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Exploring the Influence of Supportive Communication Practices on Volunteer Satisfaction, Role Identity, Safety Perceptions, Loyalty, and Burnout

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The purpose of this thesis was to assess supportive communication practices as predictors of volunteer outcomes. As healthcare organizations continue to grow and expand services to patients, the need for volunteers will expand as well. If volunteers are supported within the organization they will become a part of the healthcare environment and ultimately can make a difference for the organization. It was hypothesized that supportive communication by both staff and co-volunteers would predict higher levels of volunteer satisfaction, role identity, safety perceptions, and loyalty, and lower levels of volunteer burnout. Results indicate that emotional support from staff was the strongest predictor of volunteer satisfaction, role identity, safety perceptions, word of mouth (an indicator of loyalty), and reduced burnout. Informational support to volunteers was also significant in predicting satisfaction and safety perceptions. Emotional support from co-volunteers strongly predicted volunteer satisfaction, as well as safety perceptions. Problem-solving support by co-volunteers was also predictive of Word Of Mouth (WOM). Implications of these findings and directions for future research are discussed.

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CHAPTER I

Introduction

The next two decades are a critical time for social institutions, especially in health care areas. Analysts report that 12% of the population is over 65 years of age and in the next 20 years this older group will grow to 20% of the population as the baby-boomer generation reaches retirement age (Amara, et al., 2003). This increase in aging population growth will add stress to already burdened health care and human services agencies as they work to meet the needs of the elderly struggling with increasing organizational and health care costs (Blendon & DesRoches, 2003).

To meet the growing needs of the aging population in a climate of increasing costs, health care organizations will need to increase services to their patients in the most cost effective manner while maintaining a high quality of patient care. Workers, both paid *and* unpaid will not only work to increase customer service to patients but also maintain the highest standards of quality healthcare. Volunteers can be key to the organization's success in these areas. They can assist hospital staff, co-volunteers, and in some cases, patients and their families – resulting in better service.

Volunteers often choose to work in healthcare settings for the most basic of motivations. A study of volunteers in a hospital setting indicated that their top three motives for volunteering were tied to their wish to help others, give back to the community, and show concern for those less fortunate (Zweigenhaft, Armstrong, Quintis, & Riddick, 1996). However, working in health care environments can turn altruistic motivation into emotional distress. A study on nursing home volunteers, for instance, found that the volunteer experience could be rewarding, but dealing with the deterioration

of health and eventually death of nursing home residents could be emotionally demanding and at times lead to volunteers leaving the program (Savishinsky, 1992). AIDS volunteers are also impacted by the stress of working with patients (Omoto & Snyder, 1995). Ultimately, emotional distress can lead to burnout resulting in physiological effects, attitudinal outcomes and organizational turnover (Miller, 2003).

Emphasis on social support to volunteers is key to managing stress in hospitals and other social service organizations (Ashcraft & Kedrowicz, 2002). Individual and organizational communicative strategies for dealing with workplace stress are outlined by House (1981) and include emotional, informational, appraisal and instrumental support. However, much of the research currently available on social support in healthcare settings focuses on paid workers. Further social support research needs to extend to the unpaid workers, the volunteers, to ensure their effective integration into the healthcare environment. Toward this end, the present study examines the impact of different types of supportive communication on volunteer satisfaction, role identity, safety perceptions, loyalty and burnout.

CHAPTER II

Literature Review

Social support has been defined in multiple ways. It can be defined very simply as "the resources provided by other people" (Cohen & Syme, 1985, p. 4). Alternatively, social support is sometimes defined conceptually or operationally in terms of the existence or quantity of social relationships in general, or of a particular type such as marriage, friendship or organizational membership (House & Kahn, 1985). Broadly, Cohen, Gottleib and Underwood (2000) state that social support refers to "any process through which social relationships might promote health and well-being" (p. 4). These processes involve "the provision or exchange of emotional, informational or instrumental resources in response to the perception that others are in need of such aid" (p. 4). Cohen et al. elaborated that social support represents the social resources that persons perceive to be available or that are actually provided to them by nonprofessionals in the context of both formal support groups and informal helping relationships" (p. 4).

Research from the sociological and psychological perspectives "recognize that communication plays a role in the origin and impact of social support" (Burleson & MacGeorge, 2002, p. 383). However, communication scholars see social support and communication as more tightly connected, stating that, "social support should be studied *as communication* because it is ultimately conveyed through messages directed by one individual to another in the context of a relationship that is created and sustained through interaction" (Burleson, Albrecht, Goldsmith, & Sarason, 1994, p. xviii). In this literature review I will explore literature on supportive communication, then discuss volunteer

needs for supportive communication and finally consider predicted outcomes of supportive communication for volunteers.

Supportive Communication

Social support is studied from a communication perspective as "supportive communication" (Burleson & MacGeorge, 2002). Albrecht and Adelman (1987) describe supportive communication as "verbal and nonverbal communication between recipients and providers that reduces uncertainty about the situation, the self, the other or the relationship, and functions to enhance a perception of personal control in one's life experience" (p. 19).

Supportive communication and its positive effects have been demonstrated with self-help groups (Arntson, & Droge, 1987), with occupational stress in the workplace (Ray, 1987) and as a means of building a worker's self-esteem (House, 1981). Nurses who experience chronic stress experience burnout when supportive communication is missing (Ray, 1987). Also, Miller, Ellis, Zook, and Lyles (1990) found that "burnout and satisfaction of support staff appears to be determined in large part by supportive and participative communication" (p. 321).

Supportive communication in health care, especially for nurses and hospital workers, has been well researched. Apker, Ford, and Fox (2003) reported that nurses identified more strongly with their hospital when they experienced supportive communication from managers and co-workers. Ellis and Miller (1994) also found that supportive communication from co-workers in the hospital setting can aid in reducing stress and burnout for nurses.

House (1981) presented four types of supportive behaviors or acts based on a review of previous conceptions of social support. They include emotional support, informational support, appraisal support, and instrumental support.

Emotional support. This support involves letting other persons know "that they are loved and cared for" (Miller, 2003, p. 240). A key element to emotional support is the availability of one or more persons who will listen sympathetically when an individual is having problems, providing care and acceptance (Wills & Shinar, 2000). Emotional support is the most frequently studied type of support and often what people think of when describing supportive communication generally. Emotional support includes positive assurances and provides trust-related messages that increase positive outcomes (Ellis & Miller, 1994; Albrecht & Adelman, 1987). House (1981) describes some of the emotional support attributes as love, trust and empathy. Others emphasize emotional support benefits, including enhancing self-esteem, reducing anxiety/depression and creating a motivation for coping with problems and situations (Wills & Shinar, 2000).

House (1981) concludes, "when individuals think of people being 'supportive' toward them, they think mainly of emotional support" (p. 24). Any attempt to support a distressed person will be perceived to be providing emotional support (Tardy, 1994). Individuals who are effective in providing comforting messages will be perceived as most supportive (Burleson, 1990). Additionally, direct effects and buffering effects from emotional support have a clear link to worker health (House & Kahn, 1985, p. 105).

Informational support. This support "involves the provision of facts and advice to help an individual cope" (Miller, 2003, p. 240). It could include helpful information for

solving problems, such as providing information about community resources and services, or offering ideas and suggesting alternatives about other courses of action (Wills & Shinar, 2000). It might also include support that helps improve communication and/or problem-solving skills, provides job-related information (Ellis & Miller, 1994; Gottleib & Todd, 1979), or offers advice/suggestions needed to succeed (House, 1981). Informational support increases the availability of useful information, helps with obtaining needed services and general aid that leads to more effective coping, and includes strategies for solving practical problems, as well as other coping efforts (Wills & Shinar, 2000).

Appraisal support. This support involves information from other people used as a source for self-assessment and evaluation (House, 1981). This support is described as "honest feedback about yourself or your work" (House, 1981, p. 26). Appraisal support is based on the concept that "social relationships can provide information about the appropriateness or normativeness of behavior" (Wills & Shinar, 2000, p. 88). Benefits might include a decrease in perceived negative assessments, an acceptance of feelings and a favorable comparison to others (Wills & Shinar, 2000).

