

## PSYCHOSOCIAL DIFFERENCES BETWEEN ELDERLY VOLUNTEERS AND NON-VOLUNTEERS

K. I. HUNTER

MARGARET W. LINN

*University of Miami School of Medicine  
Veterans Administration Hospital  
Miami, Florida*

### ABSTRACT

Volunteer workers over age sixty-five were compared to retired elderly who did not engage in any type of work activity. Volunteers were found to have significantly higher degree of life satisfaction, stronger will to live, and fewer symptoms of depression, anxiety, and somatization. Since no differences were found on most demographic or background variables, participation in volunteer work appears to be the salient factor in explaining psychosocial differences between volunteers and non-volunteers.

Increased longevity, in combination with mandatory retirement, more adequate pension plans, social security reform, and various social pressures have increased the percentage of elderly persons being added to the lists of our unemployed. Volunteerism remains one of the few viable alternatives to complete retirement for this group—an alternative which serves as a buffer for many of the losses one faces with a termination of the work role. It has frequently been pointed out that volunteerism offers the participant an avenue to social approval as well as an opportunity to increase his/her feeling of usefulness and self-respect [1-5]. Additional benefits of volunteer activity which these authors have pointed out have been that it satisfies communication needs, fills unused time, neutralizes the effects of loneliness, and creates a functional, status-bearing role. Ellison has gone as far as to imply that continued work may be a good form of preventive medicine, since illness results from the "giving up" or "lack of fit" associated



with moving from a comfortable work role to a retired role [6]. He feels that additional pressures to adopt the "sick role" of retirement come from the expectations of significant others, since the roles of "the retired" and "the sick" are adopted under similar circumstances. Apropos to Ellison's statements, Fillenbaum and Maddox reported that although there were no significant differences in health status between workers and a sample of non-workers they studied, those who were working were more likely to claim excellent health while those who did not work tended to say that their health was no better than good [7]. That the psyche has an affect on one's physical state is fairly well established in recent literature.

Other characteristics of volunteers, potential volunteers and paid employees have often been studied, but empirical results have been somewhat conflicting. For example, Rosenblatt found that older persons who are working are better adjusted to their life situation than those who are not working [3]. Monk and Cryns found that those showing an interest in volunteer activities were more apt to feel well and able, have more community interest and knowledge, and believe that they have something to offer [8]. On the other hand, Carp found that happiness, increased self-concept, greater numbers of social relations, and satisfaction with the way one's day was filled was significantly different only for the elderly group engaged in paid rather than volunteer work [9]. Others found no differences between volunteers and non-volunteers on life satisfaction or morale scales [13]. Demographic data such as age, social class, education, sex, and marital status have most often been found to be unrelated to volunteer participation or intent [1, 3, 4, 9, 10].

The purpose of this is to examine more fully the differences between elderly persons who volunteer and those who do not participate in such activities. It is our intent to see if the workers differ from the non-workers in any important psychosocial ways, and whether or not any differences which may be found to exist can be explained by differences in demographic or background variables.

## METHOD

Fifty-three volunteers and forty-nine non-volunteers over age sixty-five were included in the sample. All participants considered themselves retired from paid labor. Volunteers offered their services at the Veterans Administration Hospital (VAH) in Miami, Florida on a regular, assigned basis. All were interviewed during their normal working hours. Total hours of assigned work ranged from 5 to 48, with a mean of 15 hours per week. The only compensation volunteers received for their labor was a complimentary lunch at the hospital canteen.

Non-volunteers were interviewed in private apartments within a senior citizen's housing complex, at a senior day center, and in various out-patient clinics of the VAH and University of Miami affiliated hospitals. There were no significant differences in sex, race, or age between the volunteer and non-volunteer groups.

Data were collected during individual interviews lasting approximately an hour and a half. In order to minimize variability in ratings, all interviews were conducted in private, with the same interviewer. Demographic data were collected on marital status, age, number of years in school or professional training, household composition, parental birthplace, alcohol consumption, smoking behavior, and stressful life events experienced during the preceding year. Social class was measured using Hollingshead's two-factor index [11].

