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Variations in Involvement: Motivating Bystanders to Care for Senior Citizens

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Abstract

Purpose—The purpose of this study was to determine the impact of a senior service advertising campaign designed to increase volunteerism and financial donations among bystanders.

Design/methodology/approach—A cross-sectional mail survey was administered to 2,500 adults; 384 usable responses were obtained. Survey responses were analyzed by level of exposure and involvement in senior care.

Findings—High involvement individuals viewed the ads more favorably and exhibited stronger senior caretaking intentions. Low-involvement consumers were less likely to see their own potential contributions to senior care services as effective.

Results/implications—It is argued that nonparticipants in prosocial helping may fail to notice the need (low awareness), fail to view the cause as urgent (low perceived susceptibility), or have low prior experience with the issue.

Practical implications—A typology of involvement could be developed that can be used for audience segmentation in marketing health behaviors to bystanders.

Originality—With limited theoretical and practical guidance on how to motivate bystanders to engage in prosocial behaviors, health communicators and marketers are challenged to tap into the vital resource that bystanders potentially could provide. The research reviewed and presented here indicates hope for engaging the public to become active players in making the nation a safer and healthier place.

Keywords

Persuasion; health communication; bystanders; involvement; theory; marketing

Most seniors would prefer to remain in their homes as long as is possible. Seniors who go to nursing homes or assisted living facilities are usually not in need of complex medical care,

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but have difficulty taking care of everyday, personal needs (Brandon and Flurry, 2009). Services like Meals-On-Wheels, available in most cities, can address such needs, but are dependent on volunteer contributions of time and money (Stoil, 2002). Such services require the support of uninvolved bystanders in order to succeed.

Bystanders can play an important role in reducing the physical and social isolation of seniors, yet research shows that few bystanders are willing to help (Hutlock, 2003). Despite the many opportunities available, it is uncommon to contribute to services that help seniors remain in their homes. This is because of low awareness of the significance of the problem, lack of training, and a social norm that discourages involvement with others who are not part of one's immediate family (Fischer, et al., 2011). In fact, it is rare for people to conduct prosocial behaviors in general, despite positive attitudes towards helping (Farley and Stasson, 1993; Sneath, 2007). Prosocial behaviors can be characterized as acts involving a benefactor and recipient that have been defined by society as beneficial (Dovidio et al., 2006).

Unfortunately, little is known about how to effectively motivate bystanders, whether involved or un-involved, to engage in prosocial behaviors (Anker and Feeley, 2011). The likelihood that an individual will notice an event and perceive it to be significant (or threatening) has been shown to be correlated with an individual's involvement. Petty, Cacioppo and Schumann (1983) propose in the elaboration likelihood model (ELM) that individuals who are involved in an issue are more likely to pay attention to a message about that issue, and take action. Adhering to ELM, this study suggests that people who have previous involvement in the issue of senior health are likely to perceive a credible and relevant health threat, but may need to be persuaded that an action to address senior health is both feasible and effective.

The paper proceeds in the following order. First, background information on the living conditions of the elderly and the role of bystanders are discussed. Based on this discussion several hypotheses are presented. This is followed by a description of the development of a television campaign that was implemented over the course of three months. Sections on methods and findings follow. The paper concludes with a discussion of the findings and suggestions for future research.

Literature Review

Senior Health Risks

When the frail elderly live in solitude, threats to their health are amplified (Pavlou and Lachs, 2006; Segal, 2000). The threats that make it difficult for seniors to remain independent include: insufficient physical activity, poor nutrition, lack of social contact, and financial insolvency (Eggers, 2007). Older people can become socially isolated after the death of a spouse or when adult children move away; and depression and self-neglect are a common result if they are not actively connected with others (Bachrach, 1980; Segal, 2000). Previous illnesses and fear of injury can have a negative impact on their ability or desire to be physically active (Struck and Ross, 2006). This population can then become too frail to do basic housework, personal care, and is often unable to drive to go shopping (Armstrong,

2009). “Clinical experience suggests that those who self-neglect often may not recognize or refuse to recognize the dangers of their self-neglectful behaviors. As a result, they often encounter the emergency health care system only after a catastrophic event has occurred.” (Dong et al., 2009, p. 523). One way to address the increased needs of senior health care is for nursing homes to offer services to non-residents (Davis et al., 2007). Another way to offset the problem is to enable seniors to have contact with someone on a regular basis who will provide a presence and can detect self-neglect.

