

# An Alternative Approach to Social Capital: Exploring the Linkage Between Health Consciousness and Community Participation

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In recent years, social capital has received a great deal of attention in health communication. The fundamental premise behind the increased attention to social capital is the positive health outcome of social capital. Social capital is treated as an antecedent to health. Building on recent research that points out the role of trait-level variables in the production of social capital, this article examines the role of health consciousness in the production of social capital. The central idea here is that health conscious individuals choose to participate in their communities because of the positive health benefits of such participation.

Current directions in health communication suggest the critical need for identifying the primordial role of the community in garnering social change (Arcury, Austin, Quandt, & Saavedra, 1999; Baum, 1999; Berkman, 1995; Bracht & Tsouros, 1990; Campbell & Jovchelovitch, 2000; Dube & Wilson, 1996; Kennedy, 2001; Person & Cotton, 1996; Rappaport, 1987). Individual-level prevention efforts, scholars argue, need to be complemented with community-level approaches (Rappaport, 1987; Repucci, Woolard, & Fried, 1999). Community-level preventions foster participation of community members in the change initiative (Bracht & Tsouros, 1990; Campbell & Gillies, 2001). The involvement and participation of citizens in identifying the health needs of the community and the implementation of community-generated initiatives that improve the health of neighborhood residents form the

backbone of community-based health promotion work (Butterfoss, Goodman, & Wandersman, 1996; Repucci et al., 1999). An empowered and organized community with highly participative members is better able to identify and mobilize its resources in the production of positive health outcomes (Treno & Holder, 1997). Also, empowered members of such communities are better able to take charge of their lives and engage in healthful behaviors (Campbell & Jovchelovitch, 2000).

In referring to the power of the community in the development and maintenance of preventive behaviors, health promotion scholars evoke the concept of social capital (influenced by Putnam, 1993). Social capital refers to the "ability to secure benefits through membership in networks and other social structures" (Portes, 1998, as quoted in Hawe & Shiell, 2000, p. 872). It is "the web of cooperative action that facilitates resolution of collective action problems and those features of social structure, such as interpersonal trust, norms of reciprocity and mutual aid, that act as resources for such collective action" (p. 619). With its emphasis on participatory communities, social capital is the fountainhead of community-based health promotion interventions (Hawe & Shiell, 2000; Person & Cotton, 1996), and the collective identity reflected in a high social capital community serves as the primary channel for instituting positive change through the mobilization and participation of community members in health issues that are central to the community (Hawe & Shiell, 2000).

The social capital-based approach to health communication espouses a shift from the traditional individual-based approach to an ecological approach (Lomas, 1998). In this growing body of research on community-based health interventions, therefore, the community is constructed "as a homogeneous group in which no internal discrepancies and no intra- and inter-individual differences are recognized" (Wiesenfeld, 1996, p. 338). This article uses a social-psychological framework to challenge the typically positivistic notion of the community as a homogeneous entity and locates social capital in individual action (Wiesenfeld, 1996). It argues that individuals choosing to participate in their communities make up high social capital communities (Hawe & Shiell, 2000; Lomas, 1998). Participatory networks such as churches, volunteer organizations, and community projects are explored as sites of individual community involvement. Specifically, the article examines the role of health consciousness measured at an individual level in the generation of community-participation, articulating that collective and individual responsibilities are related with each other, forming an intertwined web of responsible action.

### SOCIAL CAPITAL, COMMUNITY PARTICIPATION, AND HEALTH

That a high level of social capital in the community produces a plethora of positive health outcomes such as lower total mortality rates (Kawachi, Kennedy, Lochner, & Prothrow-Stith, 1997), lower cardiovascular mortality (Kawachi et al., 1997), and lower mortality from malignant neoplasms (Kawachi et al., 1997) has been

substantiated by an impressive body of literature that continues to build. Members of high social capital communities are more empowered in their lives, are more participative in their socio-cultural environments, are better able to secure and access community resources, and have a strong social support network (Baum, 1999; Rappaport, 1987; Repucci et al., 1999).

