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Coalitional affiliation as a missing link between ethnic polarization and well-being: An empirical test from the European Social Survey

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ABSTRACT

Many studies converge in suggesting (a) that ethnic and racial minorities fare worse than host populations in reported well-being and objective measures of health and (b) that ethnic/racial diversity has a negative impact on various measures of social trust and well-being, including in the host or majority population. However, there is much uncertainty about the processes that connect diversity variables with personal outcomes. In this paper, we are particularly interested in different levels of *coalitional affiliation*, which refers to people's social allegiances that guide their expectations of social support, in-group strength and cohesion. We operationalize coalitional affiliation as the extent to which people rely on a homogeneous social network, and we measure it with indicators of friendships across ethnic boundaries and frequency of contact with friends. Using multi-level models and data from the *European Social Survey* (Round 1, 2002–2003) for 19 countries, we demonstrate that coalitional affiliation provides an empirically reliable, as well as theoretically coherent, explanation for various effects of ethnic/racial diversity.

1. Introduction

In his seminal work on diversity in the twenty-first century, Robert Putnam (2007) argued that increased ethnic diversity is related to people's withdrawal from civic life and a reduction in social well-being. Effects of an ethnically and racially diverse life on personal health and well-being have been researched by a large number of studies illustrating the role of discrimination (Pascoe and Smart Richman, 2009a,b; Williams and Mohammed, 2009; Williams et al., 2003) as well as other factors like genetics, social and personal identities, socio-economic status, and culture (e.g., Bayard-Burfield et al., 2001; Davey Smith et al., 1998; Navarro, 1990; Oyserman et al., 2014; Silove et al., 2000). However, these factors do not sufficiently explain why some ethnic groups fare better than others on various health and well-being outcomes despite sharing similar socioeconomic conditions and experiences of discrimination (e.g., Morales et al., 2002). A growing body of literature aims to provide a more nuanced understanding for these discrepancies by suggesting that negative effects of diversity are mediated by inter-racial/ethnic contact (e.g., Savelkoul et al., 2011; Stolle et al., 2013). However, this research has produced conflicting results, with some findings indicating inter-ethnic contact is positively related to social well-being (Gundelach and Freitag,

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2014; Stolle et al., 2013), while others suggest a negative association (Stolle and Harell, 2013; Koopmans and Veit, 2014). Also, these studies have not yet explored the relationship between diversity and personal well-being outcomes.

Here, we focus on an evolutionary psychological process that may reconcile some of these discordant findings, and help specify the links between perceived diversity on the one hand and subjective health and well-being on the other. We propose that human coalitional psychology, i.e., evolved cognitive and emotional capacities for building and maintaining coalitions (Kurzban et al., 2001; Tooby and Cosmides, 2010), can help explain the links between ethnic/racial diversity and well-being. We particularly focus on a crucial component of coalitional psychology, namely *coalitional safety*, defined as an intuitive evaluation of perceived support and strength of one's alliances. We operationalize coalitional safety through *coalitional affiliation*, a measure of people's intuitive expectations of support from similar individuals. We aim to demonstrate, using multi-level analysis on the *European Social Survey* (Round 1, 2002–2003), that coalitional affiliation provides an empirically reliable, as well as theoretically coherent, explanation for various effects of perceived ethnic/racial diversity on well-being and health. This view complements cross-national research on the effects of inter-group contact on social well-being (Gundelach and Freitag, 2014; Koopmans and Veit, 2014; Stolle et al., 2008) by providing evidence for a psychological mechanism linking diverse inter-ethnic social interactions with individual-level well-being.

