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PILOT STUDY OF SAFE SISTERS: A SEXUAL ASSAULT PREVENTION PROGRAM FOR
SORORITY WOMEN

DISSERTATION

A Dissertation
presented in partial fulfillment of requirements
for the degree of Doctorate of Philosophy
in the Department of Health, Exercise Science, and Recreation Management
The University of Mississippi

By

ALICIA P. CAMBRON

December 2014

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ABSTRACT

Sexual violence is a serious problem that can have lasting, harmful effects on victims and their family, friends, and communities (CDC, 2014). Approximately one in five women will become a victim of sexual violence at some point in their lifetime (RAINN, 2009). College women are at a greater risk for rape and other forms of sexual assault than women in the general population (Fisher, Cullen & Turner, 2000). Sorority women are four times more likely to experience sexual violence compared to other college women (Minow & Einolf, 2009). To date, only one study has assessed a sexual violence prevention program targeting sorority women (Moynihan, Banyard, Arnold, Eckstein, & Stapleton, 2011). The proposed study will assess the outcomes of Safe Sisters, a sexual violence prevention program for sorority women that is based on the Health Belief Model. The study will evaluate Health Belief Model constructs and knowledge, via questionnaires, at two time-points: pre-test and post-test. The Safe Sisters program consists of knowledge of policies and definitions, bystander skill building scenarios, perpetrator stories, survivor advocacy skill building, discussion of benefits and barriers of bystander intervention, and cues to action. The comparison group program will receive a pamphlet with policy information, campus resources, and local resources. Differences in difference linear regression will be used to determine effects on the dependent variables. The primary purpose of this study will be to assess the outcomes of the Safe Sisters program for use on college campuses.

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CHAPTER I

ITRODUCTION

Statement of the problem

Sexual assault is a public health issue on college campuses (McMahon, 2010). College campuses have become somewhat of a hunting ground for sexual predators. In the late 1980's, researchers found that more than one in four women were victims of sexual assault since the age of 14 (Koss, Gidycz, & Wisniewski, 1987). More recently, a Center for Disease Control and Prevention study assessed sexual violence in a sample of 5,000 college students at over 100 colleges. Participants were asked if have they had been forced to submit to sexual intercourse against their will. An alarming 20% of women answered yes (Douglas et al., 1997). Another study found that during a 9-month academic school year, 3% of college women reported surviving rape or attempted rape (Tijaden & Thoennes, 1998). Fisher and colleagues (2000) stated that college campuses have large numbers of women who are at greater risk for rape and other forms of sexual assault than women in the general population. The same study found that for every 1,000 women attending their institutions, there were 35 incidents of rape per academic year. These statistics highlight the need for sexual violence prevention programs, as the health and safety of the student body, females in particular, should be a priority on college campuses. High rates of sexual violence highlight the need for sexual violence prevention programs.

Copenhaver and Grauerholz (1991) suggested that sorority members are at an even higher risk for sexual assault than non-sorority college women. Increased risk may be due to sorority women's connection with fraternity men (Copenhaver & Grauerholz, 1991), alcohol consumption (Mohler-Kuo, Dowdall, Koss, & Wechsler, 2004), or their rape supportive attitudes and beliefs (Kalof, 1993). An example of a rape supportive attitude would be that only promiscuous women or those that drink beyond their limits are assaulted. These attitudes place blame on the victim instead of the perpetrator. Bystander programs have been targeted to college athletes (Foubert & Perry, 2007; Katz, 1994; Kress et al, 2006; Moynihan, Banyard, Arnold, Eckstein & Stapleton, 2010), college freshmen (McMahon, 2010; Kress, Shepherd, Anderson, Petuch, Nolan, & Thiemke, 2006; Rothman & Silverman, 2007), college women (Foubert, Langhinrichsen-Rohling, Brasfield, & Hill, 2010; Hanson & Gidycz, 1993; Sochting, Fairbrother, & Koch, 2004), college men (Langhinrichsen-Rohling, Foubert, Brasfield, Hill & Shelley-Tremblay, 2011; McMahon & Dick, 2011), and fraternity men (Choate, 2003; Foubert, Newberry, & Tatum, 2007; Foubert & Newberry, 2006; Foubert & McEwen, 1998), however, only one has been found that focused on sorority women (Moynihan, Banyard, Arnold, Eckstein, & Stapleton, 2011).

Moynihan and associates (2011) assessed the Bringing in the Bystander program for sorority women. Results indicated that experiment group participants showed increased bystander efficacy, likelihood to help, and responsibility for ending violence. However, there were many limitations of this study. The treatment group consisted of only 30 participants and the control group had 18 participants. Women of the same sororities were assigned to both the treatment and control group. This research design could have resulted in information sharing between sorority women in the same organization. Authors suggested future research with larger

samples of sorority women. An effective theory-based program for sorority organizations as a whole is needed.

The National Association of Services against Sexual Violence (2009) has set standards for sexual assault education and prevention programming and stated that programmers should articulate the theoretical approach that the program is based upon. The theory used should be based on attitude change, skill development, and overall behavior change (Carmody, Evans, Krogh, Flood, Heenana & Ovenden, 2009). The authors stated that the activities used during presentations should have a conceptual link to constructs and an outcome goal in mind (Carmody, Evans, Krogh, Flood, Heenana, & Ovenden, 2009). Most sexual assault programs in the literature refer to the bystander approach (Katz, 1994; Moynihan & Banyard, 2009), learning theories (One in Four, Inc., 2013), or marketing theories (Green Dot, 2010; Potter, Moynihan & Stapleton, 2011) but few have specified the use of a health behavior theory as a framework for the prevention program (Berkowitz, 2002).

Statement of the purpose

The purpose of this study is to assess a sexual assault prevention program for Greek women at the University of West Florida (UWF). This program takes a comprehensive, multimodal, theoretical approach to addressing sexual assault. Components of the comprehensive program include information on UWF policies that address the issue, training on how to be an active bystander, training on how to help a survivor, resources in the community and on campus, and constructing a Greek system that is not conducive to sexual violence in any form. The overall aim of this program is to ultimately decrease sexual assaults in the sorority community at UWF.

Information on sexual assault prevention programs that utilize the Health Belief Model as a framework is scarce. Assessing the Health Belief Model as a foundation for program development will help prevention programmers determine if the model can be a viable framework for future use in these endeavors. Health Belief Model constructs will be measured pre-and post-program to determine the outcomes of the Safe Sisters program.

Definitions

Health Belief Model (HBM): This model is often used in health education and promotion to describe health behaviors. The basis of the HBM is that one's personal factors affect health behavior. There are four main constructs of the HBM: perceived severity, perceived susceptibility, perceived benefits, and perceived barriers, self-efficacy and cues to action (Glanz, Rimer, & Lewis, 2002).

Greek: A member of a Greek-letter fraternity or sorority (Merriam-Webster, 2011).

Panhellenic: Panhellenic is of or relating to the Greek-letter sororities or fraternities in American colleges and universities or to an association representing them (Merriam-Webster, 2011).

NPHC: National Pan-Hellenic Council is the governing body for historical black Greek-letter organizations (National Pan-Hellenic, Inc, 2014).

Sexual violence: Sexual violence is any sexual act that is against one's will. Sexual violence is the umbrella term for a number of offenses, including a nonconsensual sex act (rape), attempted rape, unwanted touching, or sexual harassment. All acts involve a lack of consent, or one who is unable of consent (Basile & Saltzman, 2002).

Rape: Anal or vaginal penetration by hand, finger, or sexual organ without one's consent (Basile & Saltzman, 2002).

Sexual assault: Any type of sexual contact without one's consent. For example: forced sexual intercourse, sodomy, child molestation, incest, fondling, and attempted rape (Department of Justice, 2004).

Hypotheses

H₀1: There is no difference in knowledge scores between the control group and the treatment group from pre-test to post-test.

H₀2: There is no difference in perceived threat scores between the control group and the treatment group from pre-test to post-test.

H₀3: There is no difference in decisional balance scores between the control group and the treatment group from pre-test to post-test.

H₀4: There is no difference in bystander self-efficacy scores between the control group and the treatment group from pre-test to post-test.

H₀5: There is no difference in survivor help efficacy scores between the control group and the treatment group from pre-test to post-test.

CHAPTER II

LITERATURE REVIEW

Sexual assault is a serious public health problem (Center for Disease Control and Prevention, 2012). Approximately 20% of women will experience a sexual assault or attempted assault during their lifetime (Rape, Abuse, and Incest National Network, 2009). The National Crime Victim Survey in 2000 found that approximately 207,000 women were victims of sexual assault or an attempted assault each year (Rennison, 2002). That number equates to approximately one woman every two minutes.

The numbers for sexual assault of college women are even higher than women in the general population. Approximately one in four college women will experience an assault or attempted assault during her college experience (Fisher, Cullen, & Turner, 2000). The National College Women Sexual Victimization study surveyed a random sample of 4,446 college women. The researchers found 3.5% of respondents had experienced rape or an attempted rape during the past six months (Fisher, Cullen, & Turner, 2000). Sorority women, in comparison to non-sorority college women, are four times more likely to become a victim of sexual assault (Minow & Einolf, 2009).

There are a number of factors that can increase one's victimization risk, which include being unmarried, drinking enough to get drunk, and living on campus (Fisher, Cullen, & Turner, 2000). Sorority women can identify with many of these factors. It is also believed that sorority women also have higher rape myth acceptance, which can decrease bystander

behaviors and increase victim blaming (Kalof, 1993). These risk factors will be discussed in greater detail in the following sections, as well as ways to address these factors using prevention education strategies.

Rape Myth Acceptance

Rape myth acceptance is a common construct addressed in multiple sexual assault prevention programs (Bannon, Brosi, & Foubert, 2013; Schwartz & Nogrady, 1996; Kress Kress, Shepherd, Anderson, Petuch, Nolan, & Thiemke, 2006). Rape myth acceptance is described as "attitudes and beliefs that are generally false but are widely and persistently held, and that serve to deny and justify male sexual aggression against women" (Lonsway & Fitzgerald, 1994, p. 134). In simplified terms, rape myths are stereotypical beliefs of the public held towards rape and the parties involved (Horvarth, 2010). According to Lonsway and Fitzgerald (1994), the two most common rape myths are that women lie about being raped and that only certain types of women are raped. The type of women most commonly being referred to are those that binge drink, dress provocatively, or are promiscuous.

Rape myths oftentimes put the burden of the rape upon the victim, instead of the perpetrator. Acquaintance rape, especially if alcohol is involved, often goes unreported because victims blame themselves or do not feel the rape meets the legal definition of rape (Iconis, 2008; Peterson & Muehlenhard, 2004). The acceptance of rape myths leads to a society that is prone to rape, where male aggression is accepted or even celebrated and women are held to blame (Sanday, 1996). If rape goes unreported, perpetrators may continue to assault.

Elite male groups, such as fraternity men and athletes, have been shown to have higher rape myth acceptance, sexual aggression, and support gender roles (Boeringer, 1999; Muren & Kohlman, 2007; Nixon, 1997). Franklin, Bouffard, and Pratt (2012) explained this link through

the Male Peer Support Model. The model has been used to explain the prevalence of sexual abuse of women for all male groups, including fraternities, athletic teams, all male residence halls, or even homogeneous social groups (Schwartz & DeKeserdy, 1997).

Schwartz and DeKeserdy (1997) believed that we live in a patriarchal society, where men are often put in positions of power. The male power influences both social and dating behaviors of men. Also, when personal relationships face trials or struggles, men seek support from their social groups (Schwartz & DeKeserdy, 1997). Research has shown a link between elite male groups and hyper masculinity, group secrecy, sexual objectification of women, and excessive alcohol consumption, which are all linked to sexual assault (Malamuth, Sockloskie, Koss & Tanaka, 1991; Sanday, 1990; Martin & Hummer, 1989). The Male Peer Support Model also addressed that many elite male groups do not experience deterrence from campus authorities for high alcohol consumption or sexual assault, therefore excusing the behavior or even motivating it (Schwartz & DeKeserdy, 1997).

All male elite groups may serve as a catalyst for learning behavior of sexual assault, degradation of women, or other abusive behaviors (Muren & Kohlman, 2007). If this negative behavior is supported or encouraged from fellow members, this produces a "group-think" mentality (Sanday, 1990). Those members who may oppose the behaviors are not likely to confront the issues because of possible negative social consequences, such as being ostracized from the group, which supports conformity to sexual assault (Franklin, Bouffard, & Pratt, 2012). Two factors seen in the Male Peer Support Model have been found to directly affect sexual assault. Those factors are group secrecy and peer pressure for sex (Franklin, Bouffard, & Pratt, 2012).

The Male Peer Support Model is not based solely on fraternity men; however, this population has been shown to have a higher rape myth acceptance (Bleecker & Murnen, 2005; Bannon, Brosi, & Foubert, 2013). Researchers have found that fraternity men are significantly more likely, compared to general college men, to commit or accept sexual coercion (Foubert, Newberry, & Tatum, 2007; Muren & Kohlman, 2007). Through a meta-analysis of 13 studies with more than 3,000 men, Muren and Kohlman (2007) found a significant association between fraternity membership and rape myth acceptance. Also, fraternity membership was significantly associated with sexual aggression. Kingree and Thompson (2013) found that there is a link between fraternity membership and sexual aggression, but it is mediated by high-risk alcohol use.

Researchers have provided support that fraternities represent a group that tolerates, if not encourages or support sexual coercion of women, including fellow Pan-Hellenic women (Copenhaver & Grauerholz, 1991). Given the high perpetration risk associated with fraternity men and their frequent interactions with sorority women, the potential for sorority women to experience assault is alarming. While sorority women are at a higher risk for becoming victims, many do not believe they are at risk at all, especially from fellow Greek members. Two studies found that sorority women believed themselves to be more at risk for stranger assaults than from acquaintances (Hickman & Muehlenhard, 1995; Nurius, Norris, Dimeff & Graham, 1996). Nurius et al. (1996) believe that if women are less aware of red flags or danger cues they may be more likely to become a victim of sexual assault. Since sorority women believe fraternity men are their allies, they may ignore or misinterpret high-risk situations such as excessive alcohol use or sexual coercion (Nurius, Norris, Dimeff, & Graham, 1996).

Alcohol

Alcohol is generally found to be highly associated with the Greek system and a part of the traditions of socializing (Norris, Nurius & Dimeff, 1996). Norris, Nurius, and Dimeff (1996) found that women felt that during Greek parties they were expected to “get wild” and possibly “mash” with someone during the event. Copenhaver and Grauerholz’s (1991) study reported that 41% of the sorority women surveyed had been sexually assaulted or had an attempted sexual assault at a fraternity house. The fact is simple; one cannot consent while under the influence of alcohol. Many Greek parties involve heavy drinking. Sorority women also attend more of these social events than non-Greek women.

Gender Roles

For both genders, affiliation with Greek organizations is associated with traditional male dominant-female submissive attitudes. Fraternity men support traditional gender roles (male dominance and female submission) and also hyper masculinity (Murnen, Wright, & Kaluzny, 2002). Non-sorority women are least likely to subscribe to traditional gender stereotypes (Kalof & Cargill, 1991). Themed parties that focus on male dominance and female submission also help to perpetuate unhealthy behaviors. Some examples of these parties: Office Hoes and CEOs, GI Joe and Army Hoe, Tennis Pros and Golf Hoes. The basic concept of these parties is for men to dress almost normal and women to attend the parties scandalously dressed and are submissive to the men. Thankfully, many colleges have banned these party themes, but at many large Universities where alumni play a large role in the oversight of these organizations and the Greek Life offices play only a small role, organizations have continued these parties. If sorority women believe their role is to be submissive, they may be less likely to report a sexual assault or support survivors.