The Role of Bystanders

Several researchers have sought to understand the factors which influence decisions about engaging bystanders in various situations (Cismaru et al., 2010; Latané and Darley, 1970; Levine and Cassidy, 2009; McKnight et al., 2009). Studies demonstrate that various efforts can increase engagement. McKnight et al. used classroom education to increase motorcycle riders' willingness to prevent fellow riders from driving after drinking. Other projects sought to increase bystander engagement to reduce sexual assaults, dating violence and child abuse (Coker et al., 2015; Potter et al., 2008). Fledderjohann and Johnson (2012) found that bystanders needed to have a ppositive perception regarding what would happen if they took action.

Theories of Involvement

To understand the conditions under which people are persuaded by others, researchers have often invoked the notion of involvement. The ELM (Petty and Cacioppo, 1986; Petty et al., 1981) has been widely utilized to study the impact of persuasive communication on consumers' attitude and behavior change. However, the potential for peripheral cues (needed for low-involvement individuals) to persuade audience members in relation to senior volunteerism is unclear. While peripheral cues may be effective for persuading consumers to make feel-good purchases that do not require extensive life changes, it is not clear that such cues (sight, sound, sensory cues) can convince individuals to make the extensive changes required to initiate a new volunteer position. Nevertheless, the ELM was employed to understand the mechanism underlying the relationships between perceived outcomes, involvement, and advertising effectiveness.

In order to further understand the motivations of bystanders, literature on different types of involvement was examined. Over time, operational definitions of involvement have differed sufficiently that researchers began to distinguish various types of involvement at a conceptual level (Johnson and Eagley, 1989). Similarly, we propose different nuances of involvement based on the previous literature: 1) *perceived severity*; 2) *susceptibility involvement*; and 3) *awareness involvement* (Petty et al., 1983; Witte et al., 2001).

Research Hypotheses

Perceived Severity

Perceived threat has long been considered to be a necessary pre-cursor for attitude and behavior change, especially in response to mass media campaigns (Prochaska et al., 1992).

Latané and Darley describe the first decisions required for bystander intervention as “noticing an event” and “interpreting an event as an emergency requiring help.”

The Latané and Darley (1970) bystander intervention model suggests bystanders make five sequential decisions that influence the likelihood of intervention in a situation: Intervening bystanders (1) notice an event, (2) *interpret the event as an emergency requiring help*, (3) accept responsibility for intervening, (4) know how to intervene or provide help, and (5) implement intervention decisions. The presence and number of other individuals in the social context potentially contributes to errors in decision making at each step. In order to notice an event and perceive it as an emergency (steps 1 and 2 in Latané and Darley's model), the bystander needs to perceive the event as significant and threatening. In the case of senior health and other health risks, such perception of an event as an emergency can be compared to the construct of perceived severity that Witte et al. (2001) propose must pre-date any action in response to a health related threat. Presumably, according to step 2 of Latané and Darley's model, messages designed to increase audience action will depend, in part, on the audience's perceived severity of the threat. In the case of senior services, one way that individuals may be come involved is to perceive existing senior health services as in critical need of repair. Therefore, this study hypothesizes that:

H1: Perceived severity is positively associated with perceived efficacy.

Susceptibility, Involvement and Awareness

The extended parallel process model (EPPM) seeks to explain behavior change based on fear (Witte et al., 2001). According to the EPPM, the greater the perception that a person is susceptible to a threat, the more motivated individuals are to take steps towards action, and evaluate the efficacy of the recommended response. When the threat is regarded as trivial or irrelevant, there is no motivation to consider the issue further (Witte et al., 2001). Furthermore, if people believe that they cannot prevent a serious threat from occurring, either because they believe the response to be ineffective and/or because they have low self-efficacy, the recommended response is often rejected (Sampson et al., 2001). Drawing from EPPM, *susceptibility involvement* captures the notion that an individual perceives an issue (in this case a health threat) to be immediately relevant to themselves and their communities. Here we posit that families with a senior who has suffered health problems or isolation are aware of the risks facing seniors insofar as they feel susceptible to the threat of declining senior health themselves.