Public health planners have specifically focused on increasing the social capital of communities based on the notion that an increased social capital would lead to an increase in community health (Kawachi et al., 1997). Of special importance in current campaigns is an attempt to increase the participation of individual members in community organizations and community-based health initiatives (Repucci et al., 1999). Community participation (Bracht & Tsouros, 1990) has been strategically used in a wide variety of health campaigns targeting a plethora of issues such as heart disease prevention (Robinson & Elliott, 1999), agricultural chemical exposure (Arcury et al., 1999), smoking (Ho, 1998; Secker-Walker, Flynn, Solomon, Skelly, Dorwaldt, & Ashikaga, 2000), HIV prevention (Flowers, Duncan, & Frankis, 2000; Person & Cotton, 1996), road safety (Howat et al., 2001), alcohol abuse (Weitzman & Kawachi, 2000), and healthy eating (Kennedy, 2001).

The positive relationship between community participation and health promotion may be explained by a number of mediating processes. Campbell and Jovchelovitch (2000) articulated that community participation gives community members the opportunity to engage in the strategic and operational decisions related to the barriers faced by the community in the context of the specific prevention. As a consequence, the intervention is tailored to and generated by the needs of the community, leading to the greater likelihood of its success. Also, established theories such as the theory of reasoned action (Ajzen & Fishbein, 1974) and the social cognitive theory (Bandura, 1977) emphasize the significant impact of social networks and social norms as catalysts of health behavior. Individuals are more likely to engage in a preventive behavior if the behavior seeps through the social cement of the community, being enacted by their trusted peers, community leaders, and role models (Campbell & Jovchelovitch, 2000; Dube & Wilson, 1996). Social capital researchers argue that health-enhancing behaviors are determined more by collectively negotiated social identities rather than by individual rational choice and high social capital communities are more likely to provide a supportive context to their members with opportunities for collectively renegotiating their social identities with respect to health behaviors (Campbell & Jovchelovitch, 2000).

In addition to reinforcing healthy behaviors through social networks, community participation generates member empowerment. Individuals living in participatory communities with high social capital are more likely to have "high levels of perceived control over their everyday lives" (Campbell & Jovchelovitch, 2000, p. 262). These individuals with an internal locus of control are more likely to take control of their health, engaging in a plethora of health enhancing behaviors and actively seeking out health enhancing resources (Campbell & Jovchelovitch, 2000). A preventive behavior, therefore, has a greater likelihood

of being adopted in a community where individual members are highly engaged in community organizations.

An empowered community with highly participative community members is also better able to seek out those health-enhancing resources and structural benefits that are quintessential to its health (Bracht & Tsouros, 1990; Campbell & Jovchelovitch, 2000). Members in such a community are able to reap the benefits of collective action, securing change through the cohesive voice of the community and collectively encountering the barriers to good health (Bracht & Tsouros, 1990; Kawachi & Berkman, 2000). Also, they are collectively able to control deviant health-related behavior (such as domestic violence, alcohol-related problems, problem adolescent behavior, etc.) to a greater extent than a low social capital community. The resource-enhancing ability of a high social capital community is further evidenced in the rapid diffusion of health-related information in such a community, enabling the individual member to live a healthier life (Kawachi & Berkman, 1998; Veenstra, 2000). Positive health effects of social capital are also documented through the processes of social support and self-esteem development in high social capital communities (Veenstra, 2000; Wolf & Bruhn, 1993).

Grounded in a sociological perspective, social capital theorists have typically espoused a macrolevel approach, treating social capital as a property of the social structure and social relationships (Kawachi, Kennedy, & Glass, 1999; Kawachi et al., 1997; Kennedy, Prothrow-Stith, Lochner, & Gupta, 1998; Veenstra, 2000; Veenstra & Lomas, 1999). According to this view, social capital is studied and analyzed at the community level, with an increase in the health indicators of communities that have greater levels of social capital (Kennedy et al., 1998; Veenstra, 2000). However, the macrolevel approach does not capture the individual-level choice involved in community participation (Veenstra, 2000). Based on the notion that a social capital rich community is based on individual participation and involvement, Veenstra (2000) argued that cross-sectional individual-level analysis of social capital could shed additional light on our understanding of social capital. Individuals, after all, are the repositories of societal norms and values, and reflect the nature of the community in their choice to participate in community organizations. Given the fundamental role of community participation in the generation of social capital, this article proposes to investigate the individual-level antecedents of community participation. More specifically, it explores the construct of health consciousness to explain additional variance in community participation beyond the demographic and personality strength constructs.

