ASSESSING A BYSTANDER INTERVENTION PROGRAM FOR FIRST-YEAR STUDENTS AT THE UNIVERSITY OF WISCONSIN – LA CROSSE

A Chapter Style Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of Master of Public Health in Community Health Education

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May 2019
ASSESSING A BYSTANDER INTERVENTION PROGRAM FOR
FIRST-YEAR STUDENTS AT THE UNIVERSITY OF WISCONSIN – LA CROSSE

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ABSTRACT

Worner, C. E. Assessing a bystander intervention program for first-year students at the University of Wisconsin – La Crosse. MPH in Community Health Education, May 2019, 212pp. (L, Reichel)

College students face many health challenges, including alcohol misuse, experiences of sexual violence, hate and bias, and poor mental health. Bystander intervention programming is a method for addressing these health concerns by increasing the willingness and ability of students to intervene for their peers. The purpose of this study was to determine the effectiveness of the bystander intervention program for first-year students by assessing changes in scores of bystander efficacy and bystander intervention behaviors after program participation. Changes in these scores were assessed in the context of several demographic characteristics (i.e. biological sex/gender identity, sexual orientation, race/ethnicity, first-generation status, fraternity or sorority membership, sports team membership, international status, and veteran status). Data analysis revealed no statistically significant changes in scores of bystander efficacy and bystander intervention behavior after program implementation and no statistically significant differences between scores for the demographic groups. However, scores of bystander efficacy and bystander intervention behavior were higher after program implementation, and scores for females, LGBTQ+, non-white, non-first-generation students, fraternity and sorority members, sports team members, and international students were higher than their peers for both bystander efficacy and bystander intervention behavior. Results from this study support the implementation of bystander intervention programming for first-year students.
ACKNOWLEDGMENTS

I would first like to thank my thesis chair, Dr. Lori Reichel, and my committee members, Dr. Michele Pettit and Ingrid Peterson, for their guidance and willingness to share their expertise throughout this process. Their support and feedback was essential for the completion of this thesis.

I would like to thank the University of Wisconsin – La Crosse Peer Health Advocates Margaret Rynkiewicz, Lilli Minor, Abbey Robers, Ashley Clark, Shelby Hagen, and Morgan Worachek for their assistance with program implementation and for bringing so much joy and energy to their work. I would also like to thank the Student Life Office for their support of this initiative and their continuous work to serve and empower students.

I would like to thank my family and friends, particularly my parents and my partner, Aaron Simoni, for their ongoing support and encouragement throughout my academic career. Mom and dad, you have always encouraged me to be a lifelong learner, and I would not have made it this far without your support. Aaron, thank you for helping me through this process and for always knowing how to help me relax and refocus so that I can continue to be productive. To my friends and fellow Master of Public Health candidates, Janessa VandenBerge, Alexandra Larsen, and Leah Bomesberger, thank you for always lending a sympathetic ear and helping me to laugh when I wanted to cry.

Finally, I would like to thank the Miami University H.A.W.K.S. Peer Health Educators and Leslie Haxby McNeill for sparking my initial interest in public health and giving me the confidence to pursue my Master of Public Health degree.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>LIST OF TABLES</td>
<td>ix</td>
</tr>
<tr>
<td>LIST OF FIGURES</td>
<td>x</td>
</tr>
<tr>
<td>LIST OF APPENDICES</td>
<td>xi</td>
</tr>
<tr>
<td>CHAPTER I: INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>Background</td>
<td>1</td>
</tr>
<tr>
<td>Statement of the Problem</td>
<td>4</td>
</tr>
<tr>
<td>Purpose of the Study</td>
<td>6</td>
</tr>
<tr>
<td>Need for the Study</td>
<td>6</td>
</tr>
<tr>
<td>Research Questions</td>
<td>8</td>
</tr>
<tr>
<td>Assumptions</td>
<td>8</td>
</tr>
<tr>
<td>Delimitations</td>
<td>9</td>
</tr>
<tr>
<td>Limitations</td>
<td>9</td>
</tr>
<tr>
<td>Definition of Terms</td>
<td>10</td>
</tr>
<tr>
<td>CHAPTER II: REVIEW OF RELATED LITERATURE</td>
<td>12</td>
</tr>
<tr>
<td>Introduction</td>
<td>12</td>
</tr>
<tr>
<td>Specific College Health Concerns</td>
<td>16</td>
</tr>
<tr>
<td>Prevalence of Specific College Health Concerns</td>
<td>17</td>
</tr>
<tr>
<td>Consequences of Specific College Health Concerns</td>
<td>29</td>
</tr>
<tr>
<td>Protective Factors for Specific College Health Concerns</td>
<td>34</td>
</tr>
<tr>
<td>Interventions for Specific College Health Concerns</td>
<td>43</td>
</tr>
<tr>
<td>Overview of Bystander Intervention Programs</td>
<td>46</td>
</tr>
<tr>
<td>Evidence for Bystander Intervention Programs</td>
<td>48</td>
</tr>
</tbody>
</table>
CHAPTER III: METHODS AND PROCEDURE

Introduction .......................................................... 52
Study Design ...................................................... 52
Subject Selection ............................................... 53
Time Schedule ................................................... 54
Program Development ....................................... 55
Program Implementation .................................... 58
Survey Development ......................................... 58
  Demographic Information .................................. 59
  Bystander Efficacy ......................................... 63
  Bystander Intervention Behavior ....................... 63
Survey Implementation ....................................... 64
Program Evaluation ........................................... 65
Data Analysis .................................................. 66

CHAPTER IV: RESULTS

Introduction ...................................................... 75
Program Feedback from Staff and Students ............ 76
Response Rate .................................................. 81
Research Questions and Results ......................... 82
  Research Question #1: Demographic Characteristics .... 82
  Research Question #2: Bystander Efficacy ............... 85
  Research Question #3: Bystander Intervention Behavior .... 85
  Research Question #4: Biological Sex ...................... 86
Research Question #5: Gender Identity………………………….86
Research Question #6: Sexual Orientation……………………….87
Research Question #7: Race/Ethnicity……………………………..88
Research Question #8: International Student Status……………..88
Research Question #9: Sorority or Fraternity Membership……….89
Research Question #10: Sports Team Membership………………90
Research Question #11: First-Generation Student Status……….91
Research Question #12: Student Veteran Status…………………92

Summary……………………………………………………………………92

CHAPTER V: CONCLUSIONS AND RECOMMENDATIONS……………….95

Introduction………………………………………………………………95

Conclusions……………………………………………………………98

Limitations……………………………………………………………...103

Recommendations to Improve This Research………………………104

Recommendations for Future Research……………………………107

Recommendations for Public Health Practice………………………109

Incorporation of Theories and Models……………………………110

Program Logistics………………………………………………….113

Special Considerations for Violence Prevention………………….114

Program Evaluation………………………………………………114

Utility of Bystander Intervention Programs………………………….115

Summary…………………………………………………………………116

REFERENCES……………………………………………………………..117
<table>
<thead>
<tr>
<th>TABLE</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Prevalence by Percentage of Violence………………………………………19</td>
</tr>
<tr>
<td>1.2</td>
<td>Prevalence by Percentage of Diagnosed Mental Health Concerns…………..25</td>
</tr>
<tr>
<td>1.3</td>
<td>Research Questions, Survey Questions, and Statistical Analysis…………..67</td>
</tr>
<tr>
<td>1.4</td>
<td>Student and Instructor Perspectives on the Bystander Intervention Program...78</td>
</tr>
<tr>
<td>1.5</td>
<td>Perspectives on the Most Valuable Parts of the Program………………….79</td>
</tr>
<tr>
<td>1.6</td>
<td>Perspectives on the Least Valuable Parts of the Program………………….80</td>
</tr>
<tr>
<td>1.7</td>
<td>Other Feedback for the Bystander Intervention Program………………….81</td>
</tr>
<tr>
<td>1.8</td>
<td>Demographic Characteristics of Study Participants………………………84</td>
</tr>
<tr>
<td>FIGURE</td>
<td>PAGE</td>
</tr>
<tr>
<td>--------</td>
<td>------</td>
</tr>
<tr>
<td>1.1</td>
<td>Adult Binge Drinking.................................22</td>
</tr>
<tr>
<td>1.2</td>
<td>Underage Drinking........................................22</td>
</tr>
<tr>
<td>1.3</td>
<td>CDC STOP SV Framework for Prevention of Sexual Violence...........45</td>
</tr>
<tr>
<td>1.4</td>
<td>Gantt Chart of Proposed Timeline..........................55</td>
</tr>
</tbody>
</table>
### LIST OF APPENDICES

<table>
<thead>
<tr>
<th>APPENDIX</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Bystander Intervention Program Presentation</td>
</tr>
<tr>
<td>B.</td>
<td>Bystander Intervention Program Facilitator’s Guide</td>
</tr>
<tr>
<td>C.</td>
<td>Institutional Review Board Application and Approval</td>
</tr>
<tr>
<td>D.</td>
<td>Bystander Efficacy and Bystander Intervention Behavior Survey</td>
</tr>
<tr>
<td>E.</td>
<td>Instructor and Student Program Feedback Survey</td>
</tr>
</tbody>
</table>
CHAPTER I

INTRODUCTION

Background

The time of transition from high school to college can be difficult for students. The first year of college is the first time students live on their own and are thus responsible for their own well-being and care (Pedrelli, Nyer, Yeung, Zulauf, & Wilens, 2015). Without the usual support from their families and friends at home, students may struggle as they work to establish their identities and support themselves. College is the first time students are asked to make decisions about their health, especially regarding participation in high-risk health behaviors (Pedrelli et al., 2015).

Examples of high-risk health behaviors students may have opportunities to partake in include substance use and poor sexual decision-making behaviors. Alcohol use, even by underage students, is common on college campuses, with 81% of students reporting consuming alcohol, and 68% reporting having been drunk at least once in their lifetime (Johnston et al., 2018). High-risk drinking is common among the college-age population, with 32% of college students consuming five or more drinks in one occasion at least once within the past 14 days (Schulenberg et al., 2017). Some students also experience sexual violence, which can contribute to mental health challenges and impact the survivor’s overall well-being. On college campuses specifically, research indicates between 19 and 25% of female college students are the victim of an attempted or
completed rape during their time in college (Banyard et al., 2017; Banyard et al., 2007; Fisher, Cullen, & Turner, 2000; Krebs, Lindquist, Warner, Fisher, & Martin, 2009a; Tjaden & Thoennes, 2000). In addition, students are likely to be exposed to new populations of people with whom they have not previously interacted, which can result in experiences of hate and bias. Nationally, there were 860 cases of hate crimes on college campuses reported in 2015 (National Center for Education Statistics, 2018).

Related to these new experiences, students may face mental health challenges they are not prepared to overcome on their own. According to the American College Health Association (2018), 31% of college students reported being diagnosed or treated by a professional for a mental health concern in the last twelve months. These health challenges experienced by students can negatively impact both their overall well-being and their academic and social success. Lower grade point averages, lower rates of retention, and decreased university involvement are potential consequences of challenges experienced by college students. As universities work to support the well-being and success of their students, they need to fully consider these challenges. Education and support services should be developed and enhanced to support students during this time of transition.

Colleges and universities have previously worked to address many of these concerns through implementation of bystander intervention programs which encourage students to intervene when their peers are experiencing health concerns. These programs are utilized as a way to prevent health concerns and their associated negative consequences by increasing social support and peer intervention. Following these recommendations, a bystander intervention program for first-year students was
implemented and evaluated at the University of Wisconsin – La Crosse to support students in this time of transition.

Bystander intervention programs teach transferable skills participants can utilize to assist their peers in emergencies and situations that could develop into emergencies. These programs take advantage of the relationships college students have formed with their peers because most of the high-risk activities students engage in are performed in the presence of their peers rather than administrators, faculty, and staff (Neighbors, Foster, Fossos, & Lewis, 2012). For this reason, primary goals of these programs are to emphasize responsibility for each other’s well-being and to create a culture in which intervening is seen as a healthy and positive behavior. When paired with skill development and practice, such as practical intervention techniques, the promotion of pro-social values has been linked to increases in actual bystander intervention behaviors (Brown, Banyard, & Moynihan, 2014; Mabry & Turner, 2016; Storer, Casey, & Herrenkohl, 2015). Thus, teaching practical intervention skills and giving participants opportunities to practice these new skills are central aims of bystander intervention programs.

Bystander intervention programs have been found to be effective in teaching students warning signs for dangerous situations and communicating techniques for intervening in a meaningful way, particularly in the context of sexual assault prevention (Katz & Moore, 2013). Bystander intervention programs have been used to encourage intervention in situations involving alcohol, mental health concerns, and hate and bias. However, most have not been evaluated for efficacy. Based on preliminary evidence, there is strong support for creating and implementing bystander intervention
programming for these health issues. Upon being developed, new bystander intervention programs should be rigorously evaluated to determine their success within specific priority populations of interest.

**Statement of the Problem**

College students currently face many health and well-being challenges, including alcohol and other drug misuse, sexual violence, mental health concerns, experiences of hate and bias, sexual health issues, chronic health issues, inadequate sleep, identity formation, limited opportunity for physical activity, communicable diseases, and poor nutritional options and choices (American College Health Association, 2018). In response to these challenges, the American College Health Association has established several goals for improving the health of college students, including decreasing rates of interpersonal and relationship violence, high-risk drinking, and mental health concerns (American College Health Association, 2010). These challenges and their associated consequences could be avoided through the use of bystander intervention behaviors in which first-year students are trained to assist their peer groups. It currently is not known if bystander intervention programming would be effective in increasing peer-based intervention to prevent negative experiences and outcomes with students at the University of Wisconsin – La Crosse, so performing assessment procedures was essential.

**Purpose of the Study**

The purpose of this study was to assess how bystander efficacy and bystander intervention behaviors of first-year students at the University of Wisconsin – La Crosse changed as a result of participation in a bystander intervention program. This was accomplished by assessing bystander efficacy and bystander intervention behaviors
before and after implementation of the program. If bystander efficacy and bystander intervention behaviors increased in conjunction with program implementation, the bystander intervention program would be deemed effective. This program would result in students feeling more able to support their peers.

The purpose of the bystander intervention program was to increase the number of interventions by students within their peer groups. In addition, the program was intended to foster a culture of support among participants and a sense of community in order to make intervention behaviors socially acceptable. The 1-hour program utilized a PowerPoint and interactive discussion to first introduce participants to the idea of the bystander effect and other reasons people may fail to intervene in potentially dangerous situations. The program taught the participants how to recognize a dangerous situation by including common warning signs, call red flags, for alcohol misuse, sexual violence, poor mental health, and experiences of hate and bias.

Next, the program emphasized a sense of communal responsibility and encouraged students to intervene on behalf of their peers. Finally, the program taught the three “Ds” of intervening – direct, distract, and delegate – and presented students with scenarios outlining different dangerous situations to allow them to practice their new skills while discussing solutions with their peers. If the program resulted in students feeling comfortable and acting to intervene with their peers in need of assistance, this would positively impact the campus culture of the university as well as student well-being. This may coincide with higher GPAs, rates of retention, academic success, and social success of students.
Need for the Study

This study was necessary to determine if the newly developed bystander intervention program was associated with an increase in bystander efficacy and bystander intervention behavior of first-year students. This particular population is important to assess because it is known first-year students are more vulnerable to alcohol misuse/illegal consumption, sexual assault and unhealthy relationships, poor mental health, and other issues addressed in a bystander intervention program than their older, more experienced peers (Cantor, Fisher, Chibnall, & Townsend, 2015).

In addition, if first-year students can adopt healthier habits and bystander intervention behaviors early in their college experiences, they will be safer and healthier throughout their time at college (Cantor et al., 2015). If this program is effective in increasing bystander efficacy and instances bystander intervention behaviors, the program should be established as part of the regular curriculum received by all first-year students. Implementing this program with all first-year students for several years could also create a more positive campus culture where students support their peers and intervene on their behalf to prevent negative experiences and poor health outcomes.

Research Questions

Research questions for this study were as follows:

1. What are the demographic characteristics of the first-year students at the University of Wisconsin – La Crosse that participated in the study?

2. How do scores of bystander efficacy differ before and after participation in a bystander intervention program for first-year students at the University of Wisconsin – La Crosse?
3. How do scores of bystander intervention behavior differ before and after participation in a bystander intervention program for first-year students at the University of Wisconsin – La Crosse?

4. How does biological sex influence scores of bystander efficacy and bystander intervention behavior before and after participation in a bystander intervention program for first-year students at the University of Wisconsin – La Crosse?

5. How does gender identity influence scores of bystander efficacy and bystander intervention behavior before and after participation in a bystander intervention program for first-year students at the University of Wisconsin – La Crosse?

6. How does sexual orientation influence scores of bystander efficacy and bystander intervention behavior before and after participation in a bystander intervention program for first-year students at the University of Wisconsin – La Crosse?

7. How does race/ethnicity influence scores of bystander efficacy and bystander intervention behavior before and after participation in a bystander intervention program for first-year students at the University of Wisconsin – La Crosse?

8. How does international student status influence scores of bystander efficacy and bystander intervention behavior before and after participation in a bystander intervention program for first-year students at the University of Wisconsin – La Crosse?

9. How does sorority or fraternity membership influence scores of bystander efficacy and bystander intervention behavior before and after participation in a bystander intervention program for first-year students at the University of Wisconsin – La Crosse?
10. How does collegiate or intramural sports team membership influence scores of bystander efficacy and bystander intervention behavior before and after participation in a bystander intervention program for first-year students at the University of Wisconsin – La Crosse?

11. How does first-generation student status influence scores of bystander efficacy and bystander intervention behavior before and after participation in a bystander intervention program for first-year students at the University of Wisconsin – La Crosse?

12. How does veteran status influence scores of bystander efficacy and bystander intervention behavior before and after participation in a bystander intervention program for first-year students at the University of Wisconsin – La Crosse?

**Study Assumptions**

Assumptions for this study were as follows:

- Each student will understand the questions asked on the survey.
- Each student will answer the survey questions to the best of their ability.
- Each student will answer the survey questions honestly.
- Students within the UWL 100 courses will be present in class the day the bystander intervention program is implemented.

**Study Delimitations**

Delimitations for this study were as follows:

- Only students who were in their first year at the University of Wisconsin – La Crosse and were enrolled in a section of the first-year seminar course, UWL 100, were included in the study population.
• Changes in bystander efficacy and bystander intervention behaviors were measured within this study, and impacts on rates or consequences of alcohol misuse, sexual violence, mental health concerns, or hate and bias incidents were not assessed.

**Study Limitations**

Limitations for the study were as follows:

• Instructors who allowed the implementation of the bystander intervention program within their UWL 100 class may have emphasized different values to their students and thus, different class sections may have been fundamentally different at the beginning of the study.

• Instruments selected for this study assessed sensitive metrics and thus, students may have provided answers they perceived to be socially desirable instead of answers reflecting their true feelings.

• First-year students in the second month of their college career may not yet have had the opportunity to experience the culture at the University of Wisconsin – La Crosse and may not have experienced a situation where bystander intervention behavior was necessary.

• The data and results generated from this study were not generalizable to the entire population of first-year students at the University of Wisconsin – La Crosse because the UWL 100 courses in which data collection took place did not represent a random sample of first-year students.
Definition of Terms

Bystander intervention behavior is defined as the actions associated with intervening when witnessing a potentially dangerous situation wherein someone needs assistance (Potter, 2012).

Binge drinking is defined as “drinking five or more drinks for men and four or more drinks for women consumed in a period of two hours or less” (CDC, 2018, n.p.).

The bystander effect “refers to the phenomenon that an individual’s likelihood of helping decreases when passive bystanders are present in a critical situation” (Latané & Darley, 1968, pg. 378).

Bystander efficacy is defined as a person’s confidence in intervening in a variety of potentially dangerous situations wherein someone needs assistance (Burn, 2009).

Bystander intervention programs “are designed to increase a student’s capacity and willingness to intervene when another student may be in danger of harming him/herself or another person due to alcohol use. Bystander intervention programs are…used to reduce consequences of drug use, sexual assault, and other problems” (National Institute on Alcohol Abuse and Alcoholism, 2015, n.p.).

Bystander opportunity occurs when a person witnesses a potentially dangerous situation wherein someone needs assistance and thus the bystander has an opportunity to intervene (Murphy, 2014).

A hate or bias incident is defined as “an act motivated, in whole or in part, by the victim's actual or perceived race, religion, ethnic background, sexual orientation, gender, gender identity or disability” (University of Wisconsin – La Crosse Campus Climate Office, 2019, n.p.).
Mental health concerns “involve changes in thinking, mood, and/or behavior. These concerns can affect how we relate to others and make choices” (Substance Abuse and Mental Health Services Administration, 2019, para. 1). Mental health concerns differ from diagnosed mental health disorders in that “reaching a level that can be formally diagnosed often depends on a reduction in a person’s ability to function as a result of the disorder” (Substance Abuse and Mental Health Services Administration, 2019, para. 2).

Sexual violence “involves a range of acts including attempted or completed forced or alcohol/drug facilitated penetration (i.e., rape), being made to penetrate someone else, verbal (non-physical) pressure resulting in unwanted penetration (i.e., sexual coercion), unwanted sexual contact (e.g., fondling), and non-contact unwanted sexual experiences (e.g., verbal harassment, voyeurism)” (Basile, Smith, Breiding, Black, & Mahendra, 2014, pg. 1).

Underage drinking is defined by the Substance Abuse and Mental Health Services Administration as “alcohol consumption by youth ages 12 to 20” (Substance Abuse and Mental Health Services Administration, 2014, pg. 1).
CHAPTER II
REVIEW OF RELATED LITERATURE

Introduction

The first year of college attendance is the first time students are living independently of their families and caregivers and must take full responsibility for themselves (Pedrelli et al., 2015). Many students struggle without the same support they received in high school, especially as they are faced with new and different challenges. This period of transition can be difficult for students, and is the first time many students start to experiment with high-risk health behaviors (Pedrelli et al., 2015). According to the American College Health Association (2018), health challenges college students may experience include alcohol and other drug misuse, sexual violence, mental health concerns, experiences of hate and bias, sexual health issues, chronic health issues, inadequate sleep, identity formation, limited opportunity for physical activity, communicable diseases, and poor nutritional options and choices (American College Health Association, 2018).

Health challenges experienced by students can negatively impact both their overall well-being and their academic and social success. Mental health challenges can affect students’ ability to succeed, with 11% of college students reporting experiencing a significant academic impairment such as dropping a course, receiving an incomplete, or taking a leave of absence from school due to mental health concerns (Sontag-Padilla, 2018).
In addition, 44% of undergraduate students nationally report their mental health affected their academic performance within the past thirty days (Eisenberg, Gollust, Golberstein, & Hefner, 2007). Dual diagnoses of depression and anxiety, as well as eating disorders, have been associated with lower grade point averages (GPAs) for college students (Eisenberg, Downs, Golberstein, & Zivin, 2009). In addition, students who have ever attempted suicide or created a suicide plan generally have less academic success in college compared to other students (Mortier et al., 2015).

Substance use can negatively impact student success. Many students engage in substance use while in college, and some students use substances as a form of self-medication to relieve stress and avoid negative feelings associated with mental health issues. Regardless of the reason for use, both excessive alcohol use and marijuana use are associated with lower GPAs for college students (Arria, O’Grady, Calderia, Vincent & Wish, 2008; Buckner, Ecker, & Cohen, 2010). Using alcohol and marijuana in combination has a greater negative effect on college student GPA than using alcohol alone (Meda et al., 2017). Research has demonstrated alcohol and marijuana not only can directly impact students’ grades, but can impact intermediary factors, such as time spent studying and skipping class (Conway & DiPlacido, 2015).

Other health issues can impact student success as well, including the experience of sexual violence. Survivors of violence often face challenges related to re-adjusting to their lives, which can result in lower academic achievement (Banyard et al., 2017). Victimization has been linked to skipping class and loss of motivation to attend or participate in class (Black et al., 2011; Krebs et al., 2009a). Additionally, sexual assault survivors endure interruptions in their course of study and may even leave their academic
programs (Banyard et al., 2017; Potter, 2012). In fact, sexual violence victims have a higher dropout rate when compared to the overall university dropout rate (Griffin & Read, 2012; Mengo & Black, 2016). Thus, it is essential for colleges and universities to recognize and address these health concerns and the effects they have on student success and retainment.

The American College Health Association recognized the impact of student well-being on student success and developed the Healthy Campus 2020 Goals to address the unique health needs of college students. These goals are meant to serve as guidelines for colleges and universities to target their efforts for improving student health and success, and provide a framework for colleges to approach assessment and health and prevention education on their campuses (American College Health Association, 2010).

The Healthy Campus 2020 Goals created by the American College Health Association relevant to the topics within this review include the following:

- **Academic Impediments (AI) – 1.3**: Reduce the proportion of students who report that their academic performance was adversely affected by anxiety in the past 12 months.

- **ECBP – 7.3**: Increase the proportion of students who report receiving information on violence prevention from their institution.

- **ECBP – 7.6**: Increase the proportion of students who report receiving information on alcohol and other drug use from their institution.

- **Injury and Violence Prevention (IVP) – 39.3**: Reduce the proportion of students who report being in an intimate relationship that was emotionally abusive within the last 12 months.
• IVP – 39.1: Reduce the proportion of students who report being in an intimate relationship that was physically abusive within the last 12 months.

• IVP – 39.2: Reduce the proportion of students who report being in an intimate relationship that was sexually abusive within the last 12 months.

• HC IVP – b: Reduce the proportion of students who report being sexually touched without their consent within the last 12 months.

• IVP – 40: Reduce the proportion of students who report being sexually penetrated without their consent within the last 12 months.

• Mental Health and Mental Disorders (MHMD) – 2: Reduce the proportion of students who report attempting suicide within the last 12 months.

• MHMD – 6a: Increase the proportion of students reporting a diagnosis of depression and receiving treatment within the last 12 months.

• MHMD – 6b: Increase the proportion of students reporting a diagnosis of anxiety and receiving treatment within the last 12 months.

• Substance Abuse (SA) – 14: Reduce the proportion of students who report engaging in high-risk drinking of alcoholic beverages within the last two weeks.

The U.S. Department of Education estimates 41% of 18- to 24-year-olds are enrolled as students at 2- and 4-year colleges (Snyder, de Brey, & Dillow, 2016). Due to the large number of young adults enrolled in colleges and universities, and the new challenges and health issues these students may face, colleges and universities are uniquely positioned to utilize innovative methods and programs to enhance their
students’ success through supporting their health and well-being. This review will focus specifically on how colleges and universities can support their students when they engage in alcohol misuse or experience sexual violence, mental health concerns, or incidents of hate and bias. As mentioned previously, many students transition from depending heavily on their parents or caregivers to having to assume responsibilities for their own health and well-being. Students may not always know where to turn for support. Thus, colleges and universities can play a role in supporting their students. Colleges and universities have worked to address these concerns through implementation of bystander intervention programs to encourage students to intervene when their peers are experiencing health concerns. These programs are discussed below as a way to prevent health concerns and their associated negative consequences.

