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Doing Well by Doing Good Benefits for the Benefactor

Aneka Khilnani
Santa Clara university

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Keywords

Volunteering, well-being, mental-health, physical-health, lifestyle-factors, low-cost interventions.

Cover Page Footnote

I thank Dr. Laura Chyu (Santa Clara University Public Health Department) for her constant guidance and help in revisions. I thank Dr. Laura Robinson (Santa Clara University Sociology Department) for her efforts in helping me prepare this piece for publication.

**Doing Well by Doing Good:
Benefits for the Benefactor**

Aneka Khilnani

Aneka Khilnani is a recent graduate from Santa Clara University with a B.S. in Public Health Science, where she graduated Summa Cum Laude and soon to be a physiology graduate student at Georgetown University. While at SCU, she researched the link between online support groups and health outcomes for diabetics and practiced grant writing to support dietary change among low income women. She also served as an organic chemistry laboratory teaching assistant and as a copy editor for the yearbook staff. This research article was successfully complete with the help of faculty members Dr. Laura Chyu (Santa Clara University Public Health Science) and Dr. Laura Robinson (Santa Clara University Sociology

Keywords

Volunteering, Well-Being, Mental-Health, Physical-Health, Lifestyle-Factors, Low-Cost Interventions.

In the United States, approximately half of adults engage in volunteering each year (Piliavin & Siegl 2007). Moreover, 70% of adults report volunteering at some point in their lifetime and participation in volunteer work has been increasing (Piliavin and Siegl 2007). Given these trends, there is interest in the consequences of volunteer participation. In its broadest conceptualization, volunteer work is unpaid work on the part of an individual or a group of individuals with the intent of benefiting others with whom one has no contractual, familial or friendship obligation (Bussell and Forbes 2002).

Extant literature suggests there are six motives that drive the desire for adults to volunteer, which are: career-related experience, enhancing self-esteem, learning more about life, improving outlook on life, acting on our values, and strengthening social ties. Not included, but perhaps also belonging in this list, is improving health and well-being. Extant research demonstrates that volunteers gain significant benefits from frequently volunteering. Volunteering contributes to decreased psychological distress and buffers the negative consequences of stressors, it increases life satisfaction and decreases depression (Musick and Wilson 2003); and it is associated with better physical health and lower mortality (Piliavin and Siegl 2007).

The types of individuals who participate in volunteering should be considered before drawing on the benefits of volunteerism. Focusing only on the consequences of volunteer work overlooks the antecedents of human agency. People with greater personality resources and better physical and mental health, theoretically, would be more likely to seek, or be sought for community service (Casiday, Kinsman, Fisher, and Bamba 2008). Extant literature suggests that people who are involved in community service may have greater life satisfaction, self-esteem, sense of purpose in life, physical health and mental health among other consequences (Mellor et al. 2008). It should be noted that much of the empirical literature producing these sets of findings rely on cross sectional data, leaving open the question of the direction of effects (Casiday et al.

2008). There are good reasons to expect bi-directionality in the relationship between various aspects of personal well-being and volunteer work, because results from extant research have demonstrated that volunteer work indeed enhances all six aspects of well-being and, conversely, people who have greater well-being invest more hours in volunteer service (Casiday et al. 2008). Given these findings, further understanding of self-versus social selection processes seems an important next step. Do positive, healthy people actively seek out volunteer opportunities, or do organizations actively recruit individuals of these types (or both)? In short, there is a question if individuals with high levels of well-being are more likely to volunteer or if volunteering is truly improving well-being.

This study sought to examine the relationship between volunteering and perceived mental and physical health status. In this study perceived mental and physical health are used to measure true mental and physical health. Extant research suggests that self-assessed mental and physical health are valid health indicators in middle-aged populations and can be used for population health monitoring (McGee et al. 1999). This study also examines the relationship between volunteering, social participation, and health-related behaviors on perceived mental and physical health status. The study hypothesizes that volunteering will be positively related to good self-reported physical and mental health, even after controlling for the effects of social participation and health behaviors.