Petty, Cacioppo and Schumann (1983) in ELM refer to involvement as something derived from prior experience with an issue, such as a family member who is a cancer victim increasing an individual's involvement with messages about cancer therapies (Baxter, 1988). According to ELM, people are more motivated to use the central route (cognitive processing) when an issue has personal relevance to them.

Although not previously compared in the literature, we find Witte's model useful to further explain how a practitioner might apply Latané and Darley's bystander model to a health intervention. Notably, step 3, “accepting responsibility for intervening,” lacks sufficient detail on how an individual comes to accept such a responsibility – i.e., what intermediate

steps are required. Incorporating EPPM, we may suppose that the barriers that prevent an individual from accepting responsibility and taking action on behalf of an at-risk senior may be due to the individual's perceived effectiveness of intervening (i.e. *self or response efficacy*). When people think about the recommended response, they evaluate its level of response efficacy (e.g., "Will it be useful if I volunteer small amounts of time to help them?"). They also evaluate their own perceptions of their ability to help (e.g., "Do I have the time or money to spare?"). Therefore, health practitioners might gear interventions to increase audience perceived efficacy of a proposed bystander action.

This leads to the following hypothesis:

H2: Awareness (awareness involvement, susceptibility involvement, awareness of services) is positively associated with perceived efficacy.

By applying the EPPM to the Latané and Darley model of bystander behavior we can infer that properly constructed marketing messages can increase an audience's perception of efficacy; thereby increasing the likelihood of bystander action. For example, such messages might stimulate audience awareness, emphasize the relevance of an issue or threat to an audience, and engage with audiences by reminding them of prior related experiences— all strategies for prompting the various types of involvement. Therefore, we hypothesize that:

H3: Media exposure is positively associated with perceived efficacy.

Methods

Caring for Seniors Campaign

A communication class at a Rocky Mountain university collaborated with a local non-profit senior care organization to design a media campaign to raise awareness of senior health risks and lack of services, and to increase donations and volunteer support.

The campaign included a set of donor-oriented mass media ads designed to: 1) raise perceived severity of, and susceptibility to, the threat of senior health care among general population adults; 2) raise perceived efficacy of donating or volunteering to help keep seniors in their homes; and 3) motivate volunteers or donors to act, by supporting low-income elderly through senior services. Three ads were disseminated on television and a senior service organization's website, and a fourth ad was shown in billboard format (based on formative research identifying media preferences). Each ad depicted the effectiveness of a volunteer or donor's contribution to an individual senior citizen's life: One ad showed a volunteer driving an elderly man to place flowers on his wife's grave (Old Man and Cemetery Ad); the second showed a volunteer calling an elderly woman who was alone on her birthday (Mrs. Davis Ad); the third-ad showed the impact of small donations by a family of volunteers (Time or Money Ad); the fourth ad was a billboard showing an attractive, elderly woman with the tag line, "Help keep her in her home" (Home Ad). Since effects were evaluated in a field experiment setting, no audience targeting was conducted. Members of the community were surveyed at post-test to compare the reactions of exposed vs. non-exposed individuals, segmented by involvement.

Ad Development

Based on feedback from the agency's director regarding which individuals were most likely to donate or volunteer, the target audience was identified as professional adults between 45 and 70 years old. Student researchers were asked to study the target audience to learn how to appeal to that age group.

Using constructs from the EPPM and media preferences, students developed an in-depth interview protocol to examine audience perceived threat of senior health risks, perceived efficacy for providing personal care and companionship to elderly strangers, perceived efficacy for donating money to a senior care agency, and media use habits. Through community contacts, students convened a snowball sample of 40 middle-aged and young senior residents of Montana, both in Yellowstone County and around the state. The sample size was based on the concept of *data saturation* (developed originally for grounded theory studies but applicable to all qualitative research that employs interviews as the primary data source). Participants were continually brought into the study until the data set was complete, as indicated by data replication or redundancy (Bowen, 2008).