Programming

Bystander intervention

One's motivation to assault has been studied for years throughout the psychology field. The perpetrator's mind set is complicated and has proven to be difficult to change. Also, there is only a very small percentage, approximately ten percent, of the population that are perpetrators, but they victimize multiple times (Lisak & Miller, 2002). Many rapists are never prosecuted or even reported. When perpetrators have been granted immunity in exchange for a list of past victims, the number of victims ranged from seven to eleven (Lisak & Miller, 2002; Weinrott, & Saylor, 1991). Because of the complexity of the issue, researchers believe that one should focus on the bystanders instead of the potential victims or perpetrators during prevention programming (Banyard, Plante, & Moynihan, 2004; Berkowitz, 2002; Schewe, 2002).

One In Four, Inc.

One in Four, Inc is a non-profit umbrella organization that specializes in sexual assault prevention programming (One In Four, Inc., 2013). This organization, founded by John Foubert, is dedicated to promoting research-based prevention programs. The two programs sponsored by One In Four, Inc. are the *Men's Program* and the *Women's Program*. Foubert's non-profit also serves as a technical assistance program for those who administer one of the two programs on college campuses, high schools, military, or in the community. There are also many student led chapters of One in Four that are supported by this organization. Details on the two prevention programs are detailed below.

Men's Program

A popular sexual assault prevention program is John Foubert's *Men's Program*. The *Men's Program* is an all-male targeted program based on the Belief System Theory and

Elaboration Likelihood Model (ELM). The Belief System Theory proposes that programs should be tailored towards men's self-concept (Grube, Mayton, & Ball-Rokeach, 2010). The belief system theory also allows for prevention programmers to tailor messages to aim at beliefs that are susceptible to change and avoid areas that are resistant to change in order to maximize persuasive effects and gain behavior change (Rokeach, 1968). Foubert used this theory to develop a sexual assault prevention program for men that does not target men as potential perpetrators, because the majority of men do not identify as that. Instead, the *Men's Program* aims to appeal to beliefs that men can be potential helpers (Foubert & Newberry, 2006). Not only are men thought of as potential helpers to intervene during high-risk situations, but also to help survivors who may come to them after experiencing a sexual assault.

The *Men's Program* is also based on the Elaboration Likelihood Model (ELM). The ELM is similar to the belief system theory in that researchers believe that men need to be motivated to hear a message, comprehend the message, and then apply the message as relevant to their lives (Petty & Cacioppo, 1986). The main component of the ELM is involvement: the level at which a participant is able to process information and supporting arguments (Cacioppo, Harking, & Petty, 1981). When one is motivated and able to process a message, elaboration is high (Cacioppo, Harking, & Petty, 1981). Elaboration involves thinking cognitively through means of evaluation, recall, critical thinking, or inferential judgment (Cacioppo, Harking, & Petty, 1981). Use of the ELM as a basis for the *Mens Program*, has resulted in long term attitude and behavior change (Foubert, 2000).

The *Men's Program's* goals are to help men understand how to help women recover from rape, to increase bystander intervention in high-risk situations, and to challenge men to change their own behaviors and influence the behaviors of others (Foubert & Newberry, 2006). The

program consists of a short, 10-15 minute video, where a police trainer describes in detail a sexual assault that was experienced by another male police officer. This video aims to increase apathy towards survivors while also increasing one's perceived susceptibility that men are actually victims too. The use of the real life story may also increase perceived severity of the effects of sexual assault on a victim. A discussion then follows as to how the experience is similar to one in four college women's experience.

Men are also challenged to use bystander intervention strategies to speak up when other men are degrading women, not asking for consent, or taking advantage of a woman. Bystander intervention strategies for alcohol facilitated sexual assaults are discussed along with the prevalence of alcohol in sexual assaults. Another aim of the program is to educate men on how to help a survivor seek assistance or simply provide support and care. At the closing of the program, men are encouraged to brainstorm ways to share the information with other men and consider ways to apply the information gained to their own lives (Foubert, 2011). The *Men's Program* has been shown to decrease rape myth acceptance, likelihood of raping, and increase empathy towards survivors for college men, fraternity men, and even athletes (Foubert & Newberry, 2006; Foubert, 2000; Foubert & Perry, 2007). Foubert and other researchers believe that single sex programs are most beneficial for sexual assault prevention programming (Foubert & Newberry, 2006; Brecklin & Forde, 2001).

Women's Program

Foubert used the *Men's Program* as a foundation to develop a similar *Women's Program*. The *Women's Program* is very similar to the *Men's Program* and even has some of the same goals. Overall, the program focuses on identifying high-risk behaviors, bystander intervention for women, particularly in situations involving alcohol, and how to help a sexual assault survivor.

The goals of the program are to enable women to recognize characteristics of high-risk perpetrators, enable and empower women to intervene in high-risk situations, and to enable women to help survivors recover and gain resources for help (Foubert, Langhinrichsen-Rohling, Brasfield, & Hill, 2010).

Similar to the *Men's Program*, the *Women's Program* uses the ELM model to motivate women to listen to the message and apply it to their own lives. Since women oftentimes do not identify as potential victims, Foubert focuses on how women can aid others. The Women's Program does not use the police training video as a means to increase empathy. The program focuses on red flags of potential perpetrators and ways for women to stop the pre-sexual assault process through multiple bystander strategies (Foubert, Langhinrichsen-Rohling, Brasfield, & Hill, 2010). An evaluation of the *Women's Program* showed an increase in bystander efficacy and willingness to intervene (Foubert, Langhinrichsen-Rohling, Brasfield, & Hill, 2010). The results also showed an increase in willingness to help a potential survivor. Overall, the Women's Program seems beneficial for college women and is one of the only prevention programs that focus on primary as well as tertiary prevention efforts.

Green Dot

Another bystander intervention program is the *Green Dot* program. The *Green Dot* program was developed by Dr. Dorothy Edwards, who previously worked as the Director of the Violence Prevention Office at the University of Kentucky. Her primary efforts were to educate students, faculty, staff, etc... on sexual violence. The program was developed to address the barriers of becoming an active bystander (Coker et al., 2011). This led to a simplified list of three ways to intervene: Direct, Distract, or Delegate.

The work of Rogers (1962) on the Diffusion of Innovation Theory (DOI) helped drive the concept of how active bystanders could influence their peers to support and engage in the same bystander behaviors, thus increasing bystander norms across a community (Coker et al., 2011). DOI is a social science theory used to explain how an idea or product gains awareness and diffuses through a population or society over time (Rogers, 1962). The DOI Theory has been utilized throughout communications and marketing work to determine how to best market products or ideas.

Five categories of people are established through the DOI. Those categories are innovators, early adopters, early majority, late majority, and laggards (Rogers, 1962). Innovators are the first to try new things. They are typically the easiest to get involved in new ideas because they are willing to take risks. The second category is early adopters. Early adopters represent what are often called “popular opinion leaders.” They are typically found in leadership roles and embrace change. Similar to innovators they typically embrace change, but need to be convinced as to why change is needed. The third category is early majority. Those in this category are generally not leaders, but they do adopt new ideas before the average person in the population. In order to adapt a new idea they need evidence the innovation works. The fourth category is late majority. These people are skeptical of change and tend to only adopt change once the majority in the population has proven the success of the innovation. The final category is laggards. Laggards are very conservative with making change and adopting new ideas. This group is the hardest to gain support.

The *Green Dot* program focuses on targeting those who belong in the early adopters’ category. Early adopters or Popular Opinion Leaders (POL) have been targeted using multiple strategies (Dorfman & Maynor, 2006; Wasserman & Faust, 1994; Rogers, 1962). Green Dot has

used the survey method in which opinion leaders do not self-identify, but report whom they consider to be leaders in their community (Dorfman & Maynor, 2006). The Green Dot literature supports the idea that once innovators and early adopters have adopted the bystander intervention strategies, others will follow, similar to the DOI Theory. The *Green Dot* in depth training program also addresses how perpetrators target their victims, especially through the use of manipulation and alcohol. Education on perpetrators helps participants spot potential high-risk situations and hopefully intervene.

The *Green Dot* program is implemented in two phases. The first phase is the short, approximately one hour, motivational speech. This speech was developed to help students connect to the issue of sexual violence, introduce students to simplified intervention strategies, persuade students to take part in bystander intervention, and introduce students to resources on campuses. These persuasive speeches are often delivered at orientation sessions to incoming freshmen, freshmen experience classes, academic foundation classes, and several other avenues. The University of Mississippi uses the *Green Dot* speech to address sexual violence at orientation, as well as for all freshmen in Freshman Year Experience Courses.

The second phase is intensive bystander intervention training. Phase two is conducted in small groups where participants are educated on recognizing high risk situations, barriers to intervening, perpetrators, patterns of perpetration, and implementing bystander intervention strategies. Phase two is intended for the Popular Opinion Leaders (POLs) on campuses. Students and resident assistants, as well as faculty and staff, nominate respected influential students. Those that are nominated more than once are considered to be POLs and invited to the training (Coker et al., 2011). The recruitment of POLs is one main factor that distinguishes *Green Dot* from other bystander programs.

In order to implement *Green Dot* on a college campus, programmers must attend a week-long *Green Dot* training institute. This institute can cost thousands of dollars, which may be a barrier for many college programmers. Each person that plans to implement the *Green Dot* program must attend the training, including students, peer educators, health educators, and resident assistants. As you can see, this program can get very expensive. Although costly, the *Green Dot* program has shown effective at decreasing rape myths and increasing observed, as well as, actual bystander behaviors for college students (Coker et al., 2011).

Bringing in the Bystander Program

The goals of the *Bringing in the Bystander* program are to develop skills for multiple interventions while addressing one's own safety, to increase knowledge and awareness of scope and causes of sexual violence, to increase a sense of responsibility for creating change in one's community related to sexual violence, and to increase recognition of high-risk behaviors along the continuum of sexual and relationship violence and how to respond to it safely and appropriately (Prevention Innovations, 2014). The developer believes that people should be viewed equally, not as perpetrators or victims, but as a community working together to end violence (Banyard, 2008). The *Bringing in the Bystander* program is based on the Community of Responsibility Model which insists that all members of the community have a role to play in increasing pro-social behaviors and decreasing sexual violence (Banyard, Plante, & Moynihan, 2004). Programming that targets men has been studied by multiple researchers and found to be successful (Katz, 1994; Foubert, 2000; Berkowitz, 2003). Banyard and associates (2004) were one of the first groups of researchers to apply bystander intervention programs specifically for women.

Similar to the *Green Dot* program, the *Bringing in the Bystander* program has two versions. The first version is a short, 90 minute program, and the second version is a more in-depth 4.5 hour program. The program consists of multiple components. First, there is an introduction to bystander intervention related to a sense of community and participants' experiences with bystander behaviors in the past (Prevention Innovations, 2014). Then, statistics are used to increase one's reality of the issue and possible susceptibility. The continuum of sexual violence is used to educate students on the reality of the severity of the issue and the impact on a victim. Then, participants discuss and practice bystander behaviors followed by a discussion of the benefits and barriers to those behaviors. While practicing bystander behaviors, the importance of one's own safety is discussed. Also, community resources that may be helpful to a survivor are presented. The program finishes with a signing of the bystander pledge in order to increase one's commitment to taking action. A bystander card, "ABC": Active Bystanders Care is given to each participant to remind him or her of the decision making process and intervention ideas as well as resources.

The *Bringing in the Bystander* program has been evaluated with multiple groups of college students (Banyard, Moynihan, & Plante, 2008; Moynihan, Banyard, Arnold, Eckstein, & Stapleton, 2011; Moynihan & Banyard, 2008). The program was found to be successful at decreasing rape myth acceptance, as well as increasing bystander efficacy and behaviors for all groups. *Bringing in the Bystander* was found to be successful for a general sample of both male and female students (Banyard, Moynihan, & Plante, 2007), a small sample of Greeks and athletes (Moynihan & Banyard, 2008), and a small sample of sorority women (Moynihan, Banyard, Arnold, Eckstein, & Stapleton, 2011). A limitation for the latter two studies is the small sample sizes of subpopulations, athletes, fraternity men, or sorority women.

When assessing effectiveness of the *Bringing in the Bystander* program for sorority women, many limitations exist. First, there were only 30 women in the program group and 18 in the control group. Also, the women were from multiple sororities in the programming group (Moynihan, Banyard, Arnold, Eckstein, & Stapleton, 2011). The authors believe it would be beneficial to have entire sororities in each group instead of a mix of members to decrease information sharing as well as increase participation within each group. All members of the program were new members, which may have affected outcomes as well. Also, chapter leadership underwent the four and a half hour training before new members underwent the 90 minute training. There is no way of knowing whether leadership shared information from the program with said new members. Although there were many limitations, this study provides a framework for future research on bystander intervention and sorority women.

Know your Power

The *Know Your Power* social marketing campaign is used in conjunction with the *Bringing in the Bystander* program. The campaign was developed by faculty, staff, and students at the University of New Hampshire (UNH). The *Know Your Power* social marketing campaign has been evaluated extensively, unlike many other marketing campaigns. Another factor that distinguishes *Know Your Power* is the use of social self-identification (Potter, Moynihan, & Stapleton, 2011). Social self-identification was used to develop content familiar to the target population by staging scenes to look similar to people and situations the target audience would see on a daily basis (Potter, Moynihan, & Stapleton, 2011). Through focus groups, the photographs used for posters, bus clings, and bookmarks were piloted with actual UNH students. These students were able to identify if the students looked like UNH students and how the students would be talking to one another. The templates had empty boxes above each person's

head in the photographs and focus group participants filled in what they believed would be said in their own words. This research process helped to identify issues with participants in the photos as well as background issues with the buildings or locations not comparable to UNH (Potter, Stapleton, & Moynihan, 2008).

After piloting the *Know Your Power* campaign for four weeks, researchers found an increased awareness regarding the problems of sexual violence. Students were more knowledgeable of appropriate bystander behaviors, and students were more willing to act as a bystander if the situation presented itself (Potter, Moynihan, & Stapleton, 2011). Also, students who were familiar with the posters also noted that they had recently acted in a manner portrayed on the posters or images (Potter, Moynihan, & Stapleton, 2011). Overall, the *Bringing in the Bystander* program in conjunction with the *Know Your Power* social marketing campaign shows promising results.

Theoretical Background

National Association of Services against Sexual Violence has set standards for sexual assault education and prevention programming. Theory used should be based on attitude change, skill development, and overall behavior change (Evans, Krogh, Flood, Heenan, & Ovenden, 2009). Activities used during programs should also have a conceptual link to constructs. The Center for Disease Control and Prevention (2012) encourages program planners to incorporate theory into planning, implementation, and evaluation of prevention programs. Many bystander intervention programs use the bystander approach or psychological persuasion theories instead of a behavior change theory (One in Four, Inc., 2013; Potter, Moynihan & Stapleton, 2011; Green Dot, 2010). Although never used to address sexual violence prevention, the Health Belief Model could be used to plan, implement, and evaluate successful health behavior change in the sexual

violence prevention field. How the models can be applied to the sexual violence prevention field, benefits, and limitations of each will be discussed in detail.

The Health Belief Model is the most commonly used theory in health promotion and health education (Glanz, Lewis, & Rimer, 1997). This model has been used to describe behavior change through four main constructs: perceived barriers, perceived benefits, perceived susceptibility, and perceived severity. Two other constructs were added later: cues to action and self-efficacy.

Perceived barriers

Perceived barriers are described as one's view of the obstacles that limit performance of a health action or behavior (Glanz, Lewis, & Rimer, 2002). Many people view barriers as a list of costs/benefits in order to make a decision about acting or not acting. One may view barriers as a danger to one's self, expensive, time-exhausting, or simply inconvenient (Glanz, Lewis, & Rimer, 2002). Barriers can be tangible or psychological costs of taking action as a bystander. Although barriers can be generalized, they are very individual and specific to each situation. Perceived barriers are the most crucial to behavior change (Glanz, Lewis, & Rimer, 2002).