Instrumental support. This support "involves physical or material assistance that helps an individual cope with stress and strain" (Miller, 2003, p. 240). It may include exchanges of time, resources or labor (Ellis & Miller, 1994; Albrecht & Adelman, 1987; Wills & Shinar, 2000), which could help people do their jobs better (House, 1981). Results from several studies found that instrumental messages were seen as more concerned and encouraging than messages without instrumental support (Tardy, 1994). Ellis and Miller (1994) found that instrumental support in the workplace could help

reduce nurses' emotional exhaustion, as well as reduce depersonalization, ultimately enhancing patient care. Benefits of instrumental support include solving practical problems, as well as helping with coping efforts (Wills & Shinar, 2000). Instrumental support in the form of training specific to a volunteer's work responsibilities can result in positive assimilation within the organization and ultimately result in reduced costs associated with administering volunteer programs (Egbert & Parrott, 2003). This instrumental support is most likely to come from supervisors (Miller, 2003).

Supportive Communication for Volunteers

When considering the volunteer's role within an organization it is important to recognize volunteers as non-traditional organizational members. Pearce (1993), in an extensive review of the behavior of unpaid works in organizations, noted many fundamental differences between volunteers and employees. He explains that the most obvious difference between the work world of the volunteer and the employee is that the volunteer's work tends to be structured differently. For instance, volunteer work is often part-time, a few hours a week or several hours a month; it is basically done in the volunteer's spare time. Volunteer work is more difficult to quantify, less tangible and often overlooked. Conversely, contribution to an organization for paid workers is easier to quantify and rewarded in dollars. Volunteer work is often motivated through intrinsic rewards. Pearce also found that when performing equivalent tasks as paid workers volunteers are more likely to be motivated by service and social rewards and their organizational commitment is most often associated with their feelings of personal importance to the organization and greater social involvement with organization members. Additionally, volunteer work can be considered a peripheral activity for the

volunteer, secondary to the primary responsibilities of job and family. It is also characterized by less formal communication and more coordination through phone and posted information.

Supportive communication can create an atmosphere that "serves as a communicative connection and compensation that affirms and anchors volunteer involvement" within the organization and for the volunteer experience as a whole (Ashcraft & Kedrowicz, 2002, p. 91). Within the organization the key sources of supportive communication for volunteers are staff and co-volunteers.

Staff supportive communication to volunteers can engender cooperation, affiliation, and positive interpersonal relations, and ultimately benefit the organization as a whole (McComb, 1995). Volunteer satisfaction and motivation to continue volunteering is greatly impacted and closely related to the volunteer-staff relationship (Mausner, 1988). To achieve this supportive relationship there must be accessibility, both physical and psychological (House, 1981). Volunteers must be able to communicate with staff relatively easily and frequently about issues and problems of concern to them" (House, 1981, p. 123).

Ashcraft & Kedrowicz (2002) found that when volunteers work in high stress areas and receive emotional support from staff they feel that their contribution is worthwhile and valuable. In addition, they found that more tangible support from staff in the areas of informational and appraisal support was viewed as necessary to increase skill level and can aid in personal and professional growth for volunteers. This support may result in more commitment to and affiliation with the organization as a whole.

While supportive communication with staff is important, volunteers also seek support from their co-volunteers. Interaction among volunteers creates positive self-assessment, more team cohesiveness and greater commitment to the organization as a whole (Sadler & Marty, 1998). Further, Ashcraft and Kedrowicz (2002) found that emotional support from co-volunteers allows for a more relationally intimate connection than from staff. Support from others that are experiencing the same stresses builds cohesiveness.

Predicted Outcomes of Supportive Communication for Volunteers

Outcomes can be categorized as positive or negative effects or results that impact or affect the individual or the organization as whole. Within health care contexts supportive communication has been found to predict positive outcomes for workers. Some of these include attitudinal outcomes such as work satisfaction and commitment (Miller et al., 1990) and organizational identification (Apker et al., 2003), as well as retention and organizational commitment (Ellis & Miller, 1994). It should follow that within health care contexts supportive communication can also predict outcomes for volunteers.

Volunteer satisfaction. Satisfaction with the volunteer experience has been described in a variety of ways. Omoto and Snyder (1995) in their study with AIDS volunteers defined volunteer satisfaction as overall personal contentment with the volunteer process, encompassing nine experiential dimensions: "satisfying, rewarding, exciting, interesting, important, disappointing, enjoyable, challenging, and boring" (p. 676). Volunteer satisfaction has also been characterized in studies as satisfaction with the organization and expressions of positive feeling about volunteering in general (Penner &

Finkelstein, 1998). Regardless of the wording or components in defining satisfaction, volunteer satisfaction is closely related to the determinants of turnover (Miller et al., 1990; Penner & Finkelstein, 1998), the processes and experiences of volunteering (Omoto & Snyder, 1995), as well as the amount of time spent volunteering for a specific organization (Penner, 2002).

The quality of the volunteer experience is closely tied to the staff-volunteer relationship (Mausner, 1988; Sadler & Marty, 1998). Mausner notes that the success of the volunteer's work and ultimately the satisfaction that is experienced by volunteers is "highly dependent on the ability of volunteers and staff to achieve both mutual trust and the concomitant willingness to share power" (p. 8). When volunteers and staff work amicably together, the volunteer's job includes input into their work activities and produces greater incentive to further the organization's goals.

Volunteers who feel supported by staff express more commitment to the organization and more fulfillment in their volunteering (Ashcraft & Kedrowicz, 2002; Reitsma-Street, Maczewski, & Neysmith, 2000; Mausner, 1988; Sadler & Marty, 1998). In addition, staff that lead by example are perceived to be more genuine and by this personal dedication build connections between individual volunteers and themselves (Pearce, 1993).

Supportive communication with volunteers may be a significant determinant of relational quality and commitment to the organization. People-oriented managers seem to be more successful because they encourage a participative/consultative decision-making process (Adams, Schlueter, & Barge, 1988). This process of instrumental support also includes positive reinforcement, both informal and formal recognition; frequent

expressions of gratitude for and importance of volunteers' work; and personal interest taking in the volunteer and their work.

Volunteer role identity. Volunteers who feel connected to the organization develop into more knowledgeable workers; this identity with the organization is often central to the volunteers' self and social identity (Pearce, 1993). In addition, Pearce found that this organizational identity can lead to a more intense involvement with the organization, an emotional commitment that can result in internalization of the organization's goals and values.

Reich (2000) found that emergency medical technician (EMT) volunteers who saw a correlation between their core self, who they are – the "real me", and the volunteer role that they were enacting felt more highly committed to the position. In addition, role identity helped to transcend situational constraints, temporary setbacks and frustrations in the volunteer position.

Social networks and emotional support within the organization can affect volunteer role identity. Key to retaining volunteers is an understanding that volunteering with a number of organizations often results in a general volunteer role identity. Grube and Piliavin (2000) found that specific role identity, identity with the specific roles within a particular organization, had a positive influence on number of volunteer hours worked as well as organizational commitment of those hours. They also reported that possible loss of important friendships within a particular organization if one were to stop volunteering likely caused volunteers to remain in their position. Conversely, Miller (2003) reports that one of the environmental factors difficult for an individual to deal with, a stressor that leads to burnout, is role ambiguity. This uncertainty about what

should be accomplished in their job adds to the uncertainty of their work situation and ultimately, reduces the extent to which workers feel they have control over their jobs (Miller et al, 1990).

V*olunteer safety perceptions.* According to McCammon and Hand (1996) it is important to note that volunteer orientation into an organization is an ongoing process, not just the initial introduction to the organization. During their study of a wide variety of organizations they found that during orientation one of the four key elements volunteers needed information on was safety. Safety questions included in their assessment were: "What are my volunteer rights and how can I expect to be treated; What is my level of autonomy and authority to make decisions; and, What risks are inherent in the job, and does the organization protect me from them." (p. 15). Effective orientation into the organization, informational support, can have a long-term impact on the commitment and satisfaction of volunteers (McCammon & Hand, 1996).

Supportive communication with volunteers helps create a safe environment for volunteers. When volunteers feel that others are interested and careful of them and their safety they will feel part of the "team", part of the organization as valued members.

Volunteer loyalty. Volunteer motivation today includes many and varied reasons. Altruism, while still a part of the volunteer's intention to volunteer, is not the only motivation. Job-related work experiences, social interaction with others, as well as experiences that promote personal growth help to drive volunteering (Mausner, 1988).