Health-related data concerning hospitalizations, prescribed medication, surgical history, sensory-motor function, ambulation, ability to perform various daily activities, and experience with pain were also recorded.

In addition to background and demographic data, seven dimensions of psychosocial adjustment were measured using valid and reliable scales. Eleven items from Rotter's Locus of Control Scale were used to measure internal versus external orientation [12]. With only two exceptions, these items were identical to those chosen by Valecha for a measure designed specifically for adults [13]. Symptomatology was measured by three factors from the Hopkins Symptom Checklist [14]. Anxiety, depression and somatization factors were chosen in accordance with analyses reported by Derogatus et al. [14]. The Life Satisfaction Scale consisted of 14 items from the original Life Satisfaction Index A [15]. As suggested by Adams, two items were dropped from the Scale's original 16 because of their weak discriminating power [16]. Items used to measure self-esteem were chosen from three reliable scales according to their face validity when dealing with an elderly population. The specific scales from which these items were drawn had been developed by Coopersmith [17-19], Rosenberg, and Brown. Five items from Ellison's Will to Live Scale were used to discriminate persons who want to live from those for whom continued life is less attractive [6]. All items were scored on four-point scales with directions changed so that a higher score always indicated a more negative standing.

Differences between volunteers and non-volunteers on demographic and health-related variables were tested by Student's t-tests. With respect to the psychosocial variables, a multivariate analysis of variance (MANOVA) was employed to test for differences between groups on the seven dimensions described. The MANOVA tests significance of all variables combined and provides univariate tests for each variable alone. Since social class and disability were significantly correlated with some of the dependent variables, and since univariate differences between the groups were found on selected disability-related measures, class and disability were used as covariates in subsequent analyses. These two variables were covaried both singly and together to determine how much of the variance in the dependent measures could be accounted for by these two factors.

## RESULTS

As seen in Table 1, the volunteer and non-volunteer groups did not differ significantly in age, sex, number of years in school or professional training,

Table 1. Comparison of Volunteers and Non-Volunteers on Various Demographic Data

Variables	Volunteers		Non-volunteers		t-Test
	Mean	S.D.	Mean	S.D.	
Age in years	73.98	6.35	73.53	5.54	N.S.
Sex	1.55	0.50	1.40	0.50	N.S.
Education in years	10.32	3.47	10.31	3.55	N.S.
Widowhood	1.40	0.49	1.56	0.50	N.S.
Number living in household	1.64	0.59	1.69	0.97	N.S.
Foreign-born father	1.30	0.46	1.47	0.50	N.S.
Degree of religious feeling	3.09	1.10	2.73	1.16	N.S.
Diet	1.36	0.52	1.56	0.69	N.S.
Social Class	3.60	0.91	3.47	1.24	N.S.

N.S. = Not significant.

Note: Sex scored 1 = male, 2 = female. Widowhood scored 1 = not widowed, 2 = widow. Foreign-born father scored 1 = Yes, 2 = No. Religious feeling scored on a 5-point scale, with 1 = Not at all, 5 = Very religious. Diet scored by rater on a 3-point scale, with 1 = Good, balanced diet, 3 = Very unbalanced. Social class scored on a 5-point scale, with 1 = highest class, 5 = lowest.

degree of religious feeling, diet, or social class. Similarly, there were no significant differences between the groups in the number of persons who were widowed, the percentage of subjects with foreign-born fathers, or the total number of occupants in the participant's household. The t-tests found in Table 2 show that volunteers did not differ significantly from non-volunteers in the number of surgical operations they had previously undergone, amount of pain typically experienced, level of alcohol consumption, smoking behavior, or ability to function in activities of daily living (IADL). When asked about the incidence of stressful events such as accidents and illnesses, or unusual marital, financial or legal problems that they had experienced in the past year, again, no significant differences were found.