Berkowitz (2009) believes that barriers to acting as a bystander in a risky sexual assault situation fall into one of five categories. The first barrier is social influence. One will observe the behaviors of other bystanders and then make a decision to act or not, based on their reactions to a situation. If one sees that no one else is acting, he or she will believe that nothing must be wrong, or it must not be that bad since no one else is acting. The second barrier is diffusion of responsibility. It is very similar to social influence. One will assume that other bystanders will do something and take responsibility off of oneself. The third barrier is pluralistic ignorance. Pluralistic ignorance is when a bystander perceives one's own view as the minority when he or

she is actually the majority. Prevention experts call this viewpoint the “silent majority” and “vocal minority.” Most often, those who are “wrong,” especially in the sexual violence field, believe they are correct and that everyone agrees with him or her, when in reality they are just more vocal. The same can be seen for sexual activity and alcohol consumption on college campuses (Beiser, 2013). The idea of pluralistic ignorance is somewhat of a foundation for social norm campaigns used around the world where actual norms are voiced and compared to perceived norms. The fourth barrier is one’s fear of embarrassment or non-support from his or her peers. Research shows that one’s opinion of how his or her peers would respond effects how he or she will respond to a situation (Berkowitz, 2009). The final barrier is fear of retaliation from the perpetrator. If a bystander feels that he or she will be retaliated against either physically, emotionally, or simply lack of support from peers or other bystanders, he or she will not take action (Berkowitz, 2009).

When applying perceived barriers to sexual violence prevention, working with organizations and university policies to insure that barriers are decreased and one is supported when attempting to act as a bystander is of crucial importance. This can be seen through many university amnesty clauses which do not punish a student who was drinking underage if he or she wants to report sexual misconduct. The priority is on helping a student who is a victim, not punishing one for drinking.

The barriers mentioned bring about awareness that there is strength in numbers. Unfortunately, it is almost impossible to train all students on bystander intervention because of funding and lack of staff resources. The *Green Dot* Program uses training that focuses on popular opinion leaders (POLs) in the college environment. These POLs have a greater influence than the general population and impact the behaviors of those around them. Once POLs are trained they

return to their social circles and diffuse information. This training method could help decrease many of the above listed barriers, mainly social influence and fear of embarrassment. Greek men and women are often seen as popular opinion leaders on campuses.

Perceived benefits

Perceived benefits are just the opposite of perceived barriers. Benefits, especially in disease related health promotion efforts, are often viewed as one's ability to reduce the threat of contracting a disease or illness. A person should take part in a recommended action if he or she views the outcome as beneficial (Glanz, Lewis, & Rimer, 2002). Perceived benefits have shown to be an effective construct when used to promote health screenings (Turner, Hunt, DiBrezza, & Jones, 2004). For example, those that undergo a colonoscopy or a mammogram view the benefits of early detection as positive enough to take part in the activity. In order for behavior change to take place, one must view the benefits as higher than the costs, or barriers. Once one knows what their barriers are, they are capable of overcoming them and initiating behavior change.

In order to apply the perceived benefits construct to sexual assault prevention, one must be able to identify the benefits of acting as a bystander. We want one to view "empowered bystanders" as McMahon (2010) refers to those who take action, in a positive light. Not as one who is a "cock block," a "tattle-tell," or simply a loser. By using the *Green Dot* programs training of POLs and DOL Theories you can empower those early innovators and popular opinion leaders to act. Once the influential people begin taking action, others will begin the same behaviors. Research shows that if one is viewed to be as part of the majority and not the minority, he or she is more likely to act. Behaviors that are reinforced by a positive result are more likely to happen again in the future. In contrast, those behaviors that are reinforced by a negative result, for example embarrassment or physical harm are less likely to occur again. This

train of thought is supported by Bandura's Social Exchange Theory. The Social Exchange Theory argues that decision making stems from maximizing rewards and minimizing costs (Aronson, Wilson, & Akert, 2007). Rewards do not have to be physical, for example helping someone may: increase the chance that someone will help you in the future, gain approval from others, or simply relieve the stress one perceives from viewing another in distress (Aronson, Wilson, & Akert, 2007). The Social Exchange Theory posits that one will only help, or become an active bystander, when the rewards or benefits outweigh the costs or barriers (Aronson, Wilson, & Akert, 2010). True altruism is assumed to be non-existent if one considers the Social Exchange Theory only, which presumes that one acts for self and not others.

Perceived severity

Perceived severity is one's belief of seriousness of the disease, illness, or condition (Akins, Davis, & Kaufman, 2006). When looking into the medical field, perceived severity is often linked to one's understanding of medical information and knowledge of disease or illness (Akins, Davis, & Kaufman, 2006). If one knows nothing about asthma, they probably will not view it to be as serious as another condition they know more about, for example heart disease. One's view of the difficulties or aftermath of a condition plays a role in perceived severity as well. McCormick-Brown (1999) found that people may have varied views of a same condition, but the difficulties associated with that condition influenced one's perceived severity. For example, if one viewed the flu as being linked to having to miss a week's worth of school or work, the severity may be higher than for those who have sick leave from work. Throughout the Health Belief Model prevention literature, perceived susceptibility, perceived benefits, and perceived barriers are consistently associated with the desired health behavior (Belcher, Sternber,

Wolotski, Halkitis, & Hoff, 2005; Chen et al., 2007; de Wit, Vet, Schutten, & van Steenbergen, 2005; Frank, Swedmark, & Grubbs, 2004; Graham, 2002; Ellingson & Yarber, 1997).

When applying perceived severity to the sexual violence prevention field, it can present difficulties, because sexual violence is not a disease or illness. Although not a disease or illness, sexual violence has been linked to negative impacts on one's physical health, mental health, personal relationships and even academics (Campbell, 2008; Koss, Koss & Woodruff, 1991; Waigandt, Wallace, Phelps & Miller, 1990). Sharing personal stories of survivors may help one understand the true seriousness of sexual assault. There are many training materials and videos that tell stories of survivors struggling with issues throughout one's life and even ending one's life because the lack of support from friends or family. This may help motivate students to take part in bystander intervention in order to decrease the likelihood that similar situations would happen to those he or she cares about.

Foubert's (2013) *Men's Program* is used with many men's groups to help raise awareness of sexual violence and help men understand how sexual assault can truly be devastating for a victim. The main goal of the program is to increase men's empathy and sensitivity to rape. The video of a police officer telling the story of a fellow officer's sexual assault experience is used to increase perceived severity. The story depicted in the video goes in depth of the actual event, which includes the aftermath and treatment from fellow officers and medical workers. Using this method to increase severity and even susceptibility has shown positive outcomes with male college students. The *Men's Program* was successful in helping men understand the severity of rape five months after the program (Foubert & Perry, 2007). The program also helped increase empathy towards female survivors (Foubert & Newberry, 2006). This is important since females are much more likely to be a victim of sexual assault than men

(RAINN, 2009). A similar strategy can be used with survivor stories of females for a female only program.

Does increasing empathy really matter? Empathy has been found to be strongly related to pro-social helping behaviors (Aronson, Wilson, & Akert, 2007). The researchers believe that a person is most likely to take part in behaviors when one experiences empathy for another person in need and able to experience events or emotions with them (Aronson, Wilson, & Akert, 2007). Basically, if one experiences empathy, he is likely to act in an altruistic fashion, regardless of what one has to gain or lose. If one does not feel empathy, social factors, for example peer influence, may come into play and someone will not act (Aronson, Wilson, & Akert, 2007).

Researchers have found that people are more likely to intervene in a risky situation when one views the situation as “severe” or high risk (Saucier, Miller, & Doucet, 2005). A bystander must be aroused enough to step in. Curphy and associates (1998) study of Air Force cadets supports this idea of a threshold of “severity.” They placed participants in a variety of situations where bystanders broke the honor code. The acts ranged in severity from simply stealing soft drinks to physically harming someone. Their findings suggest that there is a certain threshold for bystander intervention that must be met in order for one to take action. When situations involved a possible sexual assault, the threat of physical harm played a large role in one’s view of “severity” (Curphy, Gibson, Macomber, Calhoun, Wilbanks, & Burger, 1998). Other researchers found similar findings. A meta-analysis of bystander intervention literature found that one would not intervene in an argument until it became physical (Fischer et al., 2011). It is important to understand the concept of “severity” and help college students understand that there are severe consequences to sexual assault, whether it is physical or not.

Perceived susceptibility

The next construct of the Health Belief Model is perceived susceptibility (Glanz, Lewis, & Rimer, 2002). Perceived susceptibility is one's view of the risk or chance of acquiring an illness, disease, or a specific condition (Glanz, Lewis, & Rimer, 2002). It is important to point out that even though one may be at a higher risk, it is his or her view of that chance that is important, not actuality of that risk. Increasing one's view of his or her susceptibility has been shown to be successful at increasing condom use in order to decrease HIV transmission (Belcher, Sternber, Wolotski, Halkitis, & Hoff, 2005) and influenza vaccinations (Chen et al., 2007) as well as many other behaviors.

When applying to the sexual violence prevention programming world, one should start with increasing the realization that sexual assault can happen to oneself and the people he may know. Many prevention experts do this by telling personal stories of themselves or those they know. The statistics illustrate that sexual assault is extremely prevalent, but oftentimes college students believe they are still not at risk. Some students may be in the mindset that sexual assault only happens to certain types of people. Using real life statistics for college women, and more specifically sorority women, can help demonstrate the susceptibility for sorority women in college.

Overall, women perceive their risk of assault by a stranger as higher than by an acquaintance (Furby, Fischhoff, & Morgan, 1989; Hickman & Muehlenhard, 1995). Belief that women can control the risk of being assaulted is why risk reduction programs have been so prevalent in past. Examples of risk reduction strategies are (a) watching your drink to make sure someone does not drug you (b) go out in pairs (buddy system) (c) never walk alone at night (d) carry mace or a gun (e) do not dress provocatively or send mixed signals and (f) do not drink

much alcohol. Although risk reduction strategies are great, they are generally protecting college students from assault by a stranger not an acquaintance. Studies have shown that 80-90% of sexual assaults are perpetrated by an acquaintance, or someone the victim knew (RAINN, 2009; Greenfield, 1997). Therefore, risk reduction strategies are only protecting women from approximately 10-20% of stranger rape and not taking into account the larger 80-90% of acquaintance rape.

One research study shows that sorority women are at a higher risk in comparison to non-college women (Nurius, Norris, Dimeff, & Graham, 1996). Another study of sorority women found that even though they are at a higher risk, they believe they are lower risk than women in the general population (Nason, 1995). A reason given for this low perceived susceptibility was one's Greek identity. Sorority women viewed their relationships with fraternity men as "brothers and sisters" and felt secure because of this Greek connection (Larimer, 1992). Sorority women also viewed their fraternity member counterparts as members of an elite social network who would not harm them and viewed fraternity men as top potential partners. The women in the study believed that socials within their Greek community sheltered them from harm. Research shows that members, who lived in sorority houses, are three times more likely to be sexually victimized while intoxicated as the general population of collegiate women who live on campus (Mohler-Kuo, Dowdall, Koss, & Weschler, 2004). In Copenhaver and Grauerholz's (1991) study they found 41% of the sorority women surveyed had been sexually assaulted or had an attempted sexual assault at a fraternity house. Increasing one's perceived susceptibility is crucial in helping one understand their true risks, not only for sexual assault in general, but for sexual assault from acquaintances. Helping students understand that perpetrators are not always strangers, but people

that one may trust and respect helps increase susceptibility views and change one's view of sexual assault (Lisak, 2002).

Self-efficacy

Another construct of the Health Belief Model is self-efficacy. The self-efficacy construct was added to the original four belief components in 1988. Self-efficacy is one's belief in his or her capabilities to successfully organize and execute a particular action required to produce the desired results (Bandura, 1986, 1997). If a person believes that he or she is capable of performing a behavior, they are more likely to do it. Self-efficacy is highly correlated to the other constructs of the Health Belief Model. If one believes a behavior is useful (perceived benefit), but not think he or she is capable of doing it (perceived barrier), one will probably not try the activity (Akins, Davis, & Kaufman, 2006). Increasing self-efficacy decreases one's perceived barriers.

Self-efficacy should be addressed in every aspect of bystander intervention programming in order to decrease sexual assault. The CDC (2013) supports the use of multiple teaching methods and has a skill-based piece to address helping behaviors. Bystander behaviors are not a natural behavior. One must practice how to intervene and even see the benefits play out in order to truly feel comfortable taking action. Practice can take place through scenarios, role-plays, or videos of situations that require a response.

Cues to action

One of the newer constructs of the Health Belief Model is cues to action. Cues to action may be people, things or events that move someone to change their behavior (Akins, Davis, & Kaufman, 2006). An example in the literature used reminder postcards from one's health care provider of a checkup or screening (Ali, 2002). Reminders are used often in the healthcare field

to prompt someone to take action. Other non-tangible cues to action may be media reports (Graham, 2002), conversations or reminders from others, and illness of a family member.

A popular cue to action technique for sexual assault prevention efforts on college campuses is social marketing campaigns. An example is the *Know Your Power* marketing campaign that began at UNH. The campaign included posters on all locations of the campus, including city buses. The posters show actual UNH students taking part in bystander intervention. To my knowledge, this campaign is the only sexual violence social marketing campaign to date that has been evaluated. Evaluation results found that the campaign increased awareness of the problem of sexual violence. Also, students were more knowledgeable of bystander behaviors and were more willing to intervene (University of New Hampshire, 2011). This technique paired with an innovated prevention program can be extremely successful and help spread the word to a larger population whom may not be reached otherwise.

Significance of the Study

This research study is of significance to the sexual violence prevention literature. This study addresses a gap in the literature for theory-based sexual assault prevention programming. Also, this study addresses a gap in literature of sexual violence prevention programming targeting sorority women. This study would be beneficial to the sorority women at the University of West Florida. The hope of this study is to increase sorority women's understanding of the issue of sexual violence and gain useful skills to become an active bystander and survivor advocate. Another expectation of the study is to better prepare sorority women to serve as a resource to survivors of sexual violence. Therefore, this study aims to not only support current sorority women at UWF, but future sorority women as well. To future researchers, this study can

provide baseline information on the utility of the Health Belief Model as a framework for sexual violence prevention for sorority women.

CHAPTER III

METHODOLOGY

This study consists of two phases. The first phase consists of implementation of the program. The second phase consists of assessment of the outcomes of the program in: (a) increasing perceived threat, self-efficacy, and perceived benefits and decreasing barriers, and (b) increasing outcome variables significantly in contrast to the comparison group. The goal is that the program will prove effective and cost efficient, so the program can be offered to all UWF Greeks.

The design was quasi-experimental, non-equivalent groups design. Sorority women are already in a subgroup of their chapters, making it impractical to randomly assign individuals to treatment and comparison groups (Dimsdale & Kutner, 2004). However, the sorority subgroups were randomly assigned to either the experimental or comparison group. Overall, researchers support the use of quasi-experimental designs and suggest they tend to work well in natural settings (Campbell & Stanley, 1963; Schoenfeld, 2006). Rossi and associates (2003) stated that “simple pre-post design is appropriate mainly for short-term impact assessments of programs attempting to affect conditions that are unlikely to change much on their own (p. 290-291).” Therefore, a pre-test post-test design was used in order to assess short term program outcomes at three time points. Pretest was administered to all program and comparison group participants one week before the programming began. Post-test was administered during the week after the program was completed. Both assessment tools were exactly the same. The independent

variables were grouping factor (experiment or comparison), and time (pre and post). The dependent variables were bystander efficacy, survivor help efficacy, knowledge, decisional balance, and perceived threat.

There can be threats to both internal and external validity. Threats to internal validity compromise one's assurance that there is a relationship between the independent and dependent variable (Michael, 2010). In other words, one cannot state a causal relationship exists. Since random assignment was not feasible, a comparison group will be used to increase internal validity (Michael, 2010). Both groups were administered the same pre and posttests, under the same conditions, in order to assure that differences between groups is not due to testing. Threats to external validity compromise one's assurance that results are generalizable to other groups (Michael, 2010). It is not the intent of this project to provide data that are generalizable beyond the target population, therefore external validity was of less concern (Michael, 2010).

