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Research Article

Volunteering, Identities and Wellbeing in Contexts of Health Inequalities

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The causes of health inequalities are complex, involving material, psychosocial dimensions and power relations. Denigrating neoliberal discourses of individual responsibility shape and underpin policies which exacerbate poverty and compound its psychosocial impacts on people's lives. Community asset-based approaches, which mobilise voluntary action, have been proposed as a means of addressing health inequalities, and a substantial body of research suggests that participating in volunteering can bring benefits to psychological wellbeing. This study explores the experiences of volunteers with lived experience of poverty and other intersecting disadvantages, using an ethnographic psychosocial approach, adapted from the free association narrative interview method. It draws on participant observation and interviews with 11 volunteers and four managers within two settings within disadvantaged communities in a city in the north of England. The analysis of this data considers these experiences of volunteering in relation to theorised social and psychological drivers of health inequalities, as well as concepts commonly used in the literature on volunteering and health. Using a psychosocial lens reveals the significance of identity validation as a pathway through which volunteers within disadvantaged communities may resist denigrating narratives and make claims to 'respectability', which facilitate experiences of acceptance and belonging. While volunteering may ameliorate the impacts of inequalities on individual and community health and wellbeing, the individual, organisational and wider social contexts within which volunteering takes place are integral to these effects.

1. Introduction

The enduring health inequalities in the UK and globally, exposed and exacerbated by the COVID-19 pandemic, represent a significant social and economic challenge and the efforts of public health programmes to address that this have failed to make any significant impact [1–3]. In England, average 'healthy life expectancy' differs by around 18 years between the highest and lowest ranked local authority areas [4]. Health inequalities are complex in their aetiology and intersectional in their effects and have been defined as follows:

> '... the systematic, avoidable and unfair differences in health outcomes that can be observed between populations, between social groups within the same population or as a gradient across a population ranked by social position.' ([5]. p28).

Psychological wellbeing, or positive mental health, is not only important in itself but is also identified as a mediating factor in physical health inequalities [6, 7].

Interest in the potential of 'asset-based approaches' [8, 9] as a response to health inequalities has been influential in public health policy and practice (e.g., [10]). Asset-based approaches to health are founded on understandings of 'empowerment' of individuals and communities as well as the value of community and voluntary activities as social resources that can improve the health and wellbeing of people facing multiple disadvantages [8]. However, critics have argued that they play into 'dependency' narratives, which are used to justify government austerity policies and welfare cuts, while handing over responsibility for change to the people and communities with least power to bring it about [11]. Others have argued that faith, community and voluntary organisations may represent 'liminal spaces' in which people from differing social strata interact, cultivating new understandings and critiques to challenge austerity policies and the denigrating narratives used to justify them [12].

We outline below the theoretical framework through which we will consider volunteering experiences in the contexts of asset-based approaches to health and wellbeing, drawing on sociological and psychosocial analyses of health and wellbeing inequalities, as well as the literature on volunteering and psychological wellbeing.

2. Theoretical Framework

2.1. Power and Health Inequalities. The causes of health inequalities are complex and contested, with living and working conditions, behavioural patterns and stress commonly identified as causal factors [13, 14]. Sociological analyses identify complex power dynamics in modern societies as mechanisms through which health inequalities are manifested [15–17]. For example, groups experiencing economic hardship tend to have less control or influence over their own living and working conditions, while consequent low status and stigma impede access to opportunities to escape poverty. Intersecting inequalities manifest in our lived experiences, shaped by life histories, through accumulation of disadvantages and adverse experiences through the life course. In addition to the trauma and chronic stress often associated with adversity, people experiencing poverty are subjected to dominant discourses which stereotype and denigrate them and their communities on the basis of class, poverty and racialised identities, further undermining their agency [7, 18–21].

However, predominantly positivist research methods in public health tend to reduce or exclude this complexity by seeking to isolate specific psychological factors and/or interventions associated with health outcomes. Similarly, in health promotion practice, individualistic conceptions of our world are often implicitly accepted as 'truths', leading to a preponderance of 'lifestyle interventions' focussed on changing individual behaviours. This 'lifestyle drift' [22] implicitly or explicitly tends to medicalise the 'symptoms' that emerge from social inequalities [19] and endorse a neoliberal narrative of individual responsibility, while failing to address the underlying causes of health inequalities [15, 17, 23].