Underlying the theoretical structure of this research is the role of personal and social responsibility that drives health and community-based activities<sup>1</sup> (Onyx &

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<sup>1</sup>It is critical to point out here that the theoretical framework proposing the amalgamation of individual and social responsibility is culturally limited to groups that rank individualism as a higher order value. The constructions of personal and social responsibility suggested in this article may not extrapolate to other cultures.

Bullen, 2000). The constructs of personal and social responsibility have traditionally been at the center of an ongoing debate in the health promotion literature about their roles in disease prevention, grounded in the dichotomous conceptualization of individualism versus communitarianism (Lomas, 1998). Instead of conceptualizing individual responsibility and communitarian responsibility as two ends of a seesaw (Wiesenfeld, 1996), this article conceptualizes both responsibility types as an overall reflection of the commitment to responsibility, indicative of a strong sense of citizenship. A responsible way of life permeates through the different elements of attitudes, interests, and opinions that form the complete individual, the "healthy citizen" (Petersen & Lupton, 1996).

A sense of self-efficacy and an internal locus of control that define health consciousness also perhaps catalyze the participation of health conscious individuals in their communities (Walker, Sechrist, & Pender, 1987; Wilkinson, 1996). Furthermore, given the positive health outcomes of engaging in the community (Wolf & Bruhn, 1993), it is worthwhile to explore whether health conscious consumers maximize their health outcomes by participating in the community. Treating health consciousness as an antecedent to community participation instead of treating it as an outcome of the construct reverses the traditional macrolevel approach to community participation. The critical question answered here is: how much additional variance in community participation beyond demographics and personality strength is explained by health consciousness?

## DEMOGRAPHIC PERSONALITY ANTECEDENTS

Demographic factors (age, gender, education, and income) are among the most widely used individual-difference variables that have been studied as antecedents of social capital (Dutta-Bergman, 2003; Veenstra, 2000). After accounting for the contribution of the four demographic variables, Scheufele and Shah (2000) studied the additional contribution in explained variance made by personality strength. Personality strength is the extent to which individuals believe in their ability to influence others and impact social and political outcomes (Scheufele & Shah, 2000). Scheufele and Shah (2000) demonstrated that personality strength is a positive predictor of social capital.

## HEALTH CONSCIOUSNESS

Traditionally, health outcomes are treated as dependents of social capital (Kawachi & Berkman, 2000; Kawachi et al., 1999; Kawachi et al., 1997; Kennedy et al., 1998). As articulated in the introduction, a fundamental goal of this article is to reverse the macrolevel health outcome oriented research approach to social capital and instead, evaluate the effect on social capital of individual level

health attitudes, interests, and opinions. A willingness to take responsibility and perform activities that underlie health-oriented practices (Moorman & Matulich, 1993) also perhaps motivates the performance of health promoting community-oriented behaviors (Higgins, 1999; Mittelmark, 2001). The healthy citizen that feels responsible to take care of his or her health also perhaps feels responsible to take care of his or her community by participating in it. The diffusion of individual-level responsibility to social responsibility is attested in Tocqueville's (1999) elaboration of democracy in the United States.<sup>2</sup> Untangling the paradox of rugged individualism and communitarian involvement that mark the American life, Tocqueville (1999) posits that a unique sense of personal efficacy and self-interest drives the individual to participate in the community (Bellah, Madsen, Sullivan, Swidler, & Tipton, 1985; Tocqueville, 1999). Proposing the notion of self-interest rightly understood, he argues:

The Americans... are fond of explaining almost all the actions of their lives by the principle of self-interest rightly understood; they show with complacency how an enlightened regard for themselves constantly prompts them to assist one another and inclines them willingly to sacrifice a portion of their time and property to the welfare of the state. (Tocqueville, 1948, p. 122)

The next few paragraphs will build upon the Tocquevillian (1948) idea of an intertwined web of personal and social responsibility, elucidating the relationship between health consciousness and community participation. Reflective of responsible health-oriented choices, health consciousness is an individual-level variable that differentiates between individuals based on the extent to which they participate in healthful life choices (Moorman & Matulich, 1993; Walker et al., 1987). In other words, health consciousness is an indicator of the consumer's intrinsic motivation to maintain good health and is a reflection of his or her responsibility toward health (MacInnis, Moorman, & Jaworski, 1991; Moorman & Matulich, 1993; Park & Mittal, 1985). It influences the individual's health preventive and health maintenance behaviors (Moorman & Matulich, 1993). A health conscious consumer actively seeks out information and resources that are oriented toward enhancing health, and engages in those activities that lead to better health, including eating healthy, eating fruits and vegetables, searching for health information, and engaging in physical activity (Moorman & Matulich, 1993).