Participants

All Panhellenic sorority women at the University of West Florida (UWF) were given the option to participate in the study. There are six Panhellenic sororities at UWF. As of the fall 2013 semester, these six sororities consisted of 387 women. The average sorority has 75.2 members, with the maximum number of members at 85 and the minimum at 11. Demographic information is not currently being collected by UWF. National Pan-Hellenic Council sororities were not included because these organizations have regulations that currently do not allow members to take part in experimental studies.

Sorority presidents were emailed a recruitment letter (See Appendix B). This email asked presidents if they were interested in the study and willing to allow their sorority members take part in the Safe Sister program either in the spring or fall 2014 semesters. Chapter presidents are

in charge of scheduling events and risk management programs for the organizations. The convenience sample included undergraduates who were 18 years or older and enrolled during the study time frame. The preferred sample size was a minimum of four sorority organizations. In order to obtain a power of 0.8, effect size of 0.25, with alpha level of 0.05, 211 participants across the 6 sororities was needed.

Program Development

The program used in this study, titled *Safe Sisters*, was previously developed by the principle investigator. The purpose of this program is to focus not only on bystander intervention strategies, but also how to help someone who has disclosed that she is a survivor of sexual violence. The program is based on aspects taken from the *Women's Program* (Foubert, 2011), *Bringing in the Bystander* (Prevention Innovations, 2014), *Men's Program* (One in Four Inc, 2013) and *Green Dot* (Green Dot, 2010). A breakdown of which aspects were taken from each program can be seen in Table 1.

Table 1. Development of the Safe Sisters Program

Programs	Components used
Men's Program	Empathy-use story telling from past survivors to build empathy. How to help a survivor-detail steps of how to help someone who has been sexually assaulted. Aftermath of sexual violence-address the many ways that survivors may react after a violent act has taken place. Scenarios-use real life stories to build upon bystander intervention techniques.
Women's Program	Frank Video-this video details the real story of a fraternity group that plans sexual assaults upon vulnerable college women. Perpetrator Characteristics-address the beliefs of perpetrators being generalized as scary men and confirm realization that they are normal everyday men.
Green Dot	Barriers/Benefits of intervening-discuss individual and group barriers as well as benefits of taking action as a bystander. Strategies: Direct, Distract, Delegate-discuss multiple methods of bystander intervention Training POL: Sorority women-discuss how sorority women are leaders on campus and in the community.
Bringing in the Bystander	Bystander approach: discuss in detail the bystander approach and the origination of the theory. Community involvement: when addressing bystander intervention utilize the community movement and the role of community members in cultural change. Bystander barriers: discuss common bystander barriers to action.

Safe Sisters theoretical foundation is based on the Health Belief Model (HBM). Each of the six constructs (perceived susceptibility, perceived severity, perceived benefits, perceived barriers, self-efficacy, and cues to action) of the Health Belief Model was used in development of this program. Perceived susceptibility and perceived severity constructs were combined to address overall perceived threat. Self-efficacy was addressed for bystander intervention, as well as helping a survivor. HBM constructs, as well as knowledge, are listed below with a description of how they are addressed within the Safe Sisters program. A summary of the constructs and how Safe Sisters addresses each can be seen in Table 2.

Table 2. Constructs the Safe Sisters Program Addresses.

Construct	Addressed	How Addressed: Safe Sisters
Perceived Barriers	-Barriers to taking action -Personal Barriers -Skill barriers -Educational barriers	-Open discussion of barriers to taking action personal and organizational
Perceived Benefits	-Benefits to potential victim -Benefits to organization -Benefits to personal values	-Survivor stories -Relationship between the issue and organization creed/values
Perceived Threat	-Increase risk of becoming a victim -Increase belief in the outcomes of becoming a victim	-Frank video -Survivor stories -Statistics -Clicker questions that ask for victimization rates -Creativity for a Cause
fSelf-Efficacy	-How to intervene -How to help a friend	-Scenarios for bystander intervention -Role plays for bystander intervention -Role plays for helping a friend -Resources in community and on campus
Cues to Action	-Increase cues in the community -Increase cues in the dorms	-Door Decorations
Knowledge/Awareness	-Knowledge/awareness of sexual violence -UWF Policy -Title IX Policy	-Review definitions of sexual violence, sexual assault, rape, and sexual harassment -Review UWF Sexual Misconduct and Gender Discrimination Policy -Address the role alcohol plays in sexual violence through clicker questions and discussion

Perceived barriers/benefits

Before and after each scenario the group discussed barriers (individual, relationship, or institutional) that may stop one from taking action. Facilitators walked the group through strategies to overcome each barrier and then discussed benefits or consequences of not taking action. Participant's safety was also discussed. We do not want participants to take direct action if harm may be placed upon oneself. The option for referring to campus or community resources were discussed as ways to overcome this barrier.

Perceived threat

Perceived susceptibility and perceived severity were addressed simultaneously as overall perceived threat. First, in order to increase one's belief in actual risk of sexual violence, statistics for all women being assaulted during their lifetime were discussed, followed by statistics specific for women in college. Statistics of how sorority women are at an even higher sexual assault risk in comparison to other college women were also discussed. Reasons as to why sorority women are at a higher risk were then addressed as well as open discussion of why participants believed that risk exists.

Personal stories of past college women who were sexual assault survivors were briefly discussed. In an open format, participants were asked to list possible consequences of becoming a victim of sexual assault. After watching the "Frank" video, participants were asked to think how this event may have affected the victim in the story. Participants were also asked to consider how this event may affect the victim's family or friends. The effects on the perpetrator, his friends, or his fraternity were discussed as well.

Self-efficacy

Bystander self-efficacy

In order to increase one's belief in her ability to take action as a bystander, a list of scenarios was used. One scenario was taken from the Women's program, one from the *Bringing in the Bystander* program, and the other was developed with a group of peer educators at UWF. Each scenario was read and participants were then encouraged to brainstorm ways to take action. The three D's: Direct, Distract, and Delegate were discussed and participants used these strategies as a guide for bystander action ideas. The barriers and benefits of taking action were discussed along with each scenario. Participants were asked to role play these situations with their groups and discuss with the entire group. Participants were also encouraged to share personal stories in which they may have already acted as a bystander.

Survivors help self-efficacy

This section of the program began by addressing myths of survivor actions following a sexual assault. For example, many people believe that survivors must be frantic, hysterical, or sad following an assault. The reality is that survivors may display a variety of emotions. The post-traumatic survivor process was discussed along with tips of how to best help a friend who has just disclosed a sexual assault (RAINN, 2009). It is important for participants to understand this process in order to not victim blame. Local and university resources were discussed in detail, including locations of the services and contacts at each resource. Lastly, participants practiced a role-play in which a sister opens up about a recent sexual assault. Participants were asked how they should respond to multiple statements a survivor could make and how to refer her to local resources.

Cues to action

A Safe Sisters plaque or door decoration was given to each participant that took part in the program. The sorority women at UWF live in residence halls and decorate their doors, oftentimes with sorority related materials. This plaque was tailored to incorporate each sorority's creed, values, and colors into the programs purpose. The women were asked to use this plaque to inform other sisters that they are a safe zone and liaison to resources if needed. The purpose of the plaque is to serve as a cue to action of what it means to be a Safe Sister, and of what the participant may have learned during training. See Appendix A for an example.

Knowledge

The Safe Sisters program began with an overview of Wellness, Counseling, and Health Services at UWF. Participants were asked what they think about when they hear the term "sexual violence." This discussion lead into an in-depth definition of sexual violence. The University of West Florida's sexual misconduct policy, which includes defining terms of consent, was then read and discussed. Drug-facilitated sexual assault was addressed as well as alcohol-facilitated assault and statistics. Participants were then asked to describe the "typical" college sexual assault and surrounding myths. Following this discussion, the "Frank" video was shown. This video has been used in Foubert's *Women's Program*. The "Frank" video depicts a fraternity male's story of how he planned and implemented a sexual assault with the help of his fraternity brothers. Awareness of how sexual assault predators act and their behaviors was then discussed in an open format.

Implementation

Two health educators, a program assistant, a graduate assistant, as well as a peer educator were all trained through a peer education course (HSC 2990-Sex, Booze, and Peer Education) offered at UWF. This course consisted of in-depth discussion and analysis of sexual violence, relationship violence, stalking, media literacy, and alcohol. This course took place during the fall

2013 school year. The facilitators were then trained on the Safe Sisters program during the spring 2013 semester. All components of the program were discussed, activities were practiced, and feedback was received from UWF's Wellness Services' Director. Facilitators then practiced the program in various pairings so that all would be prepared to present any of the co-facilitators, depending on one's availability.

Participants in the treatment group received the *Safe Sisters* program. The comparison group received pamphlets on sexual violence. The pamphlets contained information on local resources, UWF policies, and definitions of sexual violence. These pamphlets were developed by the University of West Florida. The pamphlets were distributed to the comparison group participants by sorority presidents during chapter meetings. Participants in the comparison group will be offered the Safe Sisters program during the fall 2014 semester, after this study is completed.

Program implementation took place during chapter meetings or other times specified by each president. The president of each sorority involved in the study was given pamphlets to distribute to her members at chapter meeting. The Safe Sisters program was implemented for the treatment participants at established meeting locations both on and off campus. Each treatment Sorority received the program separately, so that it could be tailored towards the sorority's creed, values, and purpose. Implementation of *Safe Sisters* took place during a two week time span in April. Facilitators were allowed ninety minutes to implement the program.

Data Collection

Sorority presidents informed fellow sisters that a pre-test survey would be emailed to each member the week prior to the presentation of the Safe Sisters program or the distribution of the pamphlets. The women had one week to complete the survey. Program facilitators and

sorority presidents informed participants that post-test surveys were to be emailed to them the day following the program. Reminder emails were sent via Qualtrics to those who had not completed the survey during both data collections. Although each organization's president decided if the sorority would be administered the Safe Sisters program, each member had the choice not to participate in the study without any penalties.

All data were gathered via a Qualtrics, online survey administered to student email accounts. Qualtrics software insured that all data is stored securely through inscription and password protection (Qualtrics, 2014). An online format was selected instead of paper format for many reasons. First, research shows that respondents may answer more honestly with electronic surveys than with paper surveys or interviews (Boyer & Stron, 2012). The content of the survey was very personal. The intent of using an online format was so that participants would not have to answer sensitive questions during meetings while surrounded by fellow sorority members. Secondly, paper surveys would be costly to print and time consuming to distribute (Sax, Gilmartin, & Bryant, 2003). Online format allows for access to multiple participants more easily and efficiently. A disadvantage of electronic surveys is that the response rate may be higher for paper and-pencil surveys (Handwerk, Carson, & Blackwell, 2000; Matz, 1999; Tomsic, Hendel, & Matross, 2000; Underwood, Kim, & Matier, 2000). Another disadvantage of online surveys is that all participants may not have access to the internet (Gjestland, 1996). This disadvantage can be overcome because all participants should have access to the internet through computer labs and libraries on campus or in their home town. Overall, advantages of the online format outweigh those of paper format.

The first page of the survey instrument consisted of an Informed Consent Form (see Appendix C). The Informed Consent Form outlined participant confidentiality, right to

withdrawal, lack of risk, and all other ethical issues or concerns. In order to confirm agreement, participants were asked to click the forward button if they agreed to take part in the assessment. Participants were allowed to skip any questions they chose to not answer or quit the survey at any time. There were no incentives to take part in the study and also no penalties for opting out. A description of how each construct was assessed is listed below in detail. A summary of all instruments can be seen in Table 3.

Table 3. Instruments Used to Assess Dependent Variables.

Instrument	Measuring	Alpha Level	Items	Example Questions
Decisional Balance Scale	Benefits/Barriers	α : .70 (Banyard, Plante, & Moynihan, 2005)	9	Friends will look up to me and admire me if I intervene. I could get physically hurt by intervening. I could make the wrong decision and intervene when nothing was wrong and feel embarrassed.
Bystander Efficacy Scale	Bystander Efficacy	α : .87 (Banyard, Plante, & Moynihan, 2005).	14	Express my discomfort if someone says that rape victims are to blame for being raped. Speak up in class if a professor is providing misinformation about sexual assault. Criticize a friend who tells me that they had sex with someone who was passed out or who didn't give consent.
Perceived Threat Scale	Perceived Threat	α : .85 (Witte, Cameron, McKeon, & Berkowitz 1996)	6	I am concerned about the likelihood of being sexually assaulted in the near future. It is likely that I will be sexually assaulted in the future.
Survivor Help Scale	Self-Efficacy	α = .87	3	Connect someone to sexual assault resources on campus. Connect someone to sexual assault resources in the community.
Knowledge	Knowledge		6	Most common used drug in sexual assault is _____. According to the UWF Student Code of Conduct, "sexual misconduct" includes (Check all that apply):
<i>Note.</i> Perceived Threat Scale and Survivor Help Scale were developed for this study. Alpha levels were assessed during pilot testing with 30 participants.				

Instruments

Decisional Balance

The Decisional Balance Scale was used to measure benefits and barriers of bystander intervention. This measurement tool was developed to weigh the pros and cons of becoming an active bystander (Berkowitz, 2002). This is a 9-item scale that reflects the positive and negative consequences of being an active bystander when you thought someone may get hurt. For example, *Friends will look up to me if I intervene* and *I could get physically hurt by intervening*. Responses were given on a five-point scale from *not important at all* to *extremely important*. A

total score was obtained by subtracting the “con” item score from the “pro” items score. Higher scores indicated a greater perception of bystander behaviors. When used in a similar sexual assault prevention study, the Conbach’s alpha was .70 (Banyard, Plante, & Moynihan, 2005).

The Decisional Balance Scale can be seen in Appendix A.

Bystander efficacy

The Bystander Efficacy Scale was developed by researchers for a Department of Justice study of college women (Banyard, Plante, & Moynihan, 2005). The scale lists 14 behaviors and asks participants how confident he or she is in performing that behavior. Participants indicate their confidence on a scale of 1 *can’t do at all* to 5 *highly certain can do*. Some example behaviors are *How confident are you that you could do something to help a very drunk person who is being brought upstairs to a bedroom by a group of people at a party?* Scores were tabulated by calculating the mean of the 14 items. Therefore, higher scores indicated higher effectiveness. In a previous study, the Cronbach’s alpha was .87 (Banyard, Plante, & Moynihan, 2005). The Bystander Efficacy Scale can be seen in Appendix A.

Perceived threat

This scale was developed for this study based on the multiple perceived threat scales in the literature. Witte and colleagues used three questions to assess perceived threat of a disease (Witte, Cameron, McKeon, & Berkowitz 1996). Questions included, *I am at risk for getting <health outcome>*, and *It is possible I will contract <health outcome>*. When Witte’s scale was used to address genital warts for college students, Cronbach’s alpha was .85. Champion (1984) used a similar scale to assess perceived threat of breast cancer. This scale also addressed anxiety and prediction of getting the disease; for example: *within the next year I will get breast cancer*, and *I feel my chances of getting breast cancer in the future are good*. In a previous study,

Champion's scale had an alpha level of .78. For this study, questions also assessed one's belief in the risk of being sexually assaulted; for example: *It is likely that I will be sexually assaulted in the future and My whole life would change if I was sexually assaulted.* The previous questions were altered to address sexual violence. During pilot testing, Cronbach's alpha was .74 from a sample of thirty people.

In order to increase validity of the Perceived Threat Scale, the following steps were taken: (a) search the literature for perceived threats scales that may be modified for sexual violence and (b) consult experts in the sexual violence prevention field to establish face validity. A panel of prevention experts (two sexual assault prevent programmers, one sexual assault advocate, and one psychologist) established content validity of the instrument. The Perceived Threat Scale can be seen in Appendix A.

