

Racial Differences in Volunteer Engagement by Older Adults: An Empowerment Perspective

Fengyan Tang, Valire Carr Copeland, and Sandra Wexler

Volunteering is viewed as an empowerment process whereby older adults actively participate in the community and improve their well-being and health. Yet little is known about racial differences in volunteering, and even less in terms of perceived benefits from volunteering as a means of empowerment. The present study addresses this research gap by examining the differences in volunteer experience and perceived benefits from volunteering between older black people and white people. Purposive and convenience samples were drawn from the city of Pittsburgh and questionnaires were completed by 180 adults ages 60 and over. Bivariate and multivariate analyses showed that black participants were less likely than their white counterparts to volunteer in formal organizations; however, once engaged, they committed more time and perceived more psychosocial benefits from volunteering. Also volunteering and self-reported health demonstrated a stronger relationship in the black sample than among the white sample. This study suggests that black older adults have more to gain from volunteer engagement and feel empowered through meaningful involvement in the community and improved physical and emotional quality of life.

KEY WORDS: *empowerment; older adults; racial differences; volunteering*

Older Americans are increasingly engaged in volunteering to organizations. The volunteering rates for adults ages 65 and over showed an upward trend in the past three decades, rising from 14.3% in 1974 to 24.6% in 2008 (Corporation for National and Community Service, 2006; U.S. Bureau of Labor Statistics, 2009). As the first of the Baby Boomer generation has turned 60, there will be a large pool of potential older adult volunteers owing to the unprecedented size of this generation (Einolf, 2009). The aging Baby Boomers also encompass increased racial and ethnic and cultural diversification. For example, 8.3% of older adults were black in 2008; this proportion increases to 11.6% among Baby Boomers (Administration on Aging, 2009).

Volunteering is viewed as an empowerment process whereby older adults are actively engaged in the community and improve their psychosocial and physical well-being (Cheung & Kwan, 2006; Kam, 2002). Moreover, volunteering generates a host of benefits that accrue to the recipients of volunteer services, to the community in which volunteers serve, and to the social service sector that has come to rely increasingly on volunteers.

The value of volunteering and the extent of racial and ethnic diversity call for greater scholarly attention to the volunteer behavior of various ethnic groups (Sundeen, Garcia, & Raskoff, 2009).

The research on racial and ethnic difference in volunteering is very limited, and the findings are controversial (Fischer & Schaffer, 1993; Hinterlong, 2006; Sundeen et al., 2009). Some data show that white people have substantially higher rates of volunteering than other ethnic groups, whereas others find no difference or even the reverse of the trend (Fischer & Schaffer, 1993). Using the National Survey of Families and Households data, Miner and Tolnay (1998) examined the racial difference and race-related cross-over effect on volunteer participation in different types of organizations. Findings showed that young cohorts of black people and white people had similar rates of voluntary organization participation, whereas older black people had lower rates of participation than their white counterparts in social service and job-related organizations, except in neighborhood groups, especially church groups that have historically been open to black people (Miner & Tolnay, 1998). By contrast, Hinterlong (2006) documented that white older

adults volunteered to organizations at significantly higher rates than their black peers consistently across three waves of data collection through longitudinal analyses of nationally representative data from the Americans' Changing Lives surveys (see <http://www.icpsr.umich.edu/icpsrweb/ICPSR/studies/04690>).

The relevance of race to volunteering may be linked with life quality indicators that make volunteering possible—for example, education and income. Despite recent gains in educational and occupational achievements, black people “are still worse off than [white people] across a broad range of quality-of-life indicators” (Musick, Wilson, & Bynum, 2000, p. 1539). Cumulative disadvantages over the life course, including racial discrimination, have created unequal access to volunteer roles for black people and white people (Dannefer, 2003), which may explain why black people are less likely to volunteer. Racial difference in volunteering rates is even more apparent in the older population (Miner & Tolnay, 1998), probably because older black people have historically experienced more socioeconomic and political marginalization and have restricted access to certain type of volunteer organizations. The inequalities embedded in social structures of race and social class differentiate individuals and their aging experience (Dannefer, 2003), and these dynamics likely are reflected in volunteer engagement. Yet exclusion from volunteering threatens to further marginalize older black people by denying them opportunities of community participation, access to potential benefits of volunteering, and chances of contribution to the society.

Although they are less likely to volunteer to organizations, older black people tend to provide care to their family members and display high levels of participation in informal volunteering and church volunteering (Fischer & Schaffer, 1993; Hinterlong, 2006). Because of the black community's extended family tradition of kinship and caregiving ties, grandparents or other older relatives frequently assume children's care when the parents cannot. Yet these family caregiving responsibilities have not typically been recognized as a form of volunteerism, although a crucial generational resource for the black community. In addition, older black people attend churches more frequently, with higher rates of church membership than younger cohorts (Taylor & Chatters,

1991). Church attendance has more powerful effects on black volunteering than on white volunteering, indicating that older black church attendees are more likely to volunteer for the church as well as for secular organizations (Musick et al., 2000).

VOLUNTEERING AS AN EMPOWERMENT PROCESS

An empowerment perspective has been proposed to understand volunteerism as a vital means of health maintenance among older adults (Kam, 2002). Empowerment is defined as “processes whereby individuals achieve increasing control of various aspects of their lives and participate in the community with dignity” (Lord & Hutchison, 1993, p. 7). Volunteering as an empowerment process provides an avenue for older adults, especially the disadvantaged and the vulnerable, to counter loss of power in varied life domains, reduce sense of isolation and helplessness, and strengthen self-esteem and personal control (Kam, 2002; Morrow-Howell, Kinnevy, & Mann, 1999). For example, volunteer participation is likely to mitigate the negative effects of widowhood on personal well-being, facilitate social support and interactions, and bolster self-regulation of health behaviors among widowed elders (Li, 2007). Also the strong health benefits are noted for older adults with scarce personal and social resources, rather than among those with greater amounts of these resources (Musick, Herzog, & House, 1999). In particular, lower-income and less educated older adult volunteers perceived more benefits than their counterparts at higher socioeconomic status (Morrow-Howell, Hong, & Tang, 2009). To summarize, older adult volunteers perceived themselves as capable individuals, willing and able to gain control of their lives and to actively participate and exert influence in the community.