**Specific College Health Concerns**

This review specifically focuses on sexual violence, alcohol misuse, mental health concerns, and hate and bias issues. These issues are the focus of this research because they are prevalent for University of Wisconsin – La Crosse students and because efforts to address other drug use, physical activity, communicable diseases, and nutrition are in place on UWL’s campus. These issues are addressed through partnerships with the offices of Wellness and Health Advocacy, Recreational Sports, the Student Health Center, Department of Health Education and Health Promotion, and Dining Services. The issues of sexual violence, alcohol misuse, mental health concerns, and hate and bias are addressed in various ways, however, these topics present the greatest opportunities for improvement for the university.
Prevalence of Specific College Health Concerns

Sexual violence, alcohol misuse, mental health concerns, and hate and bias are common problems at most universities nationwide, and these problems are faced by students at the University of Wisconsin – La Crosse.

**Prevalence of sexual violence.** Sexual violence has been identified as a serious public health problem affecting millions of people in the world each year (Basile et al., 2016). Nationally, 23% of adult women and 14% of adult men in the U.S. report having experienced severe physical violence by an intimate partner (Smith et al., 2017). On college campuses specifically, research indicates between 19 and 25% of female college students are victims of an attempted or completed rape during their time in college (Banyard et al., 2017; Banyard, Ward, Cohn, Moorehead, & Walsh, 2007; Fisher et al., 2000; Krebs et al., 2009a; Tjaden & Thoennes, 2000). The rates of victimization for male college students are lower than those for their female peers, however, male college students are 78% more likely than male non-students of the same age (18-24) to be victims of sexual assault (Sinozich & Langton, 2014).

At the University of Wisconsin – La Crosse, it was reported 31.4% of females had experienced sexual touching or attempted or successful sexual penetration without their consent, and 5.2% of females had been victims of sexually abusive intimate relationships in 2018 (Table 1) (American College Health Association, 2018). Altogether, the data collected demonstrate almost 15% of female students had experienced emotionally, physically, or sexually abusive relationships, or some combination of the three in 2018 (Table 1) (American College Health Association, 2018). For males, these values are lower, with 9.1% experiencing sexual touching without their consent, and no male
students (0%) experiencing attempted or successful penetration without their consent (Table 1) (American College Health Association, 2018). In addition, 0% of males at the University of Wisconsin – La Crosse experienced any form of abuse within an intimate relationship (Table 1) (American College Health Association, 2018). Although some of these statistics are lower than nationally reported averages, only a small percentage of instances of sexual violence are reported (Basile et al., 2014). Therefore, it is reasonable to conclude this problem is more significant at the University of Wisconsin – La Crosse than it may appear.
Table 1. Prevalence by Percentage of Violence, Abusive Relationships, and Threats to Physical Safety at the University of Wisconsin – La Crosse (American College Health Association, 2018)

<table>
<thead>
<tr>
<th>Violent Act</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>A physical fight</td>
<td>10.9</td>
<td>2.2</td>
<td>3.8</td>
</tr>
<tr>
<td>A physical assault (not sexual assault)</td>
<td>7.4</td>
<td>3.0</td>
<td>4.2</td>
</tr>
<tr>
<td>A verbal threat</td>
<td>34.5</td>
<td>19.7</td>
<td>22.6</td>
</tr>
<tr>
<td>Sexual touching without their consent</td>
<td>9.1</td>
<td>19.6</td>
<td>18.0</td>
</tr>
<tr>
<td>Sexual penetration attempt without their consent</td>
<td>0.0</td>
<td>6.6</td>
<td>5.6</td>
</tr>
<tr>
<td>Sexual penetration without their consent</td>
<td>0.0</td>
<td>5.2</td>
<td>4.5</td>
</tr>
<tr>
<td>Stalking</td>
<td>1.8</td>
<td>3.9</td>
<td>3.8</td>
</tr>
<tr>
<td>An emotionally abusive intimate relationship</td>
<td>0.0</td>
<td>13.0</td>
<td>10.4</td>
</tr>
<tr>
<td>A physically abusive intimate relationship</td>
<td>0.0</td>
<td>3.0</td>
<td>2.4</td>
</tr>
</tbody>
</table>

Reported crimes related to sexual violence from 2014 to 2016 included seven rapes, thirteen instances of fondling, seven instances of domestic or dating violence, and sixteen instances of stalking (University of Wisconsin – La Crosse Office of Student Life, 2017). Again, these crimes may be underreported at the University of Wisconsin – La Crosse (Basile et al., 2014). Freshmen college students experience sexual victimization at higher rates than their older peers, so universities should focus on implementing interventions with first-year students (Cantor et al., 2015).

Alcohol misuse is intimately linked to sexual violence, especially in the context of sexual assault. Alcohol use is involved in approximately 50-70% of campus sexual violence cases (Abbey, 2002; Carr & VanDeusen, 2004; Krebs, Lindquist, Warner, Fisher, & Martin, 2009b). However, this relationship does not imply alcohol causes sexual assault. Instead, perpetrators may consume alcohol, consciously or unconsciously,
to lower their own inhibitions and/or to justify assaulting their victim. Rather than acting
as a cause of sexual assault, alcohol acts as a catalyst to commit sexual assault for
individuals who already hold toxic beliefs and attitudes (Abbey, 2002). Although many
perpetrators attempt to excuse their harmful actions as alcohol-induced, many victims
who were consuming alcohol at the time of the assault are often blamed for their own
assault, and report feeling more intense guilt and self-blame for the assault (Abbey,
2002). In addition, alcohol consumption has been linked to a greater likelihood of
aggression by the perpetrator during an assault and some perpetrators use alcohol to
incapacitate their victims (Abbey, Zawacki, Buck, Clinton, & McAuslan, 2004). As
described by one prevention specialist in the toolkit, Addressing Alcohol’s Role in
Campus Sexual Assault, “alcohol serves as both camouflage and a weapon” (Klein,
Helmken, Rizzo, & Woofer, 2017). Due to the related nature of alcohol misuse and
sexual assault victimization, these topics should be examined and addressed
simultaneously.

**Prevalence of alcohol misuse.** Misuse of alcohol by college students represents a
significant public health problem in the United States. More than 1,519 students die due
to alcohol-related injuries each year, including alcohol poisoning events, auto fatalities,
drownings, falls, homicides, and suicides (Hingson, Zha, & Smyth, 2017). While the
majority of college students are under the legal drinking age of 21, 81% of students report
consuming alcohol, and 68% report having been drunk at least once in their lifetime
(Johnston, Miech, O’Malley, Bachman, & Schulenberg, 2018). In addition, 63% of
students report using alcohol in the past thirty days, and 41% report being drunk at least
once in the past thirty days (Schulenberg et al., 2017).
Risky alcohol use is common among college students nationally. For example, binge drinking is more common among college students than their non-college peers of the same age (Johnston et al., 2018; National Institute on Alcohol Abuse and Alcoholism, 2015), with 32% of college students consuming five or more drinks in one occasion at least once within the past 14 days (Schulenberg et al., 2017). Due to the high rates of alcohol consumption and risky drinking behaviors, such as binge drinking, the college environment is considered a high-risk setting. In addition, students ages 18-24 are already in a high-risk period of the lifespan for alcohol misuse and the related consequences.

In addition to the pervasive alcohol culture on college campuses, there are problematic social norms in Wisconsin supporting unsafe, and often illegal alcohol consumption at the University of Wisconsin – La Crosse. In fact, in the state of Wisconsin, the per capita alcohol consumption rate is 1.3 times higher than the rate for the United States, and adult alcohol use is higher in Wisconsin than national averages for all categories of consumption, including binge drinking, heavy drinking, and current use (Wisconsin Department of Health Services, 2016). Binge drinking and underage drinking are more common in Wisconsin than they are nationally, and Wisconsin is consistently ranked among the highest rates of binge drinking in the entire country. In 2014, the rate of binge drinking for adults in Wisconsin was 22%, which was the third highest rate among all states in the U.S. (Figure 1, Wisconsin Department of Health Services, 2016). Rates for La Crosse County are high, with rates of binge drinking among adults ranging from 28% to 31% from 2011 to 2014 (Wisconsin Department of Health Services, 2016).
Youth ages twelve to twenty in Wisconsin are more likely to participate in underage drinking than youth nationally. In fact, youth in Wisconsin report high rates of both current drinking and binge drinking. From 2013-2014, 28% of Wisconsin youth report participating in underage drinking, with 18% report participating in underage binge drinking (Figure 2, Wisconsin Department of Health Services, 2016).
The period of time with the highest risk of alcohol-related problems is when students start their college experiences. The first semester of college, when students are transitioning from living with their parents, can be dangerous and may involve a high level of participation in risky behavior (K. Ebert, personal communication, March 27, 2018). The danger of this time period is demonstrated by the high rates of alcohol use reported by first-year students. At the University of Wisconsin – La Crosse, first-year students report higher rates of alcohol use when compared to national data, with 77.9% of students reporting any alcohol use during the last 30 days (American College Health Association, 2018). Interestingly, many students perceive the number of students at UWL who regularly drink as much higher than it is in reality, with perceived usage of alcohol on campus at 99.7% (American College Health Association, 2018). Most students believe the myth “everyone drinks,” which could heavily influence how students make decisions about their own individual choices. In addition, the vast majority of first-year students are not yet twenty-one, making their alcohol consumption illegal, as well as dangerous. Dangerous alcohol consumption leads to many negative consequences of alcohol use, discussed later.

**Prevalence of poor mental health.** Life can be stressful, and college can be a particularly stressful time for many students. Students must cope with the pressure to achieve academically while living independently from their family, often for the first time. This family separation represents a period of transition for many students and a subsequent reduction in social support. Students must attend to numerous responsibilities independent of their families, and often must balance academic obligations while attempting to navigate their new environment, numerous social stressors, and work and
family considerations (Pedrelli et al., 2015). With these new responsibilities and stressors, students may experience their first onset of mental health and substance use problems, or experience an exacerbation of their existing symptoms or diagnoses (Blanco et al., 2008).

In addition, poor mental health is common among college students (Blanco et al., 2008). According to the American College Health Association (2018), 31% of college students in 2018 reported being diagnosed or treated by a professional for any mental health concern in the last twelve months. The most common mental health disorders reported were anxiety (22.1% of students), depression (18.1%), and panic attacks (11%). Other mental health disorders reported by college students included anorexia, attention-deficit/hyperactivity disorder (ADHD), bipolar disorder, bulimia, insomnia or another sleep disorder, obsessive compulsive disorder, phobia, schizophrenia, and substance abuse or addiction. Nationally, 8.9% of college students reported being diagnosed or treated for one mental health concern, 14.6% of students reported both depression and anxiety, and 9.3% reported some combination of two disorders other than depression and anxiety (American College Health Association, 2006).

Among students at the University of Wisconsin – La Crosse in 2018, the prevalence rates for anxiety, depression, and panic attacks were 25.9%, 22%, and 12.8%, respectively (Table 2) (American College Health Association, 2018). The prevalence of these disorders was slightly higher than the national averages for all college students, yet it is not clear if a significant difference existed or why these rates may have differed. The prevalence rates for all other mental health disorders are included in Table 2.
Table 2. Prevalence by Percentage of Students Diagnosed or Treated for Various Mental Health Concerns at the University of Wisconsin – La Crosse (American College Health Association, 2018)

<table>
<thead>
<tr>
<th>Mental Health Concerns</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anorexia</td>
<td>0.0</td>
<td>3.0</td>
<td>2.4</td>
</tr>
<tr>
<td>Anxiety</td>
<td>9.3</td>
<td>29.4</td>
<td>25.9</td>
</tr>
<tr>
<td>Attention-Deficit/Hyperactivity Disorder</td>
<td>3.7</td>
<td>3.5</td>
<td>3.8</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>1.9</td>
<td>1.3</td>
<td>1.7</td>
</tr>
<tr>
<td>Bulimia</td>
<td>0.0</td>
<td>1.3</td>
<td>1.0</td>
</tr>
<tr>
<td>Depression</td>
<td>11.1</td>
<td>24.0</td>
<td>22.0</td>
</tr>
<tr>
<td>Insomnia</td>
<td>1.9</td>
<td>4.8</td>
<td>4.9</td>
</tr>
<tr>
<td>Other sleep disorder</td>
<td>1.9</td>
<td>2.2</td>
<td>2.1</td>
</tr>
<tr>
<td>Obsessive Compulsive Disorder</td>
<td>3.6</td>
<td>2.6</td>
<td>3.1</td>
</tr>
<tr>
<td>Panic Attacks</td>
<td>7.3</td>
<td>13.9</td>
<td>12.8</td>
</tr>
<tr>
<td>Phobia</td>
<td>0.0</td>
<td>1.3</td>
<td>1.1</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Substance abuse or addiction</td>
<td>0.0</td>
<td>0.4</td>
<td>0.3</td>
</tr>
<tr>
<td>Other addiction</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Other mental health concern</td>
<td>5.6</td>
<td>4.4</td>
<td>4.5</td>
</tr>
<tr>
<td>Students reporting none of the above</td>
<td>83.6</td>
<td>60.4</td>
<td>64.4</td>
</tr>
<tr>
<td>Students reporting only one of the above</td>
<td>1.8</td>
<td>1.7</td>
<td>13.1</td>
</tr>
<tr>
<td>Students reporting both Depression and Anxiety</td>
<td>7.4</td>
<td>18.3</td>
<td>16.7</td>
</tr>
<tr>
<td>Students reporting any two or more of the above excluding the combination of Depression and Anxiety</td>
<td>7.3</td>
<td>8.7</td>
<td>9.0</td>
</tr>
</tbody>
</table>

While the rates of diagnosed and treated mental health disorders are represented here (Table 2), it is important to note many people, including college students, may experience symptoms of these concerns but may not seek help. Students not seeking help could lead to an underestimation of the true prevalence of these disorders and could...
Inaccurately represent how problematic mental health concerns have become for college students.

In addition, although 64.4% of students at the University of Wisconsin – La Crosse reported not being diagnosed or treated for any mental health disorder in the past twelve months, many reported experiencing poor mental health in the past twelve months (American College Health Association, 2018). As measured by the American College Health Association through their National College Health Assessment at the University of Wisconsin – La Crosse, 56.3% of students indicated they felt things were hopeless and 93.8% indicated they felt overwhelmed by all they had to do. In addition, 69.8% of students indicated they felt very lonely while 72.9% felt very sad. Students also felt depressed, anxious, and angry, with 41.7% indicating they felt so depressed that it was difficult to function, 64.5% reporting they felt overwhelming anxiety, and 36.8% stating they felt overwhelming anger. Finally, 9.3% of students intentionally cut, burned, bruised, or otherwise injured themselves, 10.4% seriously considered suicide, and 2.1% attempted suicide (American College Health Association, 2018).

Rates of mental health concerns among the U.S. college population have been trending upward in recent years (Blanco et al., 2018). This trend mirrors the increase in mental health disorders among both youth and adult populations in the U.S. (Eisenberg, Ketchen Lipson, Kern, Ceglarek, & Phillips, 2018). While there is no definitive answer for why the prevalence of mental health disorders has increased among college students, or the population of the U.S., several theories exist. These include the increased academic pressure students experience; an absence of resiliency and healthy coping skills; dependency on others; the rising cost of college attendance, which has not coincided with
an increase in salaries for college graduates; the increased use of social media, which often presents a distorted view of others’ lives; and numerous other societal factors impacting most adults and not solely limited to college students (Blanco et al., 2018). It is also possible the increase in mental health disorders could be due to more students seeking assistance with their concerns and/or more accurate diagnoses than in years past and may not represent a true increase in prevalence of mental health disorders (Blanco et al., 2018).

**Prevalence of hate and bias.** Nationally, there were 860 cases of hate crimes on college campuses reported in 2015. These cases included 363 incidents of destruction, damage, and vandalism, 357 incidents of intimidation, 79 simple assaults, 25 incidences of larceny, 19 incidents of aggravated assault, 6 forcible sex offences, 4 instances of burglary, 3 incidents of robbery, and 2 incidents of both arson and motor vehicle theft (National Center for Education Statistics, 2019). Of these 363 incidents, four out of five were motivated by race, religion, or sexual orientation. Race was the primary motivating factor in 39% of the hate crimes, followed by religion for 22% and sexual orientation for 19% of hate crimes (National Center for Education Statistics, 2019). Hate crimes represent the most egregious examples of the hate and bias present in society, and incidents that do not rise to the level of a criminal offense are likely much more prevalent (University of Wisconsin – La Crosse Campus Climate, 2019). Unfortunately, reporting of incidents that do not qualify as criminal acts is not mandated by the U.S. Department of Education, so it is difficult to say to what extent these incidents are prevalent on college campuses. Fortunately, these metrics are tracked by the University of Wisconsin – La Crosse and can be examined to provide context for this issue on campus.
At the University of Wisconsin – La Crosse, there were 108 incidents of hate and bias reported by students, staff, and faculty between September 2018 and January 2019. Sex and gender identity/expression were the most common motivators for these incidents, with 53 incidents where someone was targeted based on their gender identity/expression and 51 incidents where someone was targeted based on their sex. Sexual orientation was the next most common motivator, with 28 incidents. There were 26 incidents motivated by race/ethnicity. Finally, there were 10 incidents motivated by disability status, 6 by religious identity, and 10 incidents classified as being motivated by some other factor. Of these 108 incidents, 53 were committed within residence halls, 35 within classrooms, 6 off campus, and 1 in another location. Interestingly, 73% of individuals filing reports were a witness or third party rather than the party originally targeted in the incident (University of Wisconsin – La Crosse Campus Climate, 2019). These individuals were recognized as an ‘upstander’ by the Campus Climate Office, or “someone who recognizes when something is wrong and acts to make it right.” The notion of the ‘upstander’ reinforces the positive idea that students can influence their campus culture and work to make it more positive and intolerant of hate and bias.

In addition to tracking hate and bias incidents, Campus Climate surveys were implemented at UWL in 2004, 2008, and 2013. Campus climate is a measure of the campus environment as it relates to interpersonal, academic, and professional interactions (University of Wisconsin – La Crosse Campus Climate, 2019). These surveys were implemented to assess the personal experiences and attitudes of students, faculty, staff, and administrators regarding diversity and inclusion. Results of the most recent survey indicated the most pressing hate and bias concerns at UWL included bullying,
specifically of non-white students, those with a disability, and non-heterosexual students; stereotyping, particularly of non-white or female students, those with a disability, non-heterosexual students, and students who live off-campus; discrimination, mainly for non-white students, women, those with a disability, non-Christian students, and those who did not receive any financial assistance from their family; and verbal harassment, especially for non-white students or those with a disability. Certain groups of students also felt there is not enough emphasis placed on diversity at UWL, including non-white students, those with a disability, non-heterosexual students, and non-Christian students (University of Wisconsin – La Crosse Campus Climate, 2019).

Consequences of Specific College Health Concerns

Sexual violence, alcohol misuse, mental health challenges, and hate and bias all present harmful consequences for students and may negatively impact their emotional, social, physical, and academic well-being, as well as their ability to succeed in the college environment.

**Consequences of sexual violence.** Sexual violence is a pervasive problem in society, with almost half of women and one in four men experiencing sexual violence and/or rape at some point in their lives (Breiding et al., 2014). College students, especially females, are victimized at higher rates than their non-college attending peers (Banyard et al., 2017). Sexual violence can have severe consequences for victims and survivors. People who experience violence are more likely to report symptoms of depression and anxiety (Chen et al., 2010), engage in unhealthy or antisocial behaviors (Basile & Smith, 2011), and report higher rates of suicidal thoughts (Tomasula, Anderson, Littleton, & Riley-Tillman, 2012). In addition, reproductive health is heavily
impacted by violence. For example, victims may experience difficulties with getting pregnant, high rates of unintended pregnancy, sexually transmitted infections, pelvic inflammatory disease, and other gynecological disorders associated with forceful penetration (Paras et al., 2009).

Psychological symptoms associated with the experience of sexual violence include anxiety, depression, PTSD, antisocial or suicidal behavior, fear of intimacy and emotional detachment, and low self-esteem (Yuan, Koss, & Stone, 2006). Poor social health, including isolation from social networks and homelessness, may occur (Golding, Wilsnack, & Cooper, 2002). Victims of violence are also more likely to engage in negative health behaviors, with more severe violence linked more strongly to negative behaviors. Negative health behaviors reported by victims include, but are not limited to, engaging in high-risk sexual behavior, such as having unprotected sex and/or multiple sexual partners; using harmful substances, such as cigarettes, alcohol, and illicit drugs; and disordered eating, like fasting, vomiting, abusing diet pills, and overconsumption of food (Basile et al., 2006). Sexual violence prevention is essential so students do not have to suffer these consequences.

**Consequences of alcohol misuse.** Excessive alcohol consumption has severe consequences, with more than 1800 college students per year dying from unintentional alcohol-related causes (National Institute of Alcohol Abuse and Alcoholism, 2015). Alcohol has been identified as a factor in many causes of death and injury in Wisconsin, including at least 2,907 injuries resulting from motor vehicle accidents in 2015 (Wisconsin Department of Health Services, 2016). In addition, at least 2,008 deaths in 2015 in Wisconsin were directly attributed to excessive alcohol use; 58% of these
deaths were due to acute conditions while 42% were the result of chronic conditions (Wisconsin Department of Health Services, 2016). In 2013, the economic burden of alcohol use exceeded 6.8 billion dollars (Black & Paltzer, 2013). Alcohol is a factor in a large proportion of crime, including property and violent crimes as well as homicide (Wisconsin Department of Health Services, 2016). Due to the high rates of alcohol consumption in Wisconsin and the associated severe consequences, the Wisconsin Department of Health Services has identified areas of focus to combat these issues, with underage drinking and binge drinking identified as the top two areas for action (Wisconsin Department of Health Services, 2016).

The high rates of injury and death associated with excessive alcohol use clearly demonstrate the importance of addressing excessive alcohol consumption. Lowering rates of risky alcohol consumption among college students will improve their health and safety. Reducing risky alcohol use is a goal salient for first-year students because they are more naïve and susceptible to peer pressure than their older counterparts and are at higher risk for irresponsible drinking (K. Ebert, personal communication, March 27, 2018).

When students are inexperienced with alcohol and consume alcohol irresponsibly, they are more likely to experience the legal ramifications of underage drinking, participate in binge drinking, experience alcohol poisoning, and experience or perpetrate interpersonal violence. College students' substance use is also correlated with the development of harmful health habits, delayed communication and social skills, hindered brain development, and potential negative health outcomes (Ebert, 2015).

At the University of Wisconsin – La Crosse specifically, reported consequences of illegal alcohol consumption by students under the age of 21 include hangovers, arrests,
conduct violations on campus, sexual assault, legal action, alcoholism or addiction, injury, property damage, unplanned and unsafe sexual activity, and even death (American College Health Association, 2018). In addition, students who engage in heavier alcohol use as compared to their peers report lower engagement in their academic classes, more trouble completing homework, and more health problems. Within the last twelve months, 23% of first-year students at UWL reported alcohol use as a factor negatively affecting their academic performance (American College Health Association, 2018).

**Consequences of poor mental health.** Mental health challenges can impact a student’s social, emotional, and physical health as well as their academic success. In addition, mental health challenges faced by individuals impact the campus as a whole. Students with mental health challenges can struggle to adapt to their new environment, especially in their first year of college. Some students are overwhelmed being away from home, having to make decisions regarding their health, and having to take care of themselves. Some students are unable to cope with these new challenges. Mental health disorders, such as depression, can be accompanied by loneliness or isolation, which can make it difficult for students to relate to and form relationships with others (Eisenberg et al., 2009).

Mental health challenges can prevent students from becoming active, involved, and productive members of the campus community. Students with poor mental health may thus experience a reduced quality of life, especially compared to their peers. Furthermore, mental health challenges can impact physical health, particularly in terms of the body’s ability to fight disease and a student’s motivation to seek out physical activity and consume nutritious food (Eisenberg et al., 2009). The most severe consequence of
poor mental health is attempting or completing suicide. Suicide is the second leading cause of death among young people, and can be a tragic result of an undiagnosed or untreated mental health disorder (Eisenberg et al., 2009).

Students facing mental health challenges also experience academic difficulties. In fact, almost 11% of college students report academic impairments such as dropping a course, receiving an incomplete grade, or taking a leave of absence from school (Sontag-Padilla et al., 2016). Mental health can impact students’ academic performance, with 44% of undergraduate students nationally reporting their mental health affected their academic performance within the past thirty days (Eisenberg et al., 2007). Students with mental health concerns often have lower GPAs than their peers (Eisenberg et al., 2007). Finally, students who have ever attempted suicide or created a suicide plan have less academic success compared to other students (Mortier et al., 2015).

Poor mental health impacts not just individuals, but others around the individual, the campus, and the community as a whole. People around the individual with the mental health challenge may be personally affected out of their concern for the student, including experiencing grief over student suicides and suicidal behavior (Suicide Prevention Resource Center, 2019). In addition, depression and anxiety have harmful effects on work productivity and the ability of the student to maintain healthy relationships with others. Campuses can feel the burden when individuals with poor mental health do poorly on schoolwork and drop out of school. This poor retention can impact tuition, fees, and even alumni donations. Finally, communities are negatively affected when students are unable to graduate with their degrees and contribute their valuable skills to local job markets (Suicide Prevention Resource Center, 2019). Colleges and universities need to
work to address college student mental health concerns to prevent their harmful, and sometimes deadly, consequences.

**Consequences of hate and bias.** Students and young adults who are subjected to bullying behavior or are the victim of a hate and bias incident experience feelings of fear and isolation and can suffer from poor mental health outcomes. Students may feel unsafe in their campus environment, which may lead students to disrupt their coursework or drop out of their institution completely. Mental health concerns can arise due to exposure to bullying and harassment and can include agoraphobia, generalized anxiety, panic disorder, depression (Copeland, Wolke, & Angold, 2013). The aforementioned mental health concerns have significant social, emotional, physical, and academic consequences and can lower the quality of life for an individual (Copeland, Wolke, & Angold, 2013).

Fortunately, the experience of hate and bias within a campus community is avoidable. Students must be taught harassment and hate are not tolerated in any form in order to prevent these severe, unnecessary consequences and ensure all students feel safe at their institution of higher education. No student deserves to experience hate and bias and the associated consequences. Colleges and universities must work to enhance protective factors for preventing hate and bias, implement education to prevent perpetration of hate, and provide adequate resources for students who are victimized.