Key findings showed that respondents were: 1) unaware of the severity of the problem; 2) cautious about donating to organizations they do not know for fear their money would go to administrative costs rather than to the needy; and 3) concerned about involving themselves too deeply into a time or money commitment. Some participants indicated that they would be willing to help if they knew that the problem existed and what they could do to solve it. Results were used to generate preliminary messages, and select media channels.

Pre-Testing

The students presented preliminary messages for broadcast and print media to a set of four focus groups, drawn from male and female residents, ages 47-68. Pre-test results showed that the message could best be communicated by telling an "individual story," e.g., describing one senior's situation. When questioned about what type of help would be most appropriate to ask the community, one respondent stated, "They probably have more time than money." This phrase caught the attention of the researchers and evolved into a campaign slogan, "*Your time or money make the difference*"--a theme that would carry throughout the campaign.

The final campaign, consisting of TV public service announcements and one billboard, was aired on local network television for three months, with purchased prime-airtime matched by donated airtime from the station. Ads aired three-to-four times daily, often at prime time, during those months. The billboard was displayed for three months at a prime junction of rush-hour traffic.

Experimental Procedure

A cross-sectional survey was administered immediately after the campaign to a simple random sample of 2,500 men and women using all available addresses as the sample frame. The size of the sample was determined based on the available budget for the project, a response rate estimate, and an estimation of the percentage of mailing addresses that would

be invalid. A total of 382 usable survey responses were obtained, resulting in a response rate of 15%.

Self-selection constructs were included to measure respondents' previous experience caring for senior citizens, or personal experience with age-related problems (physical, psychological, social or financial). Dosage effects were assessed by asking respondents to report how many ads they had seen, on how many media channels, using both prompted and unprompted recall.

Measures

Constructs to capture the attitudinal variables were adapted from the Risk Behavior Diagnosis scale, a validated and reliable scale designed by Witte (1996). Questions from the Risk Behavior Diagnosis Scale (Witte, 1994) probed respondents' perceived self-efficacy and response-efficacy for donating to or volunteering for senior services.

The Risk Behavior Diagnosis Scale (RBD) is a 12-item, 9-point Likert-type scale, ranging from 1 (strongly disagree) to 9 (strongly agree) (Witte *et al.*, 1996). The scale was developed to use all aspects of the EPPM as its theoretical baseline. The RBD asks individuals three questions each about their perceived attitudes toward susceptibility, severity, self-efficacy, and response efficacy toward a certain behavior or topic. The analysis enables a researcher to identify whether an individual (or individuals) is (are) in fear control or danger control processes before or after exposure to a health risk message. The results from the RBD allow researchers to create an effective message directed toward their target audience. The following scales assessed the stage of a particular individual regarding danger control or fear control toward the senior care.

Efficacy—Participants rated four items on a scale of 1 (strongly disagree) to 9 (strongly agree). The first two items measured *self-efficacy*: “I am confident I could make regular phone calls to a senior citizen;” and “I would feel comfortable donating to or volunteering with an organization dedicated to keeping seniors in their homes.” The second two items measured *response-efficacy*: “Small donations of time or money can make a difference in helping senior citizens remain in their homes;” and “Social connections are a good way to reduce the isolation of seniors.” Cronbach's alpha = .75. (For the purposes of our analysis, response- and self-efficacy were combined into a single construct; herein referred to as “efficacy”).

Severity—Participants rate the following items on a scale of 1 (strongly disagree) to 9 (strongly agree): “Our community should focus on improving senior health;” “Declining health among seniors is a serious issue;” and “Social and physical isolation of seniors is a serious issue.” Cronbach's alpha = .71.

Susceptibility—Participants rate the following four items on a scale of 1 (strongly disagree) to 9 (strongly agree): “I have a family member at risk of suffering (age related) health problems;” “I have a family member at risk of suffering (age related) isolation;” “I am likely to suffer a large financial burden to care for seniors;” and “I have received senior care.” Cronbach's alpha = .71.

