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Meaning in Life and Volunteerism in Older Adults

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Researchers explored predictors of meaning in life such as physical and mental health and volunteerism in a representative sample of older adults. Measures included the Geriatric Depression Scale and the Life Regard Index. Implications for counseling older adults are discussed.

A meaningful life is one of relatedness, significance, and fulfillment (Frankl, 1963; Maslow, 1964; Weisskopf-Joelson, 1968). Meaning provides context for life events so that people may develop connections between their experiences (Baumeister, 1991; Klinger, 1998). A consistent, meaningful existence helps humans feel connected and focused. Often, people living a meaningful life maintain coherent and congruent cognitions, affect, self-evaluation, and personal motivations (Van Selm & Dittmann-Kohli, 1998). A key aspect of meaning making is the formulation of goals that are congruent with one's meaning perspective. In that way, meaning serves as a framework to guide habits and behaviors (Hermon & Hazler, 1999). Individuals maintain internal balance when actions are formed based on a meaningful structure. Numerous factors contribute to meaning in life including self-esteem, self-integration, and relating well to one's environment (Battista & Almond, 1973; Scannell, Allen, & Burton, 2002).

Meaning in life has been investigated with individuals across the lifespan. As the population of older adults continues to rise, researchers are giving more attention to the development of personal meaning in later adulthood (Penick & Fallshore, 2005). Previous studies of older adults have found relationships between meaning in life and depression, anxiety, hope, life satisfaction, and volunteering (Mascaro & Rosen, 2005; Ryff, 1989; Steger & Frazier, 2005; Van Willigen, 2000; Zika & Chamberlain, 1992). This study explores physical health and mental health, volunteerism, and meaning in life.

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PHYSICAL AND MENTAL HEALTH

Making meaning in life appears to play an integral role in the ongoing development of human health and vitality (Maddi, 1998). Studies suggest that meaning may provide a buffer against stress (Drew & Kiecolt-Glaser, 1998; Mascaro & Rosen, 2006; Westgate, 1996). Ryff and Singer (1998) postulated that the body may experience positive reactions when a person embraces meaning in their life. Reker (1997) studied meaning in life and its effect on depression in later life and found a sense of personal meaning and adequate physical health predicted less depression in community-dwelling older adults. Prager, Bar-Tur, and Abramowici (1997) found a strong negative correlation between meaning in life and depressive symptomatology. Celso, Ebener, and Burkhead (2003) also established a significant relationship between health status and life satisfaction in older adults. Krause (2004) interviewed and surveyed older adults and found a relationship between physical health and meaning in life.

Previous research also suggests that experiencing meaning in life is in itself healing and associated with positive mental health (Adams, Bezner, Drabbs, Zambarano, & Steinhardt, 2000). Researchers have established a significant relationship between purpose in life and mental health in older women (Nygren et al., 2005). Scannell et al. (2002) found meaninglessness creates an existential vacuum establishing conditions for negative mental states such as depression. A nationwide longitudinal study of 1,093 older adults explored relationships among trauma, depressive symptoms, and meaning in life (Krause, 2007). Findings suggest having a sense of meaning in life offsets the impact of traumatic life events on depressive symptoms. Pinquart (2002) used meta-analysis to synthesize findings from 70 studies on purpose or meaning in life in middle age and old age. Strong associations between meaning in life with psychological well-being and low levels of depressive symptoms were found, particularly among older adults. In addition, high purpose in life was related to good physical health, higher everyday competence, higher income, being employed, and being married (Pinquart, 2002).

VOLUNTEERISM

Volunteering is socially valued and recognized as an important role in society. Individuals can engage in volunteering throughout their lives. In fact, volunteering may have a more positive impact on older adults than it has on younger adults (Van Willigen, 2000). Research suggests volunteering can contribute to positive well-being in older adults (Windsor, Anstey, & Rodgers, 2008). Volunteering has been shown to increase physical functioning and self-rated health among older adults (Lum & Lightfoot, 2005; Luoh & Herzog, 2002). Van Willigen (2000) demonstrated an increase in life satisfaction as a result of increased volunteering. Volunteering is also associated with reduced depressive symptoms (Hong, Morrow-Howell, Fengyan, & Hinterlong, 2009; Musick & Wilson, 2003).