Loyalty can be found in the initial stages of volunteering as altruistic, but continued dedication to a specific organization is more complex. In service organizations customer loyalty is predicated first on the relationship between a customer's attitude

toward a specific organization when compared with other like organizations; and second, on the customer's repeat use or patronage of that organization (Dick & Basu, 1994). Likewise volunteer loyalty may begin with a dedication to the process of volunteering for specific causes or need based organizations such as hospitals or health care initiatives. Continued volunteer work within a specific health care organization is predicated on the volunteers' experience and association as a valued member of that organization.

One differentiation found in volunteers that work in health care settings from other volunteer work is their dedication to the service of the organization and to the patients and their families. Sadler and Marty (1998) in their study with hospice volunteers found that one of the major turning points for volunteers was in the interpersonal area. Socialization of volunteers included the area of interactions with staff, other volunteers and patients and their families. This emotional support from staff and co-workers was a key factor in their decision to continue volunteering for hospice.

Often in volunteering positions volunteers spend extended periods of time alone away from more formalized work relationships (Ashcraft & Kedrowicz, 2002). Time spent volunteering is often done in situations with little supervision or feedback from staff. These kinds of situations can produce uncertainty by the volunteer and, according to Pearce (1993), can lead to confusion on the volunteer's part in the areas of role and organizational identity, as well as doubts about relationships with staff and other volunteers within the organization. Added emphasis needs to be placed on supportive communication and interaction with the volunteer to provide social support and interpersonal interconnectivity, thus guaranteeing "organizational experiences conducive to volunteer tenure" (Ashcraft & Kedrowicz, 2002, p. 91). Volunteers who are satisfied

with their volunteer experience often encourage others to volunteer for their organizations (Pearce, 1993).

Loyalty can also be assessed by using behavioral indicators. Ford (1995, 1998), in studies on customer service, considered different forms of customer contributions to an organization under the rubric of *customer discretionary behavior* (CDB). Within this category she included *word of mouth* (WOM), which can be assessed from cooperative CDB as *promotion* which is defined as "advertising" a place of business", such as "recommending an organization to others" (Ford, 1998, p. 113); or, WOM can be assessed from an uncooperative CDB as *destruction* which is defined as "damaging an organization's property, appearance, or reputation" including "complaining about organization to other customers" (Ford, 1998, p. 114). Organizations may rely on the WOM cooperative method for volunteer recruitment, as this type of volunteer gaining usually results from people encouraging friends or relatives to volunteer, resulting in a workforce that is more homogeneous and can lead to greater longevity (Pearce, 1993).

Volunteer longevity in one community resource center was associated with genuine relationships that were developed while volunteering (Reitsma-Street et al., 2000). In this setting profound relationships were developed and because of this volunteers appreciated themselves and their roles, resulting in more supportive communication, and ultimately volunteers create a place of self and other acceptance, appreciation, and support. In this way staff have a great impact on creating an atmosphere where volunteers can visit, talk and do meaningful work.

Volunteer burnout. Burnout has been widely researched in heath care settings. Maslach (1982) defines burnout from a three dimensional framework that includes: 1)

depersonalization – a negative shift that a caregiver experiences when caring for others; 2) reduced personal accomplishment – a negative shift in response when considering oneself; and, 3) emotional exhaustion – a state of depleted energy, fatigue and general inability to give of oneself to care for others. Emotional exhaustion is also described as negative job feelings that include frustration, tension, and discouragement (Klitzman, House, Israel, & Mero, 1990). It has been identified as the defining feature of burnout, and precursor to depersonalization and reduced personal accomplishment (Leiter, 1991).

Miller, Stiff and Ellis (1988) state that burnout is "a reaction to constant, emotional communicative contact with individuals in need of help" (p. 250). They also emphasize "the negative impacts of burnout range from physiological (e. g., fatigue, insomnia, and heart disease) to the psychological (e. g., job dissatisfaction and depression) to the organizational (e. g., turnover and absenteeism)" (p. 250). For hospice volunteers, stress and burnout is directly related to "role ambiguity, status ambiguity, patient and family issues and stress to the volunteer's personal circumstances" (Sadler & Marty, 1998, p. 51).

Studies have found that workers in health-care settings can mitigate the burnout factors by using supportive communication (Miller, Ellis, Zook & Lyles, 1990). Miller et al. found that "participation in decision making, support from supervisors, and support from coworkers can all serve to reduce the perception of stressors in the work environment, to decrease the experience of burnout, or to increase the experience of positive outcomes such as satisfaction and commitment" (p. 321).

Hypotheses

The primary objective of this study was to assess supportive communication practices as predictors of volunteer outcomes. As healthcare organizations continue to grow and expand services to patients, the need for volunteers will expand as well. If volunteers are supported within the organization they will become a part of the healthcare environment and ultimately can make a difference for the organization. Predicted relationships are displayed in the figure below.

H_1: Supportive communication by staff will predict higher levels of volunteer satisfaction, role identity, safety perceptions, and loyalty, and lower levels of volunteer burnout.

H_2: Supportive communication by co-volunteers will predict higher levels of volunteer satisfaction, role identity, safety perceptions, and loyalty, and lower levels of volunteer burnout.

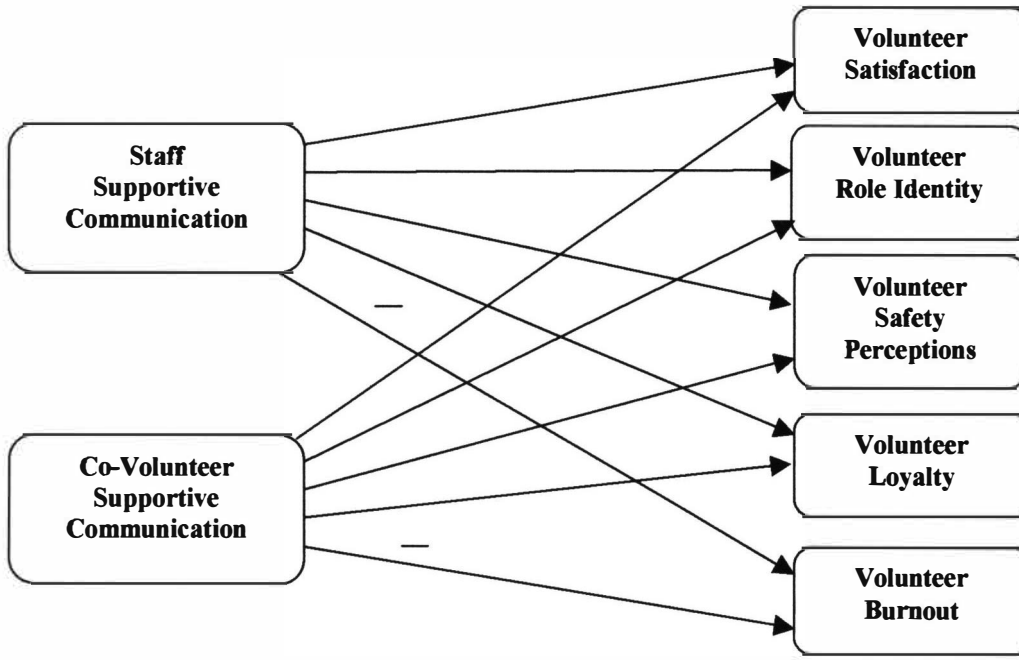

Figure 1. Supportive Communication-Outcomes Model for Volunteers in a Healthcare Environment

CHAPTER III

Method

Research Context

This study was conducted in cooperation with the volunteer department at Bronson Healthcare Group. Bronson is a community owned, not-for-profit health care system providing high quality medical care to people in Southwest Michigan and Northern Indiana. The Bronson volunteer group is comprised of approximately 250 volunteers working a total of 30,000-40,000 hours annually. Volunteers participate in over 30 service areas in the hospital system, providing assistance to staff, visitors and patients. After orientation and training is completed, volunteers are assigned to one of the service areas within the hospital and report directly to staff within that service area.

Procedure

Survey packets were mailed out to 252 volunteers in the volunteer services group at Bronson. Criteria for inclusion was all current individuals age 18 and over who had volunteered for Bronson in one of their service areas for at least 1 month.