DATA AND METHODS

The data is retrieved from a cross-sectional study titled *The Survey of Texas Adults* (2004). The purpose of this data set was to collect information about seven major aspects of adults' lives in Texas: civic management, volunteering, personality, physical health, health behaviors, mental health, religiosity and demographic characteristics.

The sample consisted of the Texas household population aged 18 and older. All surveys were administered by telephone from November 5, 2003 to January 29, 2004. Respondent level cooperation rate was 89%. A logistic regression model was used to analyze sociodemographic variables and the binary outcome variables perceived mental and physical health, and the exposure variables of volunteering, meditation, walking, relationship status, work status, feelings of isolation, and participation in religious organization. The sample size for the final model related to physical health was 1,411 and for mental health the final sample size is 1409.

Eight exposure variables were assessed: participation in monthly volunteering, meditation, walking, marital status, work status, feelings of isolation, participation in religious organizations, and meals eaten outside of the home. These variables were chosen to be able to control for the effects of socialization and health related behaviors. Each of the variables were recoded as a binary variable, except for the eight-exposure variable. In all cases when the respondents answered, “don’t know” or “confused” they were excluded from analysis.

The two outcome variables of interest are: "perceived mental health," defined as the respondents' view of the status of their own mental health and "perceived physical health," defined as respondents' view of the status of their own physical health. Both ratings of mental and physical health were recoded as binary variables, where “0” representing excellent, very good, or good rating of mental or physical health and “1” representing fair or poor rating of mental or physical health.

The six exposure variables are: monthly volunteer participation, meditation, walking, marital status, work status, feelings of isolation, participation in religious groups, and number of meals a person has outside of the house. Aside from meals outside of the house, all the other variables were recoded as binary variables. ‘Meals outside of the house’ was categorized into three categories.

RESULTS

Table 1. Social participation and health behavior characteristics as they relate to poor perceived mental and physical health among adults in Texas: 2004 *Survey of Texas Adults*.

Variable	Percent Distribution (%)	Outcome: Poor Perceived physical health (%) (N=1411)	Outcome: Poor Perceived mental health (%) (N=1409)
Gender			
Female	61.5	16.70	14.30
Male	38.5	18.67	18.68
Volunteering Monthly			
Yes	34.66	11.20	4.64
No	65.34	22.19	8.62
Work Status			
Working	56.79	12.14	5.06
Not Working	43.21	25.98	9.48
Weekly walking			
Yes	74.31	15.50	5.86
No	25.69	26.63	11.02
Practice Meditation			
Yes	58.59	14.21	7.74
No	41.41	20.79	5.96
Feelings of Isolation			
Yes	8.40	15.91	29.51
No	91.60	44.00	5.19
Relationship Status			
In a relationship	61.45	15.54	5.58
Not in relationship	38.55	22.78	9.79
Dining Outside home per week			
0 Days	11.80	28.41	12.64
1-2 Days	47.52	16.81	6.93
3-4 Days	22.39	16.52	4.20
5+ Days	18.30	17.58	8.09
Religious Participation (Weekly)			
Yes	66.56	17.40	6.55
No	33.44	20.24	8.67

Table 1 presents the distribution of volunteering characteristics related to social participation and health-related behaviors. About a third of the adults did volunteer (33.4%). In terms of health-related behaviors over half of the participants practice meditation (58.59%) and go on walks at least once a week (74.31%). The majority of participants ate out outside of the house 1-2 days (47.53). In terms of social participation, about half of the participants work full

time (56.79%), over half are in a romantic relationship (61.45%), and participate in a religion (66.56%). About every 1 in every 11 adults, reported feelings of isolation (8.40%).