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Previous research has demonstrated relationships among meaning in life and health, both physical and mental, as well as volunteerism. As professional counselors with a wellness focus, we are particularly interested in the predictive ability of the reported variables associated with meaning in life for older adults. Uncovering the impact of physical and mental health and volunteerism on meaning in life among older adults could guide our interventions when working with older adults in achieving and maintaining a meaningful life.

The purpose of this study was to examine the nature of relationships, specifically if physical and mental heath and volunteerism can predict meaning in life in older adults. Using previous literature as a guide, we hypothesized that physical and mental health would be positively associated with meaning in life. We also hypothesized older adults who volunteered their time would experience greater meaning in life than would those who did not volunteer.

METHOD

The study was approved by the Committee on Using Human Subjects in Research at a medium-sized midwestern university. Participants were interviewed by a trained research assistant (second author) and verbally completed several instruments, including the Life Regard Index (LRI; Battista & Almond, 1973) and the Geriatric Depression Scale–Short Form (GDS-SF; Sheikh & Yesavage, 1986). Participants completed a survey on heath and behaviors, provided a household description, and were interviewed regarding demographic data.

Participants

Participants living in the Midwest were recruited for this study at community meetings, learning institutes for retired persons, and social activities. The sample included 147 participants; 72.8% were female and 27.2% were male. The participants ranged in age from 63 to 98 years (M = 77, SD = 6.71). Respondents between the ages of 71 and 80 years represented 53.7% of the sample, 27.9% were ages 81 to 90 years old, 15.7% were ages 63 to 70 years old, and 2.8% were between 91 and 98 years old. In terms of racial background, the majority of participants (76.9%) were European American, 15.6% self-identified as African American, 3.4% self-identified as multiracial, and less than 1% self-identified as Hispanic (five respondents failed to answer this question). Regarding marital status, 46.3% were widowed, 37.7% were married, 13.7% were divorced, and 2.1% were single. The majority of participants (83.7%) were not currently working. Of that group, 74.8% retired because of age, 16.5% retired for a different reason, 7.2% retired because of disability, and a small percentage (1.4%) stated that they had not retired. The majority of participants (84.8%) reported that their income was sufficient to meet their needs, and 24.5 % of participants engaged in volunteer work.

Measures

LRI. Battista and Almond (1973) developed the LRI as a measure of meaning in life. The LRI consists of 28 items on a 5-point scale, with two subscales, Framework and Fulfillment. The Framework subcale assesses the degree to which a person is able to put her or his life into a context, with a sense of life purpose and goals that stem from this sense of context. The Fulfillment subcale assesses the degree to which a person has accomplished or is in the process of accomplishing her or his life goals.

Debats (1998) reviewed a number of published articles using the LRI (Battista & Almond, 1973) and examined psychometric properties of the LRI, including reliability (e.g., test–retest reliability, internal consistency reliability, factor structure) and validity (e.g., concurrent, content, discriminant, and predictive validity), concluding that the LRI "is an adequate instrument to operationalize the personal meaning construct" (Debats, 1998, p. 249). In addition, Debats recommended the LRI-R, the revised version of the LRI incorporating a randomization of the original items to reduce order effects, small adjustments to the wording of some items, and a shortened scale to account for response sets. Steger (2007) commented that no published studies of the LRI have revealed evidence of such extreme response sets.

Harris and Standard (2001) conducted a validation study of the LRI-R (English version) on 91 participants in a convenience sample from three states in the United States. Participants' ages ranged from 20 to 80 years ($M = 46$, $SD = 16.7$). They recommended a return to the 5-point Likert scale to reduce restriction of range or elimination of items endorsed by most participants. The two subscales, Framework and Fulfillment, were highly correlated and thus not empirically distinct. Until work with large samples is conducted, they recommended using the full scale as a general measure of positive life regard. In addition, they found that divorced individuals had significantly lower scores than had married individuals and that women scored significantly higher than did men, suggesting these two variables as confounds.