BENEFITS OF VOLUNTEERING

The link between volunteering and positive outcomes has been well documented in the literature. Recent empirical studies report that volunteer engagement in later life is related to better physical functioning (Lum & Lightfoot, 2005), improved self-rated health (Morrow-Howell, Hinterlong, Rozario & Tang, 2003), increased levels of muscular strength (Fried et al., 2004), reduced

depressive symptoms (Musick & Wilson, 2003), and reduced mortality (Musick et al., 1999). These studies used longitudinal analyses of nationally representative datasets, including the Americans' Changing Lives and the Health and Retirement studies (see <http://hrsonline.isr.umich.edu/>). With the samples of white people, black people, and other minorities, findings of these studies provided strong support for a significant association between volunteering and health.

Studies on Experience Corps suggest that high-intensity volunteer programs designed as health promotion interventions can lead to sustained improvement in physical activity among high-risk older adults, including black adults, thus helping address racially based health disparities (Fried et al., 2004; Tan et al., 2009). As demonstration programs launched and developed by Civic Ventures, a well-known nonprofit organization, Experience Corps engages adults ages 55 and over as tutors and mentors for public elementary schoolchildren who are struggling to learn. In the Experience Corps at Baltimore, Maryland, about 97% of 70 volunteers were black elders with varying levels of health and functional status. In contrast with the comparison group of 58 elders, with 95% being black elders, the volunteers were more physically active, felt more physical strength, and had smaller declines in walking speed—benefits that were attributed to being a volunteer (Fried et al., 2004; Tan et al. 2009). In addition, formal volunteering participation decreases the negative affect (that is related to poor health, anxiety, and fears) among older black people (McIntosh & Danigelis, 1995). These positive benefits on physical and emotional quality of life may turn into empowerment sources that make older adults further engage in the community and increase control of their personal lives.

Although there is a growing literature on volunteerism in later life, little existing research has explicated racial differences in volunteer experience regarding time commitment, activity type, and the type of organizations involved. Even less is known about how black and white older adults differ in their perceptions about volunteering as an empowerment process. Previous studies, mostly focused on the older population in general, identified the associations between volunteer engagement and health benefits, but paid little attention to racial differences in these

associations. Older black people may differ from older white people in the experiences of being empowered through volunteer engagement. Thus, this study addressed the following research questions: (1) What are the differences between older black people and older white people in their volunteer experiences? (2) What are the differences between older black people and older white people in their perceived benefits from volunteering as a mean of empowerment? (3) What is the relationship between volunteering and self-reported health in the older black and older white samples? Answers to these questions can contribute to the social work knowledge base on the values of volunteering among older adults, point to areas of future investigation, and enhance social work practice where use of volunteers is an important aspect of social service delivery.

METHOD

Design and Sample

This study used a two-phase approach to investigate racial differences in late-life volunteering and social engagement. Using a cross-sectional design, we recruited a purposive sample of older adult volunteers and a convenience sample of nonvolunteers in 2006. In the first phase, four volunteer programs based in senior centers were identified in the city of Pittsburgh. The program directors were approached to elicit their cooperation. Three agreed to participate and signed a letter of agreement. Because we were concerned about being able to recruit a sample of sufficient size from the three sites, an additional, hospital-based volunteer program was included. We then asked the program directors to distribute self-administered questionnaires to all of their current volunteers, who were to return them by mail in the self-addressed, stamped envelope provided. The four sites had 146 volunteers active during the study period, and each of these active volunteers was given a questionnaire. Of the 146 questionnaires distributed between May and October 2006, 94 were returned for a response rate of 64%.

In the second phase, we recruited nonvolunteers as the comparison group. Older adults who participated in activities or programs hosted by the three senior centers were approached and asked to take part in this study. A trained research assistant

distributed and collected the questionnaires from those who agreed to participate and who met the study's definition of "nonvolunteer." Individuals were considered nonvolunteers if they reported no volunteering to an organization (hospitals, social service agency, schools, youth organizations, churches, etc.) in the past 5 years. This screening criterion was used in the nationwide Current Population Survey (CPS) (see <http://www.census.gov/cps/>), which has been administered annually to adult respondents of about 60,000 households since 2002. Between July and October 2006, a total of 104 completed questionnaires were collected among nonvolunteers. All respondents received a \$10 gift card for participating in the study, an incentive approved by the affiliated university's institutional review board.

Final Sample Size

Of the 198 returned questionnaires, we screened out 14 because the respondents were below age 60 at the survey time. Of these 14 respondents, 11 were black, two were white, and one was of another racial or ethnic group. And there were four respondents who identified themselves as American Indian, Hispanic, or of another racial or ethnic group among adults ages 60 and over. These respondents did not represent a normal distribution to create an "other race" group, thus they were excluded from the analysis. The final sample size was 180, of which 109 (61%) were black, and 71 (39%) were white; 90 (50%) were volunteers, and 90 (50%) were nonvolunteers.