Table 2. Multivariate Logistic Regression Models for Perceived Physical Health Among Adults in Texas: *Survey of Texas Adults, 2004* (N=1411)

Variable	Model 1		Model 2	
	OR (95% CI) ^a	P	OR (95% CI) ^a	P
Do not volunteer monthly	2.26 (1.66, 3.09)	<0.001	1.87 (1.33,2.65)	<0.001
Not working			2.08 (1.54,2.82)	<0.001
Not walking weekly			1.63 (1.20, 2.23)	0.002
Practice meditation			1.45 (1.06,1.98)	0.017
Feel Isolated			2.91 (1.90, 4.46)	<0.001
Not in a relationship			1.43 (1.07, 1.92)	0.017
Dining outside home per week (ref: 0 Days)				
1-2 Days			0.70 (0.46,1.08)	0.105
3-4 Days			0.75 (0.46, 1.23)	0.257
5+ Days			0.76 (0.45, 1.28)	0.304
Participate in religious groups			0.94 (0.70, 1.29)	0.739

Note

^aOR= odds ratio, CI= Confidence Interval

When considered separately from the effects of social participation and health behaviors, poor physical health was significantly associated with not volunteering at least once a month (Table 2, Model 1). An adult who does not volunteer at least once a month has 2.26 times the odds of reporting poor perceived physical health, in comparison to an adult who volunteers at least once a month (Table 2, Model 1, $p < 0.001$). A subsequent model (Model 2) considered additional sets of variables related to social participation and health-related behaviors, that might confound associations between physical health and volunteering. Associations between physical health and volunteering were robust to the inclusion of these variables. However, the association

between perceived physical health and volunteering was slightly attenuated. Adults who do not volunteer at least once a month have a 1.87 times the odds of reporting poor perceived physical health in comparison to an adult who volunteers at least once a month after controlling for selected social participation activities (work status, relationship status, feelings of isolation, and religious participation) and certain health-related behaviors (walking, meditation, and eating outside the house) (Table 1, Model 1, $p < 0.001$). Intriguingly work status ($OR = 2.08$, $p < 0.001$), meditation ($OR = 1.45$, $p = 0.017$), walking ($OR = 1.63$, $p = 0.002$), feelings of isolation ($OR = 2.91$, $p < 0.001$), and relationship status ($OR = 1.43$, $p = 0.017$) were all predictors of poor physical health. Dining outside of the home for any number of days (1-2 days: $OR = 0.75$, $p = 0.105$, 3-4 days: $OR = 0.76$, $p = 0.257$, 5+ days: $OR = 0.70$, $p = 0.304$) and religious participation ($OR = 0.94$, $p = 0.739$) were not significant predictors of poor physical health.

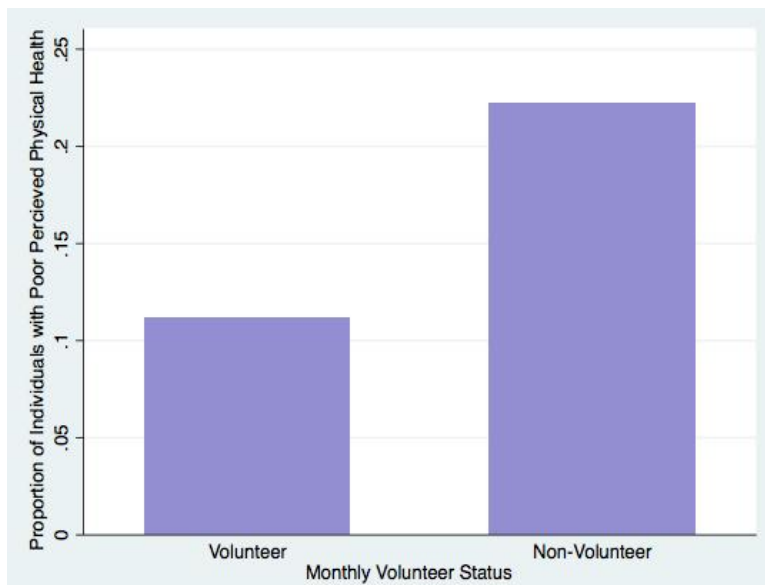


Figure 1. Proportion of volunteers and non-volunteers with poor perceived physical health among Adults in Texas from: Survey of Texas Adults, 2004 (N=1411). There was a higher

proportion of individuals who do not volunteer at least once a month who experienced poor perceived physical health, in comparison to individuals who volunteer at least once a month.