On the basis of the suggestions in the literature regarding the validity of the measure, we used the adjusted version of the LRI (Debats, 1998) but retained the original 5-point Likert scale. In addition, in our sample of older adults ($N = 147$), the two subscales (i.e., Fulfillment and Framework) were highly and significantly correlated ($r = .83$, $p < .001$). We used the entire scale of 28 items (Harris & Standard, 2001), which had internal consistency of alpha = .89; the dependent or criterion variable was an overall average of the participant's score on the LRI. The mean score on the LRI was 4.28 with a standard deviation of .46; skewness was –.57, and kurtosis was –.27. Scores ranged from 3 to 5. Thus, no adjustments for univariate normality were needed because the variable was distributed somewhat normally, although the range was in the upper three fifths of the scale. This was not surprising given that the study sample consisted of community-dwelling older adults who reported fairly high levels of physical and functional health.

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GDS. The GDS (Yesavage et al., 1982) has been tested and used extensively with the older population. The GDS (Long Form) is a brief, 30-item questionnaire in which participants are asked to respond by answering yes or no in reference to how they felt over the past week. The GDS-SF, consisting of 15 questions, was developed from the original version (Sheikh & Yesavage, 1986). Questions from the GDS-LF having the highest correlation with depressive symptoms in validation studies were selected for the short form. Sheikh and Yesavage (1986) found that both forms successfully differentiated depressed from nondepressed individuals ($r = .84$, $p < .001$). Of the 15 items on the short form, 10 indicated the presence of depression when answered positively, whereas the remaining items (Questions 1, 5, 7, 11, and 13) indicated depression when answered negatively. Scores of 0 to 4 are considered normal, depending on age, education, and complaints; 5 to 8 indicate mild depression; 9 to 11 indicate moderate depression; and 12 to 15 indicate severe depression. Kieffer and Reese (2002) conducted a reliability generalization study of 338 previously published research studies of the GDS. They found an average reliability of .85 with a standard deviation of .09. We coded the 15 items ranked 0 = *no* and 1 = *yes*. Items were reverse coded as necessary so that the higher the score, the higher the depressive symptomatology. K-R 20 (Kuder–Richardson formula 20 for internal consistency of dichotomous measures) for this scale in our study was .72.

Self-rated physical health. To measure participants' physical health, the question, "How satisfied are you with your health?" was used. Participants responded on a scale from 1 = *very dissatisfied* to 6 = *very satisfied* ($M = 4.59$, $SD = 1.40$; *range* = 1 to 6).

Volunteerism. Two questions measured volunteerism. Participants were asked whether they did volunteer work and how many hours they had volunteered during the previous week. The predictor of interest, past week volunteer hours, was a self-report of the number of hours volunteered during the previous week by the participant. Responses for the number of hours volunteered ranged from none ($n = 112$ or about 77% of the participants) to volunteering 40 hours the previous week as reported by one individual . We recoded this variable into four levels: 0 = *no volunteer hours in the past week* ($n = 112$), 1 = *1–3 hours volunteered in the past week* ($n = 8$), 2 = *4–9 hours* ($n = 10$), and 3 = *10 or more hours* ($n = 14$). A second variable assessed whether or not a participant does volunteer work (0 = *no* and 1 = *yes*) to validate our results. No appreciable differences were found, so for this article we report results for the continuous predictor, or past week volunteer hours.

Demographic control variables. The relationships among meaning in life and health and volunteerism were assessed after the effects of age, sex, marital status, and income were controlled statistically. Age was scored in a continuous format and ranged from 63 to 98 ($M = 77$, $SD = 6.71$). In contrast, sex (0 = *man,* 1 = *woman*) and marital status (0 = *married*, 1 = *otherwise*) are represented with binary indicators. Income was measured by the question, "Is your income sufficient to meet your needs?" and scored 0 = *no* and 1 = y*es*.

Data Analysis

We used SPSS (Version 18.0) to produce descriptive statistics, Pearson correlations, and hierarchical regression analyses. All analyses used listwise deletion for missing data; the analyzed sample was $N = 136$. The hierarchical regression, assessing the significance and independent contribution of predictors (as blocks and independently) of our dependent variable included three blocks of predictors of interest: control or confounding variables, physical and mental health predictors, and our predictor of interest, volunteer work (the continuous number of hours volunteered in the past week).