Survivor help efficacy

One's belief in his or her ability to help a survivor of sexual assault was measured using three questions. Three important survivor helping strategies were during the program. Those strategies were: 1) providing local resources, 2) providing community resources, and 3) how to respond when a friend discloses that he/she has been assaulted. Participants were asked, on a scale of 1 to 5, where 1 represents *cannot do* and 5 presents *very confident*, how confident they may be in helping a survivor connect with local resources, community resources, as well as help a survivor that has just disclosed. The scale was developed for this study. A panel of prevention experts (two sexual assault prevent programmers, one sexual assault advocate, and one psychologist) established face validity of the instrument. Face validity was determined by experts reading the measurement and then determining if it provides a good assessment of the

construct (Trochim, 2006). During pilot testing with a sample of 30 people, Cronbach's alpha was .87. The Survivor Help Efficacy Assessment can be seen in Appendix A.

Knowledge

Knowledge of the UWF Sexual Misconduct Policy, the most frequently used date-rape drug, acquaintance rape statistics, rate of false reports, and rate of sexual assault were assessed. In order to assess one's knowledge of the UWF Sexual Misconduct Policy students were asked to identify which sexual acts are included in the policy (sexual exploitation, sexual harassment, non-consensual sexual contact and sexual intercourse). Students were also asked who is not allowed to give consent according to the policy. Identification of all four sexual acts was classified as correct and scored as a 1. Students were asked what they believe the most frequently used date-rape drug is. If students answered correctly, with alcohol it was scored as 1. All other answers were scored as 0. For acquaintance rape, false reports rate, and overall sexual assault rapes, students were asked for percentages. Each question was scored a 0 for incorrect and a 1 for correct. All correct answers were added for a possible total score of 6. The higher knowledge score, the more knowledgeable or aware participants were of sexual violence and UWF policies. The Knowledge Assessment can be seen in Appendix A.

Analysis

The survey responses were imported into the Statistical Package for Social Sciences (SPSS) software for analysis. Differences in Differences linear regression was used to determine treatment effect on outcome variables (bystander efficacy, survivor help efficacy, knowledge, decisional balance, and perceived threat) from pre- to post-test. *Safe Sisters* will be considered a useful educational tool if there is a significant difference in pre-test and post-test scores for each

of the outcome measures between the experimental group and the control group. Descriptive statistics are used to describe the sample.

CHAPTER IV

RESULTS

The purpose of this study was to determine the outcomes of the Safe Sisters: Sexual Violence Prevention Program at the University of West Florida. Health Belief Model constructs were assessed using multiple scales to determine whether the program changed students' attitudes, beliefs, and behaviors towards sexual violence. This chapter includes analysis conducted to determine results of null hypothesis testing. Demographics describing the participants, response rates at three time points, reliability analysis, and descriptive data are also included.

Description of Participants

A total of 282 members of four PanHellenic sorority organizations at the University of West Florida were asked to participate in a survey study. After sorority presidents confirmed organization involvement in the study, two organizations (154 members) were assigned to the Safe Sisters program and two organizations were asked to take part in the comparison group (128 members).

Demographic Characteristics

At pre-test the treatment group consisted of 97 participants. The response rate for the treatment group was 63%. Three participants had missing demographics data. Majority of participants identified as Caucasian (84.5%, n = 82) followed by Hispanic/Latino (4.1%, n = 4), Asian (2.1%, n = 2), Pacific Islander (1%, n = 1), African American (1%, n = 1), and other

(4.1%, n = 4). Participants were from a diverse class rank breakdown with majority identifying as sophomore (35.1%, n = 34), followed by freshman (19.6%, n = 19), junior (28.9%, n = 28), senior (11.3%, n = 11), graduate (1%, n = 1), and other (1%, n = 1). The control group consisted of 79 participants, two of which had missing demographic data. The response rate for the control group was 62%. Majority of participants identified as Caucasian (82.3%, n = 65) followed by Hispanic/Latino (5.1%, n = 4), Asian (2.5%, n = 2), and other (7.6% n = 6). The class rank breakdown was freshman (19%, n = 15), sophomore (34.2%, n = 27), junior (32.9%, n = 26), and senior (10.1%, n = 8), other (1.3%, n = 1).

At post-test the treatment group consisted of 103 participants. The response rate for the treatment group was 67%. Demographic breakdown was as follows: Caucasian (78.6%, n = 81), Hispanic/Latino (10.7%, n = 11), American Indian/Native American (1%, n = 1), African American (1%, n = 1), Pacific Islander (1.9%, n = 2), and Asian (1%, n = 1), other (5.8, n = 6). Class rank breakdown was as follows: (22.3%, n = 23) freshman, (31.1%, n = 32) sophomore, (26.2%, n = 27) junior, (19.4%, n = 20) senior. The control group consisted of 34 participants. The response rate was much lower at 27%. Demographic breakdown was as follows: Caucasian (76.5%, n = 26), Hispanic/Latino (5.9%, n = 2), (14.7%, n = 5) other. Class rank breakdown was as follows: (23.5%, n = 8) freshman, (26.5%, n = 9) sophomore, (32.4%, n = 11) junior, and (17.6%, n = 6) senior.

Examination of the Measures

Once the data set was established, the measures were examined for reliability. Cronbach's alpha for the Bystander Self-efficacy Scale was $\alpha = .88$ at pre-test and .91 at post-test. Reliability for the Survivor Help Efficacy scale was .88 at pre-test and .91 at post-test.

Reliability for the Decisional Balance Scale was .71 at pre-test and .78 at post-test. Reliability for the Perceived Threat Scale was .58 at pre-test and .53 at post-test.

Differences in Differences regression was used in order to determine differences in means between the treatment and control group at two time periods. An interaction variable was developed in order to assess changes due to both time and grouping variables. Participants in the treatment group were coded as one and those in the control group were coded as zero. The pre-test period was coded as zero and post-test period was coded as one. The interaction variable was determined by multiplying the grouping and time variable. If differences are present for the interaction variable at post-test, those differences are a result of the treatment effect.

Group (Safe Sisters program and pamphlet only) and time (pre and posttest) served as the independent variables with 5 outcome variables (knowledge, decisional balance, bystander self-efficacy, survivor help-efficacy, and perceived threat). Overall, there was a significant difference for knowledge ($\beta = 2.09$, 95% CI [1.55, 2.64], $p = .000$), decisional balance ($\beta = .655$, 95% CI [.145, 1.16], $p = .012$), and bystander self-efficacy ($\beta = .343$, 95% CI [.031, .655], $p = .032$). Mean scores for all dependent variables over time can be seen in Table 4.

Table 4. Outcome variable results.

Dependent Variable	Possible Score		Treatment	Control	<i>p</i>
Decisional Balance	4	Pretest	1.81 (n = 91)	1.5 (n = 76)	*.012
		Posttest	2.10 (n = 94)	1.13 (n = 34)	
Knowledge	6	Pretest	2.89 (n = 97)	2.78 (79)	*.000
		Posttest	5.25 (n = 103)	3.06 (n = 34)	
Bystander Self-efficacy	5	Pretest	4.30 (n = 83)	4.36 (n = 73)	*.032
		Posttest	4.43 (n = 91)	4.15 (n = 34)	
Survivor Help-efficacy	5	Pretest	4.33 (n = 92)	4.32 (n = 77)	.062
		Posttest	4.78 (n = 102)	4.31 (n = 32)	
Perceived Threat	25	Pretest	7.93 (n = 91)	8.96 (n = 73)	.703
		Posttest	8.95 (n = 93)	10.33 (n = 33)	
*Significant at $\alpha = .05$.					

Statistical Testing of the First Hypothesis

To address the first hypothesis: There is no difference in knowledge scores between the control group and the treatment groups from pre-test to post-test; the Knowledge Scale was analyzed. The result of the Differences in Differences Regression is to reject the null hypothesis. Statistically significant differences were found between groups, $\beta = 2.09$, 95% CI [1.55, 2.64], $p = .000$. The differences in knowledge scores between post and pre-test were significantly higher

for the treatment group compared to the control. Knowledge was significantly higher for the treatment group at post-test compared to the control group. Knowledge scores over time can be seen in Figure 1. Participants in the treatment group showed a significant increase in knowledge scores for questions pertaining to the use of alcohol as a rape drug and the UWF Sexual Misconduct policy. Knowledge scores can be seen in Table 5.

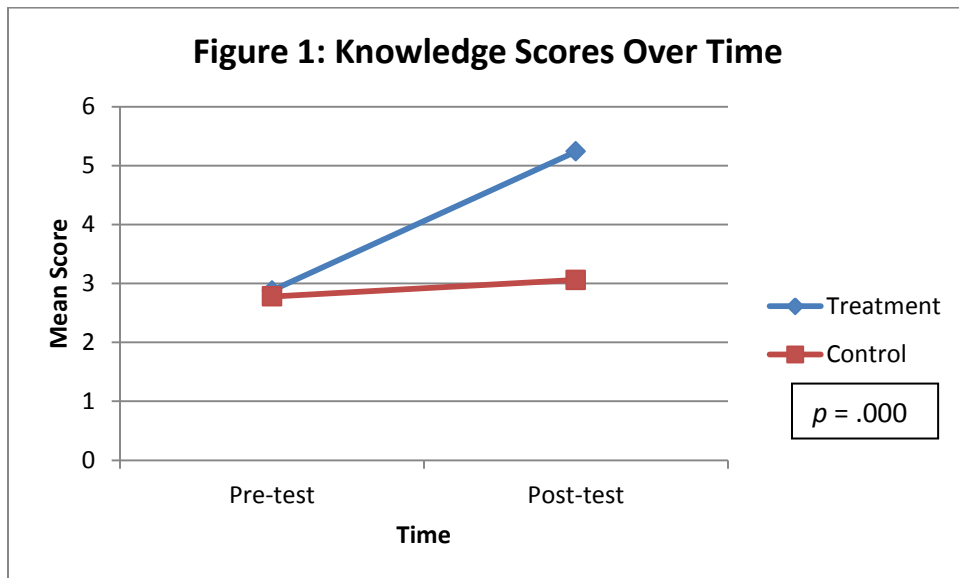


Table 5. Results of the Knowledge Questionnaire.

Questions	Group	Pre-test Correct n (%)	Post-test Correct n (%)
1. The most commonly used drug in sexual assault is <i>alcohol</i> .	Treatment	57 (58.8)	100 (97.1)
	Control	37 (46.8)	15 (44.1)
2. During college, one in 4 women will be sexually assaulted.	Treatment	41 (64.9)	84 (81.6)
	Control	23 (29.0)	12 (35.3)
3. According to the UWF Sexual Misconduct policy, sexual assault includes: <i>a)sexual exploitation b)sexual harassment c)non-consensual sexual contact d)non-consensual intercourse e)I do not know f)other</i>	Treatment	90 (92.8)	103 (100)
	Control	70 (88.6)	29 (85.3)
4. According to the UWF Student Code of Conduct, effective consent cannot be gained by: <i>a) Minors b)Coercion c)Force d) Someone incapacitated e) I do not know f) Other</i>	Treatment	63 (64.9)	95 (92.2)
	Control	57 (72.2)	28 (82.4)
5. Effective consent cannot be gained from: <i>a)minor b)coercion c)force d)someone incapacitated e)I don't know e)other</i>	Treatment	16 (16.5)	80 (77.7)
	Control	19 (24.1)	12 (35.3)
6. According to FBI statistics, the percentage of people who falsely report sexual assault is: <i>A) one half percent lower than other felony crimes. B) two percent, comparable to all felony crimes c) thirty percent, higher than other felony crimes. D) sixty percent, most allegations are ultimately found to be false. E) I do not know. F)other</i>	Treatment	12 (12.4%)	78 (75.7)
	Control	14 (17.7)	8 (23.5)

*Correct answers italicized.

Statistical Testing of Second Hypothesis

To address the second hypothesis: There is no difference in perceived threat scores between the control group and the treatment group from pre-test to post-test; the Perceived Threat Scale was analyzed. The result of the Differences in Differences Regression is to fail to reject the null hypothesis. Statistically significant differences were not found between groups, $\beta = -.341$, 95% CI [-2.16, 1.48], $p = .713$. Perceived threat increased only marginally for both the treatment and control group over time. Perceived threat scores can be seen in Figure 2.

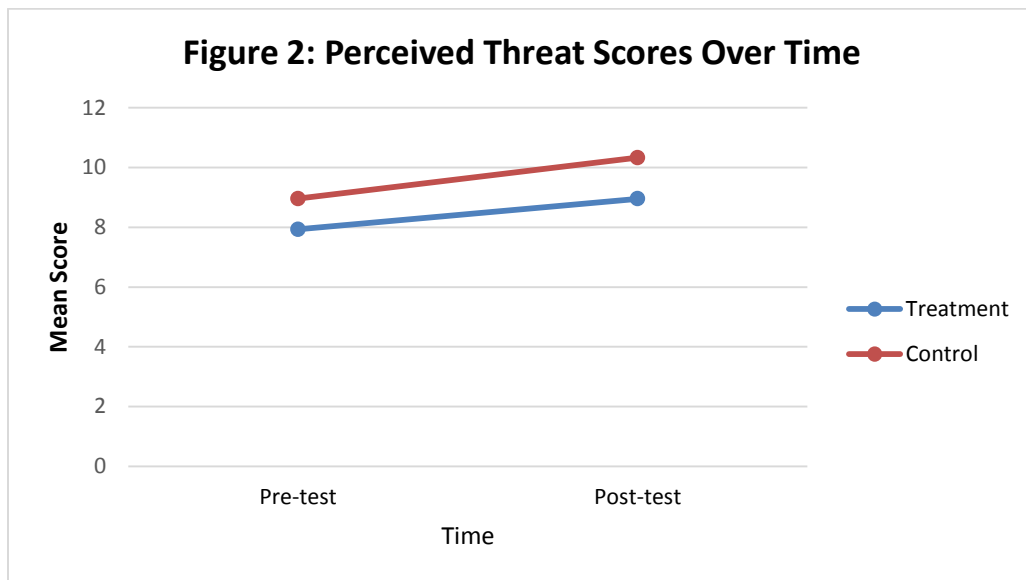


Table 6. Results of the Perceived Threat Questionnaire

Question	Level of Agreement	Group	Pre-test n (%)	Post-test n (%)
I am concerned about the likelihood of being sexually assaulted in the near future.	Strongly Agree	Treatment	6 (6.2)	9 (8.7)
		Control	4 (5.1)	3 (8.8)
	Agree	Treatment	12 (12.4)	25 (24.3)
		Control	20 (25.3)	8 (23.5)
	Neutral	Treatment	20 (20.6)	27 (26.2)
		Control	26 (32.9)	4 (11.8)
	Disagree	Treatment	37 (38.1)	23 (22.3)
		Control	16 (20.3)	3 (8.8)
	Strongly Disagree	Treatment	6	19 (18.4)
		Control	5	1 (2.9)
I feel I will be sexually assaulted sometime during my life.	Strongly Agree	Treatment	3 (3.1)	4 (3.9)
		Control	2 (2.5)	3 (8.8)
	Agree	Treatment	4 (4.1)	10 (9.7)
		Control	5 (6.3)	1 (2.9)
	Neutral	Treatment	25 (25.8)	30 (29.1)
		Control	23 (29.1)	14 (41.2)
	Disagree	Treatment	35 (36.1)	33 (32)
		Control	24 (30.4)	9 (26.5)
	Strongly Disagree	Treatment	29 (29.9)	25 (24.3)
		Control	23 (29.1)	7 (20.6)

$p = .713$

Statistical Testing of Third Hypothesis

To address the third hypothesis: There is no difference in decisional balance scores between the control group and the treatment group from pre-test to post-test. The Decisional Balance Scale was analyzed. The result of the Differences in Differences Regression is to reject the null hypothesis. Statistically significant differences were found between groups, $\beta = .655$, 95% CI [.145, 1.16], $p = .012$. The differences in decisional balance scores between post and pre-test were significantly higher for the treatment group compared to the control. A treatment effect can be seen for the decisional balance variable. Decisional balance scores over time can be seen in Figure 3.