To encourage participation, survey packets were mailed from Bronson directly to volunteers' home addresses and included a letter of introduction from the president and CEO of Bronson Methodist Hospital encouraging volunteers to take part in this study and assuring them that their responses would go directly to the researcher (Appendix A); a formal IRB-approved consent letter assuring anonymity (Appendix B); the survey instrument (Appendix C); a return envelope for direct return of the survey to an internal mailbox at Bronson Hospital which was assigned to the study; and a $2 gift certificate redeemable for food or merchandise at any of the hospital's facilities.

Participants

Of the 252 volunteers who were mailed survey packets, 122 (12% male, 88% female) responded, representing a 49% response rate. Ages ranged from 19 to 100 years with 13 (11%) between 19 and 27, 22 (19%) between 40 and 59, 27 (23%) between 60 and 69, 30 (25%) between 70 and 79, and 26 (22%) 80 and above (4 respondents did not indicate their age). Most, 114 (95%) reported they are White, 5 (4.2%) Black, 1(.8%) Asian, 0 (0%) Hispanic, and 0 (0%) Native American (2 respondents did not indicate their race/ethnicity).

Survey Pilot Test

The researcher performed a timed pilot test of the survey instrument to address issues of clarity and timing. Eight volunteers were asked to complete the survey, then discuss their reactions, as well as give feedback on wording of instructions. Adjustments were made based on feedback received.

Measures

The survey instrument was divided into three sections and consisted of 53 Likert-type questions as well as a few questions to gather basic demographic information. The independent variables of staff supportive communication and co-volunteer supportive communication were measured using 32 items. The dependent variables of volunteer satisfaction, role identity, loyalty, safety perceptions and burnout, included 21 items. All measures for the study, when possible, were comprised of items from existing instruments with modifications to more clearly focus on volunteers.

Staff and co-volunteer supportive communication. The measures used to assess informational, emotional, and instrumental support from staff and co-volunteers include

items from scales by Edwards (1980) and Lyles (1989), as modified by Ellis and Miller (1994). The measure used to assess appraisal support from staff and co-volunteers was newly constructed for the study.

Using a 5-point Likert-type scale ranging from never (1) to always (5), volunteers were asked to assess "how often do hospital employees" and "how often do other volunteers" exhibit 16 supportive communication behaviors. The scale for informational support consisted of 4 items reflecting the frequency with which others "explain how to get things done," "inform me of policies and decisions that may affect me," "talk to me if I am confused about issues related to my volunteer tasks," and "give me helpful information about other volunteers or staff members." The scale for emotional support consisted of 4 items reflecting the frequency with which others "listen to me," "show concern for my welfare," "go out of their way to praise my good work," and "show they trust me." The scale for instrumental support consisted of 4 items reflecting the frequency with which others "ask if I could use some help or if I need assistance," "'pitch in'" and help me," "help me complete my tasks," and "help me with my tasks if I get overloaded."

For appraisal support, I developed a 4-item scale based on defining features of appraisal support developed by House and Wells (1978). These reflected the frequency with which others "give me feedback about my performance as a volunteer," "tell me when I am doing a good job," "let me know when I am doing things incorrectly," and "let me know when I am doing things correctly."

Volunteer Outcomes

The survey section on the volunteers' experience with Bronson assessed volunteer's satisfaction, role identity, safety perceptions, loyalty and burnout. The

measures used a Likert-type scale ranging from strongly disagree (1) to strongly agree (5).

Volunteer satisfaction. Satisfaction was measured using a version of the satisfaction subscale on the Michigan Organizational Assessment Questionnaire (Camman, Fichman, Jenkins, & Klesh, 1979), as modified by Ford, Gregory and Kausche (2005) in a study of volunteers in two non-profit organizations. The Likert-type scale consisted of 2 items, as follows: "all in all, I am satisfied with my volunteer role at Bronson," and "in general, I like volunteering at Bronson." Ford et al. reported a Cronbach's alpha of .93 on this measure.

Volunteer role identity. Identity measures were gleaned from two previous studies of volunteer role identity. Two items were taken from a scale developed by Ford et al. (2005) for non-profit organizations. These items were, "my role as a volunteer with Bronson is important to me" and "what Bronson does for patients is important to me." Two additional items are from Grube and Piliavin (2000), using a modified version of Callero's (1985) study of blood donors. These items were, "I would feel a loss if I were forced to give up volunteering at Bronson" and "my volunteer role at Bronson is an important part of who I am."

Volunteer safety perceptions. A measurement scale for safety perceptions was created using assessment questions that originated in a volunteer orientation study by McCammon and Hand (1996). This scale has 3 items: "I feel that Bronson works to protect me from safety risks," "I feel that Bronson cares about my safety," and "I feel comfortable reporting safety issues at Bronson when I see them."

Volunteer loyalty. Loyalty was measured using two scales. First, Word of Mouth (WOM) was measured using a 4-item scale extended from a 2-item scale used in a customer service study by Ford (2003). The items are, "I am likely to say positive things about Bronson to others," "I am likely to recommend Bronson to others who need health-related services," "I am likely to recommend Bronson to others as a good place to volunteer," and "I am likely to recommend Bronson to others as a good place to work." Second, longevity intentions were measured using a 3-item scale developed by Ford et al. (2005). These items are, "It is likely I will still be a volunteer with Bronson in 6 months," "It is likely I will still be a volunteer with Bronson in 2 years," and "It is likely I will still be a volunteer with Bronson in 5 years."

Volunteer burnout. Burnout in health care workers has been extensively studied using the Maslach Burnout Inventory (MBI) (Maslach & Johnson, 1981; Maslach, 1982). Miller et al. (1990) and Miller, Zook, and Ellis (1989) used the MBI scale to assess worker burnout in a psychiatric hospital and nursing home facility, respectively, using a 16-item subscale. However, Ford, Carroll and Wade (2003) compared the emotional exhaustion subscale of the MBI with the Klitzman et al. (1990) 4-item negative job feelings scale and found the two to be highly correlated in measuring emotional exhaustion (r = .83). Based on this assessment and for brevity sake, the negative job feelings scale was chosen for this study. Wording of the 4 items was changed slightly to represent volunteer work for Bronson: "I feel frustrated about my volunteer work at Bronson," "I feel drained of energy when I volunteer at Bronson," "I feel tense when I volunteer at Bronson," and "I feel discouraged about my volunteer work at Bronson." Ford et al. (2003) reported a Cronbach's alpha of .86 for the measure.

CHAPTER IV

Results

The analyses were performed in 3 stages. First, a preliminary, unplanned analysis of interaction patterns was performed to assess differing interaction patterns indicated by volunteers on the surveys. Second, data analyses of measures were performed, including factor analyses of the newly created supportive communication behavior scales and reliability analyses for both supportive communication and volunteer outcomes. Finally, correlations and regressions were performed to test hypotheses.

Preliminary Analysis of Interaction Patterns

Prior to the data analysis of measures, review of survey responses showed differing interaction patterns than were initially expected from volunteers. Surveys showed written notations by many respondents indicating 4 different interaction patterns with co-volunteers and staff. Sample statements include "I am the only volunteer in my area," "My answers are colored by the fact that I am the only volunteer in our area," and "NA" [working with staff is not applicable to me] (Table 1).

Table 1
Interactions with Volunteers and Staff (N = 122)

Interactions	*Frequency*	*Percent*
Interact Only with Staff [a]	29	24
Interact Only with Co-volunteers [a]	4	3
No Interaction with Staff or Co-volunteers [a]	8	7
Assumed to Interact with Staff and Co-volunteers	81	66
Total	122	100

Note: [a]Based on survey respondents' written notation on survey.

There were a number of surveys with written notations indicating that the volunteer only interacted with staff or did not interact with co-volunteers (N = 29). There were also a few surveys with written notations indicating that the volunteer only interacted with co-volunteers or did not interact with staff (N = 4). In addition, there were several surveys with written notations indicating that the volunteer did not interact with staff or with co-volunteers (N = 8). Most surveys had no written notation on them, implying volunteer interaction with staff and co-volunteers (N = 81). Based on these assessments survey results addressing co-volunteer interaction (N = 85) and staff interaction (N = 110) were analyzed independently.

Measurement Analysis

Supportive communication. Principle components factor analyses with varimax rotation were performed to test the validity of all supportive communication behaviors. Staff and co-volunteer factor structures were assessed separately.

Factor solutions were required to have eigenvalues greater than 1.00. In addition, items retained in the factors had to have primary loadings of .60 or higher with secondary loadings on other factors lower than .40 (Tabachnick & Fidell, 1996).