RESULTS

Test of Association

First, we examined zero-order correlations between our study variables (see Table 1). Consistent with the literature, life regard (which measures meaning in life) was positively and significantly associated with self-reported satisfaction with health ($r = .22$, $p < .01$) and negatively and significantly associated with mental health, assessed by the GDS ($r = -.55$, $p < .001$). Life regard was associated positively and significantly with the number of hours volunteered in the past week ($r = .25$, $p < .01$). Thus, on the basis of these associations, we conducted hierarchical regression analyses with three blocks, or models, of predictors (e.g., Model 1 included control variables: sex, age, income, and marital status; Model 2 added the physical and mental health predictors: self-rated physical health satisfaction and depressive symptoms; and Model 3 added the volunteer predictor: the dichotomous predictor for the first set of analyses and the continuous number of hours volunteered in the past week for the second set of analyses). This analytic procedure allowed us to see the

TABLE 1

Zero-Order Correlations Between Study Variables

Item	1	2	3	4	5	6	7	8
1. Life Regard Index	—							
2. Sex	.03	—						
3. Age	–.05	–.04	—					
4. Marital status	.13	–.42***	–.27**	—				
5. Income	.06	–.36***	–.07	.53***	—			
6. Physical health	.22*	–.08	–.01	.05	.13	—		
7. Mental health (GDS)	–.55***	.06	.07	–.20*	–.25**	–.46***	—	
8. Volunteer hours in the past week	.25**	–.11	–.18*	–.04	–.04	.15†	–.12	—

Note. $N = 136$. GDS = The Geriatric Depression Scale.
†$p \leq .10$. *$p \leq .05$. **$p \leq .01$.***$p \leq .001$, two-tailed.

contribution of each block of predictors and each individual predictor above that of the other blocks and predictors in a systematic fashion, partialling out the contributions of the others. We predicted, based on the literature reviewed, that participants' report of past week volunteer hours would positively and significantly influence life regard beyond the contribution of the control and health variables.

Second, the assumptions of ordinary least squares regression were assessed and not violated, providing confidence in our results. Histograms and scatter plots of standardized predicted values and standardized residuals appeared to be normally distributed and randomly scattered; the Durbin-Watson statistic was 1.65 (independent errors). We checked for multicollinearity using the tolerance statistic and Menard's (1995) suggestion that values below .2 are suspect; tolerances in our analyses ranged from .59 to .92. We assessed the undue influence of individual cases based on Cook's distance greater than 1.00 (Field, 2010; Stevens, 2002). The average Cook's distance was .007, the minimum was .00 and the maximum was .09.

Third, we conducted the hierarchical regression analyses (see Table 2). Model 1, the block of control variables did not significantly explain much variance (R^2 = .03); only marital status approached marginal statistical significance (β = .17, p = .12), and the significant zero-order association between age and life regard was attenuated when the influence of sex, income, and marital status were partialled out. Thus, controlling for sex, age, and income, being married tended toward a positive association with higher levels of life regard. Model 2 added the block of physical and mental health predictors. This group of pre-

TABLE 2

Hierarchical Regression Analyses for Predictors of Life Regard Index

Predictor Variable	Model 1 Control Variables			Model 2 Physical and Mental Health			Model 3 Volunteer Hours in Past Week		
	B	*SE*	β	*B*	*SE*	β	*B*	*SE*	β
Sex	.11	.01	.11	0.07	0.08	.07	0.06	0.08	.06
Age	.00	.10	.00	0.00	0.01	.02	0.00	0.01	.06
Marital status	.16	.11	.17	0.11	0.09	.22	0.12	0.09	.13
Income	.00	.02	.01	–0.02	0.01	–.11	–0.02	0.01	–.12
Physical health				–0.01	0.03	–.03	–0.02	0.03	–.06
Mental health (GDS)				–1.81	0.27	–.58***	–1.77	0.26	–.56***
Volunteer hours in past week							0.09	0.03	.20**
ΔF			.88			27.62***			6.94**
R^2			.03			0.32			0.35

Note. N = 136. GDS = The Geriatric Depression Scale.
p < .01.*p < .001, two-tailed.

dictors significantly influenced life regard ($F\Delta = 27.62$, $p < .001$), explaining 28% more variance than the control variables alone. The zero-order correlation between life regard and physical health, like that of age and life regard, was also attenuated when the other predictors in the two blocks were included in the analysis. After the health variables were entered, only mental health (GDS) was negatively and significantly associated with life regard ($\beta = -.58$, $p < .001$).