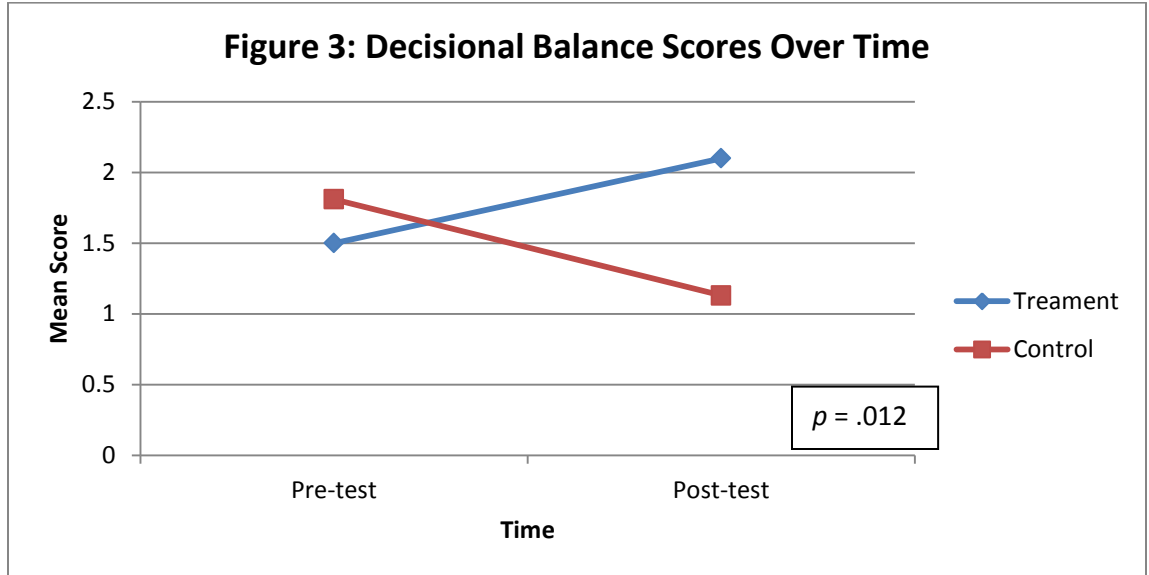


Table 7. Results of the Decisional Balance Questionnaire

Question	Level of Agreement	Group	Pre-test n (%)	Post-test n (%)
If I intervene regularly, I can prevent someone from being hurt.	Strongly Agree	Treatment	35 (36.1)	64 (62.1)
		Control	31 (39.2)	14 (41.2)
	Agree	Treatment	52 (53.6)	28 (27.2)
		Control	34 (43)	14 (41.2)
	Neutral	Treatment	8 (8.2)	8 (7.8)
		Control	9 (11.4)	3 (8.8)
	Disagree	Treatment	1 (1)	1 (1)
		Control	3 (3.8)	3 (8.8)
	Strongly Disagree	Treatment	1 (1)	0
		Control	1 (1.3)	

Statistical Testing of Fourth Hypothesis

To address the fourth hypothesis: There is no difference in bystander self-efficacy scores between the control group and the treatment group from pre-test to post-test; the Bystander Self-efficacy Scale was analyzed. The result of the Differences in Differences Regression is to reject the null hypothesis. Statistically significant differences were found between groups, $\beta = .343$,

95% CI [.343, .655], $p = .032$. The differences in bystander self-efficacy scores between post and pre-test were significantly higher for the treatment group compared to the control. Bystander self-efficacy scores over time can be seen in Figure 4.

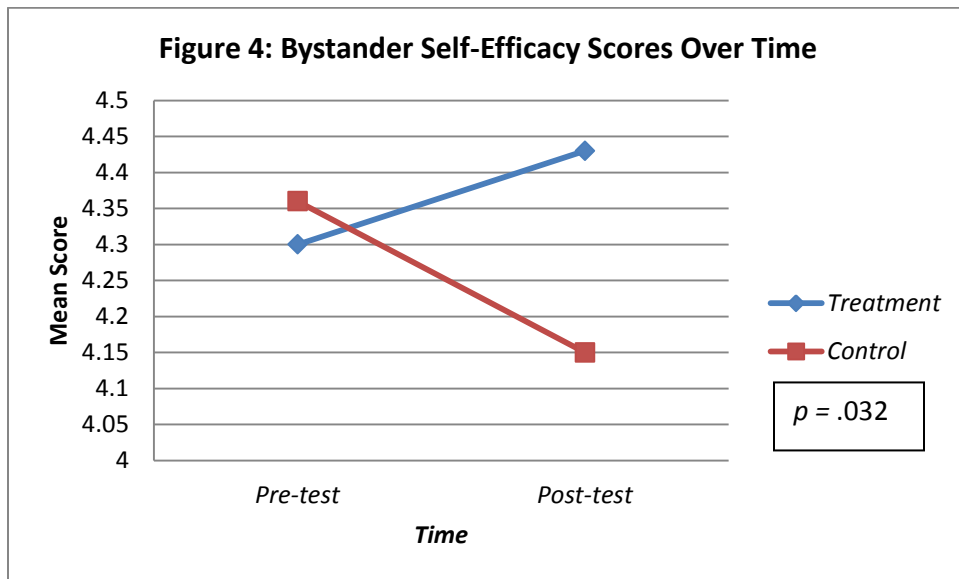


Table 8. Results of the Bystander-efficacy Questionnaire.

Question	Level of Agreement	Group	Pre-test n (%)	Post-test n (%)	
Do something to help a very drunk person who is being brought upstairs to a bedroom by a group of people at a party.	Highly Certain Can Do	Treatment	60 (61.9)	68 (66)	
		Control	45 (57)	20 (58.8)	
	Can Do	Treatment	20 (20.6)	25(24.3)	
		Control	17 (21.5)	7 (20.6)	
	Neutral	Treatment	13 (13.4)	10 (9.7)	
		Control	16 (20.3)	5 (14.7)	
	Cannot Do	Treatment	1 (1)	0	
		Control	0	2 (5.9)	
	Cannot Do at All	Treatment	0	0	
		Control	0	0	
	Ask a friend if they need to be walked or driven home from a party.	Highly Certain Can Do	Treatment	78 (80.4)	82 (79.6)
			Control	61 (77.2)	8 (23.5)
Can Do		Treatment	12 (12.4)	16 (15.5)	
		Control	13 (16.5)	9(26.5)	
Moderately Certain Can Do		Treatment	4 (4.1)	2 (1.9)	
		Control	4 (5.1)	12 (35.3)	
Cannot Do		Treatment	1 (1)	0	
		Control	0	4 (11.8)	
Cannot Do at All		Treatment	0	0	
		Control	0	1 (2.9)	
Ask a stranger if they need to be walked or driven home from a party.		Highly Certain Can Do	Treatment	31 (32)	46 (44.7)
			Control	26 (32.9)	9 (26.5)
	Can Do	Treatment	18 (18.6)	22 (21.4)	
		Control	13 (16.5)	9 (26.5)	
	Moderately Certain Can Do	Treatment	21 (21.6)	31 (30.1)	
		Control	20 (25.3)	7(20.6)	
	Cannot Do	Treatment	18 (18.6)	4 (3.9)	
		Control	11 (13.9)	6 (17.6)	
	Cannot Do at All	Treatment	6 (6.2)	0	
		Control	8 (10.1)	3 (8.8)	
		Control	4 (5.1)	1 (2.9)	

Statistical Testing of Fifth Hypothesis

To address the fifth hypothesis: There is no difference in survivor help efficacy scores, between the control group and the treatment at post-test. The Survivor Help Efficacy Scale was analyzed. The result of the Differences in Differences Regression is to fail to reject the null hypothesis. Although survivor help-efficacy increased over time for the treatment group,

statistically significant differences were not found between groups from pre-test to post-test, $\beta = .356$, 95% CI [-.01, .73], $p = .062$. Survivor help-efficacy scores over time can be seen in Figure

5.

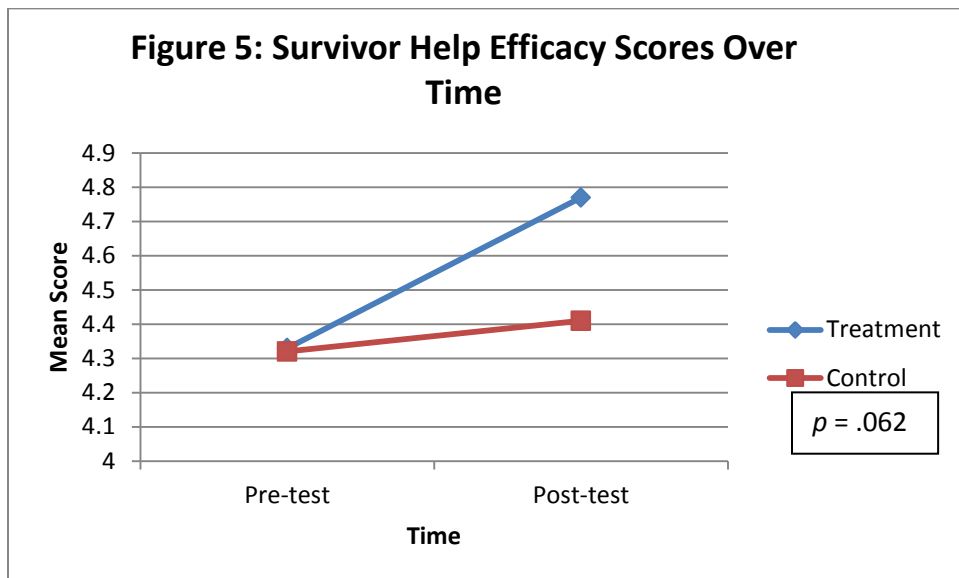


Table 9. Results of the Survivor help efficacy Questionnaire

Question	Level of Agreement	Group	Pre-test n (%)	Post-test n (%)	
Connect a friend to sexual assault resources on campus.	Highly Certain Can Do	Treatment	61 (62.9)	88 (85.4)	
		Control	54 (68.4)	23 (67.6)	
	Can Do	Treatment	18 (18.6)	9 (8.7)	
		Control	8 (10.1)	6 (17.6)	
	Moderately Certain Can Do	Treatment	9 (9.3)	5 (4.9)	
		Control	10 (12.7)	2 (5.9)	
	Can Not Do	Treatment	3 (3.1)	1 (1)	
		Control	4 (5.1)	2 (5.9)	
	Can Not Do At All	Treatment	2 (2.1)	0	
		Control	1 (1.3)	0	
	Connect a friend to sexual assault resources in the community.	Highly Certain Can Do	Treatment	54 (55.7)	85 (82.5)
			Control	47 (59.5)	18 (52.9)
Can Do		Treatment	18 (18.6)	11 (10.7)	
		Control	10 (12.7)	9 (26.5)	
Moderately Certain Can Do		Treatment	17 (17.5)	6 (5.8)	
		Control	12 (15.2)	4 (11.8)	
Can Not Do		Treatment	3 (3.1)	1 (1)	
		Control	8 (10.1)	2 (5.9)	
Can Not Do At All		Treatment	1 (1)	0	
		Control	54 (55.7)	0	
Know how to help a friend who has just been sexually assaulted.		Highly Certain Can Do	Treatment	47 (48.5)	85 (82.5)
			Control	42 (53.2)	17 (50)
	Can Do	Treatment	22 (22.7)	10 (9.7)	
		Control	18 (22.8)	7 (20.6)	
	Moderately Certain Can Do	Treatment	22 (22.7)	7 (6.8)	
		Control	15 (19.0)	7 (20.6)	
	Can Not Do	Treatment	2 (2.1)	0	
		Control	2 (2.5)	1 (2.9)	
	Can Not Do At All	Treatment	0	0	
		Control	0	0	

Summary

Overall, all five outcome variables (knowledge, perceived threat, decisional balance, bystander self-efficacy, and survivor help efficacy) increased initially after the Safe Sisters program. Knowledge, decisional balance, and bystander self-efficacy were the only outcome variables that were statistically significant at post-test follow up. Although survivor help efficacy was not statistically significant, the changes in confidence levels were notable. A discussion of these results is presented in the next chapter along with limitation, implications, and recommendations for future research.

CHAPTER V

DISCUSSION

This study was conducted in order to determine the outcomes of the Safe Sisters program. A discussion of the results is included in this chapter as well as limitations, implications, and recommendations for future research.

Implications

Despite limitations, this study provides important implications for the sorority community. The study advocates for Safe Sister training of other organizations, if only to increase knowledge and one's view of the benefits of bystander intervention' in helping a possible victim of sexual violence. As seen in Table 5, knowledge of the use of alcohol as a date rape drug increased from 58.8% correct to 97.1% correct. The more that women begin to understand the relationship between alcohol and sex as well as threatening cues for sexual violence, the more likely they are likely to resist or stop a sexual violent act from occurring (Turchik, Probst, Chau, Nigoff, & Gidycz, 2007).

Intoxicated rape victims are more likely to be blamed for their assault than sober victims (Cameron & Stritzky, 2003). If sorority women are aware that alcohol may be used as a rape drug, they may be less likely to blame a sister who was assaulted while drinking. If victims are blamed for their assault, they are less likely to move forward with the judicial process or justice system (Hanly, Healy, & Scriver, 2009). The participants in the treatment group showed greater understanding of the UWF Sexual Misconduct Policy. If one understands what actions are

covered in the misconduct policy, she may be more likely to report an incident or encourage a fellow sister to report. These changes in knowledge may not seem grandiose, but could be small steps in changing the culture or reporting and victim blaming. Reporting is the most effective tool in preventing sexual violence (RAINN, 2009).

In previous violence prevention studies of the *Women's Program* (Foubert, Langhinrichensen-Rohling, Brasfield, & Hill, 2010) as well as the *Bringing in the Bystander Program* (Brasfield & Hill, 2010), bystander efficacy was found to be significantly greater after the program. As expected, the Safe Sisters program found similar results. Those in the treatment group were more confident in one's ability to act as a bystander in multiple situations as can be seen in Table 8. When participants were asked if they were confident to take action when a intoxicated person was being brought upstairs to a bedroom during a party, a notable 66% of participants in the treatment group were highly certain they would take action. This action is important, because 90% of sexual assaults involve the use of alcohol and often take place at a party or residence of the victim or perpetrator.

Another interesting finding was participants' response when asked at post-test if they would help a friend or a stranger who is intoxicated and may need a ride home from a party. When asked about helping a friend, 79.6% of those in the treatment group said they were highly certain they could take action, whereas only 23.5% of those in the control group would. When compared to helping a stranger, only 44.7% of those in the treatment group were highly certain they could take action and only 26.5% in the control group. These findings are not shocking, but still point out that participants may need more education on bystander intervention strategies that keep one out of danger and allow for delegation of help (NSVRC, 2014). The Green Dot strategy focuses not only on strategies to directly intervene but also on ways to delegate to the victim's

friends, your friends, a bartender, or others (Green Dot, 2010). The Campus SaVE Act requires that universities and colleges are educating students on safe and positive options for bystander intervention (ACE, 2014). Although the bystander strategy was addressed during the Safe Sisters program, scenarios could focus on how to help strangers instead of only your sisters as well as safe alternatives to direct intervention.

Although bystander self-efficacy was significantly different at post-test, survivor help efficacy was not. Survivor help efficacy scores were only one point away from the maximum score for both the treatment and comparison groups. The data shows that these sorority women were confident in their ability to help survivors and serve as a liaison to resources both on campus and in the community, prior to the educational intervention. Although the Safe Sisters program did not significantly increase one's self-efficacy, there was an increase for the treatment group post-program. The treatment group increased in confidence levels for connecting a friend to resources on campus by 23% post-program. Similarly, the treatment group increased in confidence of connecting a friend to resources in the community by 27% post-program. Finally, participants also increased confidence in knowing how to help a friend that comes to them after being sexually assaulted by 34%. Although these changes were not statistically significant, one's ability to help a survivor greatly increased after the program. One's support of survivors and ability to serve as a liaison to resources can greatly impact a survivor's healing and recovery process post-assault (NSOPW, 2011).