The analysis of supportive communication from staff resulted in a three-factor solution accounting for 79% of the variance. Eigenvalues and factor loadings for supportive communication from staff scales are reported in Table 2.

The first factor, emotional support, comprised 5 items that overlapped emotional and appraisal supportive behaviors; one item from the appraisal support scale and 2 items from the emotional support scale were dropped due to lack of internal consistency with other items. The second, instrumental support, was comprised of the 4 items from the

Table 2
Supportive Communication from Staff (N = 110)

Supportive Behavior and Item	*Factor Loading*
Emotional Support from Staff	
(eigenvalue = 3.8, variance explained = 30%)	
1. Tell me when I am doing a good job	.86
2. Give me feedback about my performance as a volunteer	.82
3. Go out of their way to praise my good work	.81
4. Let me know when I am doing things correctly	.76
5. Show concern for my welfare	.73
Instrumental Support from Staff	
(eigenvalue = 3.4, variance explained = 26%)	
1. Help me complete my tasks	.91
2. "Pitch in" and help me	.89
3. Help me with my tasks if I get overloaded	.80
4. Ask if I could use some help or if I need assistance	.71
Informational Support from Staff	
(eigenvalue = 3.0, variance explained = 23%)	
1. Talk to me if I am confused about issues related to my volunteer tasks	.84
2. Inform me of policies and decisions that may affect me	.80
3. Explain how to get things done	.74
4. Give me helpful information about other volunteers or staff members	.65

instrumental support scale. The third, informational support, was comprised of the 4 items from the informational support scale.

The analysis of supportive communication from co-volunteers resulted in a two-factor solution accounting for 78% of the variance. Eigenvalues and factor loadings for supportive communication from co-volunteers scales are reported in Table 3. The first factor, emotional support, comprised 5 items that overlapped emotional and appraisal supportive behaviors; two items from the appraisal support scale and 1 item from the emotional support scale were dropped due to lack of internal consistency with other items. The second factor, problem-solving support, comprised all of the 8 items that overlapped informational and instrumental supportive behaviors.

After completion of the factor analysis, alpha reliabilities were calculated for staff and co-volunteer supportive communication. All scales were found to have Cronbach's alphas higher than .70. Means, standard deviations, and Cronbach's alphas are reported in Table 4.

Assessment of the three supportive communication variables for staff and co-volunteers demonstrated a high degree of correlation among all of the variables at $p \leq .001$, but not so high as to suggest the variables were not distinctive (Table 5 and 6). Intercorrelations needed to be above .70 to be distinctive (Tabachnick & Fidell, 1996).

Volunteer outcomes. Means, standard deviations and Cronbach's alphas were obtained for all volunteer outcomes. All scales were found to have high levels of reliability with Cronbach's alphas greater than .70. See Table 7 for means, standard deviations and reliability statistics.

Table 3
Supportive Communication from Co-volunteers (N = 85)

Supportive Behavior and Item	*Factor Loading*
Emotional Support from Co-volunteers	
(eigenvalue = 4.1, variance explained = 32%)	
1. Tell me when I am doing a good job	.90
2. Go out of their way to praise my good work	.87
3. Give me feedback about my performance as a volunteer	.83
4. Show concern for my welfare	.74
5. Show they trust me	.70
Problem-Solving Support from Co-volunteers	
(eigenvalue = 5.9, variance explained = 46%)	
1. Help me complete my tasks	.88
2. Help me with my tasks if I get overloaded	.87
3. "Pitch in" and help me	.85
4. Explain how to get things done	.84
5. Ask if I could use some help or if I need assistance	.82
6. Inform me of policies and decisions that may affect me	.80
7. Give me helpful information about other volunteers or staff members	.77
8. Talk to me if I am confused about issues related to my volunteers tasks	.75

Table 4
Means, Standard Deviations, and Cronbach's Alphas for Supportive Communication from Staff and Co-volunteers

Variables	*Mean*	SD	α
Supportive Communication from Staff (N = 110)			
Emotional Support	4.20	1.02	.85
Informational Support	4.21	.98	.78
Instrumental Support	3.82	1.29	.89
Supportive Communication from Co-volunteers (N = 85)			
Emotional Support	3.78	1.07	.87
Problem-Solving Support	3.80	1.18	.93

Table 5
Intercorrelations for Supportive Communication from Staff (N = 110)

Variables	1	2	3
1. Emotional Support	1.00		
2. Informational Support	.68***	1.00	
3. Instrumental Support	.61***	.64***	1.00

Note: ***$p \leq .001$.

Table 6
Intercorrelation for Supportive Communication from Co-volunteers (N = 85)

Variables	1	2
1. Emotional Support	1.00	
2. Problem-Solving Support	.68***	1.00

Note: ***$p \leq .001$.

Table 7
Means, Standard Deviations, and Cronbach's Alphas for Volunteer Outcomes

Variables	*Mean*	SD	α
Volunteer Outcomes (N = 122)			
Satisfaction	4.74	.59	.74
Role Identity	4.62	.55	.87
Word of Mouth	4.78	.39	.83
Burnout	1.44	.78	.94
Safety Perceptions	4.68	.64	.86

The measure of longevity was eliminated from the analysis. This measure proved to be problematic due to volunteer age potentially influencing responses. About 70% of respondents were 60 to 100 years old. When asked how "likely" they were to continue volunteering for specified times they commonly wrote statements such as, "God willing!!" and "Probably not as I am ill." It appears volunteers considered other factors beyond their control. Therefore, the measures may not be valid.

An assessment of correlations among outcome variables demonstrated that most relationships appear to have some degree of significance, though not above .70 (Table 8).

Tests of Hypotheses

H_1 stated that supportive communication by staff would predict higher levels of volunteer satisfaction, role identity, safety perceptions, and loyalty, and lower levels of volunteer burnout. In support of the hypothesis, most correlations between supportive communication from staff and volunteer outcomes were significant (Table 9). The exceptions were between burnout and instrumental support (r = -.17) and between

Table 8
Intercorrelations among Volunteer Outcomes (N = 122)

	Volunteer Outcomes				
	1.	2.	3.	4.	5.
1. Satisfaction	1.00				
2. Role Identity	.63***	1.00			
3. Word of Mouth	.66***	.54***	1.00		
4. Burnout[a]	-.36***	-.18*	-.25**	1.00	
5. Safety Perceptions	.56***	.28***	.47***	-.23**	1.00

Note: $*p \leq .05$. $**p \leq .01$. $***p \leq .001$. [a]Burnout – lower numbers equal lower levels of burnout.

Table 9
Correlations between Supportive Communication from Staff and Volunteer Outcomes (N = 110)

	Volunteer Outcomes				
	SAT	*RI*	*WOM*	*BO*[a]	*SP*
Supportive Communication from Staff					
Emotional Support	.55***	.40***	.48***	-.42***	.60***
Informational Support	.51***	.25**	.41***	-.27**	.58***
Instrumental Support	.36***	.24**	.37***	-.17	.36***

Note: $**p \leq .01$. $***p \leq .001$. [a]Burnout – lower numbers equal lower levels of burnout.
SAT = Satisfaction, RI = Role Identity, WOM = Word Of Mouth, BO[a] = Burnout, SP = Safety Perception

longevity and emotional (r = .14), informational (r = -.01) and instrumental (r = -.01) support.

Volunteers who received more *emotional* support from staff had higher levels of satisfaction (r = .55), role identity (r = .40), WOM (r = .48), and safety perceptions (r = .60), and lower levels of burnout (r = -.42).

Also, volunteers who received more *informational* support from staff had higher levels of satisfaction (r = .51), role identity (r = .25), WOM (r = .41), and safety perceptions (r = .58), and lower levels of burnout (r = -.27). In addition, volunteers who received more *instrumental* support from staff had higher levels of satisfaction (r = .36), role identity (r = .24), WOM (r = .37), and safety perceptions (r = .36).

Regression analyses were performed to assess which of the supportive communication practices by staff were most significant in predicting each of the volunteer outcomes (Table 10). Two dimensions of supportive communication were significant in predicting volunteer satisfaction, relative to other dimensions.

Emotional support was the strongest predictor (R^2 = .33; $F(2, 106) = 26.12, p \leq .001$) and *informational* support (R^2 = .33; $F(2, 106) = 26.12, p \leq .05$) also contributed significantly to volunteer satisfaction.