The final model added the predictor of interest, past week volunteer hours; beyond the other two blocks of predictors, it significantly contributed to the prediction of life regard ($F\Delta = 6.94$, $p < .01$). For this final model, the proportion of variance explained was $R^2 = .35$. In this model, mental health ($\beta = -.56$, $p < .001$) and past week volunteer hours ($\beta = .20$, $p < .01$) each contributed significantly to life regard beyond all other predictors in the final model. We did inspect for the possibility of a multiplicative effect or interaction between these two predictors, but the higher order term was not significant. Thus, both mental health, assessed by depressive symptomatology, and past week volunteer hours directly influenced participants' life regard.

Tests of Mean Differences

In addition to examining associations between variables of interest, such as which predictors were significantly related to the criterion, we conducted tests of mean differences. First, our survey data included a question that asked participants whether or not they volunteered; in other words, the variable was a dichotomous assessment where 0 = *no* and 1 = *yes*. The analyzed sample for this variable was $N = 147$ (111 participants responded no and 36 responded yes). A simple independent group's *t* test was performed to assess the differences in life regard between the two groups: those who had not volunteered and those who had. The assumption of homogeneity of variances held: Levene's test for equality of variances was $F = .15$, $p = .70$. Results confirmed our hypothesis that participants who volunteered had significantly greater levels of life regard ($M = 4.48$, $SD = .42$) than did those who did not volunteer ($M = 4.22$, $SD = .46$). The independent samples test results were $t(145) = 2.92$, $p = .004$, $d = .49$; thus, we found a relatively large effect size for volunteering on life regard (Cohen, 1992).

However, as our correlation and regression analyses revealed, it is important to consider the effects of other variables on life regard (e.g., age, physical health, and sex). We next conducted a univariate analysis of covariance on our outcome of interest, life regard, with the dichotomous assessment of whether or not participants had volunteered as our factor of interest. In addition, we included sex, age, marital status, physical and mental health (the same variables as the regression analyses reported previously) as covariates. Again, the Levene's test was nonsignificant, supporting the equality of error variances across the two groups; participants who did not volunteer reported lower levels of life regard ($M = 4.22$, $SD = .46$) than did those who had volunteered ($M = 4.48$, $SD = .42$). The global test was significant, $F(7, 139) = 9.95$, $p < .001$. Partial

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eta squared was .30. The pairwise comparison between the two groups was also significant (p = .02).

In sum, both sets of analyses—tests of association and tests of mean differences—showed that participants who either had volunteered or had volunteered for a certain period of time in the past week reported higher levels of life regard, holding constant a number of other variables known to influence life regard. Thus, beyond the contribution of these associated variables, volunteer time or level influenced the life regard for participants in this study.

DISCUSSION

This study investigated the relationship and predictive utility of mental health, physical health, and volunteerism on life regard in a sample of 147 older adults, ages 63 to 98 years. We hypothesized that there would be an inverse relationship between depressive symptoms and life regard. We expected a direct relationship between satisfaction with physical health and meaning in life. We also predicted individuals who volunteered their time would report higher positive life regard than would those who did not volunteer, controlling for sex, age, income, marital status, income, physical health, and mental health.

As expected, life regard was negatively and significantly associated with mental health, assessed by the GDS. This indicates that higher scores on an index of depression are related to lower satisfaction with life regard, or meaning in life. This finding is consistent with previous literature that suggests lack of meaning creates conditions for depression and other negative emotional states (Scannell et al., 2002). In our sample, 132 participants (90.4%) were in the "normal/no depression" range. The remaining participants (6.8%) reported mild depression. This group of older adults overwhelmingly reported the absence of depressive symptoms. Such findings are consistent with the literature, which suggests between 1% and 5% of older adults living independently experience depression (Blazer, 2002). Contrary to popular belief and stereotypes that depressive symptoms are a normal part of aging, the results of this study suggest the majority of community dwelling older adults do not suffer from depression. Many individuals experience positive mental health even into the later years of life. More research is needed in this area in order to dispel myths about normative and healthy aging in older adults.

Meaning in life was also positively and significantly associated with self-reported satisfaction with health. This supports previous research demonstrating a positive relationship between physical health and meaning in life or life satisfaction (Celso et al., 2003; Krause, 2004). In the current study, 69.4% of participants were moderately or very satisfied with their health in general. The findings of this study are consistent with previous findings that the majority of community-dwelling older adults rate their health as good or excellent (Rubinstein, 2002). Further research may explore the factors that positively influence health satisfaction in older adults.