Areas in which differences between the groups were found included number of days hospitalized during the previous six month period ( $P < .05$ ), number of medications taken daily ( $P < .01$ ), and degree of sensory-motor impairment ( $P < .05$ ). Non-volunteers were more likely to have been hospitalized more days than the volunteers, and were, on the average, taking more than two medications daily. Volunteers were taking, on the average, only one medication. Sensory-motor impairment, which included eyesight, hearing, and limb function, was greater in the non-volunteer group. However, the mean rating was still in the "good" range.

No differences were found between volunteers and non-volunteers in locus of control or self-esteem. Both groups showed a greater tendency to respond with

an internal orientation, as opposed to an external one. This indicates that they assumed most of the positive and negative events in their lives to be a function of their own actions—that they could influence the course of life events. This cause and effect attitude, by definition, excludes the importance of chance or luck in shaping of one's past and future life.

The mean self-esteem rating for the non-volunteer group was not significantly different from that of the volunteer group, indicating that despite the absence of volunteer work activities, non-volunteers still thought that they were at least equal to others, had a number of good qualities, were able to do things as well as others their age, were proud of their past accomplishments and other such feelings which comprise an overall, positive attitude toward the self.

Table 3 shows the F-ratios and significance levels for variables with and without covariance. It can be seen that volunteers were significantly different from non-volunteers in the number of anxious, depressive, and somatic symptoms they reported, in their will to live, and in their degree of life

Table 2. Comparison of Volunteers and Non-Volunteers on Health-related Variables

Variables	Volunteers		Non-volunteers		t-Test
	Mean	S.D.	Mean	S.D.	
Number of surgical operations (in lifetime)	2.58	2.21	3.10	2.24	N.S.
Number of days hospitalized (in past 6 months)	0.77	2.73	3.80	10.80	1.95 <sup>a</sup>
Amount of pain experienced daily (Self-report)	2.10	1.23	2.53	1.42	N.S.
Current alcohol use	1.66	0.63	1.45	0.65	N.S.
Current smoking	1.32	0.71	1.41	0.89	N.S.
Number of medications now taking	1.18	1.37	2.22	1.45	3.69 <sup>b</sup>
Ability to function in activities of daily living (IADL)	1.00	0.02	1.06	0.23	N.S.
Degree of sensory-motor impairment	5.08	1.59	5.94	1.70	2.59 <sup>a</sup>
Stressful life events (in past year)	1.09	0.07	1.11	0.09	N.S.

N.S. = Not significant.

<sup>a</sup>  $P < .05$ .

<sup>b</sup>  $P < .01$ .

Note: Pain rated on a 6-point scale, with 1 = None, 6 = Very severe pain. Alcohol consumption and smoking rated on a 4-point scale, with 1 = Not at all, 4 = Serious drinking problem/heavy smoker. IADL rated on a 3-point scale, with 1 = least disabled, S-M impairment range 3-14, with 3 = least impairment.

Table 3. Comparison of Volunteers and Non-Volunteers on Psychosocial Variables

Variables	Volunteers		Non-Volunteers		Free		Covaried for Soc. Class & Disability	
	Mean	S.D.	Mean	S.D.	F-ratio	P less than	F-ratio	P less than
Locus of Control	1.36	0.20	1.39	0.23	0.49	.484	0.11	.741
Somatization	1.24	0.33	1.56	0.46	16.28	.001 <sup>c</sup>	10.42	.001 <sup>c</sup>
Anxiety	1.17	0.29	1.44	0.47	11.87	.001 <sup>c</sup>	9.24	.003 <sup>b</sup>
Depression	1.26	0.34	1.48	0.48	6.95	.009 <sup>b</sup>	4.65	.033 <sup>a</sup>
Will to Live	1.34	0.47	1.65	0.77	6.29	.013 <sup>a</sup>	5.51	.020 <sup>a</sup>
Life Satisfaction	1.96	0.42	2.33	0.44	18.78	.001 <sup>c</sup>	13.34	.001 <sup>a</sup>
Self-Esteem	1.60	0.38	1.73	0.35	3.36	.069	2.30	.132

<sup>a</sup>  $P < .05$ , Univariate analysis.