Each of these health-oriented activities reflects a high level of active consumer responsibility and a willingness to engage in responsible actions, articulating the

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<sup>2</sup>Once again, worth noting is the emphasis of this research in documenting the linkage between personal and social responsibility within a highly individualistic culture, the United States. Tocqueville's description of self-interest rightly understood was essentially a depiction of the civic-minded American (predominantly White). This phenomenon might not be demonstrated in other cultures and subcultures.

notion of healthy citizenship (Dutta & Youn, 1999; Moorman & Matulich, 1993; Petersen & Lupton, 1996). Many of these responsible health choices permeate from the private sphere to the public sphere (Flowers, Duncan, & Frankis, 2000), influencing the health of others in the social network (especially in the context of infectious diseases). Also, healthy citizens actively participate in healthful choices because their health influences the extent to which they are able to productively contribute to society (Peterson & Lupton, 1996).

A sense of responsibility is also an underlying theme that defines the willingness to engage in community activities (Dutta & Youn, 1999; Higgins, 1999; Mittelmark, 2001; Petersen & Lupton, 1996). Socially responsible individuals are more willing to participate in their communities and spend personal resources (such as time and money by volunteering and donating to community organizations respectively) for the growth of the community (Tocqueville, 1948). Building on the Tocquevillean (1999) concept of an intertwined web of responsibility, this sense of social responsibility, the article argues, interpenetrates with a sense of personal responsibility. A responsible way of life becomes the guiding post for the individual community member and integrates a plethora of activities, interests, and opinions. Unifying health consciousness and community involvement under the umbrella of "holistic responsibility," it is suggested here that healthful activities will be positively associated with civic engagement while activities that are not healthy will be negatively associated with civic engagement.

Further support for the positive relationship between health consciousness and community participation comes from the active information orientation of health conscious individuals. The health-engaged individual gathers information on different healthy activities and engages in those activities. Health conscious participants are willing to invest time into resources that are positively associated with their health. With a health information orientation, individuals are aware of their social context and perform those activities that maximize positive health outcomes. The community is a repository of health enhancing factors (Kawachi et al., 1999). Socially isolated individuals suffer greater risks of poor health because of their limited access to community resources including information and emotional support (Kawachi & Berkman, 2000; Kawachi & Kennedy, 1997, 1999).

Given the long established link between the positive outcomes of community participation (community participation is thus a health creating activity), it may be argued that the individual that is motivated to maintain good health also feels a strong need to engage in the community because of the positive health resources it provides. In other words, the health conscious individual is perhaps cognizant of the health empowering resources such as health information and social support available in the community and thus participates more in the community to enhance his or her health. Community participation, therefore, is driven by the combination of long-term self-interest and short-term altruism (Taylor, 1982). Individuals are likely to provide service to others and engage in communities based on the expectation that their kindness will be reciprocated in the future (Onyx & Bullen, 2000).

At the macrolevel, high social capital in the community leads to greater community health by promoting faster diffusion of health information in the community, increasing community access to health facilities, and creating greater community ties (Hawe & Shiell, 2000; Kawachi & Kennedy, 1997). The social capital benefits of community participation percolate down to the individual level. Therefore, a health conscious (read: responsible) consumer that is motivated to maximize his or her health is also perhaps likely to participate in the community to increase the aggregate community health, knowing that an overall increase in community health would contribute to his or her individual and family health. Additionally, it may be argued that a health conscious consumer might choose to live in a high social capital community given all the health advantages of living in such a community.