Volunteer Programs and Racial Components

Services provided by the four volunteer sites varied. Three senior centers hosted programs that tutored school children, instructed computer skills, taught classes such as line dance or t'ai chi, and provided supportive services such as meal preparation, administration work, and assistance in adult day care. Hospital volunteers provided support, information, and facilitation in communication; handled on-the-spot visit-patient-family requests; and served as a liaison among visitors, patients, and staff. On the basis of the geographic location of neighborhood and agency type, the racial representation by program varied (see Table 1). Whereas the program 3 senior center was exclusively black (100%), the program 1 volunteers

Table 1: Frequency of Race Distribution in Volunteer Programs and among Nonvolunteers

Volunteer Program	N	White n (%)	Black n (%)
1	34	32 (94.1)	2 (5.9)
2	35	11 (31.4)	24 (68.6)
3	10	0 (0)	10 (100)
4	11	8 (72.7)	3 (27.3)
Total (all program volunteers)	90	51 (56.7)	39 (43.3)
Total (programs 1 through 3; nonvolunteers)	90	20 (22.2)	70 (77.8)
Total	180	71 (39.4)	109 (60.6)

Notes: Programs 1 through 3 were based in senior centers. Program 4 was sponsored by a hospital.

were primarily white (94%), and programs 2 and 4 included both black and white senior volunteers, with the ratios reversed. The hospital program volunteers were 73% white, whereas the last senior center program volunteers were 69% black. Additional analyses indicated that no difference was observed across the four programs in volunteers' age, gender, marital status, volunteering duration (how long they had been volunteering), perceived benefits, and health status. But differences were noted in education, income, and volunteer time commitment between program 3, the all-black volunteers, and others. Black and white volunteers' differences are reported in the results section.

Instrumentation and Variables

Two different survey instruments were used for the volunteer and nonvolunteer groups. Volunteers were asked about their volunteer experience, perceived benefits from volunteering, and health. Some questions were adopted from the CPS (2005) and some were from a previous study of self-perceived benefits among older volunteers (Morrow-Howell et al., 1999). The benefit questions reflect the empowerment nature of volunteering, indicating that older adult volunteers may be empowered through gaining positive benefits such as increased engagement in the community, improved socialization, enhanced self-esteem, and personal growth. Nonvolunteers were queried about their participation in senior center activities, reasons for not volunteering, other social and physical activities, and health status. Some questions were adopted from the Community

Partnership for Older Adults Program Survey 2002 (see <http://dx.doi.org/10.3886/ICPSR27181.v1>). Variables included volunteer experience, perceived benefits, self-reported health, and sociodemographics.

Volunteer Experience. It was captured by volunteer status, time commitment, activity type, and the total number of organizations in which the respondent volunteered. Volunteer status was a binary variable, indicating current volunteer (1) or nonvolunteer status (0). Time commitment was assessed by volunteering frequency, intensity, and duration. Frequency was measured with one question, "How often do you volunteer in the X program?" in which "X program" referred to a volunteer program administered by the senior center or hospital (hereafter, "agency"). Responses were coded as at least weekly (1) or less than weekly (2). Intensity was measured by the number of hours per week for a single volunteer program hosted by the agency. Duration was measured by the number of years of volunteering in a designated program. A checklist of 12 activities, taken from the CPS, was used to measure volunteer activity. The CPS asked 12 questions about activities that respondents had done for an organization (for example, "Since September 1, 2004, did you tutor or teach?"). We adopted these 12 questions and changed into response items to the question: "What activity/activities are you doing for the X program?" Because respondents could engage in more than one activity and some activities were similar in terms of the skills required, three binary variables were subsequently created: tutoring/mentoring, instrumental/supportive/non-skilled, and skilled assistance/technical advice (Morrow-Howell et al., 2009). Finally, we asked respondents whether they volunteered in other organizations in addition to the study agency and the total number of organizations in which they volunteered.

Perceived Benefits. Reflecting the empowerment process, perceived benefits were measured by 10 items in the domains of contribution to others (two questions), improved life (one question), meaningful activity (two questions), personal growth (two questions), self-worth (one question), and socialization (two questions) (Morrow-Howell et al., 2009). The questions were worded to attribute any perceived benefits to volunteering in the designated program. Response options were all

coded on a three-point scale for the purpose of analysis (1 = not at all, 2 = to some extent, 3 = a great deal). All 10 items were summed up for a total benefit score. The computed perceived benefit measures demonstrated high internal reliability ($\alpha = .91$). In addition, we asked volunteers about their subjective assessment of whether their health changed since they started volunteering in the agency program. This variable was dichotomized into "worse or the same" (0) or "better" (1). Because only five respondents (6%) reported worse health, they were grouped into the "same" group (53 respondents [59%]) to compare with those reporting better health. Among five respondents reporting worse health, one was black and four were white. Additional analysis showed that no difference was noted between "worse" and "same" groups in age, education, income, and other self-reported health indicators.

Self-reported Health. Both volunteers and nonvolunteers were asked about their health status, including self-rated health, depressive symptoms, and functional limitation. Self-rated health was measured by the question, "How would you rate your current health?" with five response options ranging from "excellent" (1) to "poor" (5). The Center for Epidemiologic Studies Short Depression Scale (CES-D10) (Carpenter et al., 1998) was used to measure the likelihood of a diagnosis with major depression. It ranges from 0 to 10, with higher scores indicating higher likelihood. The CES-D10 shows good predictive accuracy in screening for depression in well older adults (Andresen, Malmgren, & Carter, 1994). Functional limitation was measured by the number of activities of daily living (ADL) and instrumental activities of daily living (IADL) with which respondents had problems. A total of 10 activities were identified, and each was coded as performing "with difficulty" (1) or "no difficulty" (0). Responses to the 10 items were summed to a single functional limitation score, ranging from "no difficulty" (0) to "difficulty with all activities" (10).

Sociodemographics. Sociodemographic information was obtained from all respondents, including binary measures of gender, race, marital status, and employment status, and continuous measures of age, education, and annual household income. Education was measured by years in school, ranging from two to 24 years. Household income

was a 10-category variable, from “less than \$5,000” (1) to “\$80,000 or more” (10). As with previous studies (for example, Morrow-Howell et al., 2009), education ($M = 12.6$, $SD = 3.0$, skewness = 0.55) and income ($M = 4.2$, $SD = 2.2$, skewness = 0.7) were used as continuous measures; both demonstrated normal distribution in this study.