Emotional support was the sole predictor of volunteer role identity (R^2 = .23; $F(1, 105) = 30.64, p \leq .001$) and WOM ($R^2$ = .16; $F(1, 105) = 19.67, p \leq .001$). Two dimensions of supportive communication contributed significantly to volunteers' safety perceptions: *emotional* support (R^2 = .41; $F(2, 106) = 36.57, p \leq .001$) and *informational* support (R^2 = .41; $F(2, 106) = 36.57, p \leq .01$). Finally, only *emotional* support by staff

Table 10
Results of Multiple Regression Analyses Showing Dimensions of Supportive Communication from Staff as Significant Predictors of Volunteer Outcomes (Staff = 110)

Volunteer Outcomes	β	*t*	*p*
Satisfaction			
Emotional Support	.38	3.46	.001
Informational Support	.25	2.26	.03
Role Identity			
Emotional Support	.40	4.44	.001
Word of Mouth			
Emotional Support	.48	5.54	.001
Burnout[a]			
Emotional Support	-.42	-4.76	.001
Safety Perceptions			
Emotional Support	.39	3.79	.001
Informational Support	.31	3.01	.01

Note: [a]Burnout – lower numbers equal lower levels of burnout.

contributed significantly to lower levels of volunteer burnout ($R^2 = .18$; $F(1, 106) = 22.64$, $p \leq .001$).

H_2 stated that supportive communication by co-volunteers would predict higher levels of volunteer satisfaction, role identity, safety perceptions, and loyalty, and lower levels of volunteer burnout. In support of the hypothesis, correlations between supportive communication from co-volunteers and volunteer outcomes were significant for safety perceptions ($p \leq .001$) and somewhat significant for satisfaction and word of mouth (p

≤.01) (Table 11). However, the correlations were not significant for role identity, and burnout (see Table 11).

Table 11
Correlations between Supportive Communication from Co-volunteers and Volunteer Outcomes (N = 85)

	Volunteer Outcomes				
	SAT	*RI*	*WOM*	*BO*[a]	*SP*
Supportive Communication from Co-volunteers					
Emotional Support	.25**	.16	.27**	-.19	.52***
Problem-Solving Support	.31**	.18	.27**	-.15	.40***

Note: $^{**}p \leq .01$. $^{***}p \leq .001$. [a]Burnout – lower numbers equal lower levels of burnout. SAT = Satisfaction, RI = Role Identity, WOM = Word Of Mouth, BO[a] = Burnout, SP = Safety Perception

Volunteers' safety perceptions were higher if they received more *emotional* support ($r = .52$) and *problem-solving* support ($r = .40$) from co-volunteers. In addition, volunteers who received more *emotional* support from co-volunteers had moderately higher levels of satisfaction ($r = .25$) and WOM ($r = .27$), and those that received more *problem-solving* support from co-volunteers also had moderately higher levels of satisfaction ($r = .31$) and WOM ($r = .27$).

Regression analyses were performed to assess which of the supportive communication practices by co-volunteers were most significant in predicting each of the volunteer outcomes (Table 12). One dimension of supportive communication was significant in predicting volunteer satisfaction, relative to other dimensions.

Table 12

Results of Multiple Regression Analyses Showing Dimensions of Supportive Communication from Co-volunteers as Significant Predictors of Volunteer Outcomes (Volunteers = 85)

Volunteer Outcomes	β	*t*	*p*
Satisfaction			
Emotional Support	.31	2.99	.01
Word of Mouth			
Problem-Solving Support	.27	2.57	.01
Safety Perceptions			
Emotional Support	.56	5.49	.001

Emotional support was the strongest predictor ($R^2 = .10$; $F(1, 84) = 8.91$, $p \leq .01$) of volunteer satisfaction. *Problem-solving* support ($R^2 = .08$; $F(1, 83) = 6.61$, $p \leq .01$) was the sole predictor of volunteer WOM, and *emotional* support ($R^2 = .27$; $F(1, 84) = 30.13$, $p \leq .001$) was most significant in predicting safety perceptions.

CHAPTER V

Discussion

There are several trends in the healthcare industry that call for an increase in workers, paid *and* unpaid. These include increased demand for patient care, pressure to reduce overhead costs and downsize staff, and a greater emphasis on increasing the quality of customer service. The growth projections for the elderly population in the next 15 to 20 years will further challenge healthcare organizations. Developing a surfeit of volunteers and volunteer participation is becoming a necessity, not just an option.

Given the growing reliance on a volunteer workforce, organizational efforts to enhance supportive communication to all volunteers, may make a difference in the quality of their work experience. This study examined the extent to which different types of supportive communication from staff and co-volunteers affect volunteer outcomes.

Supportive Communication from Staff

Hypothesis one in this study asserted that supportive communication from staff would predict higher levels of volunteer satisfaction, role identity, safety perceptions, and loyalty, and lower levels of volunteer burnout. Forms of supportive communication included were emotional, informational, and instrumental. Results indicate that emotional support from staff was the strongest predictor of volunteer satisfaction, role identity, safety perceptions, word of mouth (an indicator of loyalty), and reduced burnout. Informational support to volunteers was also significant in predicting satisfaction and safety perceptions.

It is important to note that emotional support from staff had the greatest impact on volunteer satisfaction, role identity and burnout. These findings are consistent with

studies of supportive communication to paid staff in health care settings (e.g., Apker et al., 2003; Ellis & Miller, 1994; Miller et al., 1990). The present study extended the findings to *unpaid* staff.

The relationship of emotional support of staff to safety perceptions of volunteers in a healthcare setting is also of particular significance. Emotional support from staff may provide positive assurances and anxiety reduction for volunteers.

The role of informational support in predicting satisfaction and safety perceptions is also noteworthy. Employee satisfaction has been found in past studies to be related to informational support from managers and staff in nursing environments (Ford & Ellis, 1998; Metts, Geist, & Gray, 1994), and the relationship is now extended to volunteers. In addition, informational support, as it applies to safety perceptions, has far reaching effects on organizations. It can provide strategies for problem-solving, as well as practical advice for dealing with safety related issues.

Instrumental support was not found to be predictive of volunteer outcomes relative to informational and emotional support. A review of the instrumental support measure may be warranted. The 4 items in this measure included: "Help me complete my tasks," "'Pitch in' and help me," "Help me with my tasks if I get overloaded," and "Ask if I could use some help or if I need assistance." Volunteers may see these items as assessments of their ability to perform the tasks given to them and also whether they can accomplish the number of tasks assigned in a timely manner. Needing instrumental support from staff might indicate to volunteers that they are not able to accomplish their volunteer duties without assistance and therefore may not be capable volunteers.

When assessing the results of these supportive communications it is important to note that volunteers may experience emotional and informational support as helpful in their work within the organization. On the other hand, they may not experience instrumental support as helpful. Future research that includes supportive communication from volunteers could evaluate the relevance or measurement of instrumental support.

Supportive Communication from Co-volunteers

Hypothesis two asserted that supportive communication from co-volunteers would also predict higher levels of volunteer satisfaction, role identity, safety perceptions, and loyalty, and lower levels of volunteer burnout. Results indicate that emotional support from co-volunteers strongly predicted volunteer satisfaction, as well as safety perceptions. Emotional support has been reported to increase satisfaction and loyalty among paid workers (Apker et al., 2003; MacPhee & Scott, 2002) and co-volunteers (McComb, 1995; Penner, 2002; Pearce, 1993), so this finding was not surprising. However, results demonstrating emotional support from co-volunteers as strongly predictive of safety perceptions expand current knowledge in this area.

Problem-solving support by co-volunteers was also predictive of WOM, an indicator of volunteer loyalty. This is a significant finding. WOM is important if healthcare organizations are going to continue to expand volunteer participation within the organization, as well as promote the organization to the "outside" world.

Practical Implications

This study demonstrates that, like paid workers un-paid workers need supportive communication in the workplace. They may receive it from staff and co-volunteers. Volunteer coordinators for non-profit organizations need to develop targeted

interventions for both staff and volunteers to increase supportive communication practices.

Interventions for staff should concentrate on the necessity for and the benefits of supportive communication for volunteers, encouraging staff to concentration on all supportive areas but especially on emotional and informational support. The intervention should help staff understand that volunteers not only value, but also benefit, from staff information and encouragement.