2.2. A Psychosocial, Complexity-Oriented, Understanding of Health Inequalities. Wilkinson and Pickett's [24] work highlights the significance of status inequalities as a psychosocial determinant of health and wider societal challenges. However, it is implausible that the drivers of health inequalities can be reduced to a simple correlation between economic inequalities and health inequalities [13]. Social worlds may be best understood as complex adaptive systems, in which multiple actors dynamically interact to maintain relatively stable conditions or to bring change in emergent and contingent 'outcomes', including experiences of health and wellbeing [25, 26]. In this perspective, it is important to recognise that, as reflexive individuals, we hold multiple (intersecting) roles or positions, and our agency or power within the system is largely determined by our relative position in such structures. While manifesting in relational processes, power may also be understood as a potential that may be held, by virtue of life histories and relative social position(s) and the associated resources available to us [27].

Bourdieu [28] has described a 'silent and insidious' process ([28]:51) by which a sense of status becomes ingrained in our *habitus*, with real consequences, not only in how we relate to others but also in access to resources [19, 20, 29]. Friedli (2009:9) describes how socio-economic position, '... *structures individual and collective experiences of dominance, hierarchy, isolation, support and inclusion*', thereby influencing our sense of identity and social status. Experiences of shame, humiliation and social isolation have been described as key aspects of the social suffering associated with poverty [30] with implications for health inequalities [31].

A psychosocial understanding of *habitus*, which explores psychic and emotional responses in relation to structural dimensions, may further elucidate how personal histories affect present experiences, relationships, positions and interactions with our social worlds [32]. Frost and Hoggett [33] extend Bourdieu's [34] concept of *social suffering* through a psychosocial understanding to account for how our experiences of interactions are emotionally internalised and embodied, shaping our deeply 'felt' sense of who we are and our place in the world. This insight may be extended through sociological understandings of shame and its interrelationship with neoliberal discourses, which shape subjective understandings of acceptable positions and behaviours [20, 35–37].

These power-infused relationships and interactions shape our understandings of ourselves, the roles and identities that we enact in relation to the people and institutions around us [38–40]. The manifold identities that we inhabit are shaped through interaction of our agency and the structured contexts in which we are immersed, which variously enable or constrain such agency. The power in such relationships and interactions tends to operate subliminally through the unspoken expectations, the rules or *doxa* [41], which guide how we relate to one another, based on our readings of each other's social position, including intersecting identities of class, gender, race, sexual orientation and (dis)ability [15, 21, 33, 42, 43]. A psychosocial understanding considers our identities as always coconstructed through our interactions with the social world around us, while also grounded in an individual physical body with its unique history, orientations and motivations. This assumes a dialectical relationship between our 'inner' worlds, shaped by our individual relational life histories and the 'outer' worlds of relationships and interactions in the present [44–46].

By seeking to understand individual experiences in the social contexts of people's lives, including family, community, organisational relationships and cultures, we may gain insight into structural processes and how these emerge and interact in people's lived experiences.

2.3. Understandings of Wellbeing. Psychological wellbeing remains an ill-defined term, [47, 48], which tends to be described as a collection of concepts, associated with 'optimal experience and functioning' ([49]:141). These generally include experiences of self-determination and efficacy, as well as positive relationships and emotional states. Ryan and Deci [49] identify two distinct, interacting, aspects: hedonic wellbeing, representing transient positive emotions, including joy, pride and interest; and eudaimonic wellbeing, which relates to finding purpose and meaning in life. Such experiences may also be broadly understood as the inverse of those of powerlessness, social isolation and alienation, and blame, shame, and anomie, which have been implicated in analyses of health inequalities (e.g., [7, 37, 50]).

The conceptualisation of wellbeing in individual terms, as an attribute that can be acquired or internalised qualities of individuals, underpins discourses of individual responsibility and blame [11, 48]. Conceptions of 'health' and 'wellbeing' have been commodified in modern consumer societies, often involving practices that represent signs of status and distinction, while denigrating those without access to them [51, 52]. Atkinson [48] argues instead for a situated and relational understanding of wellbeing, as an embodied social phenomenon, emergent and dependent on resources available within particular social and spatial contexts, including experiences of recognition and misrecognition, as well as shared spaces, values and histories. Drawing on this, we would propose an understanding of wellbeing as comprising subjective experiences of meaning, agency, positive relationships and emotional states, which are emergent from dynamic and complex interactions of personal histories and social contexts, including the material and cultural resources available within such contexts.