DATA ANALYSIS

First, we undertook chi-square and t -test analyses based on race for the sample as a whole and on volunteer status within each racial group to examine the characteristics of the study sample. To examine the study’s first and second research questions about the differences between older black people and older white people in volunteer experiences and perceived benefits from volunteering, we conducted a series of bivariate analyses among volunteers based on race. Dependent variables included volunteer experiences (that is, time commitment, activity type, volunteering in other organizations, and the total number of organization involved) for research question 1; and perceived benefits (that is, contribution to others, improved life, meaningful activity, personal growth, self-worth, socialization, perceived total benefits) and health change since volunteering for research question 2. Independent variable was race. research question 3, which involved the relationship between volunteering and health for members of this study’s two racial groups, was assessed by ordinary least squares regression analyses in the samples of white people and black people. Dependent variables of self-rated health, depressive symptoms, and functional limitation were separately regressed on the independent variable of volunteer status after controlling for sociodemographic variables.

RESULTS

Sample Characteristics by Race and Volunteer Status

About 61% of the study’s respondents were black. Black people were overrepresented compared with the racial breakdown for the neighborhood in which the research sites were located (about 28% were black in the city, according to the U.S. Census Bureau). Both volunteers and senior center participations (recruited as nonvolunteers)

Table 2: Variance in Sociodemographics, Health, and Volunteering, by Race

Variable	White (<i>n</i> = 71)	Black (<i>n</i> = 109)	<i>t</i>
	<i>M</i> (<i>SD</i>)	<i>M</i> (<i>SD</i>)	
Age (60–94 years)	74.7 (7.6)	73.9 (7.4)	0.68
Education (2–24 years)	13.6 (3.1)	12.0 (2.8)	3.53***
Income (1–10 ^a)	5.2 (2.4)	3.5 (1.8)	4.60***
Self-rated health (1–5 ^b)	2.8 (1.0)	2.9 (1.0)	–0.91
Functional limitation (0–10 ^c)	0.3 (0.6)	0.8 (1.6)	3.32**
Depressive symptoms (0–10 ^d)	2.4 (2.1)	2.5 (1.7)	–0.33
	%	%	χ^2
Employed	9.9	9.2	0.02
Female	84.5	90.8	1.67
Married	22.5	18.4	0.47
Volunteer status	71.4	35.8	22.35***

^a1 = less than \$5,000; 10 = \$80,000 or more (3 = \$10,000–\$14,999; 4 = \$15,000–\$19,999; 5 = \$20,000–\$24,999). ^b1 = excellent; 5 = poor. ^cMeasured by the number of activities of daily living and instrumental activities of daily living with which respondents had problems. Each of 10 activities was coded as 1 = being performed with difficulty or 0 = being performed with no difficulty, resulting in a range of 0 = difficulty with no activities to 10 = difficulty with all activities. ^dHigher scores indicate greater likelihood of diagnosis with major depression.

* $p < .05$. ** $p < .01$. *** $p < .001$.

in two racial groups were overrepresented because of the purpose of the study and the nature of non-probability sampling. Sociodemographic, health status, and volunteering data by race for the total sample are displayed in Table 2. Black respondents reported significantly lower education ($t[177] = 3.53$, $p < .001$), lower income ($t[99.8] = 4.60$, $p < .001$), and more functional limitations ($t[149.5] = -3.32$, $p < .01$), compared with white respondents. Over 71% of white respondents volunteered through the agency compared with 36% of black respondents ($\chi^2[1, N = 180] = 22.35$, $p < .001$). None of the other demographic or health measures differed statistically by race.

As Table 3 shows, volunteers and nonvolunteers differed in several ways. White volunteers reported significantly more years of education ($t[69] = -3.14$, $p < .01$), and less depression ($t[25.9] = 2.69$, $p < .05$), than the nonvolunteering white people. By contrast, black volunteers, compared with the black nonvolunteers, reported better health status on all three indicators: better self-rated health ($t[107] = 2.30$, $p < .05$), less functional limitation, ($t[83.2] = 4.82$, $p < .001$), and fewer depressive symptoms, ($t[107] = 2.12$, $p < .05$). And volunteers were more likely to be in the labor force ($\chi^2[1, N = 109] = 5.61$, $p < .05$) than were nonvolunteers among black people.

Table 3: Variance in Sociodemographics and Health, by Race and Volunteer Status

Variable	White (n = 71)		t	Black (n = 109)		t
	Volunteer (n = 51)	Nonvolunteer (n = 20)		Volunteer (n = 39)	Nonvolunteer (n = 70)	
	M (SD)	M (SD)		M (SD)	M (SD)	
Age (60-94 years)	75.0 (7.8)	74.0 (7.2)	0.50	73.7 (7.0)	74.1 (7.7)	0.29
Education (2-24 years)	14.3 (2.7)	11.9 (3.4)	-3.14**	12.4 (3.2)	11.8 (2.5)	-0.98
Income (1-10 ^a)	5.5 (2.3)	4.3 (2.4)	-1.81	3.5 (1.9)	3.5 (1.8)	0.20
Self-rated health (1-5 ^b)	2.7 (0.9)	3.1 (1.2)	1.67	2.6 (0.9)	3.1 (1.0)	2.30*
Functional limitation (1-10 ^c)	0.1 (0.4)	0.6 (0.9)	1.89	0.1 (0.4)	1.1 (1.7)	4.82***
Depressive symptoms (1-10 ^b)	1.9 (1.7)	3.6 (2.5)	2.69*	2.0 (1.4)	2.7 (1.8)	2.12*
	%	%	χ^2	%	%	χ^2
Female	75.0	88.2	1.92	94.8	87.1	3.18
Married	27.4	10.0	2.51	20.5	17.1	0.19
Employed	9.8	10.0	0.00	18.0	4.3	5.61*

^a1 = less than \$5,000; 10 = \$80,000 or more (3 = \$10,000-\$14,999; 4 = \$15,000-\$19,999; 5 = \$20,000-\$24,999). ^b1 = excellent; 5 = poor. ^cMeasured by the number of activities of daily living and instrumental activities of daily living with which respondents had problems. Each of 10 activities was coded as 1 = being performed with difficulty or 0 = being performed with no difficulty, resulting in a range of 0 = difficulty with no activities to 10 = difficulty with all activities. ^dHigher scores indicate greater likelihood of diagnosis with major depression.