Table 3. Multivariate Logistic Regression Models for Perceived Mental Health Among Adults in Texas: *Survey of Texas Adults, 2004* (N=1409)

Variable	Model 1		Model 2	
	OR (95% CI) ^a	P	OR (95% CI) ^a	P
Do not volunteer monthly	1.93 (1.21, 3.09)	0.006	1.42 (0.84,2.41)	0.190
Not working			1.59 (0.99,2.53)	0.052
Not walking weekly			1.70 (1.07, 2.70)	0.025
Practice meditation			1.19 (0.75, 1.89)	0.468
Feel Isolated			5.78 (3.45, 9.67)	<0.001
Not in a relationship			1.39 (0.89, 2.18)	0.151
Dining outside home per week (ref: 0 Days)				
1-2 Days			0.84 (0.45,1.54)	0.564
3-4 Days			0.46 (0.21, 1.01)	0.053
5+ Days			0.94 (0.44, 1.98)	0.868
Participate in religious groups			0.98 (0.61, 1.56)	0.929

Note

^aOR= odds ratio, CI= Confidence Interval

When considered separately from the effects of social participation and health behaviors, poor mental health was significantly associated with not volunteering at least once a month (Table 3, Model 1). An adult who does not volunteer at least once a month has 1.93 times the odds of reporting poor perceived mental health, in comparison to an adult who volunteers at least once a month (Table 3, Model 1, p=0.006). A subsequent model (Table 3, Model 2) considered additional sets of variables that might confound associations between mental health and volunteering related to social participation and health behaviors. Associations between mental health and volunteering were not robust to the inclusion of these variables. After controlling for the effects of working, walking, meditation, feelings of isolation, romantic relationships, food-

related behaviors, and participation in religious groups, adults who do not volunteer at least once a month do not have significantly different odds of poor mental health in comparison to people who volunteer at least once a month after controlling for social participation and health-related behaviors (Table 3, Model 2, $p=0.190$). It should be noted that the association between volunteering and mental health remained in the expected direction. Intriguingly, the only variables associated with poor mental health were feelings of isolation ($OR=5.78$, $p<0.001$) and not walking at least once a week ($OR=1.70$, $p=0.025$). Work status ($OR=1.59$, $p=0.052$), dining outside of the home (1-2 days: $OR=0.84$, $p=0.564$, 3-4 days: $OR=0.46$, $p=0.053$, 5+ days: $OR=0.94$, $p=0.868$), religious participation ($OR=0.98$, $p=0.929$) and relationship status ($OR=1.39$, $p=0.151$) were not significant predictors of reporting poor mental health.

DISCUSSION

Understanding factors associated with mental and physical well-being of adults is a major research priority in the United States. Interest is particularly high in changes that can be made at a low-cost. This study supports the research agenda by exploring the contribution of volunteering to mental and physical well-being.

The findings of this study suggest there is an association between physical health and volunteering. As hypothesized by this study, volunteers report better physical health, even after controlling for social participation and health behaviors (Piliavin and Siegl 2007). The findings are in contrast to extant literature because this study did not find a significant association between volunteering and status of mental health, after controlling for social participation and health behaviors. In contrast, extant literature suggests that consistent volunteering is associated with improved mental health (Musick and Wilson 2003). The lack of significant association between mental health and volunteering after controlling for social participation and health behaviors was in contrast to what was hypothesized by this study.

Several factors should be considered in interpreting these results. First, it is difficult to extrapolate the results from this study and apply them to other states in the United States because of the original study focused on Texas. However, the random sample does appear to aid in the generalizability of the study. Second, perceived mental and physical health status was self-reported in the original study, so it is possible there is a reporting bias in how the respondents rated their own health. Individuals may be hesitant or cautious to share their health status on the phone with someone unknown. This may be especially true for mental health issues because they carry stigma (Van de Mortel 2008). Third, our data was cross-sectional and therefore, precluded any inferences regarding temporality between volunteering and health. It is equally possible that health determines volunteering or that volunteering determines health. It is likely that poor health constrains volunteering and certainly poor health is commonly given as a reason for not volunteering (Musick and Wilson 2003). Studies employing longitudinal designs are needed to investigate more conclusively the causal associations between volunteering and health status.