Bloch (1984) posited that healthy choices encompass the lives of health conscious individuals; they live a lifestyle oriented toward the maximization of personal well-being through prevention of health problems. Kraft and Goodell (1993) pointed out that health consciousness manifests itself in a healthy lifestyle that is marked by engagement in health enhancing activities and avoidance of health threatening activities. Health consciousness is manifested in healthy activities such as exercise, weight control, stress management, and harmful substance avoidance (Ardell, 1977; Kraft & Goodell, 1993). Since healthy activities define the health conscious individual, it may be argued that the positive relationship between health consciousness and community participation articulated in the last few paragraphs will manifest in the realm of the different healthy or unhealthy activities that constitute health consciousness. While healthy activities such as exercising and healthy eating might be expected to hold a positive relationship with community participation, unhealthy activities might be expected to demonstrate a negative relationship. Therefore, the following hypotheses are suggested:

- H1. Healthy eating will have a positive effect on community participation.
- H2. Exercising will have a positive effect on community participation.
- H3. Alcohol consumption will have a negative effect on community participation.
- H4. Gambling will have a negative effect on community participation.

## METHOD

### Data

The annual consumer survey sponsored by DDB Needham, Inc. was used for this study (explained in detail in Dutta-Bergman, 2003). Five thousand questionnaires were mailed to the panel members in the spring of 1998. A total response of 3,350 (67% response rate) was received and served as the database of the study. The data

were collected through 48 states (omitting Alaska and Hawaii). Respondents in the database varied in ages from 18 to 91. The mean age was 47.80. The sample comprised of 44% men and 56% women; 81% Whites, 8.7% Blacks, 7.3% Hispanics, and 3% others.

## Measures

The items used in this study came from the demographic and attitudes, interests, and opinions sections of the Life Styles questionnaire.

### *Dependent Measures*

The dependent measure in this study was the consumers' willingness to participate in the community and was borrowed from the substantive body of work on social capital (see Putnam, 1993 & 1995 for use of the same data and same measures). Community participation was measured by the items: "participated in a club meeting," "attended a church," "volunteered in a community organization," and "participated in a community project." All items were measured on a six-point scale ranging from "definitely disagree" to "definitely agree." On conducting a Principal Axis factor analysis, a single factor was generated. The Eigenvalue of the factor was 2.06. The aggregated scale had a moderate reliability of .62. Published articles on social capital appearing in *Communication Research*, *Political Communication*, and in Putnam's celebrated book *Bowling Alone* use the same measures and report similar reliabilities.

### *Independent Measures*

The independent variables used in this study belong to three different categories: demographic, personality strength, and health consciousness.

*Demographics.* Age was measured by a single item that simply asked the respondent to report his or her exact age in number of years. Respondents reported their gender on a single-item dichotomous variable that asked them whether they were male or female. Education was measured by a single item, "education level of respondent." The scale ranged from 1 to 7 (see Dutta-Bergman, 2003). Income was measured by the question, "Last year, that is in 1999, what was your total family income from all sources, before taxes?" The item was measured on a 1 to 15 scale.

*Personality strength.* Personality strength was measured by three items. These three items were "I have more self-confidence than most of my friends," "I am the kind of person who knows what I want to accomplish in life and how to achieve it," and "I like to be considered a leader." The Eigenvalue for the factor was 1.48 and the factor loadings ranged from .60 to .73. Cronbach's alpha was .63.

*Health consciousness.* Health consciousness comprised of four components: healthy eating, exercising, gambling, and alcohol consumption. Twenty-three items representing the four dimensions were identified from the Activities-Interests-Opinions section of the Lifestyle data. Each of these items was measured on a 1 to 6 scale ranging from “definitely disagree,” to “definitely agree.” The items were subjected to a Principal Axis factor analysis with Varimax rotation. Four factors with Eigenvalues greater than 1 were generated (see Table 1), representing each of the four components of health consciousness.

