



# Social participation and self-rated psychological health: A longitudinal study on BHPS



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## ABSTRACT

Although social capital has been hypothesized to have positive influence on psychological health, a relationship between social capital dimensions and psychological wellbeing has rarely been found. This longitudinal study investigates the relationship between social participation in associations and self-rated psychological health. The paper uses five waves of the British Household Panel Survey (BHPS) from 1991 to 1995 (unbalanced panel N=45,761). Ordered logit fixed effect methods were used to study the longitudinal link between structural social capital (being a member, active, and both a member and active in associations) and self-rated psychological health assessed by single items of the General Health Questionnaire (GHQ-12) controlling for age, marital status, household size, number of children, education, income, economic status, number of visits to the GP and health problems. The paper shows that being only a member and only active in associations has no statistical relationship with almost all the items of the GHQ-12. Instead, being both a member and active in associations is linked to all “positive” items of self-rated psychological health and to two main “negative” items of psychological wellbeing. These findings highlight the protective role of being both a member and active in associations against poor psychological health outcomes.

## 1. Introduction

The public health literature has witnessed a recent increase in the number of empirical papers, which test the association between social interaction, social participation in various kinds of associations and social trust (i.e. social capital), and psychological health.

Defined by Putnam et al. (1993) as features of social organization such as networks, norms and social trust that facilitate coordination and cooperation for mutual benefit, the concept of social capital has a structural and cognitive dimension (Uphoff, 1999). Structural social capital deals with individuals' behaviours and mainly takes the form of networks and associations that can be observed and measured through surveys. Cognitive social capital derives from individuals' perceptions, resulting in norms, values and beliefs that contribute to cooperation (Fiorillo & Sabatini, 2015). Psychological health is “a state of wellbeing in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (Ding, Berry, & O'Brien, 2015). The General Health Questionnaire (GHQ) (Craig, 2007) provides the most common assessment of psychological well-

being. The GHQ makes available a self-reported measure of mental health and consists of questions regarding the respondent's emotional and psychological health over the past few weeks that precede the interview. It captures current mental health problems in an individual's life (Lordan & Pakrashi, 2014). Available in several versions using 60, 30, 28 or 12 items, the 12-item version (GHQ-12) is the most broadly used screening instrument for common mental disorders, in addition to being a more general measure of psychological wellbeing (del Pilar Sánchez-López & Dresch, 2008).

In this paper we focus on the individual structural dimension of social capital and refer to the definitions of Bourdieu (1980) and Coleman (1988), according to whom social capital is an individual resource available through social participation/social networks. Structural social capital has been hypothesized to have a positive effect on psychological health for several reasons. (i) *Social influence*, regarding the way in which members of social organizations obtain guidance about health-relevant behaviour (physical activity, alcohol consumption or cigarette smoking), which may have a positive influence on mental health (Kawachi & Berkman, 2001); (ii) *social integration*, according to which integration in social organizations may

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have a direct positive effect on psychological states through a sense of purpose, belonging, security and recognition of self-worth and self-esteem (Brunner & Marmot, 1999; Cohen, Underwood, & Gottlieb, 2000); (iii) *social location*, which enhances the likelihood of accessing various forms of support (access to appropriate health information and/or informal health care which, in turn, protect against psychological distress) (Lin, Ye, & Ensel, 1999; Phongsavan, Chey, Bauman, Brooks, & Silove, 2006); (iv) *buffering effect*, according to which social interactions in organizations provide moral and affective support which may reduce either the negative emotional reaction to a stressful event or dampen the psychological responses to stress (Kawachi & Berkman, 2001; Harpham, Grant, & Thomas, 2002).

A number of empirical papers have sought to gauge the link between individual social capital and psychological health. McCulloch (2001) uses the BHPS (1998/1999) to ascertain whether neighbourhood problems, as a measure of social capital, are correlated to the 12-item GHQ as a measure of morbidity. The results show that people in the lowest categories of social capital are more likely to report a risk of psychiatric morbidity than people in the highest. Lindström (2004) studies the association between social participation and trust and self-reported psychological health in Southern Sweden (year 2000): higher trust and social participation are positively associated with self-reported psychological health. Ahnquist, Wamala, and Lindstrom (2012) also analyse, for Sweden, social and economic determinants of psychological distress, employing the GHQ-12 (year 2009). They find: i) a negative association between trust and psychological distress for men and women; ii) a negative correlation between social participation and psychological distress for men. In examining whether social support, social participation and networks, trust and reciprocity are related to psychological well-being (GHQ-12) for Finns, Nieminen et al. (2010) found an association between trust and reciprocity and psychological wellbeing, and between social participation and networks and psychological wellbeing, albeit much weaker. Finally, Bassett and Moore (2013) investigate the association among the psychological and the network dimensions of social capital and depressive symptoms obtained from the 10-item Depression Scale (CES – D Scale): individuals with high levels of trust were less likely to have depressive symptoms.