**Protective Factors for Specific College Health Concerns**

Protective factors exist for prevention of sexual violence, alcohol misuse, mental health concerns, and hate and bias. Many protective factors are already present at the University of Wisconsin – La Crosse. Protective factors “are characteristics associated with a lower likelihood of negative outcomes or that reduce a risk factor’s impact” (Substance Abuse and Mental Health Services Administration, 2014). Existing protective
factors should be enhanced in order to prevent the negative consequences associated with the aforementioned health concerns.

**Protective factors for sexual violence.** The University of Wisconsin – La Crosse works to enhance protective factors against sexual violence and sexual assault. All first-year students receive education about consent, healthy relationships, and sexual assault. This education begins even before students arrive on campus with the required online “Think About It” modules created by CampusClarity. These modules educate students about consent, how to recognize unhealthy relationships and sexual violence, how students can support their peers who have experienced violence, and on- and off- campus resources for victims/survivors (K. Ebert, personal communication, March 27, 2018). These messages are reinforced for students during New Student Orientation, in which peer educators facilitate programs for students with the goal of realistically portraying dangerous situations new students may encounter as part of their social life, such as a situation of sexual violence. The goal is to equip these first-year students with skills and competencies for prevention of sexual violence so they may enact them when encountered with a similar situation in their own lives (I. Peterson, personal communication, March 23, 2018).

During the school year, the Peer Health Advocates and the Violence Prevention Specialist within the Student Life Office facilitate additional consent and relationship programs. These programs are open to all students at the University of Wisconsin – La Crosse, in which attendance is voluntary. Popular programs include Consent Bingo, in which participants learn about aspects of society and culture that promote gender-based violence and the Escalation Workshop, created by the One Love Foundation, which
teaches students how to recognize the signs of intimate partner violence in their peers’ relationships before someone is harmed. Future programming endeavors will focus on positive messaging around healthy relationships, sexual communication, and how to support students who may have experienced sexual violence. These programs are facilitated by request for any interested groups on campus, but are most often presented within first-year residence halls (K. Ebert, personal communication, March 27, 2018).

**Protective factors for alcohol misuse.** The University of Wisconsin – La Crosse has instituted several programs to serve as protective factors against underage or excessive alcohol consumption. All first-year students receive alcohol education in many forms, beginning before they arrive on campus with the required online “Think About It” modules created by CampusClarity. These modules educate students about alcohol skills, such as an understanding of a standard drink and recognize the signs of alcohol poisoning (K. Ebert, personal communication, March 27, 2018). Alcohol education is reinforced when first-year students arrive on campus for New Student Orientation. During this orientation, peer educators facilitate programs for students with the goal of realistically portraying dangerous situations in which alcohol or sexual assault are included. Again, the goal is to demonstrate skills and competencies for these first-year students may enact when encountered with a similar situation in their own lives (I. Peterson, personal communication, March 23, 2018).

During the fall and spring semesters, the Wellness and Health Advocacy Office often facilitates additional alcohol education. Peer Health Advocates, with the oversight of the Wellness Coordinator, provide trainings regarding alcohol skills and choices surrounding alcohol. Upon request, these non-mandatory programs are utilized by groups
on campus. Common populations include first-year residence halls, sororities and fraternities, and club sports teams through RecSports (K. Ebert, personal communication, March 27, 2018).

Additional protective factors exist for students at UWL who choose not to consume alcohol. The Eagle Recreation Center and the Office of First Year Experience often provide alcohol-free activities to give students the opportunity to socialize without consuming alcohol. For example, during New Student Orientation, the Office of First Year Experience collaborates with the Recreation Center to sponsor late-night programming such as comedy shows (S. Joslyn, personal communication, March 23, 2018). In addition, the Recreation Center provides weekend activities as part of “Rectoberfest,” a campus alternative to typical Oktoberfest activities, which, for many students, would normally consist of all-day, excessive alcohol consumption. By providing alcohol-alternative programming, the university serves students who want to participate in campus life but prefer to socialize without the pressure to consume alcohol (S. Joslyn, personal communication, March 23, 2018).

The Collegiate Recovery Group, another university initiative, provides peer support for students in recovery for addiction. This group includes current students who attend UWL, Viterbo University, and Western Technical College. Often, addiction and recovery from addiction are associated with a social stigma, especially on a college campus where many social interactions are centered around alcohol consumption. The Collegiate Recovery Group provides an opportunity for students in recovery to receive necessary social support for each other (K. Ebert, personal communication, March 27, 2018).
UWL also has protective factors in place to protect students who choose to drink. The student-led group RiverWatch works to prevent people drinking in La Crosse’s downtown area from accidentally wandering too close to the Mississippi River, which has had deadly consequences for intoxicated UWL students in the past. This group of students is present in the park bordering the Mississippi River on Friday and Saturday nights, and informs anyone who approaches the park that the park is closed for the evening. Using this bystander intervention approach, this group prevents intoxicated people from entering the park and gaining access to the river (I. Peterson, personal communication, March 23, 2018). Restricting access to the river may be a good first step to protect UWL students who choose to drink, however, additional measures need to be implemented to ensure these students do not encounter other harms while they are still intoxicated (S. Joslyn, personal communication, March 23, 2018).

One additional measure undertaken by the university to protect students who choose to drink is the Responsible Action Policy. This policy is university-wide and makes it easier for students who have been drinking to get help for themselves or others. If a student calls emergency services for help, the Responsible Action Policy protects the student from receiving a citation from the city or university police for an alcohol-related offense. As long as the caller remains with the impaired individual, cooperates fully with the emergency responders, and fulfills the programs mandated by the university, the student will not receive a citation (Ebert, 2014). This university policy removes the barrier of legal and disciplinary punishment for students, and encourages them to act to protect their peers who they believe are in danger. Rather than citing students for underage drinking, the Responsible Action Policy stipulates that students are mandated to
complete an educational program, such as Brief Alcohol Intervention for College Students (BASICS), to help them develop skills to make less risky choices surrounding their own alcohol use and enable them to make healthier choices in the future (K. Ebert, personal communication, March 27, 2018).

According to the results of the American College Health Association’s - National College Health Assessment II (ACHA – NCHA II) conducted in the spring of 2018, many students at the University of Wisconsin – La Crosse employ a variety of risk reduction strategies when they consume alcohol. These strategies include eating before and/or during drinking (87.3% of students), using a designated driver (89.3%), and remaining with the same group of friends the entire time drinking (93.9%). Over half of students also reported keeping track of how many drinks they have consumed (61.6%) and consuming only one kind of alcohol when they drink (53.7%). Almost every student (99.6%) used at least one risk reduction technique when they choose to drink, and some students even reported choosing not to drink alcohol when they party (17.3%) (American College Health Association, 2018).

**Protective factors for poor mental health.** At the university level, the major protective factor to combat the negative consequences of mental health is a campus environment supportive of students with mental health concerns. When students feel a sense of belonging and view mental health as a priority at their school, they are much less likely to be at risk for developing mental health concerns (Eisenberg et al., 2009). In addition, supportive peers and a feeling of communal responsibility help foster a positive social environment. In an environment where peers demonstrate active bystander behavior by standing up for each other and take the time to check in with others,
especially about their mental health, students feel supported and are more likely to report positive mental health (Eisenberg et al., 2009).

At the University of Wisconsin – La Crosse, there are many protective factors for fostering positive mental health. Peer Health Advocates (PHAs), with the oversight of the Wellness Coordinator, facilitate programs for interested students where they can learn coping and resiliency skills and positive stress management and relaxation techniques. The PHAs also work to reduce the stigma around speaking out about poor mental health within the context of these campus programs. The PHAs emphasize that although everyone struggles sometimes, there are ways to work through issues and resources students can turn to for help. Just like alcohol education programming, these non-mandatory programs can be utilized by any group on campus but are commonly facilitated for first-year residence halls, sororities and fraternities, and club sports teams through RecSports (K. Ebert, personal communication, March 27, 2018).

Other resources for students struggling with mental health concerns include the Counseling and Testing Center and the psychiatry services at the Student Health Center. The Counseling and Testing Center offers private, one-on-one counseling sessions for students working through a variety of issues including anxiety, depression, and stress (University of Wisconsin – La Crosse Counseling and Testing, 2018). They also offer group counseling sessions where students struggling with similar issues can learn how to improve their mental health in a group setting, with the added benefit of providing students with social support and demonstrating that no one is alone in their path to improvement (University of Wisconsin – La Crosse Counseling and Testing, 2018). Through the Student Health Center, students also have access to a licensed psychiatrist.
who can help them determine if medication is necessary and would be useful in their path to positive mental health (University of Wisconsin – Student Health Center, 2018). All resources are free and accessible to students, and the university works to destigmatize seeking treatment for mental health concerns so utilizing these resources is more acceptable and comfortable for students (University of Wisconsin – Student Health Center, 2018).

**Protective factors for hate and bias.** Facilitating a positive campus climate is necessary to prevent incidents of hate and bias on college campuses. Universities can work toward a positive campus climate by designing and enforcing a student code of conduct that clearly states hate and bias are not accepted on their campus. In addition, universities should educate students, faculty, and staff about what a supportive, positive campus should look like and encourage students to stand up for others who are experiencing hate and bias (University of Wisconsin – La Crosse Campus Climate Office, 2018). The Campus Climate Office works to facilitate a positive environment by educating faculty and staff about diversity and hate and bias issues by hosting several voluntary ‘lunch and learn’ programs throughout the year, including during staff development day. This office also works to support faculty and staff who want to facilitate diversity programming within their classroom settings and provides guidance for standardized language around diversity, identity, and hate and bias for instructors to use in their syllabi (University of Wisconsin – La Crosse Campus Climate Office, 2018).

In addition to educating faculty and staff, the Campus Climate office also works to educate students. Diversity and inclusion education for students is primarily facilitated by the Campus Climate Students Educating and Embracing Diversity (SEEDs), and the
performance group Awareness Through Performance (ATP). SEEDs and ATP are made up of undergraduate students who are passionate about culture and diversity issues and share the goal of educating the student population about the negative effects hate, bias, and exclusion can have on their fellow students (University of Wisconsin – La Crosse Campus Climate Office, 2018). SEEDs facilitate programming within the residence halls for first-year students. Specifically, SEEDs host discussions, film screenings, and cultural events where students can explore the ideas of identity, exclusion, and diversity in a non-threatening environment where questions are encouraged (University of Wisconsin – La Crosse Campus Climate Office, 2018). The SEEDS help to introduce students to the topic of hate and bias, and encourage students to take ownership of the effects their actions have on others.

The other undergraduate student group, ATP, creates and performs skits for students throughout the year around various diversity and exclusion issues. The skits are inspired by the students’ own experiences and written entirely in the student voice. University students relate well to these two student-led groups, and they have both been instrumental in bringing attention to these campus issues and facilitating productive conversations around ways to improve our campus culture (University of Wisconsin – La Crosse Campus Climate Office, 2018).

The aforementioned protective factors present at the University of Wisconsin – La Crosse have been instrumental in the positive changes already implemented thus far, but more intentional work needs to be done to prevent these dangerous college health issues. One promising option for intervention to prevent the issues of sexual violence, alcohol misuse, mental health concerns, and hate and bias is a comprehensive bystander
intervention program implemented for first-year students to teach them how to be active bystanders and create a positive campus environment where students stand up for each other.

**Interventions for Specific College Health Issues**

As discussed previously, first-year students are most likely to experience health-related issues early in their college experiences. Recommendations include implementing bystander intervention programming to prevent the consequences of health concerns among first-year students. Bystander intervention approaches have been utilized on college campuses to teach students how to safely intervene in potentially dangerous situations and make their environment safer. Bystander intervention approaches work to combat the bystander effect, a psychological phenomenon wherein individuals are less likely to intervene in an emergency situation if other bystanders are present (Latané & Darley, 1968). The bystander effect can be particularly risky for students because alcohol related consequences are more likely to occur within the context of a college campus (Neighbors et al., 2012).

Previous research regarding bystander intervention has focused on identifying the influences impacting intervention in a dangerous situation, such as specific personality characteristics associated with altruism (e.g., Fischer et al., 2011; Kunstman & Plant, 2008), and classifying reasons why people fail to intervene (e.g., Burn, 2009; Oster-Aaland, Lewis, Neighbors, Vangsness, & Larimer, 2009). In addition, numerous studies have addressed the effectiveness of bystander intervention training to prevent other issues common on college campuses (e.g. sexual assault and interpersonal violence).

Bystander intervention programming has been recommended to prevent both alcohol misuse and sexual violence, and possibly other issues, on college and university
The National Institute on Alcohol Abuse and Alcoholism (NIAAA) developed a College Alcohol Intervention Matrix (AIM) in 2015, in which bystander intervention programs were identified as one method for reducing alcohol consumption and the associated harms on college campuses. The Centers for Disease Control and Prevention (CDC) further recommends broad, all-encompassing approaches for sexual violence prevention should include interventions targeting the levels of the social-ecological model in order to have an impact on levels of sexual violence throughout the population (Basile et al., 2016).

The CDC has created a comprehensive technical package, STOP SV, as a resource for public health practitioners working to reduce levels of sexual violence within the population (Basile et al., 2016). The strategies included in the STOP SV framework include: promote social norms that protect against violence, teach skills to prevent sexual violence, provide opportunities to empower and support girls and women, create protective environments, and support victims/survivors to lessen harms (Figure 3, Basile et al., 2016).
Research on bystander intervention behavior for prevention of health issues present on college campuses has identified three main reasons people fail to intervene: 1) failure to recognize the need for intervention (Oster-Aaland et al., 2009), 2) failure to assume personal responsibility to intervene, and 3) not having sufficient skills to effectively intervene (Burn, 2009). Based on this information, the overarching goals of bystander intervention programming are to provide students with the skills, tools, and motivation to intervene in potentially dangerous situations (Banyard, Plante, & Moynihan, 2004). Bystander intervention programming takes advantage of existing social
cohesiveness. This programming depends on every person believing in their personal responsibility to keep other members of their community safe. For this reason, emphasizing a sense of community (e.g., “I am UWL”) is also an important component to consider when creating interventions aimed at bystander intervention behaviors (K. Ebert, personal communication, March 27, 2018).

**Overview of Bystander Intervention Programs**

Bystander intervention programs take advantage of the relationships college students have already formed with their peers because most of the high-risk activities students engage in are performed in the presence of their peers rather than administrators, faculty, and staff (Neighbors et al., 2012). For this reason, the primary goal of these programs is to emphasize responsibility for each other’s well-being and create a culture in which intervening is seen as normal and positive behavior. This type of programming also works to affirm pro-social values and reinforce peer support for intervention behaviors (Jacobson & Eaton, 2018). The perception of the social acceptability of different behaviors can mediate a student’s willingness to engage in those behaviors, so it is important to situate intervention behaviors as positive and acceptable within the campus culture (Jacobson & Eaton, 2018). When paired with skill development and practice, such as practical intervention techniques, the promotion of pro-social values has been linked to increases in actual bystander intervention behaviors (Brown et al., 2014; Mabry & Turner, 2016; Storer et al., 2015).

As opposed to primary prevention programs, most risk reduction programs aim to change the behavior of potential victims and thus only address a small subset of students who identify as potential victims. These risk reduction programs almost universally
exclude males and many females who do not perceive themselves as susceptible to victimization (Berkowitz, 2010). In contrast, effective primary prevention programs aim to address as large of a population as possible. These primary prevention programs educate students who do not identify as potential victims or perpetrators. Instead, bystander intervention programming aims to address all students and communicate the positive effect everyone can have on the campus culture by intervening in a potential harmful situation. This can be particularly helpful because most perpetrators either do not care that their actions are harmful or do not realize the affect their actions have on others (Berkowitz, 2011).

Bystander intervention programming also creates opportunities for early intervention, before situations become emergencies. Dangerous situations are presented on a continuum, and problematic situations are discussed as situations that could become an emergency without intervention and situations that are already emergencies (Jacobson & Eaton, 2018). For example, a student who consumes four to five standard drinks of alcohol every night may have developed an alcohol use disorder. While this is not an immediate emergency, this student needs help to avoid the severe consequences accompanying long-term alcohol misuse. This non-emergency alcohol misuse situation can be juxtaposed with an instance of alcohol poisoning, which is an emergency and warrants immediate medical assistance. By creating opportunities for early intervention, bystander intervention behaviors can be utilized to avoid some of the most negative consequences of these health behaviors (Jacobson & Eaton, 2018).
Evidence for Bystander Intervention Programs

Bystander intervention programs have been found to be effective in teaching students warning signs for dangerous situations and communicating techniques for intervening in an effective way, particularly in the context of sexual assault prevention (Katz & Moore, 2013). Many programs increased the number of students reporting intervention to stop sexual violence, but the effect of these programs on instances of sexual violence is not well known (Katz & Moore, 2013). Bystander intervention programs have been used to encourage intervention in situations involving alcohol, mental health concerns, and hate and bias, but most have not yet been evaluated for efficacy. Based on preliminary evidence, there is strong support for creating and implementing bystander intervention programming for these health issues. Rigorous evaluations of these programs to build evidence of their success should be continued.

Prevention of sexual violence-related consequences. Early bystander intervention programs have yielded promising results in outcome evaluations (Banyard, Moynihan, & Plante, 2007; Banyard et al., 2004; Moynihan & Banyard, 2008). In fact, students on college campuses who have participated in bystander intervention programs have reported a reduction in acceptance of rape myths (Banyard et al., 2007), a greater awareness of the problems associated with sexual assault (Banyard et al., 2007; Moynihan & Banyard, 2008; Potter, 2012), higher levels of bystander-related self-efficacy (Ahrens, Rich, & Ullman, 2011; Banyard et al., 2007), increased intent to partake in bystander intervention behavior for sexual violence prevention (Potter, 2012), and increased bystander intervention behavior for prevention as compared to controls in long-term evaluations (Banyard et al., 2007; Potter, 2012). A large body of research supports the implementation of bystander intervention education on college campuses to
reduce sexual violence (Basile et al., 2015). As the principles of bystander education programming continue to be applied to topics beyond sexual assault prevention, such as prevention of alcohol misuse, mental health concerns, and hate and bias incidents, more research is needed to determine the best practices for, and efficacy of, these programs within these new contexts.

**Prevention of alcohol-related consequences.** The application of the principles of bystander intervention for prevention of alcohol-related consequences holds promise. Strategies aiming to empower students to intervene on behalf of their peers are useful within the context of college environments because serious alcohol-related consequences are more likely to occur outside of situations where professionals and educators may be present. Alcohol consumption tends to coincide with late-night partying, where students are much more likely to be present and able to help (Neighbors et al., 2012). For this reason, it is essential to engage students in prevention and educational efforts around alcohol use.

As established by previous research, programs designed to increase students’ self-efficacy and ability to identify warning signs of dangerous situations increase students’ ability and willingness to intervene for their peers. In addition, role-playing strategies should be utilized to enhance self-efficacy for intervening to prevent alcohol-related consequences (Krieger, Serrano, & Neighbors, 2017). Bystander intervention programs hold promise for application on college campuses.

**Prevention of mental health-related consequences.** While more research is needed to adequately assess the effect of bystander intervention programs on preventing the consequences of poor mental health, several leading professional organizations and
universities currently recommend and utilize this approach. The National Association of Student Personnel Administrators (NASPA) recommends the principles of bystander intervention be applied to encourage students to recognize warning signs of mental health concerns and intervene with their by peers by referring them to resources to help them manage their challenges (National Association of Student Personnel Administrators, 2018). The University of Texas – Austin educates students about mental health concerns as part of their BeVocal bystander intervention program (University of Texas at Austin, 2018), as does the University of Arizona through their Step Up bystander intervention program (University of Arizona C.A.T.S. Skills Life Program & National Collegiate Athletics Association, 2018). Current best practices support bystander intervention programs to educate students about mental health concerns and how to approach them with their peers, however, further research and evaluation is needed.

**Prevention of hate and bias-related consequences.** Current programs working to prevent bullying and incidents of hate and bias utilize the principles of bystander intervention. For example, Eyes on Bullying, an initiative of the Education Development Center, has educated students about the role of the bystander for the past ten years. In encouraging students to step up for their peers and not tolerate hateful speech or harmful actions, they have utilized the principles of bystander intervention to encourage the active combating of hate and bias. Eyes on Bullying discusses how passive bystanders who choose to stay silent and not intervene send the message that bullying behaviors are acceptable and allow the abuser to continue their harmful behavior. In this way, the initiative encourages students to intervene on behalf of their peers, so no one is subjected to hate and bias (Educational Development Center, 2008).
In addition, the recommendations from the government of British Columbia encourage students to stand up for each other by speaking directly to the abuser, diverting attention away from the victim, recruiting friends to assist in ending the harassment, and reporting the behavior to school authorities (Government of British Columbia, 2018). Within this program, the Government of British Columbia has directly incorporated the principles of bystander intervention. The application of the concepts of bystander intervention to prevention of hate and bias should be studied further to establish evidence for this technique.
CHAPTER III: METHODS AND PROCEDURE

Introduction

This study involved the analysis of a bystander intervention program and utilized a prospective descriptive design. Research questions were developed to correspond to the program goals of increasing bystander efficacy and bystander intervention behaviors. Here, the processes of program development, implementation, and evaluation are described. Information regarding the evaluation of the program includes study design, subject selection, time schedule, survey development, survey implementation, and data analysis.

Study Design

The study took place over three months, which included the implementation and evaluation of the bystander intervention program. A descriptive study design was used in order to assess the effect of the bystander intervention program on students’ beliefs and actions regarding bystander efficacy and instances of bystander intervention behaviors. This study was necessary to analyze the effectiveness of a bystander intervention program for prevention of health consequences for first-year students at the University of Wisconsin – La Crosse. This study could foster support for wider implementation of bystander intervention programming for first-year students at UWL and other universities across the United States.
Subject Selection

The setting for this study was the University of Wisconsin – La Crosse. Education and evaluation were implemented using a convenience sample of specific sections of the first-year seminar course UWL 100. The program was offered to all UWL 100 instructors, and the instructors had to opt-in for their section to receive the education and take part in the evaluation. UWL 100 courses are intended to help students be successful during their college experience and in their life beyond college. Many of the UWL 100 students are placed in the course by the university to provide them with extra assistance and increase their probability of succeeding in college. Placement in the course is based on factors such as having a below average high school academic performance, being a first-generation student, being a member of a historically disadvantaged group, and several other factors. Few students elect to take the course if they are not recommended to do so by the university.

In the UWL 100 course, students are encouraged to consider the value of education and life-long learning. The course specifically focuses on elements of college success such as community building, creating meaningful experiences, and building skills and habits to contribute to successful lives. The purpose of the course closely aligns with the purposes of the bystander intervention program, including fostering practical, lifelong skills and a sense of community and collective responsibility. For this reason, instructors of UWL 100 were approached with the offer for the researcher and peer facilitators to present the 1-hour bystander intervention program within their classes. This presentation was facilitated in 14 of 34 UWL 100 courses based on instructor request, reaching 215
students. Each student was encouraged to complete a pre-test before the intervention and a post-test upon completion.

**Time Schedule**

This study was conducted with first-year students within fourteen UWL 100 courses at the University of Wisconsin – La Crosse. The study began after the first six weeks of the semester. These first six weeks allowed new students to become accustomed to their new college life and the culture of the university. This period of time also gave the new students time to potentially witness situations which may have required bystander intervention behaviors. The pre-test was administered within each UWL 100 course between the sixth and seventh weeks of the semester. This pre-test was used to establish baseline bystander efficacy and bystander intervention behavior. Dates of pre-test administration varied based on when the bystander intervention program was implemented in each UWL 100 course section and the pre-test was open for two weeks for each course section.

A bystander intervention program was implemented during the eighth and ninth weeks of the semester. Following the bystander intervention program, students were given a wait period of four weeks in order to allow them time to experience opportunities where they could utilize bystander intervention behaviors. Finally, bystander efficacy and bystander intervention behavior were reassessed during the twelfth and thirteenth weeks of the semester. In addition, a survey was distributed to UWL 100 course instructors between the tenth and twelfth weeks of the semester in order to gather feedback regarding program implementation and improvement. The time periods in which the pre-test, program, and post-test were implemented did not overlap for any of the individual class
sections, meaning no class completed the pre- or post-test within the same time period as the program implementation. More information about these measures is included later. See the Gantt chart below for more information regarding the time schedule of this research study.

<table>
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<tr>
<th>Task</th>
<th>Weeks 6–7 of the semester</th>
<th>Weeks 8–9</th>
<th>Weeks 8–11</th>
<th>Weeks 10–12</th>
<th>Weeks 12–13</th>
<th>Weeks 13–14</th>
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<tbody>
<tr>
<td>Pre-test assessment measuring bystander efficacy and bystander intervention behavior administered to students</td>
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<td>Bystander intervention programming administered to select first-year students enrolled in UWL 100</td>
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<td>Waiting period to allow students to experience opportunities to observe situations and implement bystander intervention behaviors</td>
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<td>Instructor and student survey distributed to gather suggestions for program improvement</td>
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<td>Post-test assessment measuring bystander efficacy and bystander intervention behavior administered to students</td>
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<td>Pre- and post-assessment data analysis</td>
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Figure 4. Gantt chart of proposed timeline for implementation of the research study.

Program Development

To address the negative consequences associated with alcohol misuse, sexual violence, poor mental health, and experiences of hate and bias among first-year students, a bystander intervention program was developed, implemented, and assessed for effectiveness. As mentioned previously, the goal of the bystander intervention approach was to provide students the skills, tools, and motivation to intervene for their peers in potentially dangerous situations. The intervention targeted the three main reasons why people fail to intervene. These reasons include 1) failure to recognize the need for
intervention (Oster-Aaland et al., 2009), 2) failure to assume personal responsibility to intervene, and 3) not having sufficient skills to effectively intervene (Burn, 2009). To help students recognize the need for intervention, warning signs for these situations were discussed. To encourage students to assume personal responsibility, a sense of community was emphasized. To ensure students had the tools to effectively intervene, the program discussed different intervention strategies that could be applied to various situations a student may encounter. In addition, UWL’s Responsible Action Policy was explained and emphasized so students did not fail to call for help because they were afraid to get in trouble with law enforcement and the university.

In order to create the bystander intervention program, existing programs were examined for common themes and approaches to be included in the new program. This bystander intervention program was based off of the University of Arizona’s Step Up! Program, developed by the U of A’s C.A.T.S. Life Skills Program in collaboration with the National Collegiate Athletic Association (NCAA) (2014). This program was specifically created for athletes, so adaptations included utilizing broader language to resonate with a larger body of students and incorporating information specific to the University of Wisconsin – La Crosse. Another resource used was the Step Up! Program created by the H.A.W.K.S. Peer Health Educators at Miami University (2015). Scenarios from this program were utilized with permission from the creators of the program for the UWL bystander intervention program.