2.4. Volunteering and Wellbeing. While definitions of volunteering may be contested, we use the term to refer to

> *... an activity undertaken by an individual that is uncoerced, unpaid (or minimal compensation to offset costs), structured by an organization, and directed toward a community concern. ([53]: 461)*

Regular participation in structured voluntary activity has been found to be associated with benefits to health and wellbeing (e.g., [54, 55]). Volunteering tends to be more prevalent in relatively affluent communities [56], but some studies suggest that those volunteers experiencing adversity may benefit more from volunteering [57].

Ryan and Deci's [58] self-determination theory has been used in many studies of volunteering and wellbeing, highlighting the benefits of volunteering for experiences of autonomy, competence and relatedness, and many studies point to the significance of intrinsic, integrated or altruistic motivation in predicting positive wellbeing among volunteers [55]. Voluntary roles may provide a framework for ways of behaving and a sense of 'mattering' to others [59], enabling volunteers to construct a socially valued identity [60–62]. Faith-based volunteering may also provide a context in which individuals enact and reinforce one's community and faith identities, promoting sustained engagement in volunteering and enhanced wellbeing [63, 64].

Structural power differentials are prominent in analyses of health inequalities [15, 17], and feelings of shame may be experienced by those seeking help from voluntary organisations [65, 66]. A sense of the individual agency is implicit in concepts of autonomy, competence and 'mattering', while the 'social cure' literature on volunteer wellbeing highlights the value of the collective agency [64, 67]. However, these understandings remain framed in terms of benefits to individual psychological wellbeing. Southby et al. [57] identify the significance of structural inequalities in access to volunteering, but studies have not, as far as we are aware, explored how power relations manifest in the experiences of volunteers.

The evidence linking volunteering and wellbeing tends to be based on large-scale population studies, which measure volunteering as a single variable. We would contend that experiences of volunteering are diverse, dynamically shaped by the social, practical and organisational contexts as well as personal circumstances and histories. In-depth case studies therefore provide a more appropriate way of exploring the social and psychological processes involved in particular contexts.

2.5. Purpose of This Study. The purpose of this research was to further explore how experiences of volunteering may interact with and mitigate the relational processes which are theorised as drivers of health inequalities. If our inner sense of ourselves and the identities that we inhabit are formed through our conscious or unconscious internalisation of our social interactions and relationships, then a focus on the identities that we adopt/enact in may provide a window into how structural inequalities manifest in day-to-day life.

3. Methodology and Methods

3.1. Overview. We set out to consider in detail how social processes may manifest in people's lived experiences and relationships within specific settings, adopting an ethnographic psychosocial approach, drawing on Hollway and Jefferson's [45] free association narrative interview method, combined with ethnographic participant observation [68, 69]. This enabled us to explore in some depth (but incompletely) how the complex histories and relationships of the volunteers interact with relations in these settings, considering how processes theorised in the literature can affect the experiences of wellbeing of volunteers living in disadvantaged circumstances.

3.2. Rationale. As discussed above, if we are to understand the dynamic emotional and power relations within a setting, we must go beyond the face value of narratives shared in interviews [45]. None of us are fully self-aware, and we may hold back aspects of ourselves and our experiences to avoid potential negative judgements, while some aspects of ourselves remain unknown to us [70]. How we understand and represent ourselves is shaped by our personal histories, as well as the available language and narratives in our cultural milieu [71].

By exploring not only present circumstances but also how these relate to previous lived experiences, in subjective and emotional terms, we may gain a greater understanding of how such processes emerge and converge in the ways people understand themselves and their positions in the social order. Psychosocial methods draw on concepts from psychoanalysis, such as the 'defended subject', which explains how we seek to maintain a positive self-concept, defending against internal thoughts and feelings that make us uncomfortable or anxious, as well as real or imagined judgements of others [44, 45]. An ethnographic psychosocial approach enables exploration of relational lived experiences, through observation of the narratives, practices and power dynamics within a setting, recognising that these reflect and reproduce relations in wider society. This may provide valuable insight into how volunteering interacts with relational processes that sustain health inequalities.