The survey assessed differences in each of the following attitudinal areas targeted by the campaign: 1) awareness of senior health and elder abuse as serious problems; 2) perceived susceptibility to senior health risks among one's immediate family; 3) perceived self-efficacy to contribute (financially or through volunteer time) to senior services; and 4) perceived response efficacy of small donations of time or money to senior services.

Two types of involvement were measured, based on the interview and focus group data that revealed distinct categories of experience with senior citizens and services: 1) *Awareness involvement* reflected respondents with high levels of awareness of services or related health risks for senior citizens, measured by two items: "Have given care to someone else;" and "I know seniors who have suffered abuse, social isolation, or physical immobility;" and 2) *Susceptibility* was analyzed as a type of *involvement*, based on the focus group data indicating people with high perceived risk of a health threat were more involved in the issue. It was then postulated that these types of involvement would vary with respect to the likelihood that individuals would donate or volunteer with senior services.

Results

Data Analysis

Table 2 displays descriptive statistics and correlations for the dependent variable (perceived efficacy), the control variables (age, income, gender), perceived severity, the involvement variables (awareness, susceptibility), awareness of services, and the four campaign advertisement variables. An examination of the correlation matrix along with collinearity diagnostics indicated no evidence of multicollinearity.

Table 3 displays the results of an exploratory factor analysis using Varimax Rotation. The analysis produced 5 factors with eigenvalues above 1.00 which together, explain 62.88 of the variance. The factors scores loaded as expected in accordance with Witte's theory and previously validated questions, with 11 of the 16 items above .70. Using Cronbach's Alpha, items which loaded on each factor were identified and tested for internal reliability. Alphas' ranged from .63 to .71. Although Alphas above 0.7 are commonly viewed favorably, there is no generally agreed upon cut-off. In fact, "it is a common misconception that if the Alpha is low, it must be a bad test" (Chong and Chong, 1997). Additionally, high Alphas can indicate scale items that are redundant, too narrow, and too specific (Panayides, 2013). Kline (1979) points out that each item in a scale should measure something different, stating "if one constructs items that are virtually paraphrases of each other, the result would be high internal consistency and very low validity (p. 292 as quoted in Panayides 2013). He suggests that correlations above 0.70 should be avoided.¹

Table 4 displays the standardized and unstandardized coefficients, standard errors, and significance of the model tested. An adjusted R^2 of .32 indicates that 32% of the variation in

¹Hair, Anderson, Tatham, & Black (1992) note that common methods variance is a concern when independent and dependent variables originate from a single respondent. In order to mitigate this concern we built the following features, which have been found to lessen common methods variance, into our survey instrument: (1) questions operationalizing campaign exposure were not perceptual, but were objective in nature; (2) the identities of respondents were guaranteed to be anonymous (Podsakoff & Organ, 1986); (3) care was taken in the wording of each item (Torangeau, Rips, & Rasinski, 2000); and, (4) criterion items and predictor items were separated in the questionnaire (Parkhe, 1993).

perceived efficacy can be attributed to the 11 independent variables in the equation. Of the control variables only gender is significant ($t=-1.67$, $p < .10$). An unstandardized regression coefficient of $-.10$ shows that women have a somewhat higher degree of efficacy than men. The first variable of interest, perceived severity is significant ($t=7.204$, $p < .00$), with a standardized coefficient of $.43$, indicating that those who perceive seniors as being vulnerable to neglect also believe that senior health and wellbeing is an important issue. This finding supports the first hypothesis: perceived severity is positively associated with perceived efficacy.

The second variable of interest, awareness involvement, is significant ($t=2.08$, $p < .05$) with a standardized coefficient of $.12$. Susceptibility involvement is also significant ($t=1.7$, $p < .10$), as is the third variable of interest, awareness of services ($t=2.17$, $p < .05$). The standardized coefficients of these variables are $.10$ and $.13$ respectively. These findings support the second hypothesis, which states, “awareness (awareness involvement, susceptibility involvement, awareness of services) is positively associated with perceived efficacy.

The advertising campaign produce mixed results in terms of response efficacy for respondents. Of the four advertisements presented, only the ad “old Man and the Cemetery” was associated with the dependent variable ($t=.03$, $p < .05$). The standardized regression coefficient is $.15$, which indicates that this variable was the largest contributor to perceived efficacy after perceived severity. This finding lends support to the third hypothesis: media exposure is positively associated with perceived efficacy.