After the initial version of the bystander intervention program was created, a panel of experts reviewed the program and suggested revisions. The experts included a Violence Prevention Specialist with more than 20 years of prevention experience, a
professor with a Ph.D. in school health education and experience in program
development and implementation, and a professor with a Ph.D. in Public Health and
experience in violence prevention. These revisions involved the appearance of the
program, edits to the language within the scenarios, and inclusion of branding elements
so the appearance of the program would be consistent with other programs at UWL. After
this first round of edits was completed, the bystander intervention program was piloted to
the UWL Peer Health Advocates, a group of undergraduate student employees trained in
health education and health promotion, who viewed the program through the lens of a
student and program participant. The program was revised based on their feedback,
including several changes to language, program order, and interactive activities. The
complete program is included in Appendix A, along with the facilitator’s guide in
Appendix B.

The program utilized a PowerPoint and interactive discussion to first introduce
participants to the idea of the bystander effect and other reasons why people often fail to
intervene in a potentially dangerous situation. Then common warning signs, called red
flags, were provided for alcohol misuse, sexual violence, poor mental health, and
experiences of hate and bias so participants could learn to recognize a dangerous
situation. Next, the program emphasized a sense of communal responsibility and
encouraged students to intervene on behalf of their peers. Finally, the program taught the
three “Ds,” – direct, distract, and delegate – methods of intervention, and presented
participants with scenarios outlining different dangerous situations, allowing them to
practice their new skills while discussing solutions with their peers.
Program Implementation

Once program revisions were completed, the seven Peer Health Advocates (PHAs) were trained in facilitation of the bystander intervention program. This took place over two one-hour trainings in two consecutive weeks. During the first training, the bystander intervention program material was presented in a similar manner as it would be to the program participants. During the second training, each PHA was paired with another person and the pair read the program facilitator’s guide aloud so they would be prepared to facilitate the program for the UWL 100 courses. Once the PHAs were trained in the bystander intervention program, implementation occurred according to the timeline explained above (Figure 4). For each of the fourteen programs, one PHA assisted the researcher in implementing the program. Each PHA facilitated at least one program. The researcher and the PHA alternated PowerPoint slides to facilitate, with the researcher facilitating the scenarios for each program.

Survey Development

The independent variable identified for this study was participation in the bystander intervention programming. The effect of the bystander intervention programming on the dependent variable, scores of bystander efficacy and bystander intervention behavior, was assessed. Bystander efficacy and bystander intervention behaviors were measured before and after students had participated in the bystander intervention program utilizing a pre-test/post-test assessment technique. Demographic information was collected to determine how groups of students differed in their scores of bystander efficacy and bystander intervention behavior in order to further customize future interventions.
Within this study, the measures to assess bystander intervention behavior were carefully selected based on previous research studies. Bystander efficacy, or one’s belief in their ability to intervene, has been found to be positively related to bystander intervention behavior (Banyard, 2008; Burn, 2009). In conjunction with bystander efficacy, bystander intervention behavior was assessed. While previous studies have measured utilization of bystander intervention behaviors over time without considering bystander opportunity, bystander opportunity was considered in the current study. Failing to account for opportunity to intervene can lead to misleading rates of bystander intervention behaviors. Specifically, low rates of bystander intervention behavior may be found in a population simply because the participants had not witnessed many situations in which intervention was needed (Murphy, 2014). The number of instances of bystander intervention was then divided by the score for bystander opportunity to generate the percentage score for bystander intervention behaviors in situations where it was warranted (Uhrig & Gidycz, unpublished manuscript). Increasing bystander efficacy and the percentage of cases where the person intervened when warranted were primary goals of this bystander intervention programming and were thus necessary to assess for to determine the impact of the program.

**Demographic Information**

Demographic information was collected using the demographics inventory created for this study in order to quantify differences in bystander efficacy and bystander intervention behaviors among students with different demographic characteristics. The demographic measures for the demographics inventory included age, year in school, biological sex, gender identity, race/ethnicity, sexual orientation, membership in a
sorority or fraternity, first-generation student status, participation in an intramural or collegiate sports team, international student status, and student veteran status.

The demographic question for age allowed participants to self-report their age on their last birthday. This question was utilized to ensure that all participants were at least age 18, to meet informed consent guidelines. The demographic question corresponding with year in school asked participants to select from the options “First year,” “Second year,” “Third year,” “Fourth year,” “Fifth year or above,” or “Graduate student.” This question was utilized to ensure only responses submitted by first-year students were included in the analysis. In the demographic question for biological sex, participants were asked to indicate what sex they had been assigned at birth, with the answer options including “Female” or “Male.” The demographic question for gender asked participants to indicate how they described themselves, with answer options including “Female,” “Male,” “Transgender,” or “Do not identify as female, male, or transgender.” The sexual orientation demographic question asked respondents to pick which term best described their sexual orientation with answer options of “Straight,” “Gay or lesbian,” “Bisexual,” or “Transgender, transsexual, or gender non-conforming.”

The demographic question asking about race and ethnicity allowed participants to select all applicable answers, with options including “White,” “Black or African American,” “Hispanic or Latino/a,” “Asian or Pacific Islander,” “American Indian, Alaskan Native or Native Hawaiian,” “Biracial or Multiracial,” and “Other.” Finally, the demographic questions pertaining to if they were a membership in a sorority or fraternity, first-generation student status, participation in an intramural or collegiate sports team,
international student status, and student veteran status simply required a “Yes” or “No” response.

These demographic items were selected based on several existing measures including the Demographics Inventory (Murphy, 2014) and the American College Health Association’s National College Health Assessment (American College Health Association, 2018). Content validity was established for this demographics inventory by a panel of three experts including a Violence Prevention Specialist with more than 20 years of prevention experience, a professor with a Doctorate in school health education and experience in program development, implementation, and evaluation, and a professor with a Doctorate in Public Health and experience in evaluation.

The demographic characteristics of sorority/fraternity membership and membership on a collegiate or intramural sports teams were examined due to evidence in the literature that members of cohesive groups are more willing to intervene on behalf of their peers (Moynihan & Banyard, 2008). Many of the members of these groups socialize together and may encounter dangerous situations where bystander intervention behaviors are needed in the presence of their peers. The more tightly-knit social group is associated with social norms that are supportive of intervention to assist close friends in dangerous situations when compared to social norms present within groups of strangers. In other words, because members of the cohesive group know each other well, the perception of personal responsibility for peers’ well-being is enhanced (Brown et al., 2014).

The demographic characteristics of biological sex, gender identity, sexual orientation, and race/ethnicity were selected because individuals’ life experiences may differ due to their specific demographic characteristics. Life experience, especially
previous victimization or experiences where bystander intervention behavior was needed and no help was given, are predictive of higher future confidence (bystander efficacy) and likelihood of intervention (bystander intervention behavior) to help others (Moynihan & Banyard, 2008). This higher likelihood of engaging in helping behaviors may be due to the desire of the survivor to ensure that no one else is subjected to the same negative experience they had. Demographic groups at higher likelihood for previous victimization include biological females and female-identified individuals, LGBQT+ individuals, and non-white individuals (Brown et al., 2014).

The demographic characteristics of first-generation student status, international student status, and student veteran status were selected due to assumptions regarding the life experiences of individuals within these groups. First-generation students may know less than their peers about what to expect during their college experience because their parents did not have the context of their own college experience to assist them when attempting to advise their students (Brown et al., 2014). In addition, the life experiences of international students are often very different than their domestic peers due to cultural differences, and this may affect how prepared they feel to intervene on another’s behalf (Mabry & Turner, 2016). Finally, student veterans have different life experiences as well, and their experiences within the Armed Forces may better prepare them to intervene in dangerous situations than the average student (Brown et al., 2014). Differences in pre- and post-test scores for bystander efficacy and bystander intervention behaviors were examined for each of these demographic groups to determine the effect of the program for each of these groups and in order to further customize future interventions.
Bystander Efficacy

Bystander efficacy will be measured using the Bystander Efficacy Scale (Banyard, 2008). This scale asked respondents to indicate their level of confidence from 0 to 10, with “0” indicating no confidence and “10” indicating total confidence they could intervene in each of the fourteen situations presented. The scale included intervention options such as “Express my discomfort if someone makes a joke about a woman’s body” and “Tell a Resident Assistant or other campus authority about information I have that might help in a sexual assault case even if pressured by my peers to stay silent.” The language in this scale was adapted to be gender neutral to acknowledge that while there is a gender bias to these issues, particularly sexual assault, men and people who do not identify within the gender binary are victimized as well. The Cronbach’s alpha internal consistency value was $\alpha = 0.87$ (Banyard et al., 2008). Control group pre- to posttest correlation on this measure was 0.81 (Banyard et al., 2008). The measure was found to correlate with other instruments measuring bystander efficacy, demonstrating convergent validity (e.g. Slaby, Wilson-Brewer, & DeVos, 1994).

Bystander Intervention Behavior

Bystander intervention behavior was measured as how many times a participant had intervened when they noticed a situation in need of intervention in the form of a percentage score. The Bystander Opportunity Scale and Intervention Scale - Revised (BOIS) (Uhrig & Gidycz, unpublished manuscript) was used to assess whether or not participants witnessed situations in which bystander intervention behavior was warranted (i.e., situations in which sexual assault warning signs are present). The measure consisted of 35 items. The BOIS is the revised version of the Bystander Behavior Scale (Murphy, 2014) and the Bystander Intervention Scale (Murphy, 2014),
previously administered as two separate surveys, now administered as one. This scale has
previously yielded an internal consistency of $\alpha = .87$ (Uhrig & Gidycz, unpublished
manuscript). Content validity was established by the creators of the scale (Uhrig
& Gidycz, unpublished manuscript).

Survey participants were asked to input the number of times they had witnessed
each situation, from 0 times to more than five times. If the survey participant indicated
they had witnessed the situation (i.e. chose a number other than 0), they were then asked
how many times they had intervened in the situation, from 1 to more than 5 times.
Language in this scale was adapted to be gender neutral, except when the questions
related to societal perceptions of women. All instances of the use of the word “girl” were
changed to “women.”

**Survey Implementation**

Institutional Review Board approval was granted to administer the survey to the
students in the select UWL 100 courses (Appendix C). The Bystander Efficacy Scale,
Bystander Behaviors Scale, and demographic questions were administered twice, in the
form of pre- and post-test assessments before and after implementation of the bystander
intervention program. All survey components were re-formatted into the Qualtrics survey
platform in order to facilitate electronic administration of the survey. Links to the
Qualtrics surveys were provided to students in the selected UWL 100 classes via emails
from their instructors. All students in fourteen UWL 100 classes where the instructor had
agreed to participate in the program implementation and evaluation received the survey.
The first page of the survey included the informed consent form and explained to students
completion of the survey indicated consent and verified they were eighteen years of age.
The bystander efficacy scale, bystander intervention behavior scale, and the demographic items survey were formatted as one survey (Appendix D).

**Program Evaluation**

In order to gather feedback regarding program implementation and improvement, a process evaluation of the program implementation was completed through a survey distributed to instructors and some students in the UWL 100 courses. Respondents were asked to provide feedback about the program, including if the information was presented in a respectful and inclusive manner, if the content was relevant to students, if their students were engaged with the presentation, if the scenarios were useful for practicing the skills taught in the presentation, and if they would recommend this program for inclusion in future sections of UWL 100. The complete survey can be found in Appendix E.

**Data Analysis**

For program improvement purposes, results of the program process evaluation feedback survey administered to instructors and students were aggregated and examined. Quantitative data were summarized and analyzed for trends to determine perceptions of the program. Qualitative data were coded for consistent themes to provide recommendations for alterations to the program and possible implementation in the future.

For program evaluation purposes, the results of the bystander efficacy and bystander intervention behavior surveys were statistically analyzed. Table 3 depicts the research questions (RQs), associated survey items, and statistical analyses utilized for the research questions. Data from the online surveys were collected through Qualtrics and
downloaded into the Statistical Package for the Social Sciences (SPSS), Version 23 for analysis. Descriptive and inferential statistical analyses were performed.
<table>
<thead>
<tr>
<th>Research Question (RQ)</th>
<th>Survey Item(s)</th>
<th>Statistical Analyses</th>
</tr>
</thead>
<tbody>
<tr>
<td>RQ1: What are the demographic characteristics of the first-year students at the University of Wisconsin – La Crosse that participated in the study?</td>
<td>Question 1: How old were you on your last birthday? Question 2: What is your current year in college? Question 3: What sex were you assigned at birth, on your original birth certificate? Question 4: How do you describe yourself? Question 5: Which term best describes your sexual orientation? (Mark all that apply) Question 7: Are you an international student? Question 8: Are you in a sorority or fraternity? Question 9: Are you on a sports team? Question 10: Are you a first-generation college student? Question 11: Are you a veteran?</td>
<td>Frequencies and percentages</td>
</tr>
<tr>
<td>Research Question (RQ)</td>
<td>Survey Item(s)</td>
<td>Statistical Analyses</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------------</td>
<td>----------------------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>RQ2: How do scores of bystander efficacy differ before and after participation in a bystander intervention program for first-year students at the University of Wisconsin – La Crosse?</td>
<td>Bystander Efficacy Scale</td>
<td>Independent samples t-test</td>
</tr>
<tr>
<td>RQ3: How do scores of bystander intervention behavior differ before and after participation in a bystander intervention program for first-year students at the University of Wisconsin – La Crosse?</td>
<td>Bystander Opportunity and Behavior Scale</td>
<td>Independent samples t-test</td>
</tr>
<tr>
<td>RQ4: How does biological sex influence scores of bystander efficacy and bystander intervention behavior before and after participation in a bystander intervention program for first-year students at the University of Wisconsin – La Crosse?</td>
<td>Question 3: What sex were you assigned at birth, on your original birth certificate? Bystander Efficacy Scale Bystander Opportunity and Behavior Scale</td>
<td>Independent samples t-test</td>
</tr>
<tr>
<td>RQ 5: How does gender identity influence scores of bystander efficacy and bystander intervention behavior before and after participation in a bystander intervention program for first-year students at the University of Wisconsin – La Crosse?</td>
<td>Question 4: How do you describe yourself? Bystander Efficacy Scale Bystander Opportunity and Behavior Scale</td>
<td>Independent samples t-test</td>
</tr>
</tbody>
</table>
Table 3 Continued. Research Question Alignment with Corresponding Survey Questions and Statistical Analyses

<table>
<thead>
<tr>
<th>Research Question (RQ)</th>
<th>Survey Item(s)</th>
<th>Statistical Analyses</th>
</tr>
</thead>
<tbody>
<tr>
<td>RQ 6: How does sexual orientation influence scores of bystander efficacy and bystander intervention behavior before and after participation in a bystander intervention program for first-year students at the University of Wisconsin – La Crosse?</td>
<td>Question 5: Which term best describes your sexual orientation? Bystander Efficacy Scale Bystander Opportunity and Behavior Scale</td>
<td>Independent samples t-test</td>
</tr>
<tr>
<td>RQ 7: How does race/ethnicity influence scores of bystander efficacy and bystander intervention behavior before and after participation in a bystander intervention program for first-year students at the University of Wisconsin – La Crosse?</td>
<td>Question 6: How do you usually describe yourself? (Mark all that apply) Bystander Efficacy Scale Bystander Opportunity and Behavior Scale</td>
<td>One-Way ANOVA</td>
</tr>
<tr>
<td>RQ 8: How does international student status influence scores of bystander efficacy and bystander intervention behavior before and after participation in a bystander intervention program for first-year students at the University of Wisconsin – La Crosse?</td>
<td>Question 7: Are you an international student? Bystander Efficacy Scale Bystander Opportunity and Behavior Scale</td>
<td>Independent samples t-test</td>
</tr>
<tr>
<td>RQ 9: How does sorority or fraternity membership influence scores of bystander efficacy and bystander intervention behavior before and after participation in a bystander intervention program for first-year students at the University of Wisconsin – La Crosse?</td>
<td>Question 8: Are you in a sorority or fraternity? Bystander Efficacy Scale Bystander Opportunity and Behavior Scale</td>
<td>Independent samples t-test</td>
</tr>
</tbody>
</table>
### Table 3 Continued. Research Question Alignment with Corresponding Survey Questions and Statistical Analyses

<table>
<thead>
<tr>
<th>Research Question (RQ)</th>
<th>Survey Item(s)</th>
<th>Statistical Analyses</th>
</tr>
</thead>
<tbody>
<tr>
<td>RQ 10: How does collegiate or intramural sports team membership influence scores of bystander efficacy and bystander intervention behavior before and after participation in a bystander intervention program for first-year students at the University of Wisconsin – La Crosse?</td>
<td>Question 9: Are you on a sports team?</td>
<td>Independent samples t-test</td>
</tr>
<tr>
<td></td>
<td>Bystander Efficacy Scale</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bystander Opportunity and Behavior Scale</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Question 10: Are you a first-generation college student?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bystander Efficacy Scale</td>
<td></td>
</tr>
<tr>
<td>RQ 11: How does first-generation student status influence scores of bystander efficacy and bystander intervention behavior before and after participation in a bystander intervention program for first-year students at the University of Wisconsin – La Crosse?</td>
<td>Question 10: Are you a first-generation college student?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bystander Opportunity and Behavior Scale</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bystander Efficacy Scale</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bystander Opportunity and Behavior Scale</td>
<td></td>
</tr>
<tr>
<td>RQ 12: How does veteran status influence scores of bystander efficacy and bystander intervention behavior before and after participation in a bystander intervention program for first-year students at the University of Wisconsin – La Crosse?</td>
<td>Question 11: Are you a veteran?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bystander Efficacy Scale</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bystander Opportunity and Behavior Scale</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Independent samples t-test</td>
<td></td>
</tr>
</tbody>
</table>
Missing data were addressed by removing incomplete responses, including responses from students who did not enter a confidence score for all fourteen bystander efficacy questions or who failed to answer all questions regarding bystander intervention behaviors. The intent of the study was to examine the effect of the program for first-year students at the University of Wisconsin – La Crosse, so all responses submitted by participants identifying themselves as any other year in college were removed. In order to fulfill informed consent requirements, all respondents were asked to confirm they were age 18 or older and could give informed consent. While all respondents agreed they were age 18 or older taking the survey, several reported they were 17 or younger. These responses were not included in the analysis to meet the informed consent requirements.

Errors were found in responses for bystander intervention behaviors and deleted. Errors consisted of participants reporting they intervened in a situation more times than they had witnessed the situation. These responses were processed as if the participant had indicated they had never witnessed the situation in order to avoid under or overestimating rates of intervention among study participants.

Descriptive statistical analyses were utilized to assess demographics of the study participants. These analyses included frequencies and percentages. Inferential statistical analyses were utilized to assess differences in bystander efficacy and bystander intervention behavior scores. Bystander efficacy pre- and post-test scores were calculated as total efficacy scores by summing each individual’s score from 0-10 on all 14 questions, resulting in a possible range of scores of 0-140 for each participant. The average score from 0-10 was calculated from the total efficacy score. Changes in the
bystander efficacy scores from pre- to post-test were assessed using an independent samples t-test.

Bystander intervention behavior was measured as the percentage of cases where bystander intervention behaviors were implemented in situations where the study participant noticed a potential situation warranting intervention. This score was calculated by dividing the number of times a person intervened by the number of times they witnessed each situation. This allowed the researcher to account for the differing number of opportunities for bystander intervention each of the participants experienced. The scores of bystander intervention behavior, 0-100, or, for purposes of analysis, 0.0-1.0, were compared between the pre- and post-test assessment using inferential statistics. This was done using independent-samples t-tests for comparing pre- and post-test bystander intervention behavior scores.

Independent samples t-tests were used to examine statistical differences between demographic groups at pre- and post-test. Pre- and post-test scores grouped by demographic variables were compared to determine if any group scores were statistically different either prior to program implementation (pre-test analysis) or if the group scores differed by demographic variable after program implementation (post-test analysis). To determine the statistical differences by gender, “Female” was coded as “0” and “Male” was coded as “1” for purposes of analysis. For sexual orientation, “Straight” was coded as “0” and any other response, including “Bisexual,” and “Gay or Lesbian,” was coded as “1”, “Non-heterosexual.” For comparisons of race and ethnicity, participants identifying as “White” were coded as “0” and any other choice, including White and another identification, “Other,” “Biracial or Multiracial,” “Black or African American,” “Asian or
Pacific Islander,” “American Indian, Alaskan Native, or Native Hawaiian,” or “Hispanic or Latino/a,” was coded as “1”, “Nonwhite and/or Multiracial.” International student status was coded as “1” for “yes,” indicating international student status, or “0” for “no,” indicating domestic student status. Fraternity or sorority membership was coded as “1” and un-affiliated students were coded as “0”. Sports team membership, either collegiate or intramural, was coded as “1” while non-membership was coded as “0”. First generation students were coded as “1” while participants who were not first generation students were coded as “0”. Finally, student veterans were coded as “1” while participants who were not student veterans were coded as “0” for purposes of analysis.

Independent-samples t-tests were utilized because no matched data were available due to the design of the data collection. Pairs were not able to be matched because identifying information was not collected from the participants. Utilizing the independent-samples t-test rather than the dependent-samples t-test did not increase the possibility of committing a Type I error of finding a statistically significant p value when no significance existed. Rather, it increased the possibility of committing a Type II error of not finding a statistically significant p value when significance did exist. The most appropriate statistically analysis, determined by the researcher, the panel, and the statistical expert, was the more rigorous application of the independent-samples t-test rather than the matched pairs analysis. The p value was set at $p < 0.05$ indicating significance, but it was necessary to correct for the possibility of committing Type I error. The increase in the possibility of committing Type I error was the result of conducting multiple independent t-tests, which increased the likelihood of a finding a statistically
significant result by chance. Bonferroni corrections were utilized to lower the level of the statistically significant p-value to reduce the possibility of committing Type I error.

As stated previously, feedback was provided by instructors and students through the administration of a program process evaluation. This feedback was aggregated and analyzed. Qualitative data were coded for consistent themes to provide recommendations for alterations to the program and its implementation in the future. Quantitative data were summarized and analyzed for trends to determine instructor and student perceptions of the program.
CHAPTER IV

RESULTS

Introduction

The need to provide students with education and strategies to assist them in making healthier choices and encourage them to help their friends and peers avoid dangerous situations has been identified on college campuses. The researcher proposed to meet this need by creating a bystander intervention program. To determine the effectiveness of the program for the study population of first-year students at the University of Wisconsin – La Crosse, a comprehensive assessment of the program was completed. First, a process evaluation of the program implementation process was completed. Students and instructors were asked to respond to a survey with their thoughts regarding the program and the implementation process. Qualitative data were coded for consistent themes while quantitative data were analyzed using descriptive statistics. Data were collected through an online survey administered through Qualtrics.

The purpose of the bystander intervention assessment was to determine the effect of the bystander intervention program on participants’ scores of bystander efficacy and bystander intervention behavior before and after administration of the program. The demographic characteristics of participants were analyzed to determine if certain characteristics were associated with higher or lower scores at pre- and post-test in order to further target future programming efforts.
Data collection was conducted through an electronic survey administered through Qualtrics. The survey consisted of eleven demographic items, fourteen bystander intervention scenarios in which participants were asked to rate their confidence level for intervening in the situations, and thirty-four scenarios in which participants were asked to indicate how many times in the past month they had witnessed and intervened in each scenario. The survey totaled fifty-nine items. The fourteen bystander intervention confidence items came from the existing Bystander Efficacy Scale (Banyard, 2008). The thirty-four bystander intervention scenarios consisted of items from the existing Bystander Opportunity and Intervention Scale (Uhrig & Gidycz, unpublished manuscript). Demographic questions were created using best practices from literature to assess the characteristics of study participants.

**Program Feedback from Staff and Students**

In general, program feedback was positive, with 97.3% ($n = 36$) of the respondents agreeing or strongly agreeing with the statement, “the information was presented in a respectful and inclusive manner.” Instructors and students also indicated the program was valuable for students with 97.3% ($n = 36$) of respondents agreeing or strongly agreeing with the statement, “the content presented was relevant to students,” 94.6% ($n = 35$) agreeing or strongly agreeing with the statement, “students found the program content useful,” and 89.2% ($n = 33$) agreeing or strongly agreeing with the statement “students were engaged in the program presentation” (Table 4).

The program’s provided incentives were considered useful by respondents, with 94.5% ($n = 35$) agreeing or strongly agreeing with the statement, “the incentives provided (highlighters, gum) were helpful to encourage participation among students.”
practice provided by the scenarios was deemed useful to the participants, with 94.6% (n = 35) of respondents agreeing or strongly agreeing with the statement, “the scenarios provided good practice for students to apply what they learned from the presentation” (Table 4). The majority of respondents indicated continued program implementation would be helpful for future students, with 97.3% (n = 36) agreeing or strongly agreeing with the statement, “I would request this program again when teaching a UWL 100 course” and 94.6% (n = 35) of respondents agreeing or strongly agreeing with the statement, “information on bystander intervention strategies should be included in all UWL 100 courses moving forward” (Table 4).
Table 4. Student and Instructor Perspectives on the Bystander Intervention Program

<table>
<thead>
<tr>
<th>Statements</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The information was presented in a respectful and inclusive manner.</td>
<td>2.7 (1)</td>
<td>0.0 (0)</td>
<td>21.6 (8)</td>
<td>75.7 (28)</td>
</tr>
<tr>
<td>The content presented was relevant to students.</td>
<td>2.7 (1)</td>
<td>0.0 (0)</td>
<td>24.3 (9)</td>
<td>73.0 (27)</td>
</tr>
<tr>
<td>Students found the program content useful.</td>
<td>2.7 (1)</td>
<td>2.7 (1)</td>
<td>54.0 (20)</td>
<td>40.5 (15)</td>
</tr>
<tr>
<td>Students were engaged in the program presentation.</td>
<td>2.7 (1)</td>
<td>8.1 (3)</td>
<td>43.2 (16)</td>
<td>46.0 (17)</td>
</tr>
<tr>
<td>The incentives provided (highlighters, gum) were helpful to encourage participation among students.</td>
<td>0.0 (0)</td>
<td>5.4 (2)</td>
<td>40.5 (15)</td>
<td>54.0 (20)</td>
</tr>
<tr>
<td>The scenarios provided good practice for students to apply what they learned from the presentation.</td>
<td>2.7 (1)</td>
<td>2.7 (1)</td>
<td>35.1 (13)</td>
<td>59.5 (22)</td>
</tr>
<tr>
<td>I would request this program again when teaching a UWL 100 course.</td>
<td>2.7 (1)</td>
<td>0 (0)</td>
<td>40.5 (15)</td>
<td>56.8 (21)</td>
</tr>
<tr>
<td>Information on bystander intervention strategies should be included in all UWL 100 courses moving forward.</td>
<td>2.7 (1)</td>
<td>2.7 (1)</td>
<td>32.4 (12)</td>
<td>62.2 (23)</td>
</tr>
</tbody>
</table>
Respondents were asked to report what they considered to be the most valuable portion of the bystander intervention program. The vast majority of respondents reported working through the role-playing scenarios as a group was the most valuable part of the program \((n = 14)\). Respondents also reported learning the three “D’s” as intervention techniques \((n = 4)\), the discussion of on-campus resources \((n = 3)\), and the bystander intervention video with the presentation of warning signs and ways to intervene in a situation of possible sexual assault were valuable \((n = 3)\). Additionally, respondents reported the focus on intervening before a situation becomes an emergency, presenter engagement with program participants, and warning signs of dangerous situations were valuable. Additional information is presented in Table 5.

