino immigrants in the US have suggested that this ethnic group, specifically, Mexicans Americans, have large extended family networks and high levels of social support within these networks, both of which ameliorate the adverse consequences of poverty on health (Landale et al., 2006). The term *familism* is a used to describe this commonly cited value of Latino culture, and reflects the centrality and importance of family (Franzini, Ribble, & Keddie, 2001; Mindel, 1980; Vega & Miranda, 1985). Ethnographic research has found that in contrast to non-Latino whites who maintain fewer ties with kin and are often long distance in nature, Mexican Americans generally live in closer proximity to extended kin networks, which facilitates healthy exchange of social support (Moore, 1989; Moore & Pinderhughes, 1993; Vega, 1990). Furthermore, Mindel (1980) suggested that while non-Latino (whites) migrate away from family networks, Latinos migrate towards them (Markides & Coreil, 1986; Vega, 1990). Given the widely cited notion of Latinos as family-oriented, the established relationship between social support and health, as well as the lack of attention paid to social support as a dependent variable, the need to examine the race/ethnicity and immigrant status as predictors of social support is justified (Franzini et al., 2001; Guarnaccia, 2002; Markides & Coreil, 1986; Vega & Miranda, 1985). While the protective role of family support for Latinos, other racial/ethnic minority, and persons of low SES has been explored, the benefits of non-kin support on health are less clear (Franzini & Fernandez-Esquer, 2004; Jung & Khalsa, 1989; Pugliesi & Shook, 1998; Schwartz, 2007; Walen & Lachman, 2000). In light of Mindel's claim that non-Latino whites migrate away from family networks, and the fact that migration can result in loss of social ties, often non-kin ties, it is possible that ethnicity/nativity status is associated with differences in source of support (Finch & Vega, 2003; Menjivar, 2000). Although studies have widely documented the effect of support on health, few have provided information on the source of support, the potentially distinct effects on health, and how this resource varies across ethnicity/nativity status (Dean, Kolody, & Wood, 1990). Not only may support from kin and non-kin differ with regard to the source, but support from non-kin may also be distinguished by its voluntary rather than obligatory nature (Dean et al., 1990). Moreover, friendship ties may be subject to fewer structural constraints and obligations, and may therefore engender feelings of attachment based on egalitarianism, consensus and sharing good times (Matt & Dean, 1993).

Study objectives

Overall, we were interested in understanding the social patterning of social support, in particular across ethnicity/nativity status. Our first objective was to test whether ethnicity/nativity status was associated with familial social support, based on our hypothesis that Latinos, chiefly foreign-born Mexicans would report higher kin-based support compared to other ethnic groups, especially non-Latino whites. Second, we sought to test whether ethnicity/nativity status was associated with social support from friends. Given their newcomer status, we hypothesized that immigrants would have had less time to develop friendship ties compared to native-born, and would therefore report lower support from friends. Our third hypothesis was that retention of culture would account for any increased family support reported by foreign-born Latinos. Therefore, we tested whether retention of culture, as measured by primary language spoken at home, could explain any differences in kin support across ethnicity/nativity status. Our final goal was to examine how SES influences the relationship between ethnicity/nativity status and perceived social support, guided by our hypothesis that *familism* may be lower at higher levels of SES.

Methods

Data for this study came from the Project on Human Development in Chicago Neighborhoods (PHDCN). The PHDCN is a prospective, multidisciplinary study of children and their families residing in Chicago neighborhoods. Sampling methodology for this study is well described elsewhere (Sampson, Morenoff, &Raudenbush, 2005; Sampson, Raudenbush, & Earls, 1997). The Longitudinal