<sup>b</sup>  $P < .01$ , Univariate analysis.

<sup>c</sup>  $P < .001$ , Univariate analysis.

Note: Locus of Control rated on a 2-point scale with 1 = internal orientation, 2 = external. Other variables rated on a 4-point scale, with 1 = least somatization, anxiety or depression, and greatest will to live, life satisfaction and self-esteem.

Multivariate F-Ratio = 4.01 ( $P < .001$ ). Covarying for social class and disability,  $F = 3.01$  ( $P < .006$ ).

satisfaction. More specifically, volunteers reported fewer somatic complaints ( $P < .001$ ) such as headaches, soreness of muscles, hot or cold spells, faintness or dizziness, and trouble getting one's breath. Volunteers were also more likely to report fewer symptoms of anxiety ( $P < .001$ ) such as nervousness or shakiness inside, heart pounding or racing, feeling fearful and trembling. Symptoms of depression such as feeling lonely, blaming oneself for things, poor appetite and crying easily were more often reported by the non-volunteers ( $P < .01$ ). In addition, the non-volunteer group showed less of a will to live when measured by statements such as "Sometimes I look forward to passing on," and "Sometimes it would be better to be gone and away from it all." The most striking difference between the groups was in the area of life satisfaction ( $F = 13.34$ ,  $P < .001$ ). Volunteers were more likely to respond favorably to such statements as "These are the best years of my life," "I am just as happy as when I was younger," and "The things I do are as interesting to me as they ever were." Even when social class and disability were held constant, all differences remained statistically significant.

The multivariate difference between the groups was highly significant statistically ( $F = 4.01$ ,  $P < .001$ ); and when covaried for social class and disability, the F-ratio was 3.01 ( $P < .01$ ). This indicates that the seven psychosocial dimensions taken together were important discriminators between elderly participants who volunteer and those who do not.

## DISCUSSION

Present results indicate that elderly volunteers are significantly more satisfied with life, have a stronger will to live, and report fewer somatic, anxious, and depressive symptoms than those who do not engage in volunteer work. Since the volunteer and non-volunteer groups used in this study differed in the number of days they had been hospitalized during the previous six months, the number of medications they were taking each day, and the degree to which they experienced impairment in sensory-motor function, these areas were examined as possible explanations for the psychosocial differences which were found. It was concluded that the three health-related variables which differed significantly were in fact an indication of present disability. Thus, disability was used as a covariate in further analyses. Again, the differences remained statistically significant. Since no between-group differences were found on other demographic or background variables, the psychosocial differences that were found appear to be a function of the group's participation in volunteer activities *per se*.

Confirmation of this conclusion was found in verbal accounts which had been recorded by the interviewer. Statements such as "When I come here, I see how bad off others are and I feel like I'm pretty lucky," and "When I come here I have to do my work and there isn't time to think about all my usual aches and

pains," were quite common. One volunteer even stated that "Volunteering changed my whole life. I was really as good as dead before, but now I feel like I'm alive . . . I feel like I have some purpose."

Generalization of these findings may be limited because of the special circumstances found at the VAH. The volunteers used in this study were working in a hospital setting and were most often in direct contact with sick or disabled patients. They usually worked in coordination with at least one other volunteer and had numerous contacts with others. This peer contact could have provided some additional, personal support and access to social experiences which might otherwise have been absent. Nevertheless, since a great deal of volunteering in America focuses on psychosocial work in similar settings, these results appear to be of value not only for organizations planning to institute a volunteer staff, but also for those in charge of stimulating, remotivating or in some way helping the elderly to find meaning and purpose.

Analyses and results reported here do not alone conclude a cause and effect process, yet verbal documentation suggests that many of those engaged in volunteer activities feel that such work has changed their lives to the better. Perhaps, as Babic found, the volunteer experience causes participants to forget about or ignore chronic complaints [20]. Surely, it does provide a new focus for one's attention.