The narratives on which this study is founded are recognised as intersubjectively constructed within the social and relational contexts in which they were captured. The lead researcher's positionality in relation to the volunteers participating and their feelings towards him as an older, white British, educated man undoubtably shaped the narratives captured as well as our interpretation of them. The power relations involved are dynamic, complex and shaped by context [72]. In undertaking the fieldwork and interpreting the data, we sought to reflexively consider the power dynamics and the researcher's part in shaping the narratives and practices, as well as drawing on his own experiences and feelings, contemporaneous and past, as a source of data [45]. While informed consent was given by all interviewees, the ethical issues were not fully predictable, and therefore, our approach was responsive and reflexive, acting with care and compassion for the experiences and welfare of the participants [73]. Ethical approval was granted by the Manchester Metropolitan University Faculty of Health, Psychology and Social Care Ethics Committee in April 2017. Further details of the analysis and interpretation process are provided in Supporting Information A.

3.3. Fieldwork. To reflect the subjective nature of this research, the first person is used by the first author in the following description of the fieldwork and analysis processes.

I volunteered with two organisations in different disadvantaged neighbourhoods of a large city in the north of England. 'The Centre', a faith-based organisation, provides free hot food, advice and advocacy, education and job-seeking support, creative activities and low-cost second-hand clothes. 'The Pantry' is a community organisation supported by a small social enterprise, providing members with access to low-cost groceries, second-hand clothes, free hot drinks and light refreshments, as well as advice and support if needed.

I volunteered for 11 weekly sessions and interviewed six volunteers at the centre and volunteered 13 times, interviewing five volunteers at the pantry (plus one online follow-up). All the volunteers interviewed lived within the local communities served and had lived experiences of socio-economic and/or other intersectional disadvantages. Most interviews were conducted in a private space within the volunteering setting, with one in a nearby café and one on university premises. Drawing on Hollway and Jefferson [45], my interviews were designed to prompt free-flowing storytelling by the participants, beginning with an invitation to tell me about their life and how they came to be volunteering here. The topic guide (Supporting Information B) was used flexibly in this context to ensure a degree of consistency in the scope of the interview. Interviews were recorded and transcribed. My participant observation notes were written immediately after each session, including both description of the events and reflexive observations on my experience of the people, interactions and emotional aspects.

Interviews with the managers (two from each setting) and the second interview with one volunteer[1] were conducted online, 2-3 years after the initial research, during the COVID-19 pandemic. In the second volunteer interview, I shared my interpretation of her earlier narrative and further explored her experiences and feelings about volunteering. Interviews with the managers explored their responses to my emerging findings to deepen our understanding of the perspectives and values of the organisations involved. Table 1 provides an outline of their demographic characteristics.

3.4. Interpretive Analysis. Our interpretation of the data captured used an abductive approach to analysis [74, 75], in which existing theory is evaluated in relation to empirical observations, while recognising the importance of understanding the person as a unique and complex embodied social self, interacting within complex social and economic systems. This means considering each volunteer as a 'case in context' [76], considering in depth their narratives about their experiences of volunteering, in relation to the wider context of their life and my own observations and reflections captured during participant observation. For each volunteer interviewed, I wrote a 'case analysis' which sought to capture a sense of the whole narrative and its context [45, 77, 78], drawing on my interview and reflexive observational data, before undertaking thematic analysis within and then across cases in an iterative process [79] (see Supporting Information). Case analysis documents were organised under common headings, covering personal histories and relationships within and outside the voluntary setting, from which conceptual themes were identified in relation to three key areas of interest, drawn from the existing literature: social connection; agency and autonomy; and values,

Table 1: Demographic outlines of participants.

Pseudonym	Description
The centre	
Volunteers interviewed	
Mary	Black African British woman in her early 70s
Carol	Black African woman in her early 40s
Janet	Black Caribbean woman in her early 40s
Barry	White British man in his mid-50s
Michelle	White British woman in her late 30s
Sharon	White British woman in her early 50s
Managers interviewed	
Dawn	South Asian woman in her early 40s (centre manager)
Mark	White British man in his early 50s (senior manager of the organisation)
The pantry	
Volunteers interviewed	
Lisa	White British woman in her mid-30s
Brian	White British man in his early 70s
Kirsty	White British woman in her early 30s
Sandra	Black British woman in her late 50s
Linda	White British woman in her mid-50s
Managers interviewed	
Jonathan	White British man in his mid-40s (CEO of the social enterprise)
Lauren	White British woman in her late 30s (community development role)

purpose and meaning. To facilitate cross-case analysis, I also produced shorter summary documents and visual overviews. In interpreting this data, volunteers' constructions of their own identities emerged strongly, leading me to move beyond the structure initially employed in my case analyses.