Table 5. Student and Instructor Perspectives on the Most Valuable Parts of the Program

<table>
<thead>
<tr>
<th>Most Valuable Parts of the Presentation</th>
<th>( n )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working through the scenarios as a group</td>
<td>13</td>
</tr>
<tr>
<td>The three D’s as intervention techniques</td>
<td>4</td>
</tr>
<tr>
<td>List of on-campus resources</td>
<td>3</td>
</tr>
<tr>
<td>Bystander behavior video</td>
<td>3</td>
</tr>
<tr>
<td>Focus on intervening before a situation becomes an emergency</td>
<td>1</td>
</tr>
<tr>
<td>Presenter engagement with program participants</td>
<td>1</td>
</tr>
<tr>
<td>Warning signs of dangerous situations</td>
<td>1</td>
</tr>
</tbody>
</table>

Respondents were asked to report what they considered to be the least valuable portion of the bystander intervention program. While the majority of respondents indicated this question was not applicable or the entire program was valuable \((n = 14)\), there were a few portions respondents deemed less valuable. These included the three D’s as intervention techniques, the time constraints for the presentation, and that the
presentation was not adapted to the unique populations present in some of the class sections. Additional information is included in Table 6.

Table 6. Student and Instructor Perspectives on the Least Valuable Parts of the Program

<table>
<thead>
<tr>
<th>Least Valuable Parts of the Presentation</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A, it was all valuable</td>
<td>14</td>
</tr>
<tr>
<td>The three D’s as intervention techniques</td>
<td>1</td>
</tr>
<tr>
<td>The time constraints for the presentation</td>
<td>1</td>
</tr>
<tr>
<td>Limited interactivity of the class</td>
<td>1</td>
</tr>
<tr>
<td>Lecture-based portions</td>
<td>1</td>
</tr>
<tr>
<td>Incentives did not encourage participation</td>
<td>1</td>
</tr>
<tr>
<td>Inclusion of statistics</td>
<td>1</td>
</tr>
<tr>
<td>Not adapted to unique populations</td>
<td>1</td>
</tr>
<tr>
<td>Scenarios were not realistic</td>
<td>1</td>
</tr>
<tr>
<td>Bystander behavior video</td>
<td>1</td>
</tr>
</tbody>
</table>

Finally, respondents were asked to provide other feedback about the presentation. Respondents indicated the presentation was excellent ($n = 5$), informative ($n = 3$), engaging ($n = 2$), and presented in a professional manner ($n = 2$). Respondents also indicated the information should be presented to all students, either through the UWL 100 course, online modules for all students to complete before starting their first semester, or New Student Orientation ($n = 3$). Additional information can be found in Table 7.
Table 7. Other Feedback for the Bystander Intervention Program from Students and Instructors

<table>
<thead>
<tr>
<th>Feedback</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>This presentation was excellent.</td>
<td>5</td>
</tr>
<tr>
<td>The presentation was informative.</td>
<td>3</td>
</tr>
<tr>
<td>The presentation was engaging.</td>
<td>2</td>
</tr>
<tr>
<td>The information was presented in a professional manner.</td>
<td>2</td>
</tr>
<tr>
<td>Co-presenting was a good way to communicate this information.</td>
<td>1</td>
</tr>
<tr>
<td>Allow students to share their thoughts with their neighbor before the whole class.</td>
<td>1</td>
</tr>
<tr>
<td>Seek unincentivized student engagement.</td>
<td>1</td>
</tr>
<tr>
<td>Allow more time to practice the intervention skills.</td>
<td>1</td>
</tr>
<tr>
<td>Utilize more realistic videos.</td>
<td>1</td>
</tr>
<tr>
<td>This information was very important for males to hear.</td>
<td>1</td>
</tr>
<tr>
<td>This information should be included in every UWL 100 course or within New Student Orientation or as an alternative to Think About It.</td>
<td>3</td>
</tr>
</tbody>
</table>

**Response Rate**

Data were collected through electronic pre- and post-test surveys administered through their instructors to more than 215 students in fourteen UWL 100 courses in the fall 2018 semester. Pre-test surveys were sent two weeks before each class experienced the bystander intervention program and post-test surveys were sent four weeks after each class experienced the bystander intervention program. In most courses, pre-test completion was incentivized by the instructor with extra credit or participants were given time in class to complete the survey.

There was a total of 316 students enrolled in the fourteen UWL 100 courses. The corresponding recommended minimum sample size was 174 (Raosoft, 2004). This was calculated at a 95% confidence interval, a 5% margin of error, and a 50% response distribution. In total, 208 complete responses were received for the pre-test, resulting in a
67% response rate. Data from the pre-test survey can be generalized to all survey respondents. For the post-test, 94 complete responses were received, resulting in a 30% response rate. Due to the convenience sampling technique used to capture the data, the responses cannot be generalized to all first-year students at the University of Wisconsin – La Crosse. Another reason these results are not generalizable is due to differences in demographic characteristics between the intervention participants and the entire first-year class. For example, the number of first-generation students was much higher in the sample population than in the population of first-year students at UWL as a whole.

**Research Questions and Results**

**Research Question #1:** What are the demographic characteristics of the first-year students at the University of Wisconsin – La Crosse that participated in the study?

The majority of respondents for this study were age 18 in both the pre-test \( (n = 168, 80.8\%) \) and the post-test \( (n = 65, 69.1\%) \). Almost all of the remaining respondents were age 19 for the pre-test \( (n = 37, 17.8\%) \) and post-test \( (n = 27, 28.7\%) \). After data were prepared for analysis, all of the remaining respondents were first-year students for both the pre-test \( (n = 208, 100.0\%) \) and post-test \( (n = 94, 100.0\%) \). Biological females made up the majority of respondents in the pre-test \( (n = 153, 73.6\%) \) as well as the post-test \( (n = 73, 77.7\%) \). All respondents who identified as biological females chose female as their gender identity, and all respondents who identified as biological males chose male as their gender identity, indicating all respondents were cisgender. For this reason, female-identified participants also made up the majority of respondents, with numbers identical to those for biological females on both the pre- and post-test.
Most respondents identified their sexual orientation as straight on the pre-test \((n = 196, 94.2\%)\) and post-test \((n = 89, 94.7\%)\). The respondents mainly identified their race/ethnicity as white on the pre-test \((n = 181, 87\%)\) and post-test \((n = 82, 87.3\%)\). There were far fewer non-white respondents on both the pre-test \((n = 27, 13\%)\) and post-test \((n = 12, 12.8\%)\). There were few respondents who were international students on the pre-test \((n = 3, 1.4\%)\) and post-test \((n = 2, 2.1\%)\). There were a few respondents who were members of sororities and fraternities for both the pre-test \((n = 11, 5.3\%)\) and post-test \((n = 6, 6.4\%)\). Several respondents indicated they were members of either a collegiate or intramural sports team on the pre-test \((n = 73, 35.1\%)\) and post-test \((n = 34, 36.1\%)\). Many respondents identified themselves as first-generation students on both the pre-test \((n = 122, 58.7\%)\) and post-test \((n = 67, 71.3\%)\). Finally, no respondents reported they were a veteran on either the pre-test \((n = 0, 0.0\%)\) or post-test \((n = 0, 0.0\%)\). Additional information is included in Table 8.
Table 8. Demographic Characteristics of Study Participants at Pre- and Post-test

<table>
<thead>
<tr>
<th>Demographics</th>
<th>Pre-Test</th>
<th></th>
<th></th>
<th>Post-Test</th>
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</tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
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<td>Age</td>
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<td>1.4</td>
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<td>2.1</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>168</td>
<td>80.8</td>
<td>65</td>
<td>69.1</td>
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<tr>
<td>19</td>
<td>37</td>
<td>17.8</td>
<td>27</td>
<td>28.7</td>
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<tr>
<td>Year in School</td>
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<td>94</td>
<td>100.0</td>
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<td>Male</td>
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<td>26.4</td>
<td>21</td>
<td>22.3</td>
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<tr>
<td>Female</td>
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<td>73.6</td>
<td>73</td>
<td>77.7</td>
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<td>Gender Identity</td>
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<td>Male</td>
<td>55</td>
<td>26.4</td>
<td>21</td>
<td>22.3</td>
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<tr>
<td>Female</td>
<td>153</td>
<td>73.6</td>
<td>73</td>
<td>77.7</td>
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<td>Sexual Orientation</td>
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<td>Straight</td>
<td>196</td>
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<td>89</td>
<td>94.7</td>
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<td>Bisexual</td>
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<td>3.2</td>
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<td>Gay or Lesbian</td>
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<td>Race/Ethnicity</td>
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<td>White</td>
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<td>87.0</td>
<td>82</td>
<td>87.3</td>
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<td>Nonwhite and/or Multiracial</td>
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<td>13.0</td>
<td>12</td>
<td>12.8</td>
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<td>Student Status</td>
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<td>International Student</td>
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<td>2.1</td>
<td></td>
</tr>
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<td>Sorority or Fraternity</td>
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<td>5.3</td>
<td>6</td>
<td>6.4</td>
<td></td>
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<tr>
<td>Sports Team Member</td>
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<td>35.1</td>
<td>34</td>
<td>36.1</td>
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<td>First-Generation Student</td>
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<td>58.7</td>
<td>67</td>
<td>71.3</td>
<td></td>
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<tr>
<td>Student Veteran</td>
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<td>0.0</td>
<td>-</td>
<td>0.0</td>
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<tr>
<td>Total Responses</td>
<td>208</td>
<td></td>
<td>94</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Research Question #2:** How do scores of bystander efficacy differ before and after participation in a bystander intervention program for first-year students at the University of Wisconsin – La Crosse?

To determine if scores of bystander efficacy differed after implementation of a bystander intervention program, an independent samples t-test was used. All assumptions were met, except the assumption of independent samples. The independent samples t-test was undertaken due to the inaccurate result a matched-pairs t-test would have produced due to the inability to match participants from the pre- and post-test. Results from the independent samples t-test revealed no statistically significant difference existed in scores of bystander efficacy before \( (M = 7.11, SD = 1.52) \) and after \( (M = 7.25, SD = 1.48) \) participation in the bystander intervention program, \( t(299) = -0.755, p = 0.451 \).

**Research Question #3:** How do scores of bystander intervention behavior differ before and after participation in a bystander intervention program for first-year students at the University of Wisconsin – La Crosse?

To determine if scores of bystander intervention behavior differed after implementation of a bystander intervention program, an independent samples t-test was used. All assumptions were met, except the assumption of independent samples. The independent samples t-test was undertaken due to the inaccurate result a matched-pairs t-test would have produced due to the inability to match participants from the pre- and post-test. Results from the independent samples t-test revealed no statistically significant difference existed in scores of bystander intervention behavior before \( (M = 0.408, SD = 0.217) \) and after \( (M = 0.461, SD = 0.218) \) participation in the bystander intervention program, \( t(295) = -1.933, p = 0.054 \).
**Research Question #4:** How does biological sex influence scores of bystander efficacy and bystander intervention behavior before and after participation in a bystander intervention program for first-year students at the University of Wisconsin – La Crosse?

To determine if scores of bystander efficacy and bystander intervention behavior differed by biological sex among survey respondents, an independent samples t-test was used. All assumptions were met, except the assumption of independent samples. The independent samples t-test was undertaken due to the inaccurate result a matched-pairs t-test would have produced due to the inability to match participants from the pre- and post-test. Results from the independent samples t-test revealed no statistically significant difference existed in scores of bystander efficacy between biologically male ($M = 7.02$, $SD = 1.59$) and biologically female ($M = 7.14$, $SD = 1.50$) participants at pre-test, $t(206) = 0.534, p = 0.594$. No statistically significant differences existed in scores of bystander efficacy between biologically male ($M = 7.41$, $SD = 1.38$) and biologically female ($M = 7.41$, $SD = 1.38$) participants at post-test, $t(92) = 1.976, p = 0.051$. Scores of bystander intervention behavior for biologically female participants at pre-test ($M = 0.42$, $SD = 0.215$) and post-test ($M = 0.48$, $SD = 0.224$) were higher than scores of bystander intervention behavior for biologically male participants at pre-test ($M = 0.38$, $SD = 0.222$) and post-test ($M = 0.41$, $SD = 0.196$). These results were not statistically significant.

**Research Question #5:** How does gender identity influence scores of bystander efficacy and bystander intervention behavior before and after participation in a bystander intervention program for first-year students at the University of Wisconsin – La Crosse?

To determine if scores of bystander efficacy and bystander intervention behavior differed by gender identity among survey respondents, an independent samples t-test was
used. All assumptions were met, except the assumption of independent samples. The independent samples t-test was undertaken due to the inaccurate result a matched-pairs t-test would have produced due to the inability to match participants from the pre- and post-test. Results from the independent samples t-test revealed no statistically significant difference existed in scores of bystander efficacy between male-identified ($M = 7.02, SD = 1.59$) and female-identified ($M = 7.14, SD = 1.50$) participants at pre-test, $t(206) = 0.534, p = 0.594$. No statistically significant differences existed in scores of bystander efficacy between male-identified ($M = 6.70, SD = 1.69$) and female-identified ($M = 7.41, SD = 1.38$) participants at post-test, $t(92) = 1.976, p = 0.051$. Scores of bystander intervention behavior for female-identified participants at pre-test ($M = 0.42, SD = 0.215$) and post-test ($M = 0.48, SD = 0.224$) were higher than scores of bystander intervention behavior for male-identified participants at pre-test ($M = 0.38, SD = 0.222$) and post-test ($M = 0.41, SD = 0.196$). These results were not statistically significant.

**Research Question #6:** How does sexual orientation influence scores of bystander efficacy and bystander intervention behavior before and after participation in a bystander intervention program for first-year students at the University of Wisconsin – La Crosse?

To determine if scores of bystander efficacy and bystander intervention behavior differed by sexual orientation among survey respondents, an independent samples t-test was proposed. However, the assumptions were not met, particularly the recommendation of a sample size of thirty or more participants. For this reason, descriptive statistics were instead utilized. Results from the determination of the means revealed scores of bystander efficacy for heterosexual participants at pre-test ($M = 7.03, SD = 1.53$) and post-test ($M = 7.24, SD = 1.49$) were slightly lower than scores of bystander efficacy for non-
heterosexual participants at pre-test ($M = 8.35, SD = 0.79$) and post-test ($M = 7.24, SD = 1.49$). Scores of bystander intervention behavior for heterosexual participants at pre-test ($M = 0.41, SD = 0.217$) and post-test ($M = 0.47, SD = 0.217$) were higher than scores of bystander intervention behavior for non-heterosexual participants at pre-test ($M = 0.39, SD = 0.216$) and post-test ($M = 0.29, SD = 0.060$).

**Research Question #7:** How does race/ethnicity influence scores of bystander efficacy and bystander intervention behavior before and after participation in a bystander intervention program for first-year students at the University of Wisconsin – La Crosse?

To determine if scores of bystander efficacy and bystander intervention behavior differed by race/ethnicity among survey respondents, an independent samples t-test was proposed. However, the assumptions were not met, particularly the recommendation of a sample size of thirty or more participants. For this reason, descriptive statistics were instead utilized. Results from the determination of the means revealed scores of bystander efficacy for white at pre-test ($M = 6.97, SD = 1.50$) and post-test ($M = 7.24, SD = 1.43$) were lower than scores of bystander efficacy for non-white participants at pre-test ($M = 8.04, SD = 1.32$) and post-test ($M = 7.34, SD = 1.83$). Scores of bystander intervention behavior for white participants at pre-test ($M = 0.40, SD = 0.217$) and post-test ($M = 0.44, SD = 0.213$) were lower than scores of bystander intervention behavior for non-white participants at pre-test ($M = 0.46, SD = 0.210$) and post-test ($M = 0.60, SD = 0.216$).

**Research Question #8:** How does international student status influence scores of bystander efficacy and bystander intervention behavior before and after participation in a bystander intervention program for first-year students at the University of Wisconsin – La Crosse?
To determine if scores of bystander efficacy and bystander intervention behavior differed by international student status among survey respondents, an independent samples t-test was proposed. However, the assumptions were not met, particularly the recommendation of a sample size of thirty or more participants. For this reason, descriptive statistics were instead utilized. Results from the determination of the means included scores of bystander efficacy for international participants at pre-test ($M = 8.40, SD = 0.71$) and post-test ($M = 8.30, SD = 0.57$) were slightly lower than scores of bystander efficacy for domestic participants at pre-test ($M = 7.09, SD = 1.52$) and post-test ($M = 7.23, SD = 1.48$). Scores of bystander intervention behavior for international participants at pre-test ($M = 0.55, SD = 0.333$) and post-test ($M = 0.45, SD = 0.74$) were varied compared to scores of bystander intervention behavior for domestic participants at pre-test ($M = 0.41, SD = 0.215$) and post-test ($M = 0.46, SD = 0.221$).

**Research Question #9**: How does sorority or fraternity membership influence scores of bystander efficacy and bystander intervention behavior before and after participation in a bystander intervention program for first-year students at the University of Wisconsin – La Crosse?

To determine if scores of bystander efficacy and bystander intervention behavior differed by sorority or fraternity membership among survey respondents, an independent samples t-test was proposed. However, the assumptions were not met, particularly the recommendation of a sample size of thirty or more participants. For this reason, descriptive statistics were instead utilized. Results from the determination of the means revealed scores of bystander efficacy for participants from sororities or fraternities at pre-test ($M = 7.90, SD = 1.24$) and post-test ($M = 7.93, SD = 1.61$) were slightly higher than
scores of bystander efficacy for non-affiliated participants at pre-test \((M = 7.06, SD = 1.53)\) and post-test \((M = 7.21, SD = 1.46)\). Scores of bystander intervention behavior for participants from sororities or fraternities at pre-test \((M = 0.43, SD = 0.205)\) and post-test \((M = 0.48, SD = 0.213)\) were higher than scores of bystander intervention behavior for non-affiliated participants at pre-test \((M = 0.41, SD = 0.218)\) and post-test \((M = 0.46, SD = 0.307)\).

**Research Question #10:** How does collegiate or intramural sports team membership influence scores of bystander efficacy and bystander intervention behavior before and after participation in a bystander intervention program for first-year students at the University of Wisconsin – La Crosse?

To determine if scores of bystander efficacy and bystander intervention behavior differed by membership on a sports team among survey respondents, an independent samples t-test was used. All assumptions were met, except the assumption of independent samples. The independent samples t-test was undertaken due to the inaccurate result a matched-pairs t-test would have produced due to the inability to match participants from the pre- and post-test. Results from the independent samples t-test revealed no statistically significant difference existed in pre-test scores of bystander efficacy between members of sports teams \((M = 7.33, SD = 1.28)\) and non-members \((M = 6.99, SD = 1.63)\) participants, \(t(206) = -1.56, p = 0.120\). No statistically significant difference existed in post-test scores of bystander efficacy between members of sports teams \((M = 7.35, SD = 1.62)\) and non-members \((M = 7.20, SD = 1.40)\) participants, \(t(92) = -0.468, p = 0.641\). No statistically significant differences existed in pre-test scores of bystander intervention behavior between members of sports teams \((M = 0.40, SD = 0.210)\) and non-members \((M = 0.40, SD = 0.210)\).
Research Question #11: How does first-generation student status influence scores of bystander efficacy and bystander intervention behavior before and after participation in a bystander intervention program for first-year students at the University of Wisconsin – La Crosse?

To determine if scores of bystander efficacy and bystander intervention behavior differed by first-generation student status among participants, an independent samples t-test was used. All assumptions were met, except the assumption of independent samples. The independent samples t-test was undertaken due to the inaccurate result a matched-pairs t-test would have produced due to the inability to match participants from the pre- and post-test. Results from the independent samples t-test revealed no statistically significant difference existed in pre-test scores of bystander efficacy between participants who were first-generation students ($M = 6.94, SD = 1.58$) and participants who were not first-generation students ($M = 7.35, SD = 1.41$), $t(216) = 1.906, p = 0.058$. No statistically significant difference existed in post-test scores bystander efficacy between participants who were first-generation students ($M = 7.15, SD = 1.55$) and participants who were not first-generation students ($M = 7.48, SD = 1.27$), $t(92) = 0.984, p = 0.33$. No statistically significant difference existed in pre-test scores of bystander intervention behavior between participants who were first-generation students ($M = 0.41, SD = 0.208$) and participants who were not first-generation students ($M = 0.41, SD = 0.230$), $t(205) = 0.95, p = 0.924$. No statistically significant difference existed in post-test scores bystander
intervention behavior between participants who were first-generation students ($M = 0.45, SD = 0.211$) and participants who were not first-generation students ($M = 0.50, SD = 0.236$), $t(88) = 1.00, p = 0.318$.

**Research Question #12:** How does veteran status influence scores of bystander efficacy and bystander intervention behavior before and after participation in a bystander intervention program for first-year students at the University of Wisconsin – La Crosse?

To determine if scores of bystander efficacy and bystander intervention behavior differed by veteran status among participants, an independent samples t-test was proposed. However, no participants identified as a veteran, so no analysis was completed.

**Summary**

In general, program feedback was positive, with the majority of respondents agreeing the information was presented in a respectful and inclusive manner and the program was valuable for students with useful content. Instructors and students also found the program engaging and agreed the practice provided by the scenarios was useful to the participants. The majority of respondents also indicated continued program implementation would be helpful for future students. The vast majority of respondents reported working through the role-playing scenarios as a group was the most valuable part of the program. Respondents also indicated this information should be presented to all students, either through the UWL 100 course, the online modules for all students to complete before starting their first semester, or New Student Orientation.

The research questions addressed the demographic characteristics of the study population as well as changes in scores of bystander efficacy and bystander intervention behaviors. The majority of the study participants identified as female, were age 18, self-
identified as heterosexual, and the most prominent race/ethnicity was white. Small percentages of study participants identified as international students or members of sororities or fraternities. About one-third of respondents were members of either collegiate or intramural sports teams. More than half of study participants were first-generation college students, and no participants self-identified as a student veteran.

Inferential statistics were utilized to examine differences in pre- and post-test scores of bystander efficacy and bystander intervention behaviors. The analysis of bystander efficacy and bystander intervention behaviors did not reveal any statistically significant differences in scores before and after program implementation, however, there was a trend demonstrated by the data analysis wherein scores for both bystander efficacy and bystander intervention behavior did increase from pre- to post-test implementation.

Inferential statistics were utilized to examine differences between pre-and post-test scores among different demographic characteristics. Specific demographic characteristics included biological sex and gender identity, membership on collegiate or intramural sports teams, and status as a first-generation student status. Female-identified participants had higher scores of both bystander efficacy and bystander intervention behavior than their male-identified counterparts at both pre- and post-test. Members of either collegiate or intramural sports teams had higher scores of both bystander efficacy and bystander intervention behavior that non-members at both pre- and post-test. Participants who were first-generation college students had lower scores of both bystander efficacy and bystander intervention behavior that non-members at both pre- and post-test. There were no statistically significant differences between pre- and post-
test scores of bystander efficacy and bystander intervention behaviors for any of the demographic characteristics.

Descriptive statistics were utilized in cases where the sample size of the study participants with specific demographic characteristics were too small to properly perform inferential analyses. These specific demographic characteristics included sexual orientation, race/ethnicity, international student status, and sorority and fraternity membership. Study participants who identified as LGBTQ+ had higher scores of bystander efficacy at pre-test than their heterosexual peers, but lower scores of bystander intervention behavior at both pre- and post-test. Non-white participants had higher scores of both bystander efficacy and bystander intervention behavior at both pre- and post-test than their white peers. International students had higher scores of both bystander efficacy and bystander intervention behavior at pre-test and higher scores of bystander efficacy at post-test than domestic students. Sorority and fraternity members had higher scores of both bystander efficacy and bystander intervention behavior at pre- and post-test than their non-member peers. Finally, no study participants identified as a student veteran, so this analysis was not conducted.
CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

Introduction

For many students, the time of transition from high school to college can be difficult. The first year of college is the first time students are responsible for their own well-being and care (Pedrelli et al., 2015). The first time away from their usual supports from their families and friends at home, students may struggle as they work to establish their identities and support themselves. Contributing to their struggle is the pressure to make choices about their health behaviors, including whether or not they will choose to participate in high-risk health behaviors (Pedrelli et al., 2015).

Some examples of high-risk health behaviors students may engage in or experience for the first time when coming to college include excessive and/or illegal underage alcohol use, illegal drug use, risky sexual activity, experiences of sexual violence, experiences of hate and bias, and poor mental health. Poor mental health can be exacerbated by the previously listed experiences. These health challenges experienced by students can negatively impact both their overall well-being and their academic and social success. Lower grade point averages, lower rates of retention, and decreased university involvement are potential consequences of challenges experienced by college students. As universities work to support the well-being and success of their students,
they need to fully consider these challenges. Education and support services should be developed and enhanced to support students during this time of transition.

Following the identification of the need to address these health and well-being concerns experienced by college students on the University of Wisconsin – La Crosse campus, an extensive review of existing interventions was conducted. Other colleges and universities attempting to address these issues have implemented bystander intervention programs to encourage students to intervene when their peers are experiencing health concerns. These programs are utilized as a way to prevent health concerns and their associated negative consequences by increasing social support and peer intervention. Following these recommendations, a bystander intervention program for first-year students was implemented and evaluated at the University of Wisconsin – La Crosse to support students during this time of transition.