Discussion

In recent years, bystander research has seen a surging interest in learning how to change U.S. health lifestyles. The current research responds to this trend by proposing a merger of three models to explain bystander behavior and to inform marketing campaigns designed to motivate prosocial bystander behavior. Drawing primarily upon Witte et al. (2001), Petty et al. (1983), and Latané and Darley (1970), this study found support for the proposition that involvement may be categorized in terms of awareness or susceptibility, and that involved individuals may be motivated to take bystander action by properly designed health communication. Specifically, segmentation strategies may be developed based on our findings that perceived severity, awareness and susceptibility all predict audience likelihood of responding to health marketing to increase audience perceived self and response efficacy, and, thereby, the likelihood of prosocial action. It should be noted that our proposed segmentation strategy differs significantly in goals from the gerontographic model for segmenting senior citizens based on age and lifestyle factors (Moschis and Friend, 2008). In practical terms, this means that an individual who has experience with caring for a senior or who feels that their senior family member is vulnerable or in some way threatened, is more likely to believe in the effectiveness of senior health services (perceived response efficacy) and their own ability to make the sacrifices required to help out (perceived self efficacy). This research indicates that perceived efficacy can increase as a result of a media campaign. These findings have a number of implications for theory and for practice.

Theoretical Implications

No previous studies were identified that summarize the linkages among the various models that address the relationship between persuasion and involvement – among both bystanders and audiences in general. The three social psychological models discussed here – Latané and Darley's model of bystander intervention; Witte's extended parallel process model, and Petty, Cacioppo and Schumann's elaboration likelihood model – all posit that bystanders (and other audiences) must perceive a phenomenon as threatening, or personally relevant, in order to be motivated to take action in response to a message about that topic. Theoretical constructs concerning involvement (Petty et al., 1983), perceived susceptibility and perceived severity (Witte et al., 2001), and the occurrence of noticing and understanding an event as an emergency (Latané and Darley, 1970), share too many similarities to be overlooked.

Characterizing involvement in terms of awareness, awareness involvement, perceived severity and perceived susceptibility, provides a starting point for future examinations of the relationship between involvement, perceived efficacy, and various forms of promotion. Left unexamined are possible interactive effects among the variables. Based upon the findings here, future research could examine such interactions in the context of a more robust theory—one combining the theoretical work described above—and a large enough number of cases to apply structural equation modeling or other techniques that could provide a more nuanced view of the relationships between variables.

Practical Implications

From a practitioner's standpoint, this study identifies specific features of campaign design and audience profiling that might increase the effectiveness of bystander interventions. This study offers not only constructs that can be used to identify particular audience subsets, but also illustrates the practical ways in which perceived susceptibility and perceived response-efficacy to a given issue can be addressed through a mass media campaign.

In a practical sense, bystander campaigns are critical to changing public health behaviors – from drinking and driving to helping keep seniors in their homes. The absence of theoretically-based guidance for marketing campaigns designed to motivate prosocial bystander behavior has paralleled the rise of vast public health crises in our country. If public health messengers want to stimulate healthy behavior among a risk-prone public, they must understand how to get bystanders involved. Successful public health promotion should be based on an in-depth understanding of bystander behavior.

Clearly, all three models can be utilized to inform bystander campaigns, and all three models agree that involved individuals are the ones to target with behavior change messages. The current study provides guidance on using these three models in concert by identifying at least two distinct types of involvement that can be used for audience segmentation: 1) awareness; and 2) susceptibility. Distinct messages and audience profiles can be identified for addressing each sub-audience.

Further, Witte's model explicates prior work by identifying a key factor in motivating individuals' perceived responsibility for taking prosocial bystander action: perceived efficacy of both the recommended response and bystanders' personal commitment/ability to

contribute. The empirical findings reported here confirm that involved individuals are more likely to believe in the effectiveness of a recommended behavior change, and that such confidence can be enhanced through well-designed media messages.