Similar thematic analysis was applied to the managers' interviews, with a focus on the organisational narratives and latent meanings, including power dynamics, and this was combined with participant observation data to produce a structured narrative analysis of each setting.

4. Findings and Discussion

The ways in which we construct our identities are always in relation to our immediate and wider social context, present and past, including power relations, and infused with emotion [20, 32, 45]. Three broad interacting themes emerged as powerful and related aspects of volunteers' narratives: experiences of loss, loneliness and shame; finding belonging in volunteering; and the role of volunteering in validating them as an individual worthy of respect and acceptance. Their experiences are situated within the proximal social contexts and practices of the organisations and communities in which they volunteer and wider contexts of inequalities, including the dimensions of class, race, (dis)abilities and gendered identities.

4.1. Loss, Shame and Loneliness

> *Oh yeah, it's a challenge. I do love it though, I wouldn't want to be on my own. I'd rather have the life and be in pain and, erm, that I've got now than have no family and no y'know. Some people are just so lonely all the time aren't they and they just need – yeah, I wouldn't cope if that was me, yeah. . .* (Michelle, Centre volunteer).

> *I stopped for 15, 16 months, I wouldn't go outside the door when I lost my wife [. . .]. Life just stopped for me there and then, nothing moved. [. . .] I could have got kicked out of my house I hadn't paid any rent, I hadn't paid a bill, I didn't know how.* (Brian, Pantry volunteer)

Stories of loss and associated feelings of exclusion and loneliness emerged as a striking theme in the narratives of the volunteers in both settings. Most of the volunteers told stories of adversities they had experienced, often involving loss of social connections and support. These included traumatic bereavements, loss of employment, abusive relationships, migration, caring responsibilities and racism. Some of the volunteers had lost significant roles, as a partner or an employee, not only impacting their social networks but also representing loss of an affirmational role identity [59, 80]. While experiences of adversity may affect anyone, such losses are more prevalent in disadvantaged communities, and the impacts of such losses are exacerbated for people with less social, economic and cultural capital [1, 81].

Such experiences were often associated with a sense of 'otherness', exacerbated in some cases by the associated loss of social relationships, leading to feelings of loneliness. These emerged in different ways in the narratives of most of the volunteers interviewed, usually displaying stoical responses to the adversities they had lived through, effectively defending against being seen as dependent or as objects of pity, which would also represent a kind of humiliation. For some of the volunteers, racialised identities added another dimension of exclusion, and others experienced stigma associated with an offending history, mental illness and/or substance misuse. For Brian, whose narratives expressed a traditional masculine identity as strong and independent, grief may have been felt as shameful, as he was unable to contain his emotions and therefore withdrew from the world, remaining at home alone.

Undercurrents of shame were identified in several volunteers' narratives of loss, sometimes linked to their own regrets or the stigmatised identities that they, or someone they cared for, occupied. Shame has been described as a coconstructed emotion involving self-judgement and perceptions of how one may be judged by others, shaped by the symbolic gestures of those who claim positions of moral or social superiority [36]. While rarely spoken of, it may remain unconscious, yet emerge in allusions, tone of voice and body language, or in projection onto others, thereby contributing to feelings of alienation [20, 30, 33, 82]. Furthermore, to find oneself in need of help is, in itself, often felt as failure and therefore a source of shame in the context of dominant discourses in which success and independence are valorised. To be 'needy' is commonly understood as a mark of personal failure, reinforced in the denigrating constructions of people living in poverty and claiming welfare benefits [36, 42, 82, 83].

4.2. Places of Belonging

> *I mean not everybody would embrace you and accept you as you are, but I find so much love there, I just feel I belong there, so* that is *what made me stay there.* (Mary, Centre volunteer).
>
> *It has opened my world. I have got more of, like a friendship connection now instead of just, because I never had friends, I was just at home being a good mum and wife.* (Kirsty, pantry volunteer)

The volunteer roles not only provided a place for social interaction, but also facilitated connection through a sense of shared purpose, leading in many cases to a sense of belonging, being part of a collective [59, 64, 80]. May ([84]: 368) defines belonging as '. . . a sense of ease with oneself and one's surroundings' and involving 'a process of creating a sense of identification with one's social, relational and material surroundings.' The Pantry volunteers' sense of belonging was framed in terms of the community, while the Centre was often compared to a family. The voluntary role in an organisation may be understood as symbolising acceptance and recognition as someone who has a valuable contribution to make, and in our current social world, this is key to becoming accepted.