The goal of bystander intervention programming is to teach transferable skills participants can utilize in emergencies and situations that could develop into emergencies involving their peers. Peer intervention is emphasized because many of the high-risk activities students engage in are performed in the presence of their peers rather than administrators, faculty, and staff (Neighbors et al., 2012). For this reason, primary aims of these programs are to emphasize responsibility for each other’s well-being and create a culture in which intervening is seen as a healthy and positive behavior. The promotion of pro-social values, when paired with skill development and practice, has been linked to increases in actual bystander intervention behaviors (Brown et al., 2014; Mabry & Turner, 2016; Storer et al., 2015).
The purpose of this study was to assess how bystander efficacy and bystander intervention behavior of first-year students at the University of Wisconsin – La Crosse changed as a result of participation in the bystander intervention program. Evaluating the program was accomplished by assessing bystander efficacy and bystander intervention behavior before and after implementation of the program. If bystander efficacy and instances of bystander intervention behavior increased in conjunction with program implementation, the bystander intervention program would be deemed effective. This would hopefully result in students feeling more able to support their peers. This particular population was important to assess because first-year students are vulnerable to alcohol misuse/illegal consumption, sexual assault and unhealthy relationships, poor mental health, and other issues addressed in the bystander intervention program (Cantor et al., 2015).

The purpose of the bystander intervention program was to increase the participants’ confidence to intervene as well as the number of interventions by students within their peer groups. In addition, the program was intended to foster a culture of support among participants and a sense of community in order to make intervention behaviors socially acceptable. The 1-hour program utilized a PowerPoint and interactive components to first introduce students to the idea of the bystander effect and other reasons people may fail to intervene in potentially dangerous situations and teach the students how to recognize a dangerous situation. Then, common warning signs, called red flags, were provided for alcohol misuse, sexual violence, poor mental health, and experiences of hate and bias. Next, the program emphasized a sense of communal responsibility and encouraged students to intervene on behalf of their peers. Finally, the
program taught the three “Ds” of intervening – direct, distract, and delegate – and presented students with scenarios outlining different dangerous situations to allow them to practice their new skills while discussing solutions with their peers.

If the program resulted in students feeling comfortable and acting to intervene with their peers in need of assistance, the increased intervention would positively impact the campus culture as well as student well-being. This positive campus culture and additional support may coincide with higher GPAs, rates of retention, academic success, and social success of students. In addition, if first-year students can adopt healthier habits and bystander intervention behaviors early in their college experiences, they will be safer and healthier throughout their time at college (Cantor et al., 2015). If this program is effective in increasing bystander efficacy and instances of bystander intervention behavior, the program should be established as part of the regular curriculum received by all first-year students. Implementing this program with all first-year students for several years could create a more positive campus culture where students support their peers and intervene on their behalf to prevent negative experiences and poor health outcomes.

Conclusions

The purpose of this study was to assess how bystander efficacy and bystander intervention behavior of first-year students at the University of Wisconsin – La Crosse changed as a result of participation in a bystander intervention program. This evaluation was accomplished by assessing bystander efficacy and bystander intervention behavior before and after implementation of the program. Data were collected utilizing an electronic survey with a pre- and post-test design. Demographic information was collected to determine the influence of various demographic characteristics on scores of
bystander efficacy and bystander intervention behavior. In addition to utilizing descriptive statistics to characterize demographics of the study participants, inferential statistical analyses in the form of independent-samples t-tests were conducted to identify any differences in bystander efficacy and bystander intervention behavior among selected demographic groups. Program feedback was solicited from staff and students who participated in the program for program improvement purposes.

Instructors and students thought highly of the bystander intervention program, agreeing the information was presented in a respectful and inclusive manner and the program was valuable for students. Respondents agreed the program content was useful and engaging, and the scenarios presented were useful to provide an opportunity to practice their new skills. In fact, the majority of respondents indicated that the scenarios were the most valuable part of the bystander intervention program. Respondents recommended continued program implementation for all students through methods such as future UWL 100 courses, online modules, or presentations at New Student Orientation.

Demographic characteristics were assessed to determine the makeup of the study population. The majority of the study participants identified as female, were age 18, self-identified as heterosexual, and the most prominent race/ethnicity was white. Small percentages of study participants identified as international students or members of sororities or fraternities. About one-third of respondents were members of either collegiate or intramural sports teams. More than half of study participants were first-generation college students, and no participants self-identified as a student veteran. For many of these demographic characteristics, there were small numbers of historically
underrepresented populations. For these underrepresented groups, the small sample sizes impacted the ability of the researcher to perform statistical analyses. The effectiveness of the bystander intervention program was measured as the changes in scores of both bystander efficacy and bystander intervention behaviors. These changes in the scores were analyzed through the use of a pre- and post-test survey methodology. Inferential statistics were utilized to examine changes in scores from pre- to post-test. The analysis of bystander efficacy and bystander intervention behaviors did not reveal any statistically significant differences in scores before and after program implementation. However, while there was not statistical significance, there was a trend wherein scores for both bystander efficacy and bystander intervention behavior did increase from pre- to post-test implementation. There is a possibility that alternative statistical analyses or a more rigorous study design could have revealed true statistical significance between pre- and post-test scores. Alternative statistical analyses are included as a recommendation to improve this research, discussed below.

Inferential statistics were utilized to examine differences between pre-and post-test scores among different demographic characteristics. Specific demographic characteristics included biological sex and gender identity, membership on collegiate or intramural sports teams, and status as a first-generation student. Female-identified participants had higher scores of both bystander efficacy and bystander intervention behavior than their male-identified counterparts at both pre- and post-test. One reason female-identified participants may have had higher scores for bystander efficacy and bystander intervention behavior than their male peers is due to the higher likelihood of females previously experiencing sexual violence. Experiences of previous violence are
correlated with an increased likelihood to intervene to prevent others from encountering negative experiences. This increased probability of intervening may be because the survivor recognizes the extreme negative consequences that can be associated with experiences of sexual violence and does not want anyone else to experience these consequences (Moynihan & Banyard, 2008).

Members of either collegiate or intramural sports teams had higher scores of both bystander efficacy and bystander intervention behavior than non-members at both pre- and post-test. Collegiate or intramural sports teams often function as cohesive groups that may socialize together and be more likely to encounter dangerous situations where intervention is needed in the presence of large groups of their peers rather than in the presence of strangers. Social norms of cohesive groups are more commonly supportive of bystander intervention behaviors than within groups of strangers (Moynihan & Banyard, 2008). For example, because members of the group know each other well, it is probable that perceptions of personal responsibility for peers’ well-being is enhanced (Brown et al., 2014).

Participants who were first-generation college students had lower scores of both bystander efficacy and bystander intervention behavior than non-members at both pre- and post-test. There were no statistically significant differences between pre- and post-test scores of bystander efficacy and bystander intervention behaviors nor any statistically significant differences between participants with different demographic characteristics. First-generation students may know less than their peers about what to expect during their college experience because their parents did not have the context of their own
college experience to assist them when attempting to advise their students (Brown et al., 2014), and may thus be less prepared to intervene on behalf of their peers.

Descriptive statistics were utilized in cases where the sample sizes of the study participants with specific demographic characteristics were too small to properly perform inferential analyses. These specific demographic characteristics included sexual orientation, race/ethnicity, sorority and fraternity membership, and international student status. Study participants who identified as LGBTQ+ had higher scores of bystander efficacy at pre-test than their heterosexual peers, but lower scores of bystander intervention behavior at both pre- and post-test. In addition, non-white participants had higher scores of both bystander efficacy and bystander intervention behavior at both pre- and post-test than their white peers. For both LGBTQ+ and non-white study participants, previous life experiences likely influenced their confidence and willingness to intervene. Specifically, both LGBTQ+ and non-white individuals are more likely to have had both hate and bias and sexual violence perpetrated against them (Brown et al., 2014). Instances of previous victimization are predictive of higher future bystander efficacy bystander intervention behavior to help others (Moynihan & Banyard, 2008). One motivation of LGBTQ+ or non-white individuals to intervene may be the desire to prevent others from negative experiences similar to their own.

Sorority and fraternity members had higher scores of both bystander efficacy and bystander intervention behavior at pre- and post-test than their non-member peers. Like members of sports teams, sororities and fraternities also function as cohesive groups. As a group, they are prone to socialize together and are thus more likely to encounter dangerous situations where intervention is needed when socializing as a group.
Perceptions of personal responsibility for their peers’ well-being is enhanced, and thus, social norms are more supportive of intervention within this cohesive group. This increased social support may be one reason why scores of bystander efficacy and bystander intervention behavior are higher for members of these groups.

International students had higher scores of both bystander efficacy and bystander intervention behavior at pre-test and higher scores of bystander efficacy at post-test than domestic students. The life experiences of international students are often very different than their domestic peers due to cultural differences, and this may affect how prepared they feel to intervene on another students’ behalf (Mabry & Turner, 2016). International students may also be less accepting of pervasive norms in the United States and the State of Wisconsin that support heavy alcohol consumption. Lower acceptance of these norms may increase their sense that intervention is needed, and thus they may be more apt to intervene than their domestic peers. Finally, no study participants identified as a student veteran, so this analysis was not conducted.

**Limitations**

There were several limitations to consider when interpreting the results of this research. First, this study only measured self-reported changes in bystander efficacy and bystander intervention behavior and did not assess impacts on rates or consequences of alcohol misuse, sexual violence, mental health concerns, or hate and bias incidents. In other words, this study examined short-term outcomes and did not assess long-term outcomes. Also, as with any self-reported data, recall bias may have inhibited participants’ ability to accurately remember and report their instances of bystander intervention behavior. Third, instructors who allowed the implementation of the
bystander intervention program during their UWL 100 class time may have emphasized different values to their students and thus, different class sections may have been fundamentally different at the beginning of the study. Fourth, the survey asked sensitive questions of the participants, and it is possible students provided answers they perceived to be socially desirable instead of answers reflecting their true feelings (i.e. Social Desirability Bias).

Fifth, first-year students in the first semester of their college career may not have had the opportunity to experience the culture at the University of Wisconsin – La Crosse and may not have experienced a situation where bystander intervention behavior could be necessary. Finally, the data and results generated from this study were not generalizable to the entire population of first-year students at the University of Wisconsin – La Crosse because the UWL 100 courses in which this program was implemented did not represent a random sample of first-year students and the response rate of the post-test survey was particularly low, at 30%. In addition, participants from historically underrepresented populations, such as the LGBTQ+, non-white, and international populations, were not present in this study in high numbers which limited the ability of the researcher to conduct a meaningful analysis of the changes in bystander efficacy and bystander intervention behavior within these groups.

**Recommendations to Improve this Research**

There are recommendations for improvement of this research study. First, increased control over the process of survey implementation and data collection is recommended. In the present study, instructors were asked to administer the survey to their students, and the researcher recommended instructors provide class time in order for
the participants to complete the pre- and post-test surveys. This method of survey implementation was necessary, because the researcher did not have access to class lists for each course and instructors had to opt-in to voluntarily participate in the research study. With increased control over this process, response rates could be increased, particularly for the post-test, and the researcher could be confident both surveys were implemented according to the desired timeline.

Second, performing alternative statistical analyses is suggested. In this study, independent t-tests were utilized because no matched data were available due to the design of the data collection. The choice not to collect identifying information on which to match participants was intentional because the researcher was aware program participants may have perceived a lack of confidentiality in their responses and may not have answered the survey questions honestly. The concern of perceived lack of confidentiality was amplified due to the setting in which the research took place and the nature of the study questions. First, the program was implemented in a first-year seminar course on the University of Wisconsin – La Crosse campus. To encourage survey completion, many instructors offered their students time within their usual class period to complete both the pre- and post-test assessments. However, completing the surveys in this classroom setting may have led some participants to believe their instructor or fellow students may have been able to see their responses, and may have led them to answer dishonestly if they felt the responses could be connected back to them personally.

Another concern regarding perceived participant confidentiality was fostered by the survey questions, which asked about sensitive and potentially illegal behaviors, such as underage alcohol consumption and sexual violence. If participants perceived a lack of
confidentiality, they may have answered in a dishonest manner in order to protect themselves from the consequences admitting their actions. In addition, with questions of this nature, participants may have experienced social desirability bias, in which they answer questions in the way they believe is most acceptable within society. Due to this bias, they may have indicated they would intervene in situations more often than they would actually be willing to in day-to-day life.

Due to the above concerns regarding participant confidentiality, identifying information on which to match participants was not collected to increase participants’ sense of confidentiality. Thus, an independent-samples t-test was the most applicable statistical technique available. Utilizing an independent-samples t-test rather than the dependent-samples t-test did not increase the possibility of committing Type I error (finding a statistically significant $p$ value when no significance existed). Rather, it increased the possibility of committing Type II error (not finding a statistically significant $p$ value when significance did exist). This increase in the probability of finding Type II error may have contributed to the overall finding of no significant differences between pre- and post-test scores of bystander efficacy and bystander intervention behavior. In order to verify if these differences did exist and were not detected, or if these differences truly did not exist, the assessment of the program should be undertaken again utilizing a match-pairs analysis strategy.

Finally, utilization of a $N$-way ANOVA, with the $N$ notating the number of independent variables to be examined, should be used to determine the effect of multiple demographic characteristics as well as the effect of program participation on the measures of bystander efficacy and bystander intervention behavior together. This would
provide a benefit over analyzing the effects of the demographic characteristics separately from the effects of involvement in the program could provide a clearer picture of what truly impacts these scores. In addition, the use of an ANCOVA statistical analysis would allow the researcher to control for the effects of pre-testing in order to better determine the influence of the program on the changes of the scores of bystander efficacy and bystander intervention behavior.

**Recommendations for Future Research**

Experiences from this research study can be used to guide future research. If the program were implemented many times with a variety of program facilitators, a process objective evaluation should be conducted during each individual program implementation to ensure program fidelity (i.e. consistency in the way the program is implemented). High program fidelity is associated with better program outcomes (Nation et al., 2003) and it is important to ensure the program is implemented in as much the same manner as possible each time, especially considering the varying experience or knowledge base of each individual program facilitator.

The collection of program feedback from program participants, including students and their instructors, should be continued in order to ensure the program continues to be relevant and acceptable to the student population. As students enter the university with differing experiences and backgrounds, and as the campus culture changes over time, different portions of the program may become more or less relevant to the student population. For example, with the recent increase in the public conversation around sexual violence and harassment precipitated by the #MeToo Movement, conversations about participants’ own experiences and prevailing gender norms in society may become a topic of interest and act as a starting point for conversation about the necessary actions
to create societal change (Gidycz, Orchowski, & Berkowitz, 2011). The program should be assessed so that updates can be made to the program corresponding to the shifting conversations and norms within the university and the United States as a whole. Data collection should consist of methodology similar to strategies used in this research, and collection of qualitative data through focus groups with both instructors and students could provide a clearer picture of the effective and relevant components of the program.

To determine what effect the program has on participant knowledge, a short-term impact evaluation should be conducted. Change in knowledge often is considered an elemental piece of belief and behavior change and should be assessed to determine if the program has a possibility of changing beliefs and behaviors. In other words, if the program does not increase participants’ knowledge of warning signs of dangerous situations and methods of intervention, it is unlikely to be useful in creating changes in beliefs and behavior. Ideally, both a short-term impact assessment and a long-term outcome assessment should be implemented when conducting research on the efficacy of bystander intervention programming. With these assessments, incentives should be utilized to increase response rates. A higher response rate would increase the generalizability of the results for the entire population of first-year students at the University of Wisconsin – La Crosse.

Another recommendation for future research includes conducting additional assessments to determine the sustainability of the changes over time as a result of the program implementation. The post-test for assessing bystander efficacy and bystander intervention behavior should be re-administered at 3 months, 6 months, and 1 year after the intervention. Additional administrations would allow researchers to determine the
lasting effects of the program, and most importantly, allow researchers to determine how often follow-up sessions should be conducted to ensure the program effects persist over time. In conjunction with the short-term impact evaluation already recommended for implementation shortly after program implementation, a long-term outcomes assessment would be useful in determining true program effectiveness and would reinforce the value of implementing the program for the entire student population.

Future research endeavors should assess participants’ social desirability scores. In this research study, the researcher attempted to reduce the pressure on participants to produce socially desirable responses by not collecting any identifying information. Not collecting identifying is not recommended for future research because it limited the available statistical analysis procedures. Instead, participant social desirability scores should be assessed in order to statistically control for them in data analysis. The Social Desirability Scale (Crowne & Marlowe, 1960) would be an appropriate tool for collecting this information.

**Recommendations for Public Health Practice**

Best practices recommended for prevention programing include the incorporation of theories and models in program design, increasing dosage and duration, and inclusion of the priority population in program design to ensure effective program implementation. In addition, special considerations should be given for the prevention of gender-based violence, and rigorous evaluation of bystander intervention programming outcomes is needed. Finally, bystander intervention programs should be modeled on other evidence-based bystander intervention programs, such as the Step Up! program created by the University of Arizona C.A.T.S. Life Skills Program (University of Arizona C.A.T.S.
Skills Life Program & National Collegiate Athletics Association, 2018). Bystander intervention programs should be implemented to address a variety of health concerns for college students. Additional research may demonstrate that benefits of bystander intervention programs extend beyond teaching skills to intervene to prevent sexual violence, which has been the primary application of bystander intervention programming thus far (Katz & Moore, 2013).

**Incorporation of Theories and Models**

Both DeGue et al. (2014) and Nation et al. (2003) have noted that prevention programming should incorporate existing theories and models for behavior change. Utilizing existing theories and models helps bridge the gap between research and practice, and is useful when adequate research has not been conducted to determine the effective and ineffective pieces of bystander intervention programming. Several theories and models are recommended for application to bystander intervention programming, including the Social-Ecological Model (Centers for Disease Control and Prevention, 2019), the Health Belief Model (University of Twente, 2018), and the Transtheoretical Model of the Stages of Change (Prochaska, DiClemente, & Norcross, 1992).

The Socioecological Model recommends interventions be targeted at multiple levels of impact, including the individual, interpersonal, group, institutional, and community levels (Centers for Disease Control and Prevention, 2019). Many interventions at the University of Wisconsin – La Crosse (UWL) are implemented within the individual level, such as the “Think About It” modules by CampusClarity. The goal of this intervention is to teach students valuable risk reduction and safety skills; however, it does not address how relationships, social norms, or policy interventions impact the
students. Current group interventions include education implemented by the Peer Health Advocates, information provided during New Student Orientation, and alcohol-free events designed by the university to offer students an alternative to drinking. Institutional interventions include the Safe Ride program, which transports students from the surrounding community back to campus to discourage students from driving while intoxicated and reduce their risk of harm.

Various policies also work at the institutional level to create a culture in which students are discouraged from engaging in risky health behaviors and encouraged to seek help for their peers who may be in a dangerous situation. These include the alcohol policy, which prohibits alcohol consumption within on-campus buildings and residence halls, except in controlled and monitored places; and the Responsible Action Policy, which states that students who are drinking underage or otherwise violating the law will not be cited by the police for requesting medical assistance for their peers or themselves. Instead, these students are asked to complete education about risky behaviors in the hopes this learning opportunity can be used to encourage more healthful decision making.

While the current programming is helpful for reducing risks and associated consequences at UWL, there are not any interventions at the interpersonal level. The failure to capitalize on the peer relationships between students represents a missed opportunity, and bystander intervention programming has been proposed to fill this gap in prevention programming. By working to encourage feelings of social responsibility to one another within the context of already-existing relationships, students can take ownership of each other’s well-being and act to protect the safety and health of their friends and classmates.
The Health Belief Model is especially useful when considering student barriers and benefits to intervening (University of Twente, 2018). Within the literature, barriers to performing bystander intervention behaviors may include the perceived social cost of acting against the norm, low self-efficacy, and failure to assuming personal responsibility. In addition, it is important to emphasize the idea that barriers are experienced differently by different people because of identity and context, particularly identities such as sex and gender expression, race/ethnicity, and sexual orientation (Brown et al., 2014). Demographic factors can also influence feelings of risk and personal safety for the potential active bystander. It is essential to discuss the importance of considering personal safety when deciding to intervene, as done in this program, especially because a variety of intervention options have the potential to be effective in different situations (Katz & Moore, 2013). It is helpful to demonstrate to program participants effective ways to overcome these barriers while also emphasizing the benefits to intervening. Many program participants will be at different levels of readiness for intervention. For this reason, the Transtheoretical Model can be a useful model to guide program creation, as it was within this program (Prochaska et al., 1992). An ideal program should guide participants through the Stages of Change, from Pre-contemplation, Contemplation, and Preparation to Action and Maintenance. For the purposes of the program, the goal is to move participants to the Action stage wherein they would perform intervention behaviors by introducing them to the problem (moving from Pre-contemplation to Contemplation), increasing their perception of harm associated with not intervening (moving participants from Contemplation to Preparation) and then preparing them to
intervene by introducing them to intervention techniques and allowing them to practice their new intervention skills by responding to realistic scenarios (moving from Preparation to Action). It is essential to develop a context for participants to understand these issues and their susceptibility to them in order to truly engage participants in the program (Northwest Center for Public Health Practice, 2012).

**Program Logistics**

Interventions should be implemented with first-year students as this program was. More significant learning outcomes have been found when the intervention is implemented with younger college students, especially those in their first year (Katz & Moore, 2013). Comprehensive programming should begin early in the college career. In addition, when implementing programming covering sensitive topics, it is essential to ensure classroom expectations are set in advance and to acknowledge people may feel uncomfortable because of their own experiences. Trauma informed instruction has become more prevalent among educators in recent years, and it is recommended to follow principles of trauma informed instruction when implementing programs addressing sensitive topics (Crosby, Howell, & Thomas, 2018).

Collaborating with other groups on campus, such as collegiate sports teams and fraternities and sororities, would allow the presentation of this program in more diverse settings with different groups of students. In addition, engaging with student groups may lead to increased student engagement with the topic, which would result in improved learning outcomes. Dosage and duration of the program implementation can also greatly affect program efficacy. Although it was not possible in the setting of this research study, programs should be administered over several sessions, typically at least two sessions and
up to eight (Nation et al., 2003). Recommended session length is 1.5 to 3 hours (Nation et al., 2003). For future program implementation, class time should be utilized to discuss video clips and practice scenarios, especially as the first-year seminar course is moving to an online implementation format. Problems-based scenarios should be utilized in small groups to allow participants to practice their new skills, as they were within this program (Nation et al., 2003).

**Special Considerations for Violence Prevention**

Although it was not possible in the setting of this research study, single-gender trainings should be considered whenever possible due to the gender bias inherent in sexual violence. Single-gender trainings create the opportunity for discussions in an open and inclusive environment (Foubert, Tatum, & Godin, 2010). Program should not be presented through a heteronormative lens; instead, the inclusion of different student identities has been found to lead to more program engagement. Gender constructs dictated by society are important to examine, especially as they are relevant to societal ideas regarding masculinity (Foubert et al., 2010). With sexual violence, the relationship of the bystander to the perpetrator and the victim is important to discuss and it is essential to consider how intervention participants who have already experienced violence may perceive the materials. A wide variety of intervention strategies should be provided so students can pick what they feel comfortable with in the context of the specific relationship (Murphy, 2014).

**Program Evaluation**

A final recommendation is to perform rigorous program evaluation in order to measure the outcomes of the program and contribute to the evidence base within the field.
Continuous program feedback should be solicited from both instructors and students in order to ensure consistent university support and engagement with the program and to keep the program relevant to an evolving group of students. Evaluation of program fidelity, in the form of a process evaluation, should be completed to ensure the program is implemented in a consistent manner. Instructor and student feedback can also be included within the process evaluation. In addition, practitioners in the field should include both short-term impact and long-term outcome evaluations when conducting program assessment and work to ensure long-term outcome evaluations are conducted at additional points after program implementation to measure the persistence of different effects over time. This recommendation is consistent with recommendations for future research discussed previously.

Utility of Bystander Intervention Programs

Bystander intervention programs have the potential to be effective in addressing a variety of health concerns experienced by college students. In moving beyond teaching the skills to intervene to prevent sexual violence, the primary application of this training thus far, the skills learned in this training could help students support their peers in a variety of different situations. The transferable skills gained through this training should be emphasized so students are motivated to implement their skills in new and novel ways, as they were in this study. In implementing comprehensive bystander intervention programming for first-year students, and motivating students to care for each other, the health and well-being of college students may be improved dramatically.
Summary

In this chapter, key conclusions from the current research were presented. In addition, recommendations for improving the current research as well as limitations of the current research were discussed. Finally, recommendations for future research and public health practice were proposed. Generally, implementation of bystander intervention programming should continue for first-year students at the University of Wisconsin – La Crosse, and rigorous program assessment should be conducted. This assessment should include a program implementation process evaluation, a short-term impact evaluation to assess changes in participant knowledge, and a long-term outcome assessment should be implemented through several points in time to capture changes in participant bystander efficacy and bystander intervention behavior up to one year after implementation of the program. Both the impact and outcome evaluations should be administered using a pre-test/post-test assessment with a matched pairs data collection design. A program that is able to encourage students and help them feel comfortable acting to intervene with their peers in need of assistance could positively impact the campus culture as well as student well-being at the University of Wisconsin – La Crosse and at colleges and universities across the country.


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APPENDIX A

Bystander Intervention Program Presentation
Appendix A: Bystander Intervention Program Presentation

Slide 1

UWL 100 Bystander Intervention Program

Created by Cassandra Worner
Graduate Assistant in Violence Prevention
Masters of Public Health Program

Information adapted from University of Arizona – Step Up! created by the C.A.T.S Life Skills Program in Partnership with the NCAA and the Peer Health Educators at Miami University

Who are we, anyway?

• Cassandra Worner, Graduate Student in the Master of Public Health Program

• Peer Health Advocates from the Student Life Office

• Very passionate about this health topic and here to engage in a conversation; what you choose to do with this information is up to you
So why are we here?

Reflect with us...

Think of a time when you could have intervened to help a friend or someone in need, and didn’t...

This is common! It can be hard to intervene, and there are many reasons why a person may choose not to. We’re here today to overcome some of the common barriers to intervention.
What will we do today?

- Give you the tools, skills, and motivation to effectively intervene
- Empower you to become more comfortable and confident intervening
- Encourage you to care for your fellow students and embrace our community values

The Story of Kitty Genovese

- Kitty was walking home when she was repeatedly stabbed
- She screamed for help, but no one came to her assistance
- It was reported that 37 people either saw or heard what was happening, but the police were not called until hours later, when it was too late to save her
What is the Bystander Effect?

- Definition: A psychological phenomenon in which someone is less likely to intervene in an emergency situation when others are present than when they are alone. **Diffusion of Responsibility**

So, why else don't people intervene?