Limitations

Because mass media campaigns can only be validly tested in public settings that are dynamic in nature, a cross sectional study is less than optimal. Therefore, a longitudinal survey is needed to identify the changing attitudes and behaviors of a public in response to a long-running media campaign. A second limitation of this study is that the media campaign was short-lived, lasting only three months. Because behavior change is difficult to achieve on a mass basis through any mechanism, long-term media exposure is needed to have a greater chance of behavioral effects.

Conclusion

Snowballing healthcare costs coupled with an avalanche of baby boomers entering the elderly phase of the lifecycle, make the need for bystander involvement in the lives of seniors increasingly important. A recent editorial in the *Wall Street Journal* article stated the following:

Catholic Charities notes that it costs Medicaid (read: Taxpayers) \$43,000 per year for every senior in a nursing home. By contrast, Catholic Charities provides day care for seniors at \$6,461 per year, home-delivered meals at \$1,188 and services such as housecleaning for \$4,028. Any one of these services can keep an elderly citizen in his own house instead of being sent to a nursing home (one of the great drivers of Medicaid's escalating costs) (McGurn, 2012).

How do Catholic Charities operate so efficiently? For every staff member the organization fields seven volunteers. By involving people who would otherwise be passive bystanders in the lives of the elderly, health care costs are lowered and the quality of life for seniors is enhanced. Such organizations rely on volunteer time and donations to succeed.

Without theoretical and practical guidance on how to motivate bystanders to engage in prosocial behaviors, health communicators and marketers are challenged to address numerous and exponentially rising health threats. The research reviewed and presented here indicates hope for engaging the public to become active players in making the nation a safer and healthier place.

Appendix A

Item	Scale	Construct
Focus on improving senior health	1 completely disagree – 9 completely agree	Severity
Declining health among seniors is a serious issue	1 completely disagree – 9 completely agree	Severity
We are all responsible for improving well-being of seniors	1 completely disagree – 9 completely agree	Severity

Item	Scale	Construct	
Social and physical isolation of seniors is a serious issue	1 completely disagree – 9 completely agree	Severity	
Confident I can make regular phone calls	1 completely disagree – 9 completely agree	Self efficacy	Perceived efficacy
Confident I can make a donation or volunteer	1 completely disagree – 9 completely agree	Self efficacy	
Donating to services is a good way to help seniors	1 completely disagree – 9 completely agree	Response efficacy	
Social connections are good ways to reduce isolation for seniors	1 completely disagree – 9 completely agree	Response efficacy	
Family member at risk of suffering (age related) health problems	1 completely disagree – 9 completely agree	Susceptibility Involvement	
Family member at risk of suffering isolation	1 completely disagree – 9 completely agree	Susceptibility Involvement	
Likely to shoulder a large financial burden to care for seniors	1 completely disagree – 9 completely agree	Susceptibility Involvement	
Received senior care	1 completely disagree – 9 completely agree	Susceptibility Involvement	
Aware of services offered for victims of elder abuse	1 completely disagree – 9 completely agree	Awareness Services	
Aware of services offered by senior service agency	1 completely disagree – 9 completely agree	Awareness Services	
Have given care to someone else	1 completely disagree – 9 completely agree	Awareness Involvement	
Know seniors who have suffered abuse, social isolation, or physical immobility	1 completely disagree – 9 completely agree	Awareness Involvement	
Ad Home	0, 1-5, 5-10, >10		
Ad Old Man	0, 1-5, 5-10, >10		
Ad Mrs. Davis	0, 1-5, 5-10, >10		
Ad Time or Money	0, 1-5, 5-10, >10		

Note. Measures for constructs were taken from Witte, Myer and Martell (2001)

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Table 1
Theories of involvement

Theory	Categories of Involvement:			Change
Behavior				
Categories of Involvement:	Awareness	Susceptibility	Severity	
Latané & Darley	Noticing an event	Perceiving an event as an emergency	Accepting responsibility for intervening	Intervening
ELM	Peripheral involvement	Central involvement	Central involvement	Persuasion
EPPM		Perceived susceptibility	Perceived severity	Action

Note. Theoretical constructs as they apply to categories of involvement. EPPM = Extended Parallel Process Model; ELM = Elaboration Likelihood Model; Latané & Darley = Bystander Intervention Model.