4.3. Identity Validation. The processes of identity validation described here interact in a mutually reinforcing relationship with the sense of belonging which volunteers found in these organisations. While volunteers' experiences of adversity and loneliness were detrimental in differing ways, involving painful emotions, they also manifested in a loss of social status associated with the roles they held, as worker, a partner, or a parent. These roles are important to our sense of self, conferring a structure of expectations, interactions and activities through which we enact those identities. If '*Identities are claimed and sustained in reciprocal role relationships*' ([80]: 175), then the impact of the loss of such relationships can extend beyond the immediate broken bonds to undermine our experiences of recognition more widely, leading to feelings of otherness, loneliness and their disempowering impacts.

While experiences of adversity described in the narratives of many volunteers increased their need to find acceptance and belonging, the volunteer roles adopted provided not only new social connections but also recognition and affirmation of their status as a respectable member of their community. It also provided a means to express and enact their values, identifying as somebody motivated by a moral purpose, based on values of caring, work ethic, integrity, fairness, reciprocity and solidarity, implying a sense of congruence [49]. The declared purpose of the Centre was God's work, described in terms of responding to Jesus' call to serve those who were 'downtrodden' or 'outcast'; the expressed aim was to enable people to change their lives by changing themselves, with support of the Centre, representing a kind of redemption. For those volunteers who shared this faith, this narrative added a further layer of validation.

> *. . . it's sort of like your background, you know, wherever you are whatever you doing, if you see anything that is not, that is not right, immediately you y'know, you want to respond, because something tells you this is wrong, you should do something about it (Mary, Centre volunteer)*

The Pantry's express purpose was one of community support, and one volunteer, Linda, had been involved in a range of community activity over previous years. She expressed values of solidarity and strongly antiracist views, aligned with her commitment to equality and reciprocity:

> *. . . it's like I don't think anyone's. . . say either above or below me I don't agree I don't care whether someone has got money or not it dun't matter to me.* (Linda, Pantry volunteer)

Several participants framed their volunteering as an expression of values of reciprocity, which mitigated the shame associated with seeking help, as in Sharon's case:

> *I always do my best to help who I can, and y'know, like people can for me – what you give, y'know what you get given in return and it's return the favour if you can, in other ways* (Sharon, Centre volunteer)

Accepting 'charity' is commonly experienced as a humiliating or shameful position [42, 85], and the language of reciprocity clearly provided a role in defending volunteers' sense of themselves. In some cases, volunteers expressed a sense of felt duty to repay help received or to atone for regretted past actions. Notions of reciprocity enabled volunteers to reframe their experiences and actions as precursors to their own decisions to give back, helping to exonerate them from the stigma of dependence or past transgressions. Taking such a position not only invited social approval within the volunteer group and wider community but also enabled positive self-evaluation and affirmation, providing a buffer against the negative stereotypes and judgements associated with poverty.

Sandra also framed helping others in terms of mutual benefit and solidarity and recognised that this can help to mitigate any feelings of shame or humiliation experienced by the clients:

> *I do it for me and then if I can make somebody else feel better or help somebody else that's a bonus isn't it? So [...] it works both ways doesn't it? And that's why I think when you are a volunteer to be aware of that. That it, it's a two, you're not [pause] you're not sort of helping people because you're better than. It's more of you're helping because you can, and they can get something from it. So, they don't feel like they owe you any [...] it is a mutual thing isn't it?* (Sandra, Pantry volunteer)

Claims to 'respectability' [86] were bolstered through narratives of caring and work ethics. All the volunteers interviewed claimed a strong work ethic underpinning their volunteering, and this enabled them to defend against prevalent denigrating narratives which frame people experiencing poverty and racism as morally deficient. Sharon told how she had always worked until a few months prior to our interview, when she and her partner separated, leaving her unable to continue her shift work due to loss of childcare and leading to benefit sanctions for 'voluntarily' leaving work, and associated debt:

> Cos *I've always worked and you never, you know watching pennies and I'm not saying I was all rich and things, but comfortable, ... wouldn't have to go the shop and sit there counting down like a list of – are you going to have enough when you get there, [...]. We never had holidays really and things like that over the years, but we lived ok...* (Sharon, Centre volunteer)

Janet, a former volunteer now employed at the Centre, betrayed a need to differentiate herself from the clients at the Centre, who she saw as lacking her work ethic and dysfunctional, describing her initial shock at meeting people living in long-term unemployment:

> *Cos all my life I've got like I do like 40 hours or more, [...] and I came in here, see people so relaxed and not working then, I'm thinking to myself, 'What's wrong with them, why they're not in work?'* (Janet, Centre volunteer)

Caring featured strongly in the narratives of the nine women volunteers, including not only narratives of good parenting but also implicit or explicit claims to a caring 'nature', expressed in their voluntary work:

> *I suppose [...] I have always been there to help people [laughing] when they have needed me, yeah. Whether it's taking on my siblings or looking after my husband and the kids, yeah just me and my nature. If everyone else is happy I'm happy.* (Kirsty, Pantry volunteer)

The caring identities expressed may be seen as an internalisation of a socially approved role for working class women in particular and enabling claims to respectability, as has been described by Skeggs [86]. While caring for others is commonly constructed as an innately feminine attribute, potentially constraining women's roles [86], the 'ethic of care' expressed in these narratives may also be interpreted as a counter to dominant discourses of individualism and self-interest [87].

As others have found [85, 88], participants tended to distance themselves from the stigmatising label of 'poor', often echoing negative stereotypes to differentiate themselves by reference to their histories of work, volunteering, caring and parental roles. Such responses, while adaptive in protecting their self-concept at an individual level, may also undermine the sense of solidarity among people experiencing similar impacts of government policies [85]. In this study, power dynamics are implicit in the volunteers' positioning of themselves as morally virtuous, hence deserving respect, and in resistance to the disempowering shame involved in poverty and positions of dependence on charitable support. Demonstrating qualities of reliability, trustworthiness and gratitude was also important in opening opportunities to take on responsibility as volunteers, holding positions of relative power compared to the clients. Privileged relationships with the managers and paid workers, as well as a level of relative status within the organisation and the communities served, represent enhanced social capital [89], though power remained predominantly in the hands of those managing the organisations.

Notions of 'fairness' have been effectively appropriated in the government and media rhetoric to exacerbate division, justify welfare austerity and divert attention from the greater inequalities and injustices [85, 90], and to some extent, similar judgements permeated the narratives of the volunteers, for whom 'fairness' often involved a moral judgement as to 'deservingness', echoing narratives of the undeserving poor [86]. However, in many respects, the values expressed by the volunteers controvert neoliberal discourses, effectively resisting the denigration of people living on welfare benefits and of racialised minority communities [42, 91]. The Christian narratives of the Centre's management rejected materialism and advocated non-judgemental love for those who are excluded from society, which were often reiterated by many of the volunteers. Some of the Pantry volunteers shared insightful critiques of the ways in which neoliberal policies had impacted on their communities, including loss of local employment, amenities and community pride and identity.

Volunteering in these settings not only directly supported the wellbeing of individuals through providing a source of protection against the harms caused by denigrating narratives around poverty but also created a space in which an alternative set of values were nurtured and expressed. In a wider national context dominated by neoliberal conceptions of inequalities as inevitable and desirable and the absence of any political challenge to this orthodoxy, places in which communities are enabled to act together in solidarity may hold significant importance [12]. The opportunity to express values of care, solidarity and reciprocity in words and actions cultivates a different worldview from those dominant narratives.

5. Conclusions

This ethnographic psychosocial exploration of volunteers' experiences has illuminated the ways in which social inequalities emerge in the lived experiences of people living in disadvantaged communities and points to plausible causal pathways through which participating in voluntary activity may represent a multifaceted route to redressing some of the psychological harms of inequalities and poverty.

Psychological wellbeing may be understood as inversely related to experiences of loneliness, powerlessness and the negative mental health impacts of such and most of the volunteers' shared narratives of adversity, including loss, often conveying a sense of powerlessness as well as isolation. These experiences may reinforce each other, especially as loneliness not only undermines mental health but also negatively affects how we relate to other people [92]. Volunteering enabled experiences of agency as well as affirmation of their identities as respectable; by enacting a socially approved moral identity, volunteers developed a more positive sense of self, and this facilitated both expectations and experiences of being accepted and respected by those around them.

The settings in which volunteering takes place play a key part in shaping the narratives and creating the conditions in which volunteers may experience a degree of agency and autonomy that facilitates processes of validation and acceptance. These settings represented shared spaces in which individuals could engage in practices that realise their values, facilitating alternative narratives that counter dominant discourses of individualism, in which poverty is attributed to individual failings [12, 91, 93]. The value of such organisations may extend beyond their support for people in need and the positive emotions associated with helping others, by enabling a deeper understanding of ourselves as moral actors.