Interventions for volunteers should emphasize the necessity of volunteer support to co-volunteers. Emphasis placed on the multidimensionalites of supportive communication practices experienced by their co-volunteers will also benefit these workers and the entire organization. Concentration of training and orientation should emphasize the value of emotional support but also the impact of problem-solving support.

Research Extensions

The overall impact that this study has is more than the researcher initially anticipated and suggests potential extensions in several areas of volunteer research. The extensions address volunteer safety, volunteer discretionary behavior, volunteer categories, and volunteer age.

Volunteer safety. Requirements from governmental agencies assessing hospitals and healthcare organizations, including environmental safety for patients, have grown to include all workers, paid or unpaid. Testing and assessments are not only for the safety of patients and staff but also volunteers. Safety measures and evaluative tools regulate and evaluate volunteers' safety in healthcare environments (House & Cottington, 1986;

Martinez, 2003) and are currently mandated by the Occupational Safety and Health Act (OSHA) of 1970 (House & Cottington, 1986; Ashford, 1976).

The inclusion of a new measure in the present study to assess volunteers' perceptions of safety in the healthcare environment was predicated on ever-changing safety regulations. Workers need to feel that they understand the risks, requirements, and processes to help keep themselves and their co-workers safe. This assures them that the organization is dedicated to protecting their health and welfare.

Volunteer discretionary behavior. Volunteer loyalty has received significant research attention (e.g., Omoto & Snyder, 2002; Penner, 2002). The present study focused specifically on WOM as an indicator of volunteer loyalty.

A valuable extension in the loyalty literature would focus on Volunteer Discretionary Behavior (VDB). The concept of VDB has been inspired by the literature on Organizational Citizen Behavior (OCB) (Organ, 1988) and Customer Discretionary Behavior (CDB) (Ford, 1998). These types of behavior are enacted by an individual to benefit a particular organization.

OCB includes employee behaviors that help the organization function more effectively and are a matter of personal choice. Volunteers embody these behaviors such as altruism, prosocial behavior that helps another person; conscientiousness, instances in which a person carries out certain role behaviors that exceed what is required of them; sportsmanship, refraining from certain actions such as making complaints or voicing petty grievances; courtesy, informing others when actions you might take could affect another's work or cause problems for them; civic virtue, participating in good

organizational citizenship behaviors and working responsibly within and for the organization's benefit (Organ, 1988; Smith, Organ & Near, 1983).

CDB are cooperative behaviors that customers willingly perform for organizations to which they are committed (Ford, 1998). Ford described five forms and some examples of each CDB that customers could enact. These are synthesized in Table 13.

Review of Ford's (1995, 1998) forms of CDB demonstrates that these descriptions of customer's cooperative behaviors, with some minor alterations, are already present in the behaviors enacted by hospital volunteers. Expanding the CDB construct to volunteers would provide an opportunity to identify additional volunteer contributions to organizations.

In the healthcare environment, staff support to volunteers will likely increase satisfaction and volunteer retention. It may also impact customer service and customer friendly perceptions by WOM from volunteers to relatives and other community members. When staff engage in supportive communication behaviors they may find that satisfied volunteers will take part in VDB. Volunteers may go beyond their roles as volunteers and consider themselves "partners" with the organization and use VDBs.

Beyond healthcare, this study takes supportive communication practices and adds significant research that can have implications for volunteers in other types of non-profit and not-for-profit organizations. These organizations also depend on volunteer involvement to maintain a high level of customer service (Egbert & Parrott, 2003; Miller, Powell & Seltzer, 1990; Omoto & Snyder, 1995). Further, helpful behavior positively correlates with length of volunteer service (Penner & Finkelstein, 1998).

Table 13
Customer Discretionary Behaviors*

CDB	*Description and Examples*
Altruism	Showing concern for the welfare of others • *helping an employee lift a heavy item* • *directing a new customer to the rest rooms*
Loyalty	Faithfully patronizing an organization • *driving out of the way to go to a particular store* • *rejecting offers from competitors*
Promotion	"Advertising" a place of business • *recommending an organization to others* • *displaying a bumper sticker to show support for an organization*
Preservation	Protecting the organization and its image • *picking up after oneself* • *reporting safety hazards to employees*
Development	Contributing toward organizational improvements • *participating in consumer boards* • *mailing suggestions or feedback to management*

*Note: Adapted from Ford (1998, p. 113)

Volunteer categories. Four different groups of volunteers emerged in this study. Interestingly, the groups are defined not by function but by communication relationships that they have with others. Each group has different interaction patterns with staff and co-volunteers. One group of volunteers assesses their interaction with staff and co-volunteers as nonexistent. These volunteers work independently at home or in areas of the hospital requiring only interaction with patients and visitors, and rarely with other workers in the organization. A second group interacts only with co-volunteers and rarely with staff, perhaps only in initial orientation or to receive assignments. A third group interacts only with staff, performing roles not involving volunteer teams. A fourth group interacts with both staff and co-volunteers and is clearly involved in larger staff-volunteer team functions.

With future research the levels of interaction should be considered as they can, or may, impact volunteer integration into the organization. In addition, ongoing communication patterns, or lack thereof, may affect volunteer outcomes as well as support needed by volunteers. Further research might focus on evaluating and distinguishing the differing types of communication patterns for volunteers, considering their implications not only for hospitals, but for other organizations that employ volunteers.

Practical implications for volunteer coordinators may include training programs or other interventions that emphasize different types of supportive communication for each unique volunteer group. Clearly all volunteer groups could benefit from efforts to enhance emotional support from staff and/or co-volunteers.

Volunteer age. Finally, additional analyses assessing the effects of demographics on supportive communication practices and volunteer outcomes are proposed for future research. Factors such as age-related effects began to emerge as potential variables to consider when assessing the volunteer experience. Research considering generational effects of a specific age group, especially when age may impact citizenship and loyalty behaviors, could be beneficial. In healthcare and hospital organizations where many volunteers are approaching or have reached retirement age (Miller et al., 1990; U.S. Bureau of Labor Statistics, 2005), patterns of interaction may be a particularly important factor when determining approaches to providing supportive communication.

The present study suggests the need to test the age factor to discover if and how volunteer age impacts perception of supportive communication from staff and co-volunteers, and if age affects volunteer outcomes. One study found that as age increases, motivation to volunteer is linked with social interaction available to volunteers (Okun & Schultz, 2003). Others found that volunteering was beneficial for older adults in terms of improving and sustaining health (Wilson & Musick, 1999) and possibly extending the volunteer's life (Musick, Herzog, & House, 1999). Older volunteers in a hospital setting were found to be more dependable than younger volunteers (Zweigenhaft, Armstrong, Quintis & Riddick, 1996). It is important to assess age, for advantages and in consideration of possible problematics when researching volunteers.

Conclusion

Supportive communication in a healthcare setting can potentially have significant positive effects on volunteers. It is hoped that this study provides increased awareness of the value of different types of supportive communication practices. Findings from this

study demonstrate the importance of these supportive practices. Emotional support from staff was the most significant outcome impacting volunteer satisfaction, role identity, WOM, burnout, and safety perceptions. Informational support affected volunteer satisfaction and safety perceptions. Emotional support from co-volunteers had the most significant impact on volunteer's safety perceptions and also impacted volunteer's satisfaction with problem-solving support as the sole predictor of WOM.

Volunteers have many opportunities for choosing meaningful volunteer work. As this study indicates, if they feel supported and valued for their work they will not only continue as dedicated volunteers, but they may also display discretionary behavior on behalf of the organization. Volunteer coordinators, staff, and the organization need implement processes to foster supportive communication.

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APPENDIX A

Bronson Methodist Hospital Letter

BRONSON
Methodist Hospital

DRAFT (need date info when approved)

Date

Dear Bronson Volunteer:

Volunteers are a key resource in helping us realize our vision of being a national leader in healthcare quality. You volunteer your time and unique skills to assist us in meeting the needs of our patients and other customers. And, you, as one of our customers, can provide us with ideas for opportunities to make our workplace better for you.

Your opinion is important. That is the reason we are inviting all Bronson volunteers to complete a *Volunteer Communication Survey*. This survey is part of a graduate student research project being conducted by the Department of Communication at Western Michigan University (WMU) in collaboration with Bronson's Volunteer Services Department. The survey will be completely anonymous. You will not be asked to sign your name and no one at Bronson will see any of the completed questionnaires. WMU will tabulate the surveys and provide summarized results. Those results will also be shared with you in the future.