- Social Identifiers
- Bystander Effect
- Authority
- Conformity
- Pluralistic Ignorance
- Ambiguity
- Shared Responsibility
- Diffusion of Responsibility
- Willful Neglect
- Cultural Identifiers
How can we intervene? Steps for Intervention

- Notice the event
- Interpret the event as a problem
- Assume personal responsibility
- Know how to help
- Implement the help

Notice the Event

- Brainstorm: What could prevent you from noticing a problem?
- What could help you better notice a problem?
  - Pay attention to your surroundings
  - Know red flags for situations you may encounter
Red Flags of Alcohol Poisoning

- Cannot be awakened or is unresponsive
- Cold, clammy, pale, or bluish skin
- Vomiting while passed out
- Slow or irregular breathing or heartbeat

Red Flags of Intimate Partner Violence

- Jealousy
- Physical Injuries
- Attempts at monitoring activities
- Not respecting boundaries
- Possessiveness
- Threats of destruction of property
- Questioning beliefs and choices
- Putting the person down
Red Flags of Poor Mental Health

- Changes in sleep patterns
- Unexpected tearfulness or excessive moodiness
- Change in eating habits
- Expressions of hopelessness or worthlessness
- Paranoia and excessive secrecy
- Mention of hurting oneself
- Excessive isolation
- Abandonment of friends and social groups
- Drop in academic performance/motivation

Red Flags of Hate and Bias

- A hate or bias incident is any physically or verbally harmful act that is motivated by a person’s identity.
- Characteristics of a person’s identity could include:
  - Race or ethnicity
  - Religion
  - National origin/immigration/citizenship status
  - Sex, sexual orientation, or gender identity/expression
  - Economic status, language, age, or disability
  - Veteran or military status
- Any other identity status protected by University policy
Slide 15

Interpret the Event as a Problem

- Investigate the situation further!
- Perspective taking

Ask yourself:
"What's the worst that can happen if you investigate?"

Slide 16

Assume Personal Responsibility
Know How to Help

DIRECT
DISTRACT
DELEGATE

Direct - Distract - Delegate

• Direct: Take action by inserting yourself in the situation

• Distract: Divert attention to avoid a bad situation

• Delegate: Recruit someone else to help
What Would You Do?

What were some examples of Direct, Distract, and Delegate that you saw in the video?
Know Your Resources!

- University of Wisconsin – La Crosse Police
  - Non-emergency: 608.789.9000 | Emergency: 608.789.9999
- Sexual Assault/ Unhealthy Relationships
  - Violence Prevention Specialist, ipeterson@uwlac.edu
- Mental Health
  - Counseling and Testing at UWL, 608.785.8073
- Hate and Bias
  - Campus Climate Office, campusclimate@uwlac.edu
- Alcohol
  - Wellness within the Student Life Office, wellness@uwlac.edu
  - Responsible Action Policy

Responsible Action Policy

UW – La Crosse will not arrest or take disciplinary action for a violation of the alcohol policies (drinking under the legal age of 21) against those students who seek emergency medical assistance for themselves or other students.

- Student must remain with the impaired individual until assistance arrives, and must be completely cooperative with emergency responders
- Caller must complete any programs deemed necessary by the Dean of Student’s Office
- For more questions, contact the Wellness Office at wellness@uwlac.edu
Implement the Help and Step Up!

- Once we have noticed an event, interpreted it as a problem, assumed personal responsibility for intervening, and know how to intervene, the last step is to intervene and implement the help.

How will you intervene?
**Scenario #1: Coming Back to Your Room**

It is a Saturday night, and you are coming back to your room with some friends to hang out before going your separate ways. As you walk in, you all notice your roommate passed out on their bed. They still have their clothes and shoes on from the day, and they do not open their eyes when you turn on the light. Suddenly, they vomit all over their bed.
Scenario #2: Corridor-Mate's Partner

Your corridor is very close this year. You do lots of things together, and almost everyone is present except for one person. They never hang out because they are always with their partner. One night you pass the two of them in the hallway and ask why they never hang out with the rest of you. Your corridor-mate's partner angrily brushes you off, saying they are super busy. They pull your corridor-mate away mumbling that they are tired of having to come to their stupid building.
Scenario #3: Hateful Speech

You are working in the Union and you see two young women who are holding hands and obviously in a relationship. Another person starts shouting about "stupid people flaunting their perverted relationship in front of others". The situation is starting to escalate.

Scenario #3: Hate and Bias

You are working in the Union and you see two young women who are holding hands and obviously in a relationship. Another person starts shouting about "stupid people flaunting their perverted relationship in front of others". The situation is starting to escalate.
Scenario #4: Exam Nerves

As your friend awaits their exam, they express they should have prepared more. They have been so nervous for this final that they haven’t gotten any sleep in 2 nights and have hardly eaten anything. After the test, your friend tells you they were sick to their stomach the entire time. You and your other friends have noticed their distance. When your friend received the score the next day, they are dismayed that it is a D...later that night they tell you that they were so nervous the entire time that they do not think they performed to their best ability.
How to Have a Hard Conversation

An effective 1:1 conversation involves:

- Expressing care and concern for the person
- Being specific and sharing your feelings
- Using “I” statements
- Asking questions
- Offering support

Help Make La Crosse and UWL a Better Place

- Why do students intervene?
  - It’s the right thing to do!
- We can make a difference!
- We can create a culture of support and wellness on our campus.
Questions?

Know Your Resources!

• University of Wisconsin – La Crosse Police
  – Non-emergency: 608.789.9000 | Emergency: 608.789.9999
• Sexual Assault/Unhealthy Relationships
  – Violence Prevention Specialist, ipeterson@uwlaex.edu
• Mental Health
  – Counseling and Testing at UWL, 608.785.8073
• Hate and Bias
  – Campus Climate Office, campusclimate@uwlaex.edu
• Alcohol
  – Wellness within the Student Life Office, wellness@uwlaex.edu
  – Responsible Action Policy
Appendix B: Bystander Intervention Program Facilitator’s Guide

UWL 100 Bystander Intervention Facilitator’s Guide
Created by Cassandra Worner, Graduate Assistant in Violence Prevention – Student Life and Student in the Master of Public Health Program for the Peer Health Advocates
October, 2018

Slide 1: Bystander Intervention - Cassandra

- Welcome everyone! Today, we’ll be talking about bystander intervention.

Slide 2: Who are we, anyway? – Cassandra/PHA

- But first, we’d like to introduce ourselves. My name is Cassandra, my personal gender pronouns are she/her/hers, and I am a graduate student in the Master of Public Health Program and the Graduate Assistant to the Violence Prevention Specialist.
- And I’m name, my preferred gender pronouns are she/her/hers, and my major is major. I am a Peer Health Advocate out of the Wellness Office.
- We are very passionate about this topic and wellness on our campus, and we hope you’ll be willing to engage in a conversation with us today.
- Trigger Warning: Before we start, we want to let everyone know that we will be talking about topics that can be difficult for students, specifically intimate partner violence and sexual assault. Please take care of yourself. If, at any point, you need to leave to take a break or get a drink, please do. We only briefly touch on these topics, so we hope you’ll rejoin us if you are able.
- Finally, we want to let everyone know that we are mandatory reporters. This means that we would have to file a report with the university if anyone were to disclose to us that they had experienced sexual assault or another crime against them. Please know that there are confidential resources on this campus that you can speak to without reporting anything, and that we will be providing you with their information.

Slide 3: So why are we here? - PHA

- Okay! To start off the presentation, we’re going to show you a short video about bystander intervention to give you an idea of why we’re here today.
- Play video --> 3 minutes long

Slide 4: Reflect with us... - Cassandra

- We’d like everyone to take a moment to reflect to themselves about a time that they could have intervened to help someone in need and didn’t choose to act.
- Click so the rest of the slide shows up
• It’s likely that everyone could think of a situation in which they did not intervene – and this is common! It’s hard to intervene, and there are many reasons why someone may choose not to. We hope that not intervening in the past will not hold you back in the future, and we’re here to help you overcome some of those common barriers to intervention.

Slide 5: What will we do today? - PHA

• So today, we hope to first, give you the tools, skills, and motivation to effectively intervene; second, empower you to become more comfortable and confident intervening; and finally, encourage you to care for your fellow students and embrace our community values.

Slide 6: The Story of Kitty Genovese - Cassandra

• We want to tell you the story of Kitty Genovese and how the intervention of a bystander could have saved her life.
• This story takes place in 1964. Kitty was a bar manager in New York City and was headed home from her job one evening. She had parked her car and was headed inside to her apartment when she noticed a man following her. He caught up to her and stabbed her several times. She screamed for help, which scared the man, so he ran away. She struggled to her feet and tried to make it inside the building but could not. The man, seeing that no help was coming, returned. He stabbed her several more times and eventually raped her. It was reported that 37 people witnessed the crime or heard Kitty screaming, yet no one called for help. When someone finally did call for help, the police did not arrive in time to save Kitty’s life. The police have been quoted as saying that if someone had called when they first heard the screams, it is likely that Kitty would have survived.
• When researchers studied this incident and tried to figure out why no one called for help, they discovered the bystander effect.

Slide 7: What is the Bystander Effect? - PHA

• So, what is the bystander effect? The bystander effect is a psychological phenomenon in which someone is less likely to intervene in an emergency situation when others are present than when they are alone.
• In other words, there is a diffusion of responsibility – meaning that people assume that someone else will do something, so they don’t feel responsible.

Slide 8: So, why else don’t people intervene? - Cassandra

• There are also some other barriers to intervention that people may face.
• There are social and cultural identifiers that may make people feel like they are part of separate groups, and thus not responsible for each other.
• There’s the bystander effect and diffusion of responsibility, which we just talked about.
• People in authority may be instructing them not to intervene.
• They want to conform to social expectations to ‘mind their own business.’
• Pluralistic ignorance, which is when no one else in the group does anything about the situation so the person assumes that everything must be fine and that there is no need for intervention.
• The situation may be ambiguous, so people are unclear if intervention is needed.
• The people lack a sense of shared responsibility.
• And finally, there is willful neglect, where people simply choose not to get involved even though they recognize that the situation is, or may become, dangerous.
• We want to help all of you overcome these barriers, realize that it is your responsibility to intervene, and utilize the skills that we will be teaching you today.

Slide 9: How can we intervene? Steps for intervention - PHA

• Now that we know how important it is to intervene to help someone in need before a situation becomes dangerous, we’d like to share with you these steps for a successful intervention.
• These steps include: noticing the event, interpreting the event as a problem, assuming personal responsibility, knowing how to help, and implementing the help – or intervening.
• These steps can be applied to many different situations where a person may be in trouble, but we will specifically be talking about alcohol poisoning, intimate partner violence, hate and bias, and poor mental health.
• We will now go through these steps in more detail.

Slide 10: Notice the event - Cassandra

• The first step is to notice that the event is happening. We’d like to hear from you all on what could prevent you from recognizing a problem.
  o Wait for class to provide examples. Examples could include: having headphone in so they couldn’t hear a call for help, being tired and not paying attention to their surroundings, texting and walking, not knowing if something truly is a problem...
• Great! So now that we know what is preventing us from noticing a problem, how can we overcome this?
  o Wait for class responses.
• Thank you! So, in terms of everything that could help us notice a problem, it really comes down to two things: paying attention to your surroundings, and
knowing common red flags, or signs of danger, for situations you may encounter. Those red flags are what we will cover next.

Slide 11: Red Flags of Alcohol Poisoning - PHA

- Does anyone know of any red flags for alcohol poisoning?
  - Wait for class responses.
- Yeah! So, this group got many red flags correct, but here’s a complete list: the person cannot be awakened or is unresponsive; they have cold, clammy, pale, or bluish skin; they are vomiting while passed out; and their heartbeat and breathing may be slow or irregular.

Slide 12: Red Flags of Intimate Partner Violence - Cassandra

- Now we’re going to talk about intimate partner violence, which is an umbrella term for violence that occurs between two people in an intimate relationship. This could include people who are dating, married, or are sexually and/or romantically interested in each other.
- Some of the red flags for intimate partner violence include: jealousy, physical injuries, one person attempts to monitor the other’s activities, boundaries aren’t respected, there is possessiveness or threats of destruction of property, or one person questions the other’s beliefs and choices or puts the other person down.

Slide 13: Red Flags of Poor Mental Health - PHA

- Many students come to college with anxiety and depression, and many more students may develop these problems when they make the transition to college.
- Can anyone name some red flags that could indicate poor mental health?
- Thank you for sharing! So as many of you stated, some red flags of poor mental health include: changes in sleep patterns, unexpected tearfulness or excessive moodiness, change in eating habits, expressions of hopelessness or worthlessness, paranoia and excessive secrecy, mention of hurting oneself, excessive isolation, abandonment of friends and social groups, and a drop in academic performance or motivation.

Slide 14: Red Flags of Hate and Bias - Cassandra

- Now, we’re going to talk about Hate and Bias. First, it may be helpful to define what would constitute a hate or bias incident, which is any physically or verbally harmful act that is motivated by a person’s identity. These characteristics of a person’s identity could include: race or ethnicity; religion; national origin, immigration, or citizenship status; sex, sexual orientation, or gender identity and expression; economic status, language, age, or disabilities; or veteran or military status.
Now, this is not an exhaustive list, but if you feel someone is being targeted based on part of their identity, it is likely a hate and bias incident, and you should try to help.

Slide 15: Interpret the Event as a Problem - PHA

- Now that we know how to notice an event, by paying attention to our surroundings and knowing common red flags, the next step is to interpret that event as a problem.
- Sometimes, red flags can be ambiguous. It can be hard, for instance, to tell if a child is screaming from joy or fear. That is why it is important to investigate the situation further. This can be particularly useful if you notice that your friend has been acting differently lately, and you don’t know why. You can gather more information by asking them how they’re doing and if everything is okay.
- It can also be helpful to adopt different perspectives when you are considering if an event is a problem – think about how the situation is making the person being targeted feel, and how they may be interpreting it.
- Overall, it’s important to ask yourself: ‘what’s the worst that could happen if you investigate?’ Take a minute to weigh the benefit of intervening and helping someone else with the possibility of ‘bothering’ someone else to ask if they are okay. If they are okay, they will just appreciate you checking in, and if they’re not, this lets them know that you’re here to talk to, even if they don’t want to talk at that moment.

Slide 16: Assume Personal Responsibility - Cassandra

- Once we have noticed an event and interpreted it as a problem, it is time to assume personal responsibility for intervening. It is incredibly easy to think, ‘I don’t know them, and I am not responsible for what happens to them.’ But think of yourself and your friends – if one of you was in trouble, wouldn’t you want help?
- It’s also important to note that because we are all part of the UWL and La Crosse community, what happens to one of us will affect all of us. That is what this image is depicting – we are all ‘in the same boat,’ and if that boat goes down, we’re all going down with it. Take a minute to reflect on how your actions affect others, and how you can be a positive force within our community.
- Give students a moment to reflect before moving on to the next slide.

Slide 17: Know How to Help - PHA

- After we have noticed an event, interpreted it as a problem, and assumed personal responsibility for stepping up, the next step is to know how to help. We are going to talk about the 3D’s of bystander intervention, which are: direct,
distract, and delegate. By learning and practicing these 3D's, you should be able to think through possible courses for intervention in many different situations.

Slide 18: Direct – Distract – Delegate - Cassandra

- The first D is direct. Direct intervention involves taking action by inserting yourself in the situation. This can be useful in situations where you’re one-on-one with another person you know well and want to ask them how they are doing or talk with them about how their actions are impacting you.

- The second D is distract. Distracting involves diverting the attention of the people involved to avoid a bad situation. This could look like asking your friends if they want to go get food instead of drinking more at a party or offering to do another fun activity instead of letting your friend drive home while intoxicated.

- The third D is delegate. Delegating involves recruiting someone else, who may know better how to handle the issue, to help. This could look like asking your RA to talk to a friend in your hall that you are concerned about or calling 911 for a friend who is displaying symptoms of alcohol poisoning.

- It is important to pick methods for intervention that you are not uncomfortable with and will keep you safe. For instance, a direct intervention may not always be the safest option, especially in situations involving a physical fight. Keeping yourself safe comes first, and there are plenty of options for intervention that can be effective while keeping you safe.

Slide 19: What Would You Do? – PHA (at this point, 20 minutes into presentation)

- Now we’re going to watch video that depicts different options for intervening. At the end, we will ask you all to provide examples of how each of the characters used the 3Ds. This video does depict a dangerous situation and implies a sexual assault. Please take care of yourself. If, at any point, you need to leave to take a break or get a drink, please do. The video is approximately 7 minutes long, and we hope you’ll join us again once it’s over if you are able.

- Play video – 7 minutes long

Slide 20: What were some examples of direct, distract, and delegate that you saw in the video? - Cassandra

- Ask: What were some examples of direct, distract, and delegate that you saw in the video?

- Let students respond
  
  - Possible answers could include:
    - The strangers at the party directly intervene to remove the woman from the situation and delegate by finding her friends
- The man’s friend **directly** intervenes by saying ‘hey man, not tonight’
- The bartender **delegates** by finding the woman’s friends
- The woman’s friend **directly** intervenes by offering to take her home
- The woman’s friend **distracts** by asking her to go to the bathroom
- The stranger **directly** intervenes by asking the man, ‘hey, what are you doing?’

**Slide 21: Know Your Resources! - PHA**

- **We talked a lot about delegating and what that may look like in a real-life situation. Here are some resources on UWL’s campus that you can access.** Remember, we are not asking you to solve a problem all on your own. We want you to be able to support your friends and direct them to trained resources that can help them further. **These resources can include:** the UWL police, the office of violence prevention, counseling and testing, the campus climate office, the wellness office, and the responsible action policy. The resources sheet posted on your class Canvas or D2L page has more information on how to contact these resources, and if you’d like a physical copy of that sheet, we will have some up at the front for you at the end.

**Slide 22: Responsible Action Policy - Cassandra**

- **We just mentioned the responsible action policy, and we want to explain that policy further.** This policy states that UWL will not arrest or take disciplinary action for a violation of the alcohol policies, such as drinking under the legal age of 21, against those students who seek emergency medical assistance for themselves or other students. Basically, this means that if you are concerned that you or a friend may be experiencing alcohol poisoning, or needs medical assistance for another reason, you can call 911 to get help for them without risking getting in trouble.

- **To use this policy, you need to follow a few rules:** You must remain with the impaired individual until assistance arrives; you must be completely cooperative with emergency responders; and the caller must complete any programs deemed necessary by the Dean of Student’s Office. If you have any more questions about that policy, you can email wellness@uwlax.edu.

- **Please know, this policy is in place so that students can get the help they need without having to worry about the barrier of getting in trouble. Please use it if you or a friend is in danger.**
• Once we have noticed an event, interpreted it as a problem, assumed personal responsibility for intervening, and know how to intervene, the last step is to intervene and implement the help.

• We’re going to practice this step next.

Slide 24: How will you intervene? – Scenarios – Cassandra

30 minutes +5 minutes to establish groups and work through the scenario

• Now that you all have had a chance to hear this information, we want to give you a chance to practice this information using scenarios that you may encounter in real life. We are going to split you up in to groups and give each group a scenario. We’d like each group to read through their scenario, identify the red flags of the situation, and tell us how they would intervene using the 3Ds. We will then ask each group to share their responses with the class in about 5 minutes.

• Split participants into 4 or 8 groups, with at least 3 but no more than 6 people per group.

• Give the groups 5 minutes of work time before you ask for their responses. During this time, go around to each group and ask if they have questions and how they would intervene in this situation.

*Note: Once students are divided in to groups, give them 4 – 5 minutes to work through the situations. Then, you have ~16 minutes to go through each scenario. You need 2 minutes to cover the last three slides.

Slide 25 and 26: Scenario #1 – Coming Back to Your Room

• PHA read scenario aloud: It is a Saturday night, and you are coming back to your room with some friends to hang out before going your separate ways. As you walk in, you all notice your roommate passed out on their bed. They still have their clothes and shoes on from the day, and they do not open their eyes when you turn on the light. Suddenly, they vomit all over their bed.

• Ask: What are the red flags in this scenario?

• Let them give their answers, and then go to the next slide with the red flags highlighted.

• Cassandra: So, as you all mentioned, some of the red flags here could include that they are passed out, still wearing their shoes, don’t wake up, and vomit on the bed.

• What do you think this scenario is an example of?
  o Answer: Alcohol poisoning

• Okay, so now that we know this is possibly alcohol poisoning, what can you do to intervene?
  o Talking Points, use and phrase as needed:
Delegate: Call 911
- Could respond “tell my RA,” but emphasize that the RA would then just call 911, and it’s better to act fast and call your RA later.
- After the fact, can refer them to the Wellness office, where they can explore their choices around alcohol use in a free, non-judgmental space.

Direct: Roll them on to their side so the vomit does not block their windpipe
- This is a good answer – but they will still need to call 911.

Distract: This is not applicable in this situation. We can mention how we could have used distract earlier in the evening if we had been with them to encourage them to drink less, or even offered to do another activity instead of drinking that night

Slides 27 and 28: Scenario #2 – Corridor-Mate’s Partner
- PHA read scenario aloud: Your corridor is very close this year. You do lots of things together, and almost everyone is present except for one person. They never hang out because they are always with their partner. One night you pass the two of them in the hallway and ask why they never hang out with the rest of you. Your corridor-mate’s partner angrily brushes you off, saying they are super busy. They pull your corridor-mate away mumbling that they are tired of having to come to their stupid building.
- Ask: What are the red flags in this scenario?
- Let them give their answers, and then go to the next slide with the red flags highlighted.
- Cassandra: So, as you all mentioned, some of the red flags here could include that they never hang out because they are always with their partner, their partner is angry and brushes you off, not letting your friend speak to you; and that the partner says they are tired of having to come to their stupid building.
- What do you think this scenario is an example of?
  o Answer: Intimate Partner Violence
- Okay, so now that we know this is possibly intimate partner violence, what can you do to intervene?
  o Talking Points, use and phrase as needed:
    - Delegate: Talk to their RA or their other friends to figure out what to do/gather more information about the situation; refer their friend to the violence prevention specialist or the counseling center.
Direct: When they are alone with their corridor-mate, ask them how they are doing and if they are okay, let them know that they are always there to talk – if they don’t want to talk at that moment, at least they know you are there for them if they ever change their mind.

- Do NOT confront the abuser!

Distract: Could offer to go do another activity with your corridor-mate in the moment or on another day to give them some options of things to do without their partner.

Slides 29 and 30: Scenario #3 – Hateful Speech

- PHA read scenario aloud: *You are working in the Union and you see two young women who are holding hands and obviously in a relationship. Another person starts shouting about "stupid people flaunting their perverted relationship in front of others". The situation is starting to escalate.*

- Ask: *What are the red flags in this scenario?*

  - Let them give their answers, and then go to the next slide with the red flags highlighted.

- Cassandra: *So, as you all mentioned, some of the red flags here could include that the person is targeting these two women based on their sexual orientation, and that the situation is starting to escalate.*

- What do you think this scenario is an example of?
  - Answer: Hate and Bias

- *Okay, so now that we know this is possibly a hate and bias incident, what can you do to intervene?*
  - Talking Points, use and phrase as needed:
    - Delegate: Get help from others noticing the situation, the front desk workers at the union, or the University Police.
    - Direct: Go up to the person harassing the couple and tell them their words are not appropriate and that they need to leave, escort the couple to somewhere they feel safe, ask the couple how they are feeling and if you can help in any way.
    - Distract: Go up to the harasser and ask them for directions or what time it is to give the couple time to leave.
Slides 31 and 32: Scenario #4 – Exam Nerves

- PHA read scenario aloud: As your friend awaits their exam, they express they should have prepared more. They have been so nervous for this final that they haven’t gotten any sleep in 2 nights and have hardly eaten anything. After the test, your friend tells you they were sick to their stomach the entire time. You and your other friends have noticed their distance. When your friend received the score the next day, they are dismayed that it is a D...later that night they tell you that they were so nervous the entire time that they do not think they performed to their best ability.

- Ask: What are the red flags in this scenario?

- Let them give their answers, and then go to the next slide with the red flags highlighted.

- Cassandra: So, as you all mentioned, some of the red flags here could include that they haven’t slept the past two nights and haven’t eaten, felt sick to their stomach, have become withdrawn, and that feelings of nervousness prevented them from doing their best.

- What do you think this scenario is an example of?
  - Answer: Poor Mental Health

- Okay, so now that we know this is possibly a mental health concern, what can you do to intervene?
  - Talking Points, use and phrase as needed:
    - Delegate: Talk to your RA if they live in your building, talk to your professor for the class, recruit your other friends to help.
    - Direct: Ask them if they want to talk, or if you can walk them to the counseling center.
    - Distract: Ask them for coffee and talk about anything besides school to get their mind off of the problem

Slide 33: How to Have a Hard Conversation - PHA

- A lot of the strategies that were suggested as ways to intervene involved talking to someone directly about your concerns for them or the ways that their words or actions were harming others.

- We want to give you some strategies that you could use in some of these conversations to make them more effective and less difficult. As you can see here, an effective one-on-one conversation involves: expressing care and concern for the person, rather than judgement; being specific and sharing your feelings; using ‘I’ statements, such as I feel...; asking questions; and making sure to offer support. Using these strategies can help ensure that the conversation remains constructive rather than confrontational.
Now that you have all learned how to notice an event, interpret that event as a problem, assume personal responsibility, know how to help, and step up, we want to remind you that you all have the power to contribute to our community and make UWL a better place.

Remember, students intervene because it’s the right thing to do, and we are capable of making a difference. Together, we can create a culture of support and wellness on our campus, where it’s normal to care for and step up for others.

If enough time: What questions do you have for us?
If short on time: We will stick around if anyone has any questions, or if you have questions at a later date, your instructor has my contact information!
Thank you all for being here and engaging with us today!
APPENDIX C

INSTITUTIONAL REVIEW BOARD APPLICATION AND APPROVAL
ATTACHMENT A - APPLICATION FOR UNIVERSITY IRB REVIEW
(All submissions must be typewritten) Date September 13, 2018

1. a. Principal Investigator/Project Director (if thesis or undergraduate research project, student’s name):
   Cassandra Worner

   b. Applicant Status: (Check all that apply)
      ☑ Faculty
      ☑ Academic Staff
      ☑ Graduate Student
      ☐ Undergraduate Student

   c. Investigator/Project Director Local Address:
      3333 East Avenue South, La Crosse, 54601

   d. Investigator/Project Director Local Telephone # 651-332-0873
      E-mail: worner_cassand@uwlae.edu

2. a. Title of Proposed Project: Effect of a Bystander Intervention Program on the Bystander Attitudes and Behaviors of First-Year Students at the University of Wisconsin - La Crosse

   b. Project Period: Begin Date: October 1, 2018 End Date: December 12, 2018

   c. If a student project of any type, Faculty Advisor’s Name, Department, and Phone:
      Name: Dr. Lori Reichel
      Department: Health Education and Promotion
      Phone #: 608-785-6787
      E-Mail: lreichel@uwlae.edu

   *Names and Signatures of Thesis Committee Members:*

   Ingrid Peterson ___________________________  Signature: ___________________________
   Name
   Dr. Michele Pettit ___________________________  Signature: ___________________________
   Name

3. If the researcher believes his/her project may be reviewed under expedited procedures (p. 6-9) and/or falls within the exemptible category, (p.4-5) please check the appropriate box(es) below
   ☑ Expedited
   ☐ Exemptible
   a. If expedited, please indicate the number(s) of the categories listed on pages (6-9) 1,2
   b. If exemptible, please indicate the number(s) of the categories listed on pages (4-5) __________

4. By signing this application, I agree to comply with any decisions made by the University of Wisconsin-La Crosse IRB in regard to the above named research project, and or the standards of professional ethics in my field of study.