It would be interesting to see if a program of volunteer activities initiated for those elderly who have symptoms of depression, anxiety, or general dissatisfaction with life would in fact change their state of mind in any significant way. Surely, with the increasing numbers of elderly persons facing the losses which accompany old age, retirement, widowhood, and dispersion of the nuclear family, it seems well worth the effort.

#### REFERENCES

1. D. Dye, M. Goodman, M. Roth, N. Bley and K. Jensen, The Older Adult Volunteer Compared to the Nonvolunteer, *Gerontologist*, 13, pp. 215-218, 1973.
2. R. Havighurst, The Nature and Value of Meaningful Free Time Activity, *Aging and Leisure*, R. W. Kleemeier (ed.), Columbia University Press, New York, 1961.
3. A. Rosenblatt, Interest of Older Persons in Volunteer Activities, *Social Work*, 11, pp. 87-94, 1966.
4. J. Sainer and M. Zander, Guidelines for Older Person Volunteers, *Gerontologist*, 11, pp. 201-204, 1971.
5. S. S. Tobin and B. L. Neugarten, Life Satisfaction and Social Interaction in the Aging, *Journal of Gerontology*, 16, pp. 344-346, 1961.
6. D. L. Ellison, Will to Live: A Link Between Social Structure and Health Among the Elderly, *Sociological Symposium*, 2, pp. 37-47, 1969.
7. G. G. Fillenbaum and G. L. Maddox, Work After Retirement: An

- Investigation Into Some Psychologically Relevant Variables, *Gerontologist*, 14, pp. 418-414, 1974.
8. A. Monk and A. G. Cryns, Predictors of Voluntary Intent Among the Aged: An Area Study, *Gerontologist*, 14, pp. 425-429, 1974.
9. F. M. Carp, Differences Among Older Workers, Volunteers, and Persons Who are Neigher, *Gerontologist*, 23, pp. 497-501, 1968.
10. C. Lambert, M. Guberman and R. Morris, Reopening Doors to Community Participation for Older People: How Realistic?, *Social Service Review*, 38, pp. 42-50, 1964.
11. A. B. Hollingshead, Two-Factor Index of Social Position, mimeograph, New Haven, Connecticut, 1957.
12. J. B. Rotter, Generalized Expectancies for Internal Versus External Control of Reinforcement, *Psychological Monographs*, 80, (1 Whole No. 609), 1966.
13. G. K. Valecha, Construct Validation of Internal-External Locus of Control as Measured by an Abbreviated 11-Item Scale, unpublished doctoral dissertation, The Ohio State University, 1972.
14. L. R. Derogatis, R. S. Lipman, K. Rickels, E. H. Uhlenhuth and L. Covi, The Hopkins Symptom Checklist (HSCL): A Self-Report Symptom Inventory, *Behavioral Science*, 19, pp. 1-15, 1974.
15. B. L. Neugarten, R. J. Havighurst and S. S. Tobin, The Life Satisfaction Index A & B, *J. Gerontol*, 16, p. 134, 1961.
16. D. L. Adams, Analysis of a Life Satisfaction Index, *Journal of Gerontology*, 24, pp. 470-474, 1969.
17. S. Coopersmith, *The Antecedents of Self-Esteem*, W. H. Freeman, San Francisco, 1967.
18. M. Rosenberg, *Society and the Adolescent Self-Image*, Princeton University Press, Princeton, New Jersey, 1965.
19. O. Bown, The Development of a Self-Report Inventory and Its Function in a Mental Health Assessment Battery, *American Psychologist*, 16, p. 402, 1961.
20. A. L. Babic, The Older Volunteer: Expectations and Satisfaction, *Gerontologist*, 12, pp. 87-90, 1972.

Direct reprint requests to:

Kathleen Hunter, M.Ed.  
 Social Science Research  
 Veterans Administration Hospital 151  
 1201 N.W. 16th Street  
 Miami, FL 33125