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Original Research

# Particularized trust, generalized trust, and immigrant self-rated health: cross-national analysis of World Values Survey

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ABSTRACT

*Objectives:* This research examined the associations between two types of trust, generalized and particularized, and self-rated health among immigrants.

*Study design:* Data were drawn from the World Values Survey (WVS6), the latest wave of cross-sectional surveys based on face-to-face interviews.

*Methods:* The immigrant subsample analyzed herein contains 3108 foreign-born individuals clustered from 51 countries. Given the hierarchically nested data, two-level logistic regressions models were estimated using HLM (Hierarchical Linear Modeling) 7.1.

*Results:* At the individual level, net of socio-economic and demographic factors (age, gender, marital status, education, income, neighborhood security, and subjective well-being), particularized trust was *positively* related to physical health (odds ratio [OR] = 1.11, $P < .001$). Generalized trust, however, was not a significant predictor. At the country level, based on alternative models, the aggregate measure of particularized trust was *negatively* associated with subjective health. The odds of being healthy were on average about 30% lower.

*Conclusion:* The interdisciplinary literature on social determinants of health has largely focused on the salubrious impact of trust and other forms of social capital on physical well-being. Many previous studies based on general, not immigrant, populations also did not differentiate between generalized and particularized types of trust. Results from this study suggest that this conceptual distinction is critical in understanding how and to what extent the two are differentially related to immigrant well-being across multiple levels of analysis.



## Introduction

The contemporary world has witnessed accelerating flows of people traversing across national borders in what has been called 'the age of migration'.[1] As of 2015, there were 244 million immigrants in the world, an increase of more than 40% since 2000.[2] Approximately 60 million people had also been forcibly displaced worldwide, the highest number since the

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World War II.[3] In short, immigration has become a hallmark of the global community today, creating new opportunities and challenges for both foreign and native members of host societies. At the top of the agenda is the issue of reducing global health disparities by delivering equitable services to all, as advocated by international organizations and governments alike.[4,5] Indeed, health and well-being are integral to the 2030 Agenda for Sustainable Development Goals which form the part of the United Nation's vision and policy of 'leaving no one behind,' especially vulnerable groups such as immigrants.

Studies have shown that foreign nationals on average face poorer health outcomes than their native counterparts in their adopted homelands as the so-called 'healthy migrant effect' eventually fades over time.[6–14] Given this fact and the ever-rising influx of immigrants all over the world, systematic investigations of their health status are clearly warranted, if not overdue. Because of the scarcity of data, unfortunately, there has been limited understanding of the specific causes of and needs concerning immigrant health.[15–17] Migration also affects individual physical and mental well-being throughout different phases or time periods (e.g. preimmigration, process of immigration, postsettlement, and return), further complicating the matter.[18–20]

In social epidemiology, there have been increasing efforts to explore the social determinants of health.[21] In particular, whether 'social capital is good for health' has become a central concern in both academic and policy circles.[22–26] Disagreements over its precise definition notwithstanding, social capital denotes resources (information, emotional support, instrumental assistance, etc.) that exist in and are accessed through interpersonal relationships, group memberships, and communal affiliations.[27–30] Along with network ties and organizational associations, social or interpersonal trust has been a frequently used proxy for social capital in relation to health in diverse empirical settings, e.g. the US,[31,32] Europe,[33,34] Latin America,[35] Africa,[36,37] East Asia,[38,39] and the Caucasus,[40] among others. Even a brief look at the literature reveals, however, that the vast majority of research deals with general (native), not immigrant, populations. Findings that do focus on immigrant health primarily address topics related to 'acculturation'.[18,41]

The scale of health disparity tips in favor of native populations vis-a-vis immigrants. Yet, we have significantly less evidence on the sources of health-related vulnerability of immigrants. In particular, how and to what extent social capital (trust) is related to immigrant well-being remains elusive. For the most part, previous research using nonimmigrant data also does not differentiate between generalized (i.e. out-group) trust and particularized (i.e. in-group) trust, which have divergent implications and consequences.[42–44] The former refers to trust in unfamiliar others ('people unlike us'); the latter is defined as trust in familiar others ('people like us').[45,46] Put another way, generalized trust is akin to bridging social capital involving heterogeneous members, whereas particularized trust is related to bonding social capital consisting of homogenous members.[47–49]

Another way of characterizing this difference is in terms of strong versus weak ties.[50] Strong ties refer to those with close and intimate others, whereas weak ties imply connection with more formal and distant others. The former type is also conducive to creating trust and cooperation, whereas the latter type is more useful for accessing novel information.[51,52] Hence, on the one hand, it could be said that relations among socially *homogenous* actors tend to be 'strong.' Interpersonal dynamics within a socially *heterogeneous* group are more likely to be 'weak,' on the other hand. Although exceptions clearly exist, there is a general tendency found in social reality and observed by scholars as human interactions are powerfully driven by status homophily, i.e. the process of similar people gravitating toward one another.[53]

Although this conceptual dichotomy has been well recognized in the academic community, there is a dearth of research as it relates specifically to immigrant health.[54] To the extent that this issue is addressed, the argument primarily focuses on the economic adaptation and integration of immigrants. Therefore, for example, prior research indicates that foreign-born workers with more bridging (weak) ties to natives (heterogeneous others) enjoy better labor market outcomes such as formal sector employment and higher pay.[55,56] This has to do with the fact that the job-related information available through weak, as opposed to strong, ties is richer, newer, and less redundant. By contrast, when it comes to ethnic networks and immigrant health, evidence is very thin concerning the respective role of bonding (particularized) and bridging (generalized) social capital.

The empirical gap in the scholarship thus leads to the following related but distinct questions. *First, how is an immigrant's in-group trust versus out-group trust differentially related to self-rated health (SRH)? Second, above and beyond individual-level measures, how does living in a particular country with its unique aggregate degrees of generalized trust and particularized trust among immigrants associated with subjective health?* The main objective of the present research is to investigate these critical questions that have escaped serious scholarly attention. A scoping review of the literature (academic articles published in English during the last 15 years) suggests that this study is the first to systematically probe the nexus between immigrant SRH and the aforementioned dual conceptions of trust using cross-national, population-based surveys in a multilevel statistical framework.

## Methods

### *Study design and setting*

The questions aforementioned are empirically tested using data from the World Values Survey (WVS), an international research network headquartered in Stockholm, Sweden. Since 1981, six separate waves of cross-national studies have been conducted worldwide. This article is based on WVS6 (2010–2014), the most recent version of nationally representative cross-sectional surveys comprising face-to-face interviews with more than 90,000 respondents in 57 countries. Details on sampling procedures for each country, along with datasets and technical documents, are available at http://www.worldvaluessurvey.org/WVSContents.jsp. The WVS questionnaire contains an item that inquired about participants' respective native status (*Were you born in this country or are you an immigrant?*). This question was not asked to 10,712

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