### *Regression*

To test the hypothesis and observe the effects of the independent variables on the dependent variable, a hierarchical multiple regression was conducted. The theoretical model suggested in this study predicted that health consciousness would

TABLE 1  
Factor Loadings and Reliabilities of Health Consciousness Measures

<i>Factors</i>	<i>Loading</i>	<i>Eigenvalue</i>	<i>Cronbach's <math>\alpha</math></i>
Healthy Eating		5.59	.89
Try to avoid foods that are high in fat.	.76		
Try to avoid foods that are high in cholesterol	.75		
Nutrition information determines what I buy	.67		
Make a special effort to get enough fiber	.66		
Am concerned about how much sugar I eat	.66		
Try to avoid foods with a high salt content	.64		
Try to select food fortified with vitamins	.62		
Use a lot of low calorie products	.60		
Try to avoid foods with high additives	.59		
Careful what I eat to keep weight in control	.55		
Am concerned about getting enough calcium	.55		
Alcohol Consumption		2.90	.74
Had a cocktail or drink before dinner	.91		
Went to a bar or tavern	.58		
Had wine with dinner	.55		
Had too much to drink	.52		
Gambling		1.89	.68
Bought an instant or scratch-off lottery	.82		
Bought a state lottery ticket	.78		
Participated in a sweepstakes, game etc.	.44		
Gambled in a casino	.31		
Exercising		1.53	.60
Exercised at home	.62		
Walked more than 1 mile for exercise	.52		
Jogged	.45		
Rode a bicycle	.41		

predict the extent to which individuals participate in their communities, in addition to the effects of the demographic and personality strength variables. The nine independent variables were entered in three different blocks. Demographic variables (age, gender, income, and education) were entered in the first block. Personality strength was entered in the second block. The study used a total of four variables as indicative of health consciousness: healthy eating, exercising, alcohol consumption, and gambling. These variables were entered in the third block. The rationale for this analytic framework was guided by the exploratory nature of this study in detecting the additional variance in health information seeking explained by theoretically meaningful psychographic and personality variables.

## RESULTS

The nine variables included in this study cumulatively accounted for 16.5% of the variance in community participation. The results of this study indicate that psychographic and attitudinal variables can account for additional variance beyond demographic variables such as age, gender, and education (see Table 2). Demographic variables, as a block, accounted for 9.5% of the variance of the consumers' willingness to participate in his or her community. Gender, education, and age were significant predictors of community participation. Also, personality strength explained an additional .7% of variance in community participation. Individuals with

TABLE 2  
Hierarchical Multiple Regression Explaining  
Community Participation

	<i>Community Participation</i>	
	<i>Final Beta</i>	<i>R<sup>2</sup></i>
Demographics		.095***
Gender	.12***	
Education	.22***	
Age	.20***	
Income	.02	
Personality		.007***
Personality Strength	.09***	
Health Consciousness		.063***
Healthy Eating	.01	
Exercise	.25***	
Alcohol Consumption	-.07***	
Gambling	-.04*	
Total R <sup>2</sup>		.165***

†*p* < .10. \**p* < .05. \*\**p* < .01. \*\*\**p* < .001.

greater personality strength were more likely to participate in their communities, supporting the findings from previous research.

Health consciousness accounted for another 6.3% of the variance in community participation, after controlling for the personality and demographic variables. Among the different reflectors of health consciousness, exercising was the strongest predictor of community participation, providing support for H2. However, healthy eating did not have a significant positive effect on community participation. H3 and H4 dealt with unhealthy practices. H3 was supported with the observation that alcohol consumption had a negative effect on the consumers' willingness to participate in his or her community; the results also supported H4 with gambling negatively predicting community participation.

## DISCUSSION

Most social scientists have traditionally investigated social capital as a macrolevel phenomenon, a phenomenon that resides in the community. Considered to be reflective of neighborhoods, states, and countries, a high level of social capital is associated with greater health outcomes. Within this framework social capital has been treated as an antecedent of the health indicators of a community, demonstrating that health outcomes are related to social capital. Therefore, while high social capital communities enjoy good health, low social capital communities suffer from disease and high mortality. As articulated in this article, the macrolevel approach does not provide a clear mechanism for action. This research reverses the health outcomes approach to study the effect of an individual-level variable, health consciousness, on community participation of individuals.

The traditionally used macrolevel approach has been countered by researchers who have argued that social capital eventually resides in the individual (Veenstra, 2000). Based on the core idea that communities are made up of individuals, the individual-difference perspective situates social capital in the individual and in his or her engagement with the surrounding community. The individual becomes the repository of social capital. After all, the individual-level argument suggests, individuals participating in their communities make up high social capital communities. Low social capital communities comprise of individuals who choose to refrain from civic participation or choose to reside in communities with low social capital. This article takes the individual-level approach a step further and studies the role of health consciousness in shaping community participation.