Table 2

Statistics and correlations

	Perceived Efficacy	Age	Income	Gender	Perceived Severity	Awareness Involvement	Susceptibility Involvement	Awareness of Services	Ad Home	Ad Old Man	Ad Mrs. Davis	Ad Time or Money
	25.48	57	49,936	54% Female	29.24	10.58	18.07	8.90	1.17	1.29	1.30	1.14
	5.23	14.61	28,429	-----	5.83	5.36	6.73	4.28	.45	.66	.66	.41
	1.00											
	.08	1.00										
	-.05	-.18***	1.00									
	-.21***	.02	.36***	1.00								
	.49***	.05	-.17***	-.24***	1.00							
ment	.25***	.13**	-.00	-.13**	.14**	1.00						
vement	.25***	.02	-.01	-.08	.24***	.28***	1.00					
ces	.18***	.15**	-.10*	-.16***	.06	.12*	.10	1.00				
	-.04	.04	-.11**	-.07	.02	.06	.025*	.07	1.00			
	.13**	.13**	-.30***	-.10*	.11*	.05	.01	.08	.25*	1.00		
	.08	.18**	-.23***	-.18***	.12*	.13**	.11**	.12**	.05	.48***	1.00	
	.02	.04	-.15***	-.15**	.07	.09*	.13**	.18***	.18*	.27***	.48***	1.00

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Table 3

Exploratory factor analysis

Item	Rotated Components (Varimax with Kaiser normalization)				
	1	2	3	4	5
	Perceived Severity	Susceptibility Involvement	Efficacy	Awareness Services	Awareness Involvement
Initial Eigenvalues Total	4.25	1.91	1.58	1.22	1.12
Percent of Variance	26.55	11.97	9.88	7.59	6.90
Cronbach's Alpha	.679	.628	.679	.706	.623
Focus on improving senior health	.810	.072	.198	-.009	-.032
Declining health among seniors is a serious issue	.843	.071	.109	.058	-.015
We are all responsible for improving well-being of seniors	.825	.057	.112	.090	.079
Social and physical isolation of seniors is a serious issue	.761	.15	.198	-.035	.174
Confident I can make regular phone calls	.176	.122	.646	.022	.133
Confident I can make a donation or volunteer	.054	.002	.823	.098	.099
Donating to services is a good way to help seniors	.432	.064	.617	.047	-.0557
Social connections are good ways to reduce isolation for seniors	.446	.019	.502	.069	.027
Family member at risk of suffering (age related) health problems	.147	.697	.030	-.007	.236
Family member at risk of suffering isolation	.113	.778	.009	-.061	.121
Likely to shoulder a large financial burden to care for seniors	.055	.720	.087	.044	.074
Received senior care	-.041	.443	.089	.278	-.322
Aware of services offered for victims of elder abuse	.064	-.034	-.040	.857	.198
Aware of services offered by senior service agency	.048	.079	.206	.853	-.042
Have given care to someone else	.091	.119	.038	.044	.812
Know seniors who have suffered abuse, social isolation, or physical immobility	.005	.220	.201	.131	.741

Table 4
Perceived efficacy, involvement and campaign exposure (standardized coefficients)

Constant	Unstandardized Coefficients (Standard Error)	Standardized Coefficients
	10.22 (2.43)	
Age	.01 (.02)	.033
Income	.25 (.18)	.090
Gender	-1.09 * (.65)	-.10 *
Perceived Severity	.38 *** (.05)	.43 ***
Awareness Involvement	.12 ** (.06)	.12 **
Susceptibility Involvement	.08 * (.05)	.10 *
Awareness of Services	.15 ** (.07)	.13 **
Ad Home	-1.03 (.68)	-.09
Ad Old Man	1.17 **	.15 **
Ad Mrs. Davis	-.46 (.57)	-.06
Ad Time or Money	-.77 (.83)	-.05
n	235	
R^2	.32	
Adjusted R^2	.29	
F	9.51 ***	

Note.

*
p<.10, two-tailed test;

**
p<.05, two-tailed test;

p<.01, two-tailed test. Unstandardized standard error in parentheses.