   Cassandra Worner ___________________________  Date September 13, 2018
   Signature

The IRB has reviewed the above research project and has determined that:

1. ________ APPROVAL IS GRANTED -as submitted or as modified per attached (check one)
   ☑ a. the protocol does not contain procedures which place human subjects at risk, or
   ☑ b. the protocol contains procedures which place human subjects at minimal but acceptable risk, or
   ☐ c. the protocol contains or is likely to contain procedures that may place human subjects at greater than minimal risk; however, the risk(s) are outweighed by the sum of the anticipated benefits of the research.

2. ________ APPROVAL NOT GRANTED

The following IRB members participated in this review:

On behalf of the board:

IRB Chairperson or Coordinator Signature ___________________________  Date ___________________________
1. Purpose: The purpose of this study is to determine the effect of a bystander intervention program on bystander attitudes and behaviors for first-year students at the University of Wisconsin – La Crosse. The research will take place between October 1st, 2018 and December 12th, 2018.

Procedures: Participants will be asked to complete a pre-test survey, participate in an educational intervention, and complete a post-test survey. The educational intervention will take place during one session of scheduled UWL 100 courses, in which no additional time is required for participation in the intervention. Each survey will take approximately 10 – 15 minutes to complete and will be on the Qualtrics platform. The survey will be accessed through a link on participants’ UWL 100 class D2L or Canvas site. Participants will be asked to complete the pre-test survey two weeks preceding the intervention and the post-test survey four weeks after the program.

To encourage completion of the pre- and post-tests, instructors of UWL 100 will be asked to offer students time in class to complete both the pre- and post-tests and/or offer extra credit points to students who complete the surveys. Students would be asked to take a screenshot of the submission confirmation for the survey on Qualtrics to ensure that they could prove that they completed the survey while ensuring that their responses are kept confidential.

Proposed Timeline:

Administer pre-test assessment – two weeks prior to program implementation in UWL 100

Program implementation in UWL 100 – October 25th through November 9th

Administer post-test assessment – approximately four weeks after program implementation in UWL 100

2. Characteristics of the study population and rationale for study participants:

Characteristics of the study population: The subject of this research is first-year students at the University of Wisconsin – La Crosse. These students will be accessed through their enrollment in the course UWL 100. Consent of the instructor has been obtained for all courses to be assessed. Approximately 200 students will participate in the research. These first-year students are generally age 18-19, of normal mental and physical health, and the race or ethnicity of the students is thought to reflect the population of first-year students at the university as a whole.

Rationale for study participants: This particular population is important to assess because it is known that first-year students are particularly vulnerable to the issues of alcohol misuse/illegal consumption, sexual assault and unhealthy relationships, poor mental health, and other issues that are addressed in the bystander intervention program.
In addition, if first-year students can adopt healthier habits and bystander behaviors early on in their college experiences, they will potentially be safer and healthier throughout their time at college (Cantor et al., 2015).

3. **Vulnerable population information:**

N/A, no members of any vulnerable populations will knowingly be asked to participate in the research.

4. **Voluntary informed consent:**

Participants will be able to access an electronic version of the Informed Consent Form (Appendix A) on the first page of the Qualtrics Survey (Appendix B). A copy of the electronic Informed Consent Form will also be available for students to download and save if they so choose. The form will state that by proceeding with the survey, participants are indicating their voluntary, informed decision to participate and certifying that they are 18 years of age or older.

5. **Procedures to ensure the confidentiality of the subjects:**

Information will be collected anonymously, and any demographic information collected will not be linked with any personally identifiable information. All information will be kept confidential through only allowing access to the data to select University of Wisconsin – La Crosse personnel, including Dr. Lori Reichel, Ingrid Peterson, and Dr. Becki Elkins. This research study will be completed in conjunction with the Student Life Office – Violence Prevention, and for this reason the data will be shared with the following individuals:

Dr. Lori Reichel, my thesis chair and a professor in Health Education and Health Promotion, Ingrid Peterson, Violence Prevention Specialist at the University of Wisconsin – La Crosse and Dr. Becki Elkins, professor within Student Affairs Administration.

Ingrid Peterson and Dr. Becki Elkins are both members of the Violence Prevention Advisory Committee working to assess different aspects of violence prevention programming at UWL, with bystander intervention as one piece of this assessment.

Individual surveys will not be shared with UWL 100 instructors, although the instructors will have the opportunity to see the aggregated results of the study. It is expected that the results of this study will be published in scientific literature or presented at professional meetings using grouped data only by Ingrid Peterson, Becki Elkins, Lori Reichel, or myself.

6. **Any anticipated risks and/or inconveniences:**

Minimal to no risk is expected for participants, however, it is important to acknowledge that there is a small chance that due to the nature of the questions on the survey and/or the
content of the presentation, students may remember past experiences of trauma or times they may have failed to intervene. These memories may trigger uncomfortable experiences for students.

The pre-test and post-test surveys should each take between 10 – 15 minutes to complete. The educational intervention will take place during one session of normally scheduled UWL 100 courses, and thus no additional time is required from participants for completion of the intervention.

7. Procedures to minimize potential risks to subjects:

Due to the small chance that these memories may trigger uncomfortable experiences for students, students will be provided with information regarding on-campus resources that could assist them in working through their experiences. Information will be provided for:

Ingrid Peterson, Violence Prevention Specialist within the Student Life Office, 149 Graff Main Hall, ipeterson@uwlax.edu, 608-785-8026

Counseling and Testing, 2106 Centennial Hall, 608-785-8073

8. Potential benefits to participants:

Participants are expected to learn information regarding skills for bystander intervention through their participation in the program. Participants will not receive any direct benefit through the completion of the survey, yet the data provided may help the researchers improve future educational interventions and will thus participation may benefit future students.
INFORMED CONSENT FORM

Protocol Title: Assessing a Bystander Intervention Program for First-Year Students at the University of Wisconsin – La Crosse

Principle Investigator: Cassandra Worner
149 Graff Main Hall
1725 State Street, La Crosse, WI 54601
Worner.cassand@uwlax.edu
(651) 332 – 0873

Dr. Lori Reichel
202 Mitchell Hall
1820 Pine Street, La Crosse, WI 54601
lreichel@uwlax.edu
(608) 785 – 6787

Emergency Contact: Cassandra Worner
Worner.cassand@uwlax.edu
(651) 332 – 0873

Dr. Lori Reichel
lreichel@uwlax.edu
(608) 785 – 6787

• Purpose and Procedure
  o The purpose of this study is to determine the effect a bystander intervention program has on bystander attitudes and behaviors for first-year students.
  o My participation will involve completion of the pre-test survey, participation in the educational intervention, and completion of the post-test survey.
  o The survey should take between 10 – 15 minutes to complete.
  o The survey will take place on the Qualtrics platform, and the survey will be accessed through your UWL 100 class D2L or Canvas site.
  o The educational intervention will take place during one session of a normally scheduled UWL 100 course, and thus no additional time is required.

• Potential Risks
  o Completing this survey may trigger memories of uncomfortable experiences for you. If you need additional assistance after completing this survey, please contact:
• Ingrid Peterson, Violence Prevention Specialist within the Student Life Office, 149 Graff Main Hall, ipeterson@uwlax.edu, 608-785-8026
  
• Counseling and Testing, 2106 Centennial Hall, 608-785-8073

• Rights and Confidentiality
  o My participation is voluntary. I can refuse to answer any question without consequences at any time.
  o I can withdraw from the study at any time for any reason without penalty.
  o The results of this study may be published in scientific literature or presented at professional meetings using grouped data only.
  o Data collected from this study will be aggregated to ensure my identity is anonymous, in which my data will not be linked with personally identifiable information.

• Possible Benefits
  o You will receive information regarding skills for bystander intervention through your participation in the program. You will not receive any direct benefit through the completion of the survey, but the data you provide may help the researchers improve educational interventions and thus your participation may benefit future students.

Questions regarding study procedures may be directed to Cassandra Worner (worner.cassand@uwlax.edu), the principal investigator, or the study advisor Dr. Lori Reichel, Department of Health Education and Health Promotion, UW-L (lreichel@uwlax.edu).

Questions regarding the protection of human subjects may be addressed to the UW-La Crosse Institutional Review Board for the Protection of Human Subjects (608-785-8124 or irb@uwlax.edu).

By completing this survey, you are indicating your voluntary, informed decision to participate and certifying that you are 18 years of age or older.
Certificate Number: 258243.

Date of completion: 10/10/2017.

“Protecting Human Research Participants:”

Cassandra Womar successfully completed the NIH Web-Based Training course

The National Institutes of Health (NIH) Office of Extramural Research certifies that
To: Cassandra Worner  
From: Bart Van Voorhis, Coordinator  
Institutional Review Board (IRB) for the Protection of Human Subjects  
bvanvoorhis@uwlax.edu  
5-6892  

Date: September 24, 2018  
Re: RESEARCH PROTOCOL SUBMITTED TO IRB  

The IRB Committee has reviewed your proposed research project: "Effect of Bystander Intervention Program on the Bystander Attitudes and Behaviors of First-Year Students at the University of Wisconsin – La Crosse."

Because your research protocol will place human subjects at minimal risk, it has been approved under the expedited review category in accordance with 45CFR46, 46.110(a)(b).

Since you are not seeking federal funding for this research, the review process is complete and you may proceed with your project. Remember to provide participants a copy of the consent form and to keep a copy for your records. Consent documentation and IRB records should be retained for at least 3 years after completion of the project.

Please note that this approval is for a one year period only, from the date of this letter. If the project continues for more than 12 months, an IRB renewal must be requested using Attachment C on the IRB website. Please submit Attachment C one month prior to the date on this letter. Continued data collection beyond this date will place your project in non-compliance. The IRB is required to report instances of noncompliance to the Federal Office of Human Research Protections.

Good luck with your project!

cc: IRB File
APPENDIX D

Bystander Efficacy and Bystander Intervention Behavior

Survey
Appendix D: Bystander Efficacy and Bystander Intervention Behavior Survey

An electronic version of the survey can be accessed via the following link:
https://uwlax.ca1.qualtrics.com/jfe/form/SV_aaEx2bvTN6xcqj3
The aim of this survey is to assess confidence and behaviors related to bystander intervention. This survey should take between 10 and 15 minutes to complete.

Please note that your participation is completely voluntary and that you can skip any question that you do not want to answer by clicking the forward arrow. Your responses are confidential and will only be shared in aggregate to ensure your identity is anonymous.

Completing this survey may trigger memories of uncomfortable experiences for you. If you need assistance, please contact one of the following confidential resources:

Ingrid Peterson, Violence Prevention Specialist, 149 Graff Main Hall, ipeterson@uwlae.edu
Counseling and Testing, 2106 Centennial Hall, 608-785-8973

Questions regarding study procedures may be directed to the principle investigator, Cassandra Worner, worner.cassand@uwlae.edu.

Please see the informed consent document on your UWL 100 course page for a more thorough statement of your rights and responsibilities as a study participant. You can also request a copy of the informed consent document by emailing Cassandra Worner.

By completing this survey, you are indicating your voluntary, informed decision to participate and certifying that you are 18 years of age or older.

Please answer the questions as truthfully and accurately as possible. Thank you for your participation.
Please answer the following questions regarding your demographic characteristics.

How old were you on your last birthday?

What is your current year in college?
- First year
- Second year
- Third year
- Fourth year
- Fifth year or above
- Graduate student

What sex were you assigned at birth, on your original birth certificate?
- Female
- Male
- Transgender
- Do not identify as female, male, or transgender

How do you describe yourself?
Which term best describes your sexual orientation?

- Straight
- Gay or Lesbian
- Bisexual
- Transgender, transsexual, or gender non-conforming

How do you usually describe yourself? (Mark all that apply)

- White
- Black or African American
- Hispanic or Latino/a
- Asian or Pacific Islander
- American Indian, Alaskan Native, or Native Hawaiian
- Biracial or Multiracial
- Other

Are you an international student?

- Yes
- No

Are you in a sorority or fraternity?

- Yes
- No
Are you on a sports team?
- Yes, collegiate/varsity
- Yes, intramural
- No

Are you a first-generation college student?
- Yes
- No

Are you a veteran?
- Yes
- No
Please read each of the following behaviors. Rate your degree of confidence that you could perform each behavior by recording a number from 0 to 10 using the scale given below. 0 indicates no confidence and 10 indicates total confidence.

**Confidence You Could Perform the Behavior**

0 1 2 3 4 5 6 7 8 9 10

Express my discomfort if someone makes a joke about a woman's body.

Express my discomfort if someone says that rape victims are to be blamed for being raped.

Call for help (i.e., call 911) if I hear someone in my dorm yelling “help.”

Talk to a friend who I suspect is in an abusive relationship.

Get help and resources for a friend who tells me they have been raped.

Ask a stranger who looks very upset at a party if they are ok or need help.

Ask a friend if they need to be walked home from a party.
<table>
<thead>
<tr>
<th>Behavior</th>
<th>Confidence Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask a stranger if they need to be walked home from a party.</td>
<td></td>
</tr>
<tr>
<td>Speak up in class if a professor is providing misinformation about sexual assault.</td>
<td></td>
</tr>
<tr>
<td>Confront a friend who tells me that they had sex with someone who was passed out or who didn’t give consent.</td>
<td></td>
</tr>
<tr>
<td>Do something to help a very drunk person who is being brought upstairs to a bedroom by a group of people at a party.</td>
<td></td>
</tr>
<tr>
<td>Do something if I see a person surrounded by a group of men at a party who looks very uncomfortable.</td>
<td></td>
</tr>
<tr>
<td>Get help if I hear of an abusive relationship in my dorm or apartment.</td>
<td></td>
</tr>
<tr>
<td>Tell an RA or other campus authority about information I have that might help in a sexual assault case even if pressured by my peers to stay silent.</td>
<td></td>
</tr>
</tbody>
</table>
Please read the situation and estimate the number of times that you witnessed or intervened in the situation over the past 4 weeks.

I heard someone yelling and fighting.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times

Please read the situation and estimate the number of times that you called 911 when I heard someone yelling and fighting.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times
Please read the situation and estimate the number of times that you **witnessed or intervened** in the situation **over the past 4 weeks**.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times

---

Please read the situation and estimate the number of times that you **witnessed or intervened** in the situation **over the past 4 weeks**.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times
Please read the situation and estimate the number of times that you witnessed or intervened in the situation over the past 4 weeks.

I saw someone at a party who had had too much to drink.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times

Please read the situation and estimate the number of times that you witnessed or intervened in the situation over the past 4 weeks.

I asked someone I saw at a party who had had too much to drink if they needed to be walked home so they could go to sleep.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times
Please read the situation and estimate the number of times that you **witnessed or intervened** in the situation **over the past 4 weeks**.

Someone said that they had an unwanted sexual experience.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times

Please read the situation and estimate the number of times that you **witnessed or intervened** in the situation **over the past 4 weeks**.

When someone said that they had had an unwanted sexual experience but they didn't call it "rape" I questioned them further.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times
Please read the situation and estimate the number of times that you witnessed or intervened in the situation over the past 4 weeks.

I saw a woman being shoved or yelled at by a man.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times

Please read the situation and estimate the number of times that you witnessed or intervened in the situation over the past 4 weeks.

I asked a woman who was being shoved or yelled at by a man if she needed help.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times

Survey Powered By Qualtrics
Please read the situation and estimate the number of times that you witnessed or intervened in the situation over the past 4 weeks.

I heard what sounded like yelling and fighting through my dorm walls.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times

---

Please read the situation and estimate the number of times that you witnessed or intervened in the situation over the past 4 weeks.

I knocked on the door to see if everything was ok or talked with a resident assistant or someone who could help when I heard what sounded like yelling and fighting through my dorm walls.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times
Please read the situation and estimate the number of times that you witnessed or intervened in the situation over the past 4 weeks.

I saw someone grabbing, pushing, or insulting their partner.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times

Please read the situation and estimate the number of times that you witnessed or intervened in the situation over the past 4 weeks.

When I saw someone grabbing, pushing, or insulting their partner I confronted them or got help from other friends or university staff.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times
Please read the situation and estimate the number of times that you **witnessed or intervened** in the situation **over the past 4 weeks**.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times

---

Please read the situation and estimate the number of times that you **witnessed or intervened** in the situation **over the past 4 weeks**.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times
Please read the situation and estimate the number of times that you **witnessed or intervened** in the situation **over the past 4 weeks**.

I saw someone's drink get spiked with a drug.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times

---

Please read the situation and estimate the number of times that you **witnessed or intervened** in the situation **over the past 4 weeks**.

I grabbed someone else's cup and poured their drink out after I saw that someone slipped something into it or I said something to the person whose drink was spiked even though I didn't know them.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times
Please read the situation and estimate the number of times that you **witnessed or intervened** in the situation **over the past 4 weeks**.

Someone told me they were sexually assaulted.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times

Please read the situation and estimate the number of times that you **witnessed or intervened** in the situation **over the past 4 weeks**.

I called a rape crisis center or talked to a resident assistant for help after someone told me they were sexually assaulted.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times
Please read the situation and estimate the number of times that you witnessed or intervened in the situation over the past 4 weeks.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times

I suspected someone was in an abusive relationship.

Please read the situation and estimate the number of times that you thought they were in an abusive relationship and let them know that I'm here to help.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times
Please read the situation and estimate the number of times that you witnessed or intervened in the situation over the past 4 weeks.

I suspected someone had been sexually assaulted.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times

Please read the situation and estimate the number of times that you witnessed or intervened in the situation over the past 4 weeks.

I let someone I suspected had been sexually assaulted know that I was available for help and support or shared information with them about sexual assault and violence.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times
Please read the situation and estimate the number of times that you **witnessed or intervened** in the situation **over the past 4 weeks**.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times

---

Please read the situation and estimate the number of times that you **confronted** someone who made excuses for abusive behavior by others.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times
Please read the situation and estimate the number of times that you witnessed or intervened in the situation over the past 4 weeks.

I heard sexist jokes.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times

Please read the situation and estimate the number of times that you witnessed or intervened in the situation over the past 4 weeks.

I spoke up against sexist jokes.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times
Please read the situation and estimate the number of times that you **witnessed or intervened** in the situation **over the past 4 weeks**.

I saw commercials that depict violence against women.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times

Please read the situation and estimate the number of times that you **witnessed or intervened** in the situation **over the past 4 weeks**.

I spoke up against commercials that depicted violence against women.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times
Please read the situation and estimate the number of times that you witnessed or intervened in the situation over the past 4 weeks.

I heard someone explain that women like to be raped.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times

0% 100%

Please read the situation and estimate the number of times that you witnessed or intervened in the situation over the past 4 weeks.

I spoke up when someone explained that women like to be raped.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times

0% 100%
Please read the situation and estimate the number of times that you **witnessed or intervened** in the situation **over the past 4 weeks**.

I heard someone say "they deserved to be raped."

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times

---

Please read the situation and estimate the number of times that you **witnessed or intervened** in the situation **over the past 4 weeks**.

I spoke up when I heard someone say "they deserved to be raped."

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times
Please read the situation and estimate the number of times that you *witnessed or intervened* in the situation **over the past 4 weeks**.

I had a drink with friends at a party.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times

Please read the situation and estimate the number of times that you *witnessed or intervened* in the situation **over the past 4 weeks**.

I watched my drinks and my friends' drinks at parties.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times
Please read the situation and estimate the number of times that you witnessed or intervened in the situation over the past 4 weeks.

I went to a party with friends.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times

Please read the situation and estimate the number of times that you witnessed or intervened in the situation over the past 4 weeks.

I made sure I left the party with the same people I came with.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times
Please read the situation and estimate the number of times that you witnessed or intervened in the situation over the past 4 weeks.

I heard a sexist comment.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times

Please read the situation and estimate the number of times that you witnessed or intervened in the situation over the past 4 weeks.

I heard a sexist comment and indicated my displeasure.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times
Please read the situation and estimate the number of times that you witnessed or intervened in the situation over the past 4 weeks.

I saw a man and his partner get in a heated argument.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times

Please read the situation and estimate the number of times that you witnessed or intervened in the situation over the past 4 weeks.

I asked if everything was ok.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times
Please read the situation and estimate the number of times that you witnessed or intervened in the situation over the past 4 weeks.

I saw a man talking to a woman at a bar. He was sitting very close to her and by the look on her face I could see she was uncomfortable.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times

Please read the situation and estimate the number of times that you witnessed or intervened in the situation over the past 4 weeks.

I saw a man talking to a woman at a bar. He was sitting very close to her and by the look on her face I could see she was uncomfortable. I asked her if she was ok.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times
Please read the situation and estimate the number of times that you **witnessed or intervened** in the situation **over the past 4 weeks**.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times

Please read the situation and estimate the number of times that you **witnessed or intervened** in the situation **over the past 4 weeks**.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times
Please read the situation and estimate the number of times that you witnessed or intervened in the situation over the past 4 weeks.

I saw someone who looked drunk go to a room with someone else at a party.

- 0
- 1
- 2
- 3
- 4
- More than 5 times

Please read the situation and estimate the number of times that you witnessed or intervened in the situation over the past 4 weeks.

I checked in with someone who looked drunk when they went to a room with someone else at a party.

- 0
- 1
- 2
- 3
- 4
- More than 5 times
Please read the situation and estimate the number of times that you witnessed or intervened in the situation over the past 4 weeks.

I heard someone use the words "ho," "bitch," or "slut" to describe women.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times

Please read the situation and estimate the number of times that you witnessed or intervened in the situation over the past 4 weeks.

I challenged someone who used the words "ho," "bitch," or "slut" to describe women.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times
Please read the situation and estimate the number of times that you **witnessed or intervened** in the situation **over the past 4 weeks**.

I heard someone plan to give someone alcohol to get sex.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times

---

Please read the situation and estimate the number of times that you **witnessed or intervened** in the situation **over the past 4 weeks**.

I confronted someone who planned to give someone alcohol to get sex.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times
Please read the situation and estimate the number of times that you **witnessed or intervened** in the situation **over the past 4 weeks**.

I witnessed an activity in which women’s appearances were ranked/rated.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times

Please read the situation and estimate the number of times that you **witnessed or intervened** in the situation **over the past 4 weeks**.

I refused to participate in an activity in which women’s appearances were ranked/rated.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times
Please read the situation and estimate the number of times that you **witnessed or intervened** in the situation **over the past 4 weeks**.

I saw/heard about someone who was hooking up with someone who was passed out.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times

Please read the situation and estimate the number of times that you **witnessed or intervened** in the situation **over the past 4 weeks**.

I confronted someone who was hooking up with someone who was passed out.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times
Please read the situation and estimate the number of times that you **witnessed or intervened** in the situation **over the past 4 weeks**.

I heard rumors that someone forced sex on someone else.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times

Please read the situation and estimate the number of times that you **witnessed or intervened** in the situation **over the past 4 weeks**.

I confronted someone when I heard rumors that they had forced sex on someone else.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times
Please read the situation and estimate the number of times that you witnessed or intervened in the situation over the past 4 weeks.

I heard that someone had committed a rape. (Here, rape is defined as unlawful sexual intercourse or other sexual penetration of another person, with or without force, without the consent of the person).

0 1 2 3 4 5  More than 5 times
0% 100%

Survey Powered By Qualtrics

Please read the situation and estimate the number of times that you witnessed or intervened in the situation over the past 4 weeks.

I reported someone who had committed a rape. (Here, rape is defined as unlawful sexual intercourse or other sexual penetration of another person, with or without force, without the consent of the person).

0 1 2 3 4 5  More than 5 times
0% 100%

Survey Powered By Qualtrics
Please read the situation and estimate the number of times that you witnessed or intervened in the situation over the past 4 weeks.

I saw someone doing things that might meet the definition of sexual assault. (Here, sexual assault is defined as sexual intercourse or sexual contact with person without the consent of that person.)

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times

Survey Powered By Qualtrics
Please read the situation and estimate the number of times that you witnessed or intervened in the situation over the past 4 weeks.

I saw someone trying to take advantage of someone's intoxicated state to have sex with them.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times

Please read the situation and estimate the number of times that you witnessed or intervened in the situation over the past 4 weeks.

I intervened when I saw someone trying to take advantage of someone's intoxicated state to have sex with them.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times
Please read the situation and estimate the number of times that you **witnessed or intervened** in the situation **over the past 4 weeks**.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times

---

Please read the situation and estimate the number of times that you **discouraged** someone from talking about women in sexually degrading ways.

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times
Please read the situation and estimate the number of times that you witnessed or intervened in the situation over the past 4 weeks.

I saw someone possibly committing a sexual assault. (Here, sexual assault is defined as sexual intercourse or sexual contact with person without the consent of that person.)

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times

Please read the situation and estimate the number of times that you witnessed or intervened in the situation over the past 4 weeks.

I interfered with another guy's "action" because I thought it might stop them from possibly committing a sexual assault. (Here, sexual assault is defined as sexual intercourse or sexual contact with person without the consent of that person.)

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5 times
APPENDIX E

INSTRUCTOR AND STUDENT PROGRAM FEEDBACK SURVEY
Appendix E: Instructor and Student Program Feedback Survey

Thank you for inviting me in to your UWLL 100 course to provide bystander intervention training to your students! I greatly appreciate it. It would be incredibly helpful if you could answer the following four questions regarding the program in order to ensure that we are providing the best experience possible to students and instructors in the future.

*Please note, this survey is being administered for program improvement purposes, and thus is not subject to Institutional Review Board approval. You are under no obligation to complete the survey, and may choose to end your participation at any time.

Thank you!

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree</th>
<th>Somewhat disagree</th>
<th>Somewhat agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The information was presented in a respectful and inclusive manner.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The content presented was relevant to my students.</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>My students found the program content useful.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>My students were engaged in the program presentation.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The incentives provided (highlighters, gum) were helpful to encourage participation among my students.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>The scenario provided good practice for my students to apply what they learned from the presentation.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would request this program again when teaching a UWLL 100 course.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information on bystander intervention strategies should be included in all UWLL 100 courses moving forward.</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
What was the most valuable part of the presentation?

What was the least valuable part of the presentation?

What other feedback would you like to provide about the presentation?

We thank you for your time spent taking this survey. Your response has been recorded.