Power is implicit in relations of connection and belonging, and being part of a collective implies some degree of potential power as well as the individual experiences of support and belonging. However, the process of bonding as a group may exclude some who cannot or will not conform with the consensus on appropriate and acceptable values and behaviours. Furthermore, the voluntary organisations' narratives of purpose in both places were shaped by the dominant framings of individual responsibility, focussing on personal development or redemption narratives, which may have undermined the potential to generate collective action to challenge the power relations that maintain inequalities (see forthcoming companion paper). Volunteers presented themselves as resilient and independent, conforming to dominant narratives of acceptable ways of participating in society [37, 42].

Directly asking people about their experiences of psychological wellbeing is likely to prompt answers which conform with socially endorsed ways of being, such as displaying independence and resilience. By developing a psychosocial understanding of the experiences and social contexts of volunteering in these settings, involving ethnographic immersion in the places, and deep interrogation of the data captured, this study provides new insight into how volunteering may benefit the psychological wellbeing in the contexts of structural inequalities. The data captured are not impartial but are the products of interactions between participants and me, in particular social, temporal and place contexts, shaped by our mutual, imperfect, perceptions of each other. Our interpretations, while reflexive, are inevitably and intentionally subjective. The intended collaborative element of the study was limited by the COVID-19 pandemic, which prevented the planned second interviews with all but one of the volunteer participants. The scope of this study, primarily focussed on socioeconomic disadvantage, led to only limited analysis of intersecting inequalities, including gender and race.

We would make no claims to 'objectivity' or universal generalisability of these findings, but this study provides further insight into experiences of adversity associated with health inequalities and the potential of volunteering to mitigate these. Our interpretation has drawn on the data produced, including reflexive observations, in a systematic and iterative process, as well as the theoretical base from which our research question has emerged [45, 74, 75]. While our interpretations do not represent a single 'truth', they are transparently justified in relation to the data and informed by the theory to draw reasonable conclusions [94]. They demonstrate the value of the in-depth psychosocially informed ethnographic approach in further exploration of the role of volunteering and other practices in mitigating the impacts of inequalities on health and wellbeing, while elucidating the need and the potential for more fundamental systemic change to address the underlying drivers of health inequalities.

Further research is needed to explore the experiences of volunteering in the contexts of intersectional health inequalities, including in different organisational settings, in order to explore the effects in terms of self-perceptions and social identities. The use of complexity-sensitive methodologies (e.g., [95, 96]) is recommended to further develop theoretical accounts of how the effects of volunteering observed in this study may interact with each other and with contexts to affect psychological well-being outcomes.

Data Availability Statement

The data collected in this study include significant details of individual participants' life histories and circumstances that preclude effective anonymisation, and therefore, these data cannot be made available for ethical reasons.

Disclosure

This work was undertaken as part of a PhD programme at Manchester Metropolitan University.

Conflicts of Interest

The authors declare no conflicts of interest.

Author Contributions

Simon J. Armour: conceptualisation (lead); data curation (lead); formal analysis (lead); investigation (lead); methodology (lead); project administration (lead); writing – original draft publication (lead); and writing – review and editing (equal). Gemma Yarwood: conceptualisation (supporting); methodology (supporting); supervision (lead); and writing – review and editing (equal). Hugh McLaughlin: conceptualisation (supporting); methodology (supporting); supervision (supporting); and writing – review and editing (supporting). Julia Robinson: conceptualisation (supporting); formal analysis (supporting); methodology (supporting); supervision (supporting); and writing – review and editing (supporting).

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Endnotes

[1] Follow-up interviews had been planned for all volunteers to reflect with them on my interpretations of their narratives and to further explore potentially significant or missing aspects of their experiences. However, the requirement to conduct these online due to COVID-19 restrictions, proved to be a barrier which prevented me from re-engaging with the volunteer participants, with one exception who was willing and able to engage in an online interview.

Supporting Information

Additional supporting information can be found online in the Supporting Information section.
Supporting Information 1. A: Edited extract from first author's thesis [97]. This describes analysis, interpretation and synthesis processes, including reflexive processes and rigour.

Supporting Information 2. B: Volunteer interviews topic guide. Summary of the introduction and prompts used in interviews with volunteers.

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