* $p < .05$. ** $p < .01$. *** $p < .001$.

Racial Differences among Volunteers

The results of the study's first research question regarding the differences between black and white volunteers' experiences are presented in Table 4. Compared with white people, black people volunteered at the agency on a more frequent basis [$\chi^2(1, N = 89) = 5.70, p < .05$] and contributed more hours per week [$t(57.9) = -2.53, p < .05$]. They were also more often engaged in instrumental, supportive, and nonskilled activities [$\chi^2(1, N = 89) = 8.21, p < .01$], whereas the white volunteers more often tutored [$\chi^2(1, N = 89) = 5.27, p < .05$]. Although white people more likely volunteered in other organizations [$\chi^2(1, N = 89) = 11.06, p < .001$], white people and black people who did volunteer elsewhere did not differ in the total number of organizations to which they lent their assistance.

The results of the second question, about the differences between black and white volunteers in perceived benefits from volunteering, are also presented in Table 4. Black volunteers were more likely than white volunteers to agree that they had contributed to the well-being of people served and to the community [$t(87) = -2.38, p < .05$], that volunteering had improved their life [$t(87) = -2.11, p < .05$], that volunteering had increased their social activities and enlarged their circle of friends and acquaintances [$t(87) = -2.35, p < .05$], and that volunteering had increased their

ability to interact with different kinds of people and expanded their leadership ability [$t(87) = -2.32, p < .05$]. No difference was observed in meaningful activity and self-worth. When examining the confidence interval for effect size, we can reject the hypothesis that the difference in meaningful activity and self-worth by race is greater than 0.03 and 0.14 at the 2.5% level, and negative effect sizes were 0.22 and 0.10, respectively. In general, black volunteers perceived more benefits or felt more empowered than their white peers [$t(87) = -2.66, p < .01$]. In addition, black people more likely reported that their health status was better since volunteering in the designated program [$\chi^2(1, N = 89) = 11.55, p < .001$].

Volunteering and Health

The results from the ordinary least squares regression analyses for the study's third research question are presented in Tables 5 and 6. Among the white respondents, volunteering was only related to depressive symptoms after controlling for covariates. White volunteers reported fewer depressive symptoms than nonvolunteers [$\beta = -.29, t(70) = -2.34, p < .05$] (see Table 5). By contrast, for black people, volunteer status was significantly related to all three health indicators. The black volunteers, compared with their nonvolunteer peers, reported fewer functional limitations [$\beta = -.35,$

Table 4: Volunteer Experience and Perceived Benefits, by Race among Volunteers

Variable	White (n = 51)	Black (n = 39)	95% CI	Effect Size	t/χ ²
Volunteer Experience					
Frequency of volunteering					
Weekly	68.6 ^a	89.7 ^a	-0.01, 0.48	0.21	5.70 ^{ab}
Less than weekly	31.4 ^a	10.3 ^a			
Intensity (1-40 hours/week)	4.8 (5.0) ^c	9.0 (9.2) ^c	-7.14, -1.09	-0.27	-2.53 ^{ad}
Duration (1-28 years)	8.0 (7.4) ^c	5.9 (4.8) ^c	-0.68, 4.76	0.16	1.49 ^d
Tutoring/mentoring activity	37.3 ^a	15.4 ^a	0.03, 0.40	0.25	5.27 ^{ab}
Instrumental/supportive activity	47.1 ^a	76.9 ^a	-0.50, -0.10	-0.31	8.21 ^{ab}
Skilled assistance/technical advice activity	21.6 ^a	25.6 ^a	-0.22, 0.14	-0.05	0.20 ^b
Volunteer in other organizations	68.6 ^a	33.3 ^a	0.15, 0.55	0.35	11.06 ^{***ab}
Total number of organizations involved (1-5)	1.8 (1.1) ^c	2.2 (1.3) ^c	-1.18, 0.32	-0.18	-1.16 ^d
Perceived Benefits/Empowerment					
Contribution to others (2-6)	4.1 (1.0) ^c	4.6 (1.1) ^c	-0.99, -0.09	-0.24	-2.38 ^{ad}
Improved life (1-3)	2.4 (0.6) ^c	2.6 (0.5) ^c	-0.48, -0.01	-0.19	-2.11 ^{ad}
Meaningful activity (2-6)	4.5 (1.1) ^c	4.9 (1.1) ^c	-0.89, 0.03	-0.22	-1.84 ^d
Personal growth (2-6)	4.0 (1.1) ^c	4.6 (1.1) ^c	-1.02, -0.08	-0.26	-2.32 ^{ad}
Self-worth (1-3)	2.0 (0.6) ^c	2.2 (0.7) ^c	-0.41, 0.14	-0.10	-0.96 ^d
Socialization (2-6)	4.2 (1.3) ^c	4.8 (1.0) ^c	-1.05, -0.07	-0.24	-2.35 ^{ad}
Perceived total benefits (11-30)	21.2 (4.2) ^c	23.7 (4.5) ^c	-4.29, -0.62	-0.27	-2.66 ^{***ad}
Health changed since volunteering					
Better	21.6 ^a	56.4 ^a	-0.54, -0.16	-0.35	11.55 ^{***ab}
Worse or same	78.4 ^a	43.6 ^a			

Notes: Perceived benefits were measured by 10 items: contribution to others (two questions), improved life (one question), meaningful activity (two questions), personal growth (two questions), self-worth (one question), and socialization (two questions). All were coded on a three-point scale: 1 = not at all, 2 = to some extent, and 3 = a great deal. Effect sizes were calculated using the means and standard deviations for the two groups. CI = confidence interval.

^aPercentage. ^bChi-square test. ^cMean (with standard deviation in parentheses). ^dt test.

* $p < .05$. ** $p < .01$. *** $p < .001$.