When considering the decisional balance variable, research shows that one will take action if risky situations present themselves because the benefits to taking action outweigh the barriers (Berkowitz, 2003) . In order to decrease victimization rates for sorority women, one needs to be confident in taking action and possess the knowledge or how to do so safely

(Banyard, Plante, & Moynihan, 2005). Throughout the Bringing in the Bystander program, the researchers focus on not only the benefits of taking action but how your role as a community member reinforces these positive actions (Banyard, Plante, & Moynihan, 2005). The Safe Sisters' program is promising in helping sorority women develop skills that aid in member's ability to take action. Participants in the treatment group increased decisional balance and also enabled sisters to have an open dialogue about the issue of sexual violence and how important being an active bystander was to their organization. Both sororities in the treatment group were able to relate bystander action to their own creed and values as an organization.

Frequency scores in Table 7 show that the greatest increase in benefits can be seen for question one "If I intervene regularly, I can prevent someone from being hurt." Many participants in the treatment group strongly agreed at pre-test (n = 35, 36%). At post-test that percentage increased by almost 30% (n = 64, 62.1%). After the Safe Sister's program only 1% of treatment group participants strongly disagreed with this statement. Through skills training and scenarios, participants were able to discuss how their actions can help a sister or a fellow friend. Approximately 80% of treatment group participants also believed at post-test that sorority members should play a role in keeping everyone safe. Hopefully, these benefits will continue to outweigh the barriers of taking action as a bystander.

Recommendations

The time frame of the study should be altered to control for community and campus events on similar topic areas to ensure outcomes were dependent upon programming only. Also, a time span that enables researchers to assess long-term change would be beneficial. Backsliding effects, or results converting back to the norm, may have taken place after the one-week follow

up time period. Gaining an understanding of when backsliding begins can aid program planners in developing marketing campaigns or booster sessions to maintain positive change over time.

Future research should assess actual bystander behaviors instead of self-efficacy. The sole purpose of bystander intervention programming is to increase bystander behaviors, not simply one's belief that she can take action. In order to determine true effectiveness of the program, behaviors should be assessed at a long term follow up, allowing time for opportunities to engage in bystander behavior. A follow-up qualitative study would be useful to assess the utilization of survivor help skills as well. Asking participants if they have used any of the information gained during Safe Sisters, and if so how could lead to a true understanding of what information was most and least useful for participants.

If behavior is assessed and not intention, the Health Belief Model's effectiveness could be evaluated. The Health Belief Model was developed years ago in order to improve health behavior. Research is very limited however, on the effectiveness of its utility in the development or design of interventions and then the effectiveness of those interventions (Jones, Smith, & Llewellyn, 2013). In a systemic review of HBM based interventions, many successes were unrelated to HBM construct being addressed (Jones, Smith, & Llewellyn, 2013). Although the use of theory in future research studies is strongly encouraged, an understanding of the utility of the HBM versus other health behavior models and theories would be useful for health educators in the field of program development.

As seen in Table 5, many participants are still in need of further education on consent and laws that surround the meaning of consent. Before the program, less than 25% of participants in both the treatment and control group knew what groups are considered protected classes and are not capable of giving effective consent. After the program, the treatment group increased

immensely (77%), but there were still some which did not answer correctly. Since consent is the deciding factor in whether or not a sexual assault has occurred, it is vital that students understand consent and the protected classes whom cannot consent under any circumstance. Not only is consent education needed, but it is currently the law. The Campus SaVE Act requires that students are educated on the issues of consent in sexual relationships (ACE, 2014). This is considered a primary prevention that many believe may lead to a decrease in sexual victimization rates (ACHA, 2008). Safe Sisters program addressed this issue, but findings suggest that further discussion is needed to gain complete understanding of not only the law, but the consent and communication process.

A portion of the program focused on addressing the fact that sorority women are at an increased risk for sexual violence and that the after effects of an assault may be damaging. The results showed that this aspect of the program might not be important in increasing positive beliefs or attitudes. As seen in Table 6, although sorority women are at an increased risk for sexual violence, they still do not believe that the risk will affect them. Majority of participants were neutral when asked if they believed they were at risk for sexual assault in the future. Health promotion programs have begun to phase out scare tactics because they do not seem to change one's behavior long term. Since other program aspects showed greater significance, perceived threat could be removed and more focus placed upon helping behaviors or preparing to take action as a bystander.

Clearly, future research with the membership of sororities should include a much larger sample from a number of postsecondary institutions representing geographical as well as racial and ethnic diversity. In the present study, majority of participants identified as Caucasian and only PHC sororities were allowed to participate. Likewise, conducting the study over a number

of years would determine if changes in behaviors are present and if they persist over time. Also, whether “boosters” are helpful to maintain the changes seen from educational programs over time. In addition, one of the goals of future research in this large, multiyear study would also include a measure of victimization to determine if, over the long term, victimization rates go down or reporting of sexual violence increases. This would help demonstrate whether bystander intervention provides a protective effect to other members of sororities. Although the focus of this pilot study was on sororities, research is needed on the role of fraternity culture in facilitating men’s violence against women (including their sorority “sisters”). The potential for fraternity men to be engaged in prevention efforts is needed. Based on the results of this study, using a Greek tailored bystander program may be a helpful way for both fraternities and sororities to work to make the campus community a safer place for college women.

Limitations

There are a number of limitations to the current study. In particular, there were significant errors in study design and methodology. The survey instrument was anonymous, meaning that no identifying information was collected from participants. This limitation restricted the researcher’s ability to match participants from the pre-test group to the post-test group and follow individuals over time. This study design error limited statistical capabilities when analyzing the data. An Analysis of Variance Analysis (ANOVA) is the ideal statistical tool for this research study. ANOVA can identify not only differences between group, but also differences within groups. Since there were two organizations in both the treatment and comparison groups, there may have been variability within the group, which could not be identified with the Differences in Differences analysis. For future studies, participants should be matched in order to determine not only outcome differences, but also effectiveness due to the

Safe Sisters program. Anonymity is very important to sorority organizations; therefore, participants could be matched by non-identifying questions. For instance, participants could be asked their shoe size, number of siblings, birth month, or other characteristics but still remain confidential.

The study time period coincided with sexual assault awareness month, in which many awareness campaigns, marketing outreach, campus and community events may have contributed to an increase in awareness for the topic as well as increased knowledge about sexual violence as a whole. The perceived threat scale showed low internal consistency, which may indicate that the scale is not accurately assessing perceived threat. Although this scale showed good psychometric properties during pilot testing, alpha levels were much lower with a larger sample size. This scale was also developed for this study, therefore further research on how to properly measure perceived threat is needed.

Summary

This study was designed to determine the outcomes of the Safe Sisters program for sorority women at the University of West Florida. The results indicate statistical significance in participants' knowledge and decisional balance. The results suggests the utility of a Health Belief Model based program on the improvement of one's positive view of taking action as a bystander, one's confidence in performing bystander behaviors, and one's knowledge of UWF policies and sexual violence as a whole. These findings will aid in advocating for continued programming with sorority women and even encourage booster sessions throughout the semester. The Safe Sister's program is only the second program to date that has focused not only on primary prevention of sexual violence but also tertiary prevention and help of survivors during recovery. This study also contributes to the literature regarding sexual violence prevention programming

for sorority women as well as the development of a program based on the Health Belief Model constructs.

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LIST OF APPENDICES

APPENDIX A

Measurement tools

Bystander Efficacy Questionnaire

Please read each of the following behaviors. Indicate how confident you are in performing each behavior.

	Can Not Do at All (1)	(2)	Moderately Certain Can Do (3)	(4)	Highly Certain Can Do (5)
Criticize a friend who tells me that they had sex with someone who was passed out or who didn't give consent.					
Do something to help a very drunk person who is being brought upstairs to a room by a group of people at a party.					
Get help if I hear an abusive relationship in my dorm or apartment.					
Tell an RA or other campus authority about information I have that might help in a sexual assault case even if pressured by peers to stay silent.					
Express my discomfort if someone makes a joke about a woman's body.					
Express my discomfort if someone says that rape victims are to blame for being raped.					
Call for help (i.e. Police, RA, Friend) if I hear someone in my residence hall yelling for help.					
Talk to a friend who I suspect is in an abusive relationship.					
Get information for my friend who tells me they have been raped.					
Ask a stranger who looks very upset at party if he/she needs help.					
Ask a friend if they need to be walked or driven home from a party.					
Ask a stranger if they need to be walked or driven home from a party.					
Speak up in class if a professor is providing misinformation about sexual assault.					

Perceived Threat Questionnaire

Please indicate your level of agreement with each statement.

	Strongly Disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly Agree (5)
My chance of being sexually assaulted in the next few years is great.					
Being sexually assaulted would damage my relationship with my significant other.					
I am concerned about the likelihood of being sexually assaulted in the near future.					
My whole life would change if I was sexually assaulted.					
I have other problems more important than worrying about sexual assault.					
It is likely that I will be sexually assaulted in the future.					

Decisional Balance Questionnaire

Each statement represents a thought that might occur to a person who is deciding whether or not to help someone who may be in trouble. Please indicate how important each of these statements would be to you if you were considering intervening in a situation where you thought someone might get hurt.

	Not Important All (1)	Slightly Important (2)	Moderately Important (3)	Very Important (4)	Extremely Important (5)
If I intervene regularly, I can prevent someone from being hurt.					
It is important for all sorority members to play a role in keeping everyone safe.					
Friends will look up to me and admire me if I intervene.					
I like thinking of myself as someone who helps others when I can.					
Intervening might cost me friendships.					
I could get physically hurt by intervening.					
I could make the wrong decision and intervene when nothing was wrong and feel embarrassed.					
People may think I'm too sensitive and overreacting to the situation.					
I could get in trouble and make the wrong decision about how to intervene.					

Survivor Help Efficacy Questionnaire

Please read each of the following behaviors. Indicate how confident you are in performing each behavior.

	Cannot Do at All (1)	(2)	Moderately Certain Can Do (3)	(4)	Highly Certain Can Do (5)
Connect a friend to sexual assault resources on campus.					
Connect a friend to sexual assault resources in the community.					
Know how to help a friend who has just been sexually assaulted.					

Knowledge Questionnaire
1. The most commonly used drug in sexual assault is <u>alcohol</u> .
2. During college, approximately one in <u>4</u> women will experience sexual assault.
3. According to the UWF Student Code of Conduct, "sexual misconduct" includes (Check all that apply)
a. Sexual exploitation
b. Sexual harassment
c. Non-consensual sexual contact
d. Non-consensual sexual intercourse
e. I do not know.
f. Other _____.
4. According to the UWF Student Code of Conduct, effective consent can not be gained by:
a. Minors
b. Coercion
c. Force
d. Someone incapacitated
e. I do not know.
f. Other _____.
5. What percentage of sexual assaults is committed by someone the victim knew (0-100%)?
6. Based on FBI statistics, the percentage of people who falsely report sexual assault is _____.
a. One half percent lower than other felony crimes.
b. Two percent, comparable to all felony crimes.
c. Thirty percent, higher than other felony crimes.
d. Sixty percent, most allegations are ultimately found to be false.
e. I do not know.
f. Other _____.

Demographics Questions	
-------------------------------	--

1. How would you classify yourself?	
--	--

a. White/Caucasian	
--------------------	--

b. American Indian/Native American	
------------------------------------	--

c. Black/African American	
---------------------------	--

d. Pacific Islander	
---------------------	--

e. Hispanic/Latino	
--------------------	--

f. Asian	
----------	--

g. Other _____	
----------------	--

2. How would you classify your class rank?	
---	--

a. Freshman	
-------------	--

b. Sophomore	
--------------	--

c. Junior	
-----------	--

d. Senior	
-----------	--

e. Graduate	
-------------	--

f. Other _____	
----------------	--

APPENDIX B

Recruitment Email

Recruitment Email

Dear XXX Chapter President:

I am writing to let you know about a new prevention program Wellness Services has developed. The program is called Safe Sisters. The purpose of Safe Sisters is to help sorority women decrease the myths about sexual assault, become active bystanders in the community, and help a sister who may have been assaulted or in an abusive relationship. The program is specifically for sorority women and will be tailored towards your sorority's creed and values. We are piloting this program, as it has not been implemented on a college campus at this point. The Safe program could be implemented as a part of your organizations risk management requirement. We are more than willing to tailor the program to address any issues you believe your organization may be facing.

We will begin offering this program later in the semester to half of the UWF sorority women. We will randomly select 3-4 sororities to take part this semester and 3-4 for the Fall. I wanted to know if your organization may be interested. If you are still interested, you would need to agree to take part in the pre/post/and follow up surveys. This survey will take approximately 10 minutes and will be sent via Qualtrics to your member's UWF email account. If you are not interested in the program, but would still be willing to have your sorority take part in the study that would be great as well.

Please let me know if you are interested or have any questions at all. We will be randomly selecting sororities at the beginning of next month. I hope your organization will take part in this great program initiative at UWF!

Thanks,

Alicia Cambron
Health Education Coordinator
Wellness Services
University of West Florida
Phone (850) 473-7112
acambron@uwf.edu
www.uwf.edu/wellness

APPENDIX C

Consent Form

Consent Form

The purpose of this research is to assess the Safe Sisters program. I am asking sorority women to complete this electronic survey. More specifically, you will be asked to answer a few short questions about your opinions and attitudes towards certain topics. Please feel free to be open and honest.

The potential benefits of this study are to help develop tailored programming for UWF sorority women. The risk of participating in this survey is possibly experiencing emotions of past events. It will take about 10 minutes to complete the survey. Your responses will be automatically compiled in a spreadsheet and cannot be linked to you individually. All data will be stored in a password protected electronic format. The results of the study will be used for scholarly purposes only.

By clicking on the next arrow below you acknowledge that you have read this information and agree to participate in this research. You are free to withdraw your participation at any time without penalty.

If you have any questions, feel free to contact Alicia Cambron at 850-474-2512.

[Click Here to Move to Next Page and Accept](#)


APPENDIX D

Program Materials

Pamphlet

WHAT IS THE UNIVERSITY POLICY ON SEXUAL ASSAULT?

The university will not tolerate violence, including sexual assault or the threat of violence to students, faculty, or staff. Sexual battery is a felony and will be prosecuted by the State of Florida. A student accused of sexual battery can also be disciplined under the Code of Student Conduct. Sanctions up to and including expulsion can be imposed. Pending the outcome of legal and disciplinary proceeding, every effort will be made to insure that the victim and the accused do not have to interact in classes or in residence hall settings. University policy regarding sexual assault is presented in more detail in the *Student Handbook*.



The information in this brochure is available in an alternate format upon request.

WHAT SHOULD I DO IF I HAVE BEEN SEXUALLY ASSAULTED?

The first thing people usually want to do is take a hot shower, douche, not talk to anyone, and try to eliminate every trace of what happened. However, acting on these natural feelings may prevent police from finding or prosecuting the person who assaulted you. The following steps will allow you to keep your options open until you decide what to do:

- ▲ **Get medical attention immediately.** Specially trained staff members at Baptist Hospital will carry out the exam needed for possible prosecution. You should also be examined for internal or other injuries, sexually transmitted diseases, or pregnancy that may result from rape.
- ▲ **Do not bathe, douche, or brush your teeth.** These are the things you most want to do, but they will destroy evidence of an assault.
- ▲ **Save your clothing.** It is best not to change clothes. If you do change, save all the clothes you were wearing in a paper bag.
- ▲ **Report the incident to the police.** This is your choice, but it may be the first step toward recovery, and it may prevent another assault on you or someone else.



WHERE CAN I GET HELP?

There are people who can help you deal with what has happened while you take steps toward recovery. If you have been assaulted, it is important that you receive assistance and support to help you regain control over your life. Listed below are offices and agencies that can offer assistance.

Medical Assistance:

▲ **Baptist Hospital Emergency Room (434-4811).** The staff at Baptist Hospital is specially trained to work with victims of sexual battery, and this is the only facility in Escambia County

at which the staff is trained and equipped to gather evidence of sexual assault.

▲ **UWF Health Center (474-2172).** The Health Center can provide emergency health care Monday-Friday from 8:30 a.m. until 4:30 p.m.