Elsewhere longitudinal data are used to study the effect of structural and cognitive dimension of social capital on self-rated psychological wellbeing. Giordano and Lindström (2011) investigate the link between interpersonal trust, active social participation, and frequency of talking with neighbours and changes in self-rated psychological health obtained by means of the GHQ-12 with the BHPS (2000/2007). Trust is the only social capital variable that maintains a positive and highly significant effect on self-rated psychological health. Lindström and Giordano (2016) employ data from BHPS pre- and immediately post- the 2008 crisis to compare the buffering effects of generalised trust and social participation against worse psychological wellbeing (GHQ-12) during and after the 2008 financial crisis. The authors found that individuals with low levels of trust had an increased risk of worse psychological wellbeing in 2008 compared to 2007, while social participation was not associated with psychological health.

Moving on from the studies surveyed above, we aimed to test the longitudinal relationship between social participation in associations and self-rated psychological health in the UK. In particular, our contribution to the literature lies in our analysis whether being a member or active, or both a member and active in associations is effectively beneficial for perceived psychological health using a single item of GHQ-12 and ordered fixed effect model specifications between 1991 and 1995.

Our original contribution to the literature is threefold. First, the study uses the 12-item GHQ-12 as separate items instead of considering them as a summary score. To our knowledge, it is the first time that this has been attempted within the field of social capital. Employing as

dependent variables the single items of GHQ-12 allows a clear evaluation of the specific relationship between social participation measures and each component of psychological health, preventing the loss of information that an aggregation method involves. Second, we consider individuals who are both members and active in associations; the combination of the two states can be considered a further measure of social capital. This hitherto unexamined grouping highlights the importance, for the individual’s psychological well-being, of both social integration related to being a member of associations and social support linked to the intense person-to-person interactions that such associations supply. Finally, we employ fixed-effect model specifications with a dependent categorical variable as implemented by Baetschmann, Staub, and Winkelmann (2015). Applying a fixed effects estimator in a short panel is a promising solution to accommodate the unobserved heterogeneity as this estimator, imposing that the heterogeneity is time-invariant, permits unbiased coefficients to be estimated.

## 2. Methods

### 2.1. Data

The BHPS is a longitudinal survey of randomly selected private households in Great Britain. Individuals within selected households are interviewed annually with a view to identifying social and economic changes within the British population. The BHPS data contain information on various domains of the respondents’ lives, ranging from income to

jobs, household consumption, education, health, and social and political values. We use waves 1–5 (years 1991/1995) because our variables of interest concerning social participation in associations are continuously present in the waves in question. Table 1 shows the participation rates and the individuals observed across the waves. Bar charts of social participation and psychological health variables across the waves are provided in Appendix A.

### 2.2. Dependent variables

The dependent variables are self-rated psychological health from the GHQ-12. The twelve items are all ordinal variables varying from 1 to 4. These variables are:

- 1) *ghqa: concentration. Have you recently been able to concentrate on whatever you are doing?*
- 2) *ghqb: loss of sleep. Have you recently lost much sleep over worry?*
- 3) *ghqc: playing a useful role. Have you recently felt that you were playing a useful part in things?*
- 4) *ghqd: capable of making decisions. Have you recently felt capable of making decisions about things?*
- 5) *ghqe: constantly under strain. Have you recently felt constantly under strain?*
- 6) *ghqf: problem overcoming difficulties. Have you recently felt you could not overcome your difficulties?*
- 7) *ghqg: enjoy day-to-day activities. Have you recently been able to enjoy your normal day-to-day activities?*

**Table 1**  
Participation rates and individuals observed across waves.

	1991	1992	1993	1994	1995
Total # obs	10,264	9845	9600	9481	9249
Response #	9822	9352	8904	8965	8718
Non-response	4.31%	4.99%	7.25%	5.44%	5.74%
Unbalanced non-response	9822	19,174	28,078	37,043	45,761

Notes: BHPS, UK; individuals aged 16 and over.

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