2. Background

2.1. Diversity, well-being and health

Multiple studies show that ethnic diversity has important implications for well-being and health, especially for members of ethnic minority groups. Ethnic and racial minorities fare worse on various health outcomes, and rate their well-being lower than non-minority members of a nation. For example, Blacks have lower levels of subjective well-being (Thoits and Hewitt, 2001), higher mortality rates (Geronimus et al., 1996; Kochanek et al., 2004), higher hypertension prevalence (Egan et al., 2010) and are more likely to be obese (Flegal et al., 2012) than Whites in the U.S. Native tribal groups in New Zealand, Australia, Canada and the U.S. have higher rates of disease-specific mortality rates than non-indigenous populations (Bramley et al., 2004). Health disparities extend beyond racial lines. Immigrants in the U.S. and other Western countries have poorer health than natives. Immigrants and refugees in the U.S. have higher rates of mental health problems such as depression, anxiety and post-traumatic stress disorders (Fox et al., 2001; Pumariega et al., 2005) and immigrants rate their health worse than the host population (Finch and Vega, 2003). Other studies also demonstrated the disadvantages in especially mental health and well-being of immigrants in Europe. For example, suicide attempts were higher among younger women of Mediterranean origin than their German counterparts in a psychiatric ward in Frankfurt (Storch and Poutska, 2000). Moroccan women in Spain rated their psychological well-being (i.e., happiness and life-satisfaction) much lower than Spanish women (Martinez Garcia et al., 2002).

Socio-economic inequalities and poverty play an important role in explaining health disparities across ethnic and racial lines (Braveman et al., 2010; Nazroo and Williams, 2006; Nazroo, 2003). However, even after taking into account socio-economic and demographic factors, disparities in health persist, steering researchers' attention towards discrimination and experiences of racism as potential contributors to health inequalities (Mays et al., 2007; Paradies, 2006; Williams et al., 1997). Various studies have demonstrated that perceived discrimination significantly deteriorates both physical and mental health (Pascoe and Smart Richman, 2009a,b; Williams and Mohammed, 2009; Williams et al., 2003). Experiences of discrimination and racism are associated with psychological distress, anxiety and depression as well as increased alcohol, tobacco and marijuana use among Black Americans (Brown et al., 2000; Landrine and Klonoff, 1996; Sanders-Phillips et al., 2014). Discrimination leads to health disadvantages by elevating physiological stress responses such as blood pressure, cardiovascular reactivity and heart rate (Brondolo et al., 2003; Clark et al., 1999; Clark, 2000, 2006a,b; Harrell et al., 2003; Mays et al., 2007; Pascoe and Smart Richman, 2009a,b; Williams, 2012). Cumulative exposure to discrimination causes especially deleterious effects on health through increased allostatic load (overwhelming the body's capacity to respond to challenges, referred to as allostasis) (McEwen and Stellar, 1993; McEwen, 1998, 2000, 2004, 2005). In line with this hypothesis, for example, Black Americans have significantly higher allostatic load biomarkers, associated with stress-related conditions like heart disease, hypertension, and obesity than their White counterparts (Geronimus et al., 2006).

Despite the significance of discrimination in explaining health disparities, there are still various health patterns that cannot be explained by experiencing discrimination. For example, White Americans are more likely to report depression than Blacks (Breslau et al., 2006; Dunlop et al., 2003; LaVeist et al., 2014). Although experiencing worse socioeconomic conditions, Hispanics in the U.S. fare equal to or better than Whites (described as the Hispanic health paradox) (Morales et al., 2002). In a 2000–2001 survey, Jewish Americans – a White ethnic group – rated their own health significantly worse than non-Jewish Americans and similar to Black Americans (Pearson and Geronimus, 2011). Moreover, minority status was shown to be a positive predictor of eudaimonic well-being (described as having a purpose in life, autonomy, self-acceptance and positive social relations) (Ryff et al., 2003). Therefore, the concept of discrimination is insufficient in accounting for health differences. While discrimination and socio-economic conditions constitute crucial predictors of well-being and health, a more refined framework that takes into account inter-individually variable social experiences like inter-ethnic contact is better able to explain some of these disparate effects of diversity on well-being and health.