Within the context of the predominantly White American sample, personal and social responsibilities are intricately intertwined in the life of the healthy citizen (Tocqueville, 1999). A unified sense of responsibility integrates the lifestyle of the highly participative individual, determining active engagement in positive health choices and in the community (Bellah et al., 1985). The health conscious individ-

ual actively seeks out community resources and takes an active role in his or her community so the resources can be maximized. Health conscious individuals are also more likely to voice their opinions, as reflected by the willingness to write a letter to the editor. This active participation ensures that the community has access to structural resources that improve the health of its people. Surely, within certain communities and cultures, the health consciousness–community participation linkage might not hold (such as for some subcultures in India or China where community members attend community organizations, irrespective of their health orientation). Future research needs to explore the linkage between personal and social responsibility in other races. Also warranted here is the examination of the health consciousness–community participation relationship in other cultures, particularly collectivistic cultures.

Supporting the nomological network, age, gender, and education had significant effects on community participation. Age was positively related with civic participation, with an increase in community engagement with age. Women were more likely than men to participate in their communities, supporting the theoretical framework. Education was a positive antecedent of social capital. In agreement with the findings of Scheufele and Shah (2000), personality strength had a positive effect on community participation. The concept of an actively oriented, responsible, individual is supported in the realm of personality strength.

Health consciousness was a positive predictor of participation in the community. The health conscious consumer monitors the resources in his or her environment to optimize the health benefits. Since community participation enhances individual health by increasing access to resources and providing social support, health conscious consumers are more likely to engage in their communities. This relationship between health consciousness and community participation may be further explored in future research. Also, the constructs may be contextualized with respect to socioeconomic indicators. The relationship between health consciousness and community participation is critical to our understanding of the relationship between social capital and the health of the community, and raises important questions about the relationship among health consciousness, social capital, and health outcomes of a community. Is the good health of a high social capital community actually a result of the social capital in the community or is it a result of the healthy activities engaged in by the individuals in the community? Is a deeper level of “personal and social responsibility” seen among the individual members of a high social capital community the primary source of its greater health? Is social capital simply a surface-level manifestation of more profound processes?

Extending health consciousness to a macrolevel, it may also be argued that highly health conscious communities are more likely to report better health than communities with lower levels of health consciousness. This observation has been supported by multiple studies and forms the fundamental premise of public health campaigns targeted at changing individual health behavior based on the argument

that individual health behaviors lead to cumulative health behaviors and positive health outcomes in neighborhoods, states, and countries.

The health consciousness constructs used here provide valuable guidelines for developers of public health campaigns who propose to use community-based strategies for diffusing interventions and preventive behaviors. The positive relationship between health consciousness and community participation provides support for the use of community-based interventions as avenues for reinforcing already existing healthy behaviors. Community-based interventions that are strategically designed to act as channels for reinforcement are likely to reach the appropriate target group of health conscious individuals.

Yet another strategic choice for campaign planners involves the targeting of unhealthy individuals. The results of this study point out that unhealthy consumers are less likely to participate in community organizations compared to their healthier counterparts. Therefore, instead of simply placing their messages in community outlets, campaign planners need to strategically identify and target specific at-risk populations in the context of the specific health behavior. Interventions need to address structural, cultural, and individual-level factors that limit individual action; a homogenized "one size fits all" approach is perhaps not the solution.

This study suffers from some important limitations. First, the indices used here have low internal reliabilities. Second, self-reported measures of health consciousness and community participation pose problems to the validity of the measures. Third, the mailback panel used in the study suffers from problems of attrition and panel bias, and the reliability of the dependent measure was moderate. Finally, the use of an American sample that is predominantly White limits the generalizability of the study results. Future research needs to extrapolate the research findings to other cultural domains.

Also, the research conducted here raises important questions for future interrogation. How are health consciousness and community participation related to demographic and personality variables? Perhaps, the demographic and trait-level variables serve as antecedents to an overall sense of responsibility, which in turn serves as an antecedent to the web of activities, interests, and opinions including community participation. Future modeling of the relationship between responsibility and consumer lifestyle choices in the realms of health, community, work, and so on, would benefit both the theory and practice of community participation.

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