Table 5: Relationships between Volunteering and Health in the White Sample

Variable	Functioning			Depression			Self-rated Health		
	β	t	95% CI	β	t	95% CI	β	t	95% CI
Age	.01	0.06	-0.02, 0.02	-.16	-1.39	-0.09, 0.02	-.05	-0.40	-0.04, 0.02
Female	-.21	-1.57	-0.70, 0.09	-.24	-2.02*	-2.81, -0.01	-.06	-0.45	-0.96, 0.61
Married	.03	0.25	-0.08, 0.11	.16	1.40	-0.10, 0.57	-.06	-0.46	-0.23, 0.15
Employed	-.04	-0.28	-0.44, 0.33	-.13	-1.05	-2.08, 0.65	-.18	1.37	-1.29, 0.24
Education	.04	0.26	-0.05, 0.07	.04	0.25	-0.19, 0.24	.02	0.14	-0.11, 0.13
Income	-.19	-1.24	-0.11, 0.03	-.30	-2.27*	-0.49, -0.03	-.41	-2.80**	-0.31, -0.05
Volunteer	-.25	-1.80	-0.59, 0.03	-.29	-2.34*	-2.39, -0.18	.13	0.97	-0.32, 0.92
F		1.50			4.04**			2.00	
R ²		.17			.35			.21	
ΔR ²		.05			.06			.02	
Effect size		-0.31			-0.11			-0.22	

Notes: Effect sizes (Cohen's *d* and the effect-size correlation, r_{vz}) were calculated using the means and standard deviations for the two groups (volunteers and nonvolunteers). Cohen's $d = M_1 - M_2 / \sigma_{\text{pooled}}$, where $\sigma_{\text{pooled}} = [(s_1^2 + s_2^2) / 2]$ and $r_{vz} = d / (d^2 + 4)$. β = standardized coefficient; CI = confidence interval.

* $p < .05$. ** $p < .01$. *** $p < .001$.

$t(108) = -3.70, p < .001$], fewer depressive symptoms [$\beta = -.22, t(108) = -2.26, p < .05$], and better self-rated health [$\beta = -.28, t(108) = -2.82, p < .01$] (see Table 6). The variances attributed to volunteering ranged from 0.02 to

0.10, with more increments in the black sample. The effect sizes calculated with the means and standard deviations of two groups (volunteers and nonvolunteers) were larger in the models for black people than for white people. To sum up,

Table 6: Relationships between Volunteering and Health in the Black Sample

Variable	Functioning			Depression			Self-rated Health		
	β	t	95% CI	β	t	95% CI	β	t	95% CI
Age	.24	2.22*	0.00, 0.08	-.11	-1.04	-0.06, 0.21	.05	0.49	-0.02, 0.03
Female	.06	0.53	-0.75, 1.30	-.23	-2.12*	-2.43, -0.08	-.09	-0.81	-0.96, 0.41
Married	-.02	-0.22	-0.27, 0.22	.18	1.64	-0.05, 0.51	-.17	-1.56	0.29, 0.04
Employed	-.06	-0.65	-1.26, 0.64	-.17	-1.73	-2.05, 0.14	-.09	-0.88	-0.92, 0.35
Education	.15	1.37	-0.04, 0.19	-.22	-1.94	-0.26, 0.00	-.06	-0.54	0.10, 0.06
Income	.08	-0.16	-0.27, 0.05	-.02	-0.19	-0.20, 0.17	-.17	-1.52	-0.19, 0.03
Volunteer	-.35	3.70***	-1.69, -0.51	-.22	-2.26*	-1.45, -0.09	-.28	-2.82**	-0.96, -0.17
F		3.76			3.00**			2.82	
R ²		.23			.19			.18	
ΔR^2		.10			.03			.06	
Effect size		-0.39			-0.14			-0.24	

Notes: Effect sizes (Cohen's *d* and the effect-size correlation, r_{vs}) were calculated using the means and standard deviations for the two groups (volunteers and nonvolunteers). Cohen's $d = M_1 - M_2 / \sigma_{pooled}$, where $\sigma_{pooled} = [(s_1^2 + s_2^2) / 2]$ and $r_{vs} = d / (d^2 + 4)$. β = standardized coefficient; CI = confidence interval.
* $p < .05$, ** $p < .01$, *** $p < .001$

the positive relationship of volunteering with health was stronger for older black people than for older white people in this study.

DISCUSSION

This study contributed to the knowledge base about the racial difference in volunteering through examining volunteer engagement as an empowerment process between black and white older adults. Consistent with Fischer and Schaffer's (1993) review, our study found that older black people were involved in organizational volunteering less often than were white people. But once engaged, they devoted a greater amount time. In a similar manner, although volunteering for other organizations was more common among white volunteers, the older black people volunteering to other organizations in addition to the agency were comparable with their white counterparts in terms of the average number of organizations in which they were involved. These findings suggest that when older black people are involved in volunteering to organizations, they do so with intensity and commitment.

Older black and older white volunteers differentially perceived the benefits of volunteering. We found that race did matter in perceived health change, with a significantly higher proportion of black people than white people reporting better health since they started volunteering in the designated program. Perceptions of psychosocial benefits also varied by race, with black volunteers again seeing themselves as obtaining more benefits from volunteering. Older adults, particularly of

black or other ethnic groups, have more to gain in resources and recognition from volunteering (Martinez et al., 2006). As shown in this study, older black people were more likely than their white peers to feel empowered through organizational volunteering, which creates potential for a sense of accomplishment, social integration, personal growth, and improved life quality.

The older adult volunteers in this study, regardless of their race, had lower depression screening scores than their nonvolunteering peers, a finding similar to that reported by Musick and Wilson (2003). However, whereas depression screening was the only indicator on which white volunteers and nonvolunteers differed, volunteering was associated with all three health measures among the black volunteers compared with their nonvolunteer peers. Generally, black volunteers reported better overall health than their nonvolunteer counterparts in this study. Findings suggest that health status makes difference in volunteering decisions, and volunteer engagement, in turn, generates positive health benefits. Thus, a positive cycle of social causation and selection exists between volunteering and health. Volunteering as a social force can shape individual's life, and personal resources including health affect older adults' decision and performance in volunteering (Thoits & Hewitt, 2001).