Please take a moment to complete the survey and return it in the envelope provided by **DATE**. As you take the survey, you will notice that some items appear similar. This is important for survey validation procedures.

As our thanks to you for participating in the survey, enclosed is $2.00 in "Bronson Bucks" that you may redeem at the various locations throughout the organization.

Sincerely,

Frank J. Sardone
President & CEO

Enclosures

601 John Street
Kalamazoo, MI 49007
www.bronsonhealth.com

APPENDIX B

IRB-Approved Consent Letter

Principal Investigator: Wendy Ford, Ph.D.
Co-Principal Investigator: Virginia Gregory
Title of Study: Supportive Communication Practices With Volunteers

You are invited to participate in the "Volunteer Communication Survey" designed to examine supportive communication practices and outcomes for volunteers. The survey is being distributed to all volunteers at Bronson Methodist Hospital.

Dr. Wendy Ford and Virginia Gregory from Western Michigan University's Department of Communication are conducting this research in collaboration with Bronson's Volunteer Services Department. The findings from our study will be used by Bronson to enhance supportive communication practices with volunteers.

This survey consists of 58 questions and will take approximately 10-15 minutes to complete. Your responses will be completely anonymous, so do not put your name anywhere on the form. If the results are published, only aggregate (summary) data will be used. You may choose not to answer any question and simply leave it blank. If you choose not to participate in this survey, you may either return the blank survey or you may discard it. Returning the survey indicates your consent for use of the answers you supply. There will be no prejudice or penalty if you choose not to participate or if you choose to stop your participation once you have started. Completed surveys will be kept in a locked file cabinet in the primary investigator's office for at least 3 years. As an incentive for completing the survey, we are enclosing $2 in "Bronson Bucks" that may be used to purchase goods or services at Bronson.

If you have any questions, please contact Dr. Wendy Ford at (269) 387-4355, or Virginia Gregory at (269) 945-6231. You may also contact any or all of the following if questions or problems arise during the course of the study:

Bronson Methodist Hospital
James W. Carter, MD, Chair, Institutional Review Board, (269) 341-7898
Western Michigan University
Chair, Human Subjects Institutional Review Board, (269) 387-8293
Vice President for Research, (269) 387-8298.

This consent document has been approved for use for one year by the Bronson Methodist Hospital Institutional Review Board and the Western Michigan University Human Subjects Institutional Review Board as indicated by the stamped dates and signatures of the board chairs in the upper and lower right corners. Do not participate in this project if the stamped date is more than one year old.

APPENDIX C

Survey Instrument

Volunteer Communication Survey
Bronson Healthcare Group

How often do hospital employees:	**Never**				**Always**
1. Explain how to get things done	1	2	3	4	5
2. Inform me of policies and decisions that may affect me	1	2	3	4	5
3. Talk to me if I am confused about issues related to my volunteer tasks	1	2	3	4	5
4. Give me helpful information about other volunteers or staff members	1	2	3	4	5
5. Ask if I could use some help or if I need assistance	1	2	3	4	5
6. "Pitch in" and help me	1	2	3	4	5
7. Help me complete my tasks	1	2	3	4	5
8. Help me with my tasks if I get overloaded	1	2	3	4	5
9. Listen to me	1	2	3	4	5
10. Show concern for my welfare	1	2	3	4	5
11. Go out of their way to praise my good work	1	2	3	4	5
12. Show they trust me	1	2	3	4	5
13. Give me feedback about my performance as a volunteer	1	2	3	4	5
14. Tell me when I am doing a good job	1	2	3	4	5
15. Let me know when I am doing things incorrectly	1	2	3	4	5
16. Let me know when I am doing things correctly	1	2	3	4	5

How often do other volunteers:	**Never**				**Always**
1. Explain how to get things done	1	2	3	4	5
2. Inform me of policies and decisions that may affect me	1	2	3	4	5
3. Talk to me if I am confused about issues related to my volunteer tasks	1	2	3	4	5
4. Give me helpful information about other volunteers or staff members	1	2	3	4	5
5. Ask if I could use some help or if I need assistance	1	2	3	4	5
6. "Pitch in" and help me	1	2	3	4	5
7. Help me complete my tasks	1	2	3	4	5
8. Help me with my tasks if I get overloaded	1	2	3	4	5
9. Listen to me	1	2	3	4	5
10. Show concern for my welfare	1	2	3	4	5
11. Go out of their way to praise my good work	1	2	3	4	5
12. Show they trust me	1	2	3	4	5
13. Give me feedback about my performance as a volunteer	1	2	3	4	5
14. Tell me when I am doing a good job	1	2	3	4	5
15. Let me know when I am doing things incorrectly	1	2	3	4	5
16. Let me know when I am doing things correctly	1	2	3	4	5

	Strongly Disagree				Strongly Agree
1. In general, I like volunteering at Bronson	1	2	3	4	5
2. My role as a volunteer with Bronson is important to me	1	2	3	4	5
3. What Bronson does for patients is important to me	1	2	3	4	5
4. I would feel a loss if I were forced to give up volunteering at Bronson	1	2	3	4	5
5. My volunteer role at Bronson is an important part of who I am	1	2	3	4	5
6. I am likely to say positive things about Bronson to others	1	2	3	4	5
7. I am likely to recommend Bronson to others who need health-related services	1	2	3	4	5
8. I am likely to recommend Bronson to others as a good place to volunteer	1	2	3	4	5
9. I am likely to recommend Bronson to others as a good place to work	1	2	3	4	5
10. I am likely to apply for a paid position at Bronson	1	2	3	4	5
11. I feel frustrated about my volunteer work at Bronson	1	2	3	4	5
12. I feel drained of energy when I volunteer at Bronson	1	2	3	4	5
13. I feel tense when I volunteer at Bronson	1	2	3	4	5
14. I feel discouraged about my volunteer work at Bronson	1	2	3	4	5
15. I feel that Bronson works to protect me from safety risks	1	2	3	4	5
16. I feel that Bronson cares about my safety	1	2	3	4	5
17. I feel comfortable reporting safety issues at Bronson when I see them	1	2	3	4	5
18. It is likely I will still be a volunteer with Bronson in 6 months	1	2	3	4	5
19. It is likely I will still be a volunteer with Bronson in 2 years	1	2	3	4	5
20. It is likely I will still be a volunteer with Bronson in 5 years	1	2	3	4	5
21. All in all, I am satisfied with my volunteer role at Bronson	1	2	3	4	5

Demographic Information

In order for us to know a bit more about you, please complete the demographic information below. The information you provide is confidential and Bronson will have access only to collapsed data for well-represented groups.

What is your age? _____

What is your sex? ____ Male ____ Female

Are you currently a student? ____ Yes ____ No

What is your race/ethnicity?

____ White ____ Black ____ Hispanic ____ Native American ____ Asian ____ Other

In what area(s) do you volunteer? (check all that apply)

____ Out Patient Testing (OPT), Trauma & Emergency Ctr (T&EC), Cuddler, Child Life, Adult Medical Unit (AMU), Pet Therapy (Pet TX), Nutrition Svs, Rehab, Pastoral Care, Bronson Vicksburg Hospital (BVH)

____ Center for Women, Senior Adult Svs, Managed Care, Breast-feeding Boutique, Gift Shop, Children's Svs, Wellness, Lab, HR, Gilmore Center for Health Ed Ofc (CHE Ofc), Corporate Communications, Sibling Ed

____ Special Projects, Volunteer Ofc, Baby Guild, Flower Gulld, Nurses Guild, Book Service, Coffee Cart, Flower Delivery, Greeter, Patient, Mail

____ Other, not listed above.

Comments: _____

Thank You! ☺

APPENDIX D

Approval Letter from the Human Subjects Institutional Review Board

Date: June 4, 2004

To: Wendy Ford, Principal Investigator
Virginia Gregory, Student Investigator for thesis

From: Mary Lagerwey, Ph.D., Chair

Re: HSIRB Project Number: 04-05-36

This letter will serve as confirmation that your research project entitled "Supportive Communication Practices with Volunteers" has been **approved** under the **exempt** category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note that you may **only** conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: June 4, 2005

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