As mentioned above establishing a temporal relationship between mental and physical well-being and volunteering is difficult to do so, due to the cross-sectional design. For example, it is possible that if people are unwell they may be unable to volunteer and thus, it seems like good health is associated with volunteering, when those who have poor health are excluded based on ability to volunteer. If that were to be the case, implementing volunteer programs, as a public health intervention would be ineffective, because they would not be able to reach those who are meant to be reached. Moreover, other variables need to be examined that could be confounding the relationship between mental and physical well-being and volunteering. For example, feelings of isolation explored in this study were significantly associated with both mental and physical well-being. The possibility exists, such that the benefits of volunteering are more about connecting with community and engaging socially opposed to the actual act of

volunteering. Extant literature suggests the majority of explanations for the link between volunteering and health have been framed in terms of the individual benefits to the volunteer. These psychosocial benefits include the improvement of health related behaviors such as reduced smoking, maintaining social networks, and increased exercise (Musick and Wilson 2003). Nearly all explanations in the current literature point to the importance of socialization and physical and mental health. While this study attempted to control for social participation, it is important to note that this study did not account for all the complex components of social participation.

Despite this, this study consistently found across all models that volunteering is associated with good physical health, as hypothesized by this study. While volunteering was not significantly associated with good mental health after controlling for other variables, the association between volunteering and perceived mental health remained in the expected direction postulated by this study.

Based on the findings of this study and extant literature, policymakers may consider utilization of volunteer programs as a low-cost way to maintain physical health and well-being. However, before implementation, further research in the form of longitudinal designs and/or randomized control trials, are needed to develop the causal association between volunteering and physical health status. While this research concludes that volunteering is associated with good self-reported physical health, it is still not clear if better health is a result of volunteering. Furthermore, before considering implementing such programs it would be necessary to further investigate why volunteering that improves health, whether it be socialization, increased physical activity, or another explanation.

REFERENCES

- Anderson, J. C., and L. F. Moore. 1978. "The Motivation to Volunteer." *Journal of Voluntary Action Research* 7(3):120-129.
- Bussell, H., and D. Forbes. 2002. "Understanding the Volunteer market: The What, Where, Who and Why of Volunteering." *International Journal of Nonprofit and Voluntary Sector Marketing* 7(3):244-257.
- Casiday, R., E. Kinsman, C. Fisher and C. Bamba. 2008. "Volunteering and Health; What Impact Does it Really Have." *London: Volunteering England* 9(3):1-13.
- Keyes, C. L. and M. B. Waterman. 2003. "Dimensions of Well-Being and Mental Health in Adulthood." *International Journal of Nonprofit and Voluntary Sector Marketing* 7(8): 267-299.
- McGee, D. L., Y. Liao, G. Cao and R. S. Cooper. 1999. "Self-Reported Health Status and Mortality in a Multiethnic US Cohort." *American Journal of Epidemiology* 149(1):41-46.
- Mellor, D., Y. Hayashi, L. Firth, M. Stokes, S. Chambers and R. Cummins. 2008. "Volunteering and Well-Being: Do Self-Esteem, Optimism, and Perceived Control Mediate the Relationship?" *Journal of Social Service Research* 34(4):61-70.
- Musick, M. A. and J. Wilson. 2003. "Volunteering and Depression: The Role of Psychological and Social Resources in Different Age Groups." *Social Science & Medicine* 56(2):259-269.
- Musick, Marc A. 2004. *Survey of Texas Adults* [Computer File]. Austin, TX: The University of Texas at Austin.
- Piliavin, J. A. and E. Siegl. 2007. "Health Benefits of Volunteering in the Wisconsin Longitudinal Study." *Journal of Health and Social Behavior* 48(4):450-464.
- Wilson, J. 2000. "Volunteering." *Annual Review of Sociology* 26(1):215-240.
- Van de Mortel, T. F. 2008. "Faking it: Social Desirability Response Bias in Self-Report Research." *Australian Journal of Advanced Nursing* 25(4):40.