To sum up, this study lends empirical support for the relevance of the empowerment perspective to volunteering benefits in the older population, particularly among older black people. Research suggests that well-structured (providing, for

example, financial incentives, training, and role flexibility), well-designed (involving, for example, physical, social, and cognitive activity) volunteer programs serve as a health promotion or intervention, especially for the nonwhite and low-income older population (Morrow-Howell et al., 2009; Tan et al., 2009). Older black people, compared with their white peers, are likely to experience higher rates of frailty, disability, morbidity, and mortality; therefore, increased physical activity is considered a primary way to maintain their health (Tan et al., 2009). Engaging and retaining older volunteers of various ethnic groups can not only help address their communities' needs, but also improve the quality of life and physical and psychological well-being for themselves. The association between volunteering and self-reported health demonstrated among the black volunteers in this study appears to point in that direction, suggesting that volunteering is a possible intervention for reducing health disparities.

There are limitations to this study. First, although an empowerment perspective suggests a mechanism through which volunteering benefits older adults, longitudinal designs among volunteer samples with greater diversity will provide a strong basis for testing the validity of the volunteering empowerment model. Second, our data collection was limited to a single city, and sites were purposefully chosen to ensure the inclusion of black respondents. The overrepresented size of black people may not accurately estimate the relationship between volunteering and health, because of the lack of weighting adjustment for the disproportionate sampling. Thus, findings cannot be generalized to a large population. Third, the measures of perceived benefits may not fully capture the empowerment process of volunteering. More specific indicators are needed to develop and test from the empowerment model. Furthermore, race is a key concept in this study but was simply measured by black versus white. This binary measure falls far from capturing the full range of biological, cultural, social, and political characteristics embedded in this variable (LaVeist, 1994). Future research need consider contributions of behavioral and social factors that account for racial differences in volunteering. Last, this study did not ask about volunteers' engagement in other activities outside of volunteering; thus, these activities cannot be ruled out as

alternative explanations for the fact that volunteers fared better than the nonvolunteers.

Nonetheless, findings of this study are sufficient to indicate that racial differences in volunteering deserve much more research. Future investigations need to address the types of organizations optimal for older adults from different ethnic groups, as certain organizational settings may be more conducive to promoting volunteerism and maximizing its benefits among ethnic groups. Also community is a contextual variable wherein the standards, norms, resources, and institutions in the community provide a backdrop for volunteer efforts (Omoto & Snyder, 2002). Future efforts are needed to examine what and how contextual variables affect older adults' volunteer efforts and outcomes by race. Additional research is also needed to address how other forms of volunteerism (for example, informal, faith based, neighborhood based) interact with organizational volunteering and whether these forms of volunteering are related to positive benefits. Although the conceptualization of volunteering as an empowerment process appears promising from this study, more rigorous testing is needed to assess the utility of volunteering in prevention against health decline among the older populations. And greater scholarly attention is needed to focus on volunteering and its benefits within other racial and ethnic communities.

With the implications of racial differences in volunteering as an empowerment process, this study sheds light on social work practice. Social workers are in key positions of volunteer administration, involved in recruiting, training, placing, and supporting volunteers (Kovacs & Black, 1999). They work in a variety of organizations in which volunteers are used, such as senior centers, mental health centers, hospitals, schools, nursing homes, and child caring settings. Understanding racial and ethnic differences and the effects on volunteer engagement will help recruit and retain a diverse pool of older adult volunteers in social service delivery. Also social workers should better use volunteer activity as an effective strategy in transforming older adults to a state of sufficiency in self-efficacy, self-worth, and self-esteem (Kam, 2002).

The aging of the Baby Boomer generation and increased racial and ethnic diversification calls for increasing involvement of older adults in

organizational volunteering and maximizing the benefits of volunteering to older adults. Older people of various ethnic groups are a tremendous source of social capital to address pressing community issues. Not drawing on this resource will be a loss for all. Especially in difficult economic times, the power and value of volunteer service becomes even greater. Among the older population, volunteering is a public approach to social integration and health promotion. The inclusion of racial and ethnic groups in volunteering will improve their representation and influence in the community as well as their physical and psychosocial well-being. Efforts are needed to remove institutional barriers to volunteering, extend volunteer opportunities to members of ethnic groups, and make volunteering an empowerment process to all participants. **SWR**