We predicted individuals who volunteered would report higher life regard than would those who did not volunteer, controlling for demographic and health variables. Our hypothesis was supported because volunteering predicted positive life regard over and above other variables. These findings contribute to the current literature regarding volunteerism and meaning in life. Previous studies suggest an increase in life satisfaction as a result of increased volunteering (Van Willigen, 2000). Thus, it was not surprising to find participants who had volunteered reported higher levels of life regard than did those who had not volunteered. This study demonstrates that volunteering has a large effect on life regard.

These results may be representative of the general population of community-dwelling older adults. However, specific factors particular to this population of older adults must be considered. Respondents for this study were recruited at community meetings, learning institutes for retired persons, and social activities. People attending these functions likely feel healthy enough to socialize, thus they may experience greater physical and mental health than their less socially connected counterparts. Individuals who are depressed and physically ill can become socially withdrawn and discontinue outside activities. Thus, older adults who are depressed and/or sick may have been less likely to participate in this research. The majority of participants also indicated they had sufficient income to meet their needs. Individuals with less financial security may have been reluctant to spend unpaid time as an interview participant. Future studies may recruit participants from mental health agencies, hospitals, and community centers in order to obtain a more representative sample of community-dwelling older adults. Further research may also include older individuals from different regions and levels of socioeconomic status inhabiting a variety of living arrangements.

IMPLICATIONS FOR COUNSELORS

Professional counselors can assist older adults in meaning making in a number of ways. Counselors can support clients to identify and reduce depressive symptoms, thereby increasing the potential for positive mental health. Counselors also serve as advocates for older adults by informing the general community that normal aging does not include depression (Gonçalves, Albuquerque, Byrne, & Pachana, 2009). Depression should not be an expected outcome of growing older. Instead, depression in older adults must be identified and treated. If a client appears depressed at the onset of counseling, Savolaine and Granello (2002) suggested the individual may benefit from exploring meaning and hope in counseling. This might include engaging in sources for meaningful living, including partaking of creative work, participating in meaningful relationships, striving for self-transcendence, enjoying life's simple pleasures, having hope for the future, and engaging in life review (Wong, 1998). By the time individuals reach

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older adulthood, they have likely learned a variety of coping techniques to manage life stressors. Counselors can build on older adults' strengths to obtain additional coping skills to overcome challenges as one ages. Counselors could also help clients understand how their lives fit into a particular context. Individuals may experience relief from depressive symptoms and increased mental health as they create a more meaningful life framework.

Research from this study also suggests a strong relationship between satisfaction with health and reported meaning in life. Counselors could assist clients in setting goals to improve the quality of their health in multiple domains. Counselors might investigate a client's image of his or her overall health, including physical, sexual, psychological, and mental health domains. Counselors could use this information to create goals and measure progress on clients' perceptions of overall health. Discussing and setting goals surrounding health may also help clients create a realistic perspective about health and aging. Counselors are advised to appropriately refer clients to physicians and medical providers to support physical health.

Results from this study suggest older adults who volunteer experience higher life regard. Thus, counselors could discuss the value of volunteerism with their older adult clients. Volunteering has been shown to contribute to positive well-being and life satisfaction (Van Willigen, 2000; Windsor et al., 2008). Volunteers may experience an increase in physical functioning and self-rated health and reduced depressive symptoms (Hong et al., 2009; Lum & Lightfoot, 2005). Findings from the current study also suggest volunteerism predicts meaning in life. Many counselors work with individuals experiencing loss from the transition of traditional Western societal roles of worker or parent–guardian into retirement. Older adult clients may experience role loss or confusion, and volunteering could provide a renewed sense of meaning and fulfillment in their lives. Numerous agencies and nonprofit organizations connect older individuals of varying levels of physical capacities with opportunities to mentor, coach, and support others through volunteer efforts.

CONCLUSION

Individuals are capable of experiencing meaning throughout their lives. Counselors can support meaning-making activities in a variety of ways. Counselors must appropriately identify and treat depression in older adults and assist clients to develop appropriate coping skills to manage stressful life events. Counselors might discuss health satisfaction with their clients and connect them with resources. Finally, counselors can encourage clients to become involved in their community through volunteer activities in order to promote a healthy, more positive experience in the later seasons of life.

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