REFERENCES

- Administration on Aging. (2009). *A profile of older Americans: 2009*. Retrieved from http://www.aoa.gov/AoARoot/Aging_Statistics/Profile/2009/docs/2009profile_508.pdf
- Andresen, E. M., Malmgren, J. A., & Carter, W. B. (1994). Screening for depression in well older adults: Evaluation of a short form of the CES-D. *American Journal of Preventive Medicine, 10*, 77-84.
- Carpenter, J. S., Andrykowski, M. A., Wilson, J., Hall, L. A., Rayens, M. K., Sachs, B., & Cunningham, L. L. C. (1998). Psychometrics for two short forms of the Center for Epidemiologic Studies—Depression Scale. *Issues in Mental Health Nursing, 19*, 481-494.
- Cheung, C., & Kwan, A. Y. (2006). Inducting older adults into volunteer work to sustain their psychological well-being. *Ageing International, 31*, 44-58.
- Corporation for National and Community Service. (2006). *Volunteer growth in America: A review of trends since 1974*. Retrieved from http://www.nationalservice.gov/pdf/06_1203_volunteer_growth.pdf
- Dannefer, D. (2003). Cumulative advantage/disadvantage and the life course: Cross-fertilizing age and social science theory. *Journal of Gerontology: Social Sciences, 58B*, S327-S337.
- Einolf, C. J. (2009). Will the boomers volunteer during retirement? *Nonprofit and Voluntary Sector Quarterly, 38*, 181-199.
- Fischer, L. R., & Schaffer, K. B. (1993). *Older volunteers: A guide to research and practice*. Newbury Park, CA: Sage Publications.
- Fried, L. P., Carlson, M. C., Freedman, M., Frick, K. D., Glass, T. A., Hill, J., et al. (2004). A social model for health promotion for an aging population: Initial evidence on the Experience Corps model. *Journal of Urban Health, 81*, 64-78.
- Hinterlong, J. E. (2006). Race disparities in health among older adults: Examining the role of productive engagement. *Health & Social Work, 31*, 275-288.
- Kam, P. (2002). Senior volunteerism and empowerment. *Asia Pacifica Journal of Social Work, 12*, 112-133.
- Kovacs, P. J., & Black, B. (1999). Volunteerism and older adults: Implications for social work practice. *Journal of Gerontological Social Work, 32*(4), 25-39.
- LaVeist, T. A. (1994). Beyond dummy variables and sample selection: What health services researchers ought to know about race as a variable? *Health Services Research, 29*(1), 1-16.
- Li, Y. (2007). Recovering from spousal bereavement in later life: Does volunteer participation play a role. *Journal of Gerontology: Social Sciences, 62B*, S257-S266.
- Lord, J., & Hutchison, P. (1993). The process of empowerment: Implications for theory and practice. *Canadian Journal of Community Mental Health, 12*(1), 5-22.
- Lum, T., & Lightfoot, E. (2005). The effects of volunteering on the physical and mental health of older people. *Research on Aging, 27*(1), 31-55.
- Martinez, I., Frick, K., Glass, T. A., Carlson, M., Tanner, E., Ricks, M., & Fried, L. P. (2006). Engaging older adults in high impact volunteering that enhances health: Recruitment and retention in the Experience Corps Baltimore. *Journal of Urban Health, 83*, 941-953.
- McIntosh, B. R., & Danigelis, N. L. (1995). Race, gender, and the relevance of productive activity for elders' affect. *Journal of Gerontology: Social Sciences, 50B*, S229-S239.
- Miner, S., & Tolnay, S. (1998). Barriers to voluntary organization membership: An examination of race and cohort differences. *Journal of Gerontology: Social Sciences, 53B*, S241-S248.
- Morrow-Howell, N., Hinterlong, J., Rozario, P., & Tang, F. (2003). Effects of volunteering on the well-being of older adults. *Journal of Gerontology: Social Sciences, 58B*, S137-S145.
- Morrow-Howell, N., Hong, S., & Tang, F. (2009). Who benefits from volunteering? *Gerontologist, 49*, 91-102.
- Morrow-Howell, N., Kinnevy, S., & Mann, M. (1999). The perceived benefits of participating in volunteer and educational activities. *Journal of Gerontological Social Work, 32*, 65-80.
- Musick, M. A., Herzog, A. R., & House, J. S. (1999). Volunteering and mortality among older adults: Findings from a national sample. *Journal of Gerontology: Social Sciences, 54B*, S173-S180.
- Musick, M., & Wilson, J. (2003). Volunteering and depression: The role of psychological and social resources in different age groups. *Social Science & Medicine, 56*, 259-269.
- Musick, M., Wilson, J., & Bynum, W. B., Jr (2000). Race and formal volunteering: The differential effects of class and religion. *Social Force, 78*, 1539-1571.
- Omoto, A. M., & Snyder, M. (2002). Considerations of community: The context and process of volunteerism. *American Behavioral Scientist, 45*, 846-867.
- Sundeen, R. A., Garcia, C., & Raskoff, S. A. (2009). Ethnicity, acculturation, and volunteering to organizations. *Nonprofit and Voluntary Sector Quarterly, 38*, 929-955.
- Tan, E. J., Rebok, G. W., Yu, Q., Frangakis, C. E., Carlson, M. C., Wang, T., et al. (2009). The long-term relationship between high-intensity volunteering and physical activity in older African American Women. *Journal of Gerontology: Social Sciences, 64B*, 304-311.
- Taylor, R. J., & Chatters, L. M. (1991). Non-organizational religious participation among elderly blacks. *Journal of Gerontology: Social Sciences, 46*, S103-S111.
- Thoits, P. A., & Hewitt, L. N. (2001). Volunteer work and well-being. *Journal of Health & Social Behavior, 42*, 115-131.
- U.S. Bureau of Labor Statistics. (2009). *Volunteering in the United States*. Retrieved from <http://www.bls.gov/news.release/pdf/volun.pdf>

Fengyan Tang, PhD, MSW, is assistant professor, and **Valire Carr Copeland, PhD, MPH**, is associate professor, School of Social Work, University of Pittsburgh. **Sandra Wexler, PhD, ACSW**, is associate professor, Middle Tennessee State University, Murfreesboro. The research reported in this article was funded by the Center on Race and Social Problems, School of Social Work, University of Pittsburgh. The authors thank Merrille Weissman and Jeongim Grace Heo for their research assistance. Address correspondence to Fengyan Tang, School of Social Work, University of Pittsburgh, Pittsburgh, PA 15260; e-mail: fet7@pitt.edu.

Original manuscript received June 29, 2009

Final revision received May 12, 2010

Accepted July 9, 2010

Advance Access Publication September 20, 2012

Do Something Powerful

CAYA Specialty Practice Section



Join NASW's Children, Adolescents, and Young Adults Specialty Practice Section Today!*

NASW's Children, Adolescents, and Young Adults (CAYA) Specialty Practice Section (SPS) links you with the key information, resources, and expertise you need to stay at the forefront of your practice specialty:

- Specialized newsletters
- Practice updates
- Opportunity for FREE CE credits by reading *InterSections in Practice*, the SPS annual bulletin
- *eConnection*, a yearly electronic update
- Members-only Web-based products designed to enhance your professional development within the field

JOIN TODAY!

Go to www.socialworkers.org/sections or call 202.408.8600 ext. 476.

*You must be a current NASW member to join a Specialty Practice Section.

ASJ05033



National Association of Social Workers
Specialty Practice Sections

www.socialworkers.org/sections
202.408.8600 ext. 476