▲ **Emergency Contraception.** There is a 72-hour period of time following an assault in which emergency contraception will be effective to prevent pregnancy. Emergency contraception can be obtained from the UWF Health Center, the Community Health Care Center (478-9660), or your private physician.

Police Assistance:

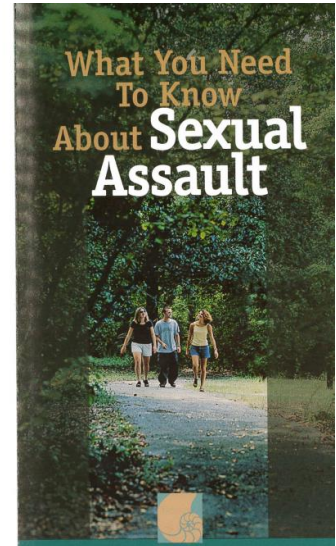
▲ **UWF Police (474-2415).** You can also call 911 if you need emergency assistance on or off campus. If you have been sexually assaulted or think you have been assaulted, the police can help you regarding your rights and legal options. Victim advocacy services may also be obtained through UWF Police.

Counseling Services:


▲ **Counseling Center (474-2420).** The Center is located in Bldg. 19, and psychologists are on call 24-hours-a-day to help with emergencies as well as during regular office hours Monday through Friday. The results of a sexual assault are usually traumatic and may affect your state of mind, your ability to cope with school or work, your relationships with others around you, and your ability to participate in many normal activities. The staff of the Counseling Center can help you take steps toward recovery.

▲ **Rape Crisis/Trauma Center (433-RAPE).** Provides a telephone hotline and personal counseling to rape victims and their families.

▲ **Student Affairs (474-2384).** The Office of Student Affairs provides assistance to students who are victims of crimes or violations of the Code of Student Conduct. Questions about victim's rights and information regarding the disciplinary process and procedures should be directed to this office, located in Bldg. 21.



What You Need To Know About Sexual Assault



University of West Florida

Talking Points for the Safe Sister's Presentation

Safe Sisters Welcome

Today we are going to present a program called *Safe Sisters*. We hope to share some information with you today that will empower you to help your sisters reduce their risk for experiencing sexual assault and to help your sisters recover from it in case it does happen.

Icebreaker

Why do you decide to join your sorority? (Let participants share their reasons—We will refer back to these throughout the program).

Wellness Services

Today we are representing Wellness Services. For those of you who may not know, we are located in Building 960, across from the gym and tennis courts.

Our focus areas are: Sexual Assault Prevention, Sexual Health Promotion, Alcohol and Other Drugs, Stress and Sleep. We have many programs that focus on harm reduction techniques as well as overall health and wellbeing of students here at UWF.

Massage Chairs-We also have free massage chairs located downstairs in Building 960. (Point to the photo on the screen). These massage chairs are free for UWF students. You simply have to make an appointment and watch a short instructional video. Some students are beginning to make weekly appointments before or after class to help with tension during midterms.

Campus Wide Training and Events-Wellness Services offers many campus wide training on our topic areas as well as community events. Our two biggest events are Take Back the Night, which will be April 3rd. This event, as many of you may know focuses on raising awareness of sexual assault as well as other forms of violence and offers a platform for survivors in our community to share their experiences. Rock Out the RedZone is another annual event held during Argo Arrival week. These events focus on raising awareness of the redzone during the first few weeks of the semester.

Peer Educators

A large part of what Wellness Services offers UWF students is implemented by our peer educators. Peer Educators travel to national conferences (Bacchus and Gamma), take part in large events on campus, plan and implement programs in residence halls, and even implement training of UWF organizations. UWF Peer Educators are leaders on campus and educate students on health promotion and risk reduction strategies. By being a UWF Peer Educator you can gain leadership experience and even have a full time job on campus. Let us know if any of you are interested in becoming a peer educator for the Fall 2014 semester.

Group Rules and Expectations

Take care of yourself. If at any time you need to take a break, use the restroom, get water or a snack, please do so.

Suggested group rules:

Personal experiences discussed here stay here

Respect those around you and their experiences

Any to add?

Safe Sister Training Goals

We have developed the following goals for this training:

To help you better understand the issue of sexual violence and UWF's policies.

To demonstrate increased self-efficacy regarding bystander intervention.

To help you respond to a friend who has been sexually assaulted.

This will not be everything you need to know about sexual violence but should be a good introduction to the subject.

Sexual Violence

What do you think of when you hear the term "sexual violence?"

Okay, rape is (read definition). What's the most important word in this definition?

FEMALE! This means legally only women are raped. This does not mean, however, that only women ARE raped...

Sodomy, sexual battery, and aggravated sexual battery are additional forms of sexual assault.

Sexual violence- Umbrella term for unwanted sexual attention, contact, or both. Sexual contact without consent. Sexual harassment – may or may not include physical contact. Today we will be focusing on sexual assault.

The legal term for sexual assault/rape in the state of Florida is Sexual Battery.

It is defined as oral, anal, or vaginal penetration by, or union with, the sexual organ of another or the anal or vaginal penetration of another by any other object when consent is not given.

What's an object? Oral sex: giving/receiving? Finger?-(Seville- is that sexual assault).

Coercion- Violent vs nonviolent. Put out of get out, forcing someone to drink more, abuse of power, making someone vulnerable. Physically helpless means unconscious, asleep, or for any other reason physically unable to communicate unwillingness to an act. If you are under the influence= legal definition of sexual assault. Does this mean in a relationship? Can it happen in a relationship?

Clicker question

What is the defining criterion in determining whether or not a sexual assault has occurred? Use of force, Lack of Consent, Saying NO, Resisting with force/fighting back

There are many myths about what constitutes rape. Most people think about the act of rape involving physical violence where the victim is battered, bruised. This does happen but not the majority of the time (only about 25% of the time does it involve physical/violent/battering.

People think that in all rape situations people will resist with force but because of the many dynamics involved in the majority of rape situations, most people actually don't resist with force or even say NO. Because of this the law does not state that people must do either of these things. If in this situation, and it will not further jeopardize your safety, it is a good idea to say no very clearly and with force and to physically resist, but

Also there is often a freeze response – want to say no or fight back but freeze and can do nothing

Rather than asking it a question of resistance, the law centers on whether there is agreement so the correct answer is Consent....how do we know if a person has consented? They say YES. In order to say YES, what has to happen first (a question must be asked)

In order to get consent we have to ask for it and get it! Use of verbal skills, body language, not saying no does not equal a yes.

Consent and UWF's policy

According to UWF's Sexual Misconduct Policy:

Consent, to be valid, must meet the following: Freely and actively given, mutually understandable words or actions, Consent to one form of sexual activity can never imply consent to other forms of sexual activity. Consent is not the lack of resistance; there is no duty to fight off a sexual aggressor. Consent can be withdrawn at any time, as long as the withdrawal is clearly communicated by the person withdrawing consent through words or actions. A person shall not physically or verbally coerce another person to engage in any form of sexual conduct, to the end that consent as defined above is not given.

A person shall not knowingly take advantage of another person who is under 18 years of age, mentally defective, under the influence of prescribed medication, alcohol or other chemical drugs, or who is not conscious or awake, and thus is not able to give consent as defined above.

Clicker Question

Have you or anyone you know ever been the victim of a sexual assault? Yes, No, Maybe I'm not sure, I would not exactly call it sexual assault.

Do the math w/ the room.... ____% of people in this room answered _____

Be respectful of the issue...we don't know each other's history. We don't know how people are answering yes to this question.

For those who answer 4 ---you are not alone; there is confusion in identifying what SA is. We will define it a little further today and talk about what we can do to prevent it and how to respond.

Statistics

As you can see from the response on the last slide, sexual assault is far too common in our society. Approximately 1 in 4 women will be a victim of sexual assault during college. Approximately 1 in 5 women will be a victim of a sexual assault during her lifetime.

Clicker Question

What is the most common date rape drug? Roofies, GHB, Alcohol, Ecstasy

90% report that one partner was doing drugs or drinking alcohol, YET most people do not think about alcohol as a rape drug. We have been brainwashed to be blind to this issue. We have bought the marketing line that alcohol leads to great mutually consensual sex with no regrets and certainly no rape.

Clearly promoting sex under the influence is a common practice and one that maintains rape culture. Further, alcohol plays a large component in our next issue as well. Victim blaming practices.

Alcohol marketing photos

Messages about alcohol and sex are everywhere. Many of them sexually objectify people (both men and women...predominantly women though) which also influences sexual assaults, especially when alcohol is around.

What do these images say to you....what do they normalize?

Typical Sexual Assault

Now lets talk about what the "typical" sexual assault looks like. How has sexual assault or rape been portrayed on television? On the news? Is it a stranger? Is there a weapon used?

Frank Video

There has actually been a lot of research done on men who rape-both those who rape strangers and those who rape women they get to know. We are going to show you a video where a college guy is interviewed by a college professor who studies men who rape. This college guy is actually an actor, but he is reading-word for word- the transcript of an interview with a real person on a campus who set up a woman for rape. The woman never reported the rape, so of course he never got in trouble.

In this case the rape happened in a fraternity, but it could have happened almost anywhere on campus. This video is a few years old, but we hope you will pay attention and see how it relates to stuff we address today. Of course it talks about rape, which can be upsetting. Again, you can leave any time. After this brief video, we will discuss key points.

I'm sure we all agree that what Frank did was wrong, his choice, his responsibility, and his fault. It was also the shared responsibility of the others in his organization who supported him. The first-year woman he raped was certainly in no way at fault.

Research shows that men who rape actually plan things out much as Frank did in this video. As the researcher said at the end of this interview, we can all learn a lot from Frank's language. He uses words like prey, target, and staked out to describe what he did. He uses these words to dehumanize his victim. Like most men who rape, Frank shows that he views women as sexual objects to be conquered, coerced, and used for his own desires. Frank also showed no empathy for his victim.

Frank doesn't believe it when women say no to sex. He also makes light of the violence he used, even cutting off her breathing. Like most men who rape, Frank used only as much violence as was needed. He did not see anything wrong with what he was doing. Most men who rape do not use a weapon. They tend to use alcohol deliberately so that women will be easier to take advantage of.

This video helps us see little more clearly some red flags to watch out for in the type of guy who targets women for rape. You can see how open Frank was about what he did to this woman. We hope that we can give you some tactics to better prepare you to help yourself or friends if you encounter a similar guy to Frank.

Clicker question

How many sexual assaults are committed by an acquaintance? 80%, 65%, 45%, 33%, 25%, 10%

False Stereotypes of perpetrators

Actually, an alarming 80% of rapes are committed by an acquaintance or someone that you may know. Not a stranger or creepy man in the bushes as often portrayed throughout television. As stated earlier, perpetrators do not often use weapons (guns, knives) or physical force and brutally injure their victims. There tends to be two trains of thought about perpetrators:

All rapists are sick, crazy, deranged – not respectable, credible, or likeable

Otherwise: "Nice guy" Drank too much, Miscommunication, Won't happen again, "She must have regretted it the next day"

Photo examples: Ched Evans –welsh football player said all women "wanted" him and he took women home every night. Steubenville, Ohio students Trenton Mays and Malik Richmond. Debbi LaFave: High school teacher. Arrested for sexual battery of a 14 year old student. Her lawyer stated that " placing Debbie in to FL state penitentiary, to place an attractive young woman in that kind of a hellhole, is like putting a piece of raw meat in with the lions."

False Stereotypes of victims

We also similarly have false stereotypes about victims. All victims: Fight back, Hysterical, Report to law enforcement immediately, suffer visible injuries, and have never reported a sexual assault in the past.

Common Responses to Sexual Assault

Survivor recovery from sexual assault is greatly impacted by three variables: individual variables/pre-assault functioning, specifics of the event, and environment (particularly the responses of law enforcement and loved ones.)

Aftermath of sexual assault

When sex isn't consensual, the aftermath can be devastating to the victim-survivor both inside and outside the classroom.

Victim-survivors may experience: anxiety/fear, difficulty in their relationships (i.e. family, friends, dates), drop in GPA, transfer/drop out of school.

Acute Distress/Severe Anxiety may also take place after an assault. This may result in confusion, multiple fears (death, rapist, situations), depression (helplessness/hopelessness), anger, guilt, loss of self-esteem, thoughts of suicide, and other dysfunctional behaviors.

How a Chapter Responds

How do you respond, as a chapter?

What if the accused party is a member of a fraternity you're friends with?

What can the chapter do in order to best respond to a sexual assault?

Qualities in an Ally

What makes a good ally for someone who may have been assaulted? What are potential barriers for allies? (Write these on the board or flip board.)

Responding as a Safe Sister

Believe them- It doesn't matter if the assault fits GT's definition, the legal definition or your personal beliefs. What matters is that the person feels violated. Fewer than 2% of the cases reported are found to be false reports.

Reassure them- That you are there for them. That they did not do anything wrong. Remember rape is never the victim-survivor's fault – not even when the victim-survivor has been drinking, has had consensual sexual activity in the past, etc. Do not buy into these rape myths. It is not appropriate to critique the victim-survivor's actions.

Accept their feelings- Victim-survivors may react in a wide range of emotions. Don't assume they will react the way you think you might in the situation.

Use active listening skills-Victim-survivors probably will not want to tell you all the details. That's okay. Be there for what they want to share

Provide support without taking over- It's easy to want to take control and take care of a person in crisis. However, sexual assault is about taking away power; don't re-victimize the person by taking charge and making decisions for them.

Referrals and Resources

Give the survivor appropriate referrals and be willing to go with her/him if that would make them more comfortable.

Lakeview Rape Crisis Center

UWF Counseling and Psychological Services

UWF or Pensacola Police

Office of Student Rights and Responsibilities

Title IX Coordinator/Office of the Dean of Students can serve as an advocate for the victim-survivor to help with above referrals or the impact on their academics (i.e. missed class, etc.)

Standard protocol

If you or someone you know has been assaulted...

Get to a safe place.

Seek medical attention.

Consider reporting the assault.

Seek follow up counseling.

Clicker question

Now lets transition to how we can try to intervene and keep sexual violence from ever happening.

If you know someone who has had an act of sexual violence committed against them, was there a bystander who could have attempted to intervene and stop the violence at any point along the way? Yes or No

Bystander Intervention

What barriers do you have that keep you from acting?? (Write answers on board or flipboard.)

Barriers to action: Bystander dynamics, peer influence, personal

Bystander dynamics: Diffusion of responsibility, evaluation apprehension, pluralistic ignorance, cause of misfortune, helping model

Peer Influence: Nobody else is doing anything. What would my peers think?

Personal: I'm shy

I can't stand confronting people.

I'm concerned for my own safety.

I don't want to end up in a fight.

It's none of my business.

I'm not sure the right thing to do

What are the benefits to deciding to take action? (Write answer on board or flipboard.)

Taking part in bystander intervention coincides with your organizations creed/values...incorporate each organizations theme here.

Self-Defining moment: You must have a self-defining moment where you decide do I act or do I not? There are 3 ways to overcome these previously mentioned barriers. Direct, Delegate, Distract
Direct intervention: Ask the victim "Do you need help?" Tell the harasser, "Knock it off" "Stop, or I will call the cops." Distract: Give the target an out: "oh look at how I've just dropped my bag!" or "Hey, I've been looking for you! We are going to be late!" Delegate: Friends, police, RA

Scenarios

Divide into groups and discuss your scenario. What is your first reaction as an individual? What is the reaction in your group? How might UWF policy apply here? What are your barriers? What are the benefits? How would you react? Select someone in your group to report back in the larger session.

You are at a party and you see a woman who is obviously intoxicated, being pulled up the stairs toward the designated room. Given your barriers, what are you most likely to do?

You and a friend go out to an off-campus party together. You know a few people there, but not many. People are drinking beer and doing shots. After having a beer, your friend Julia talks to this guy Mike for about 5 minutes. Later that night Julia has had a lot to drink and is so intoxicated that she is having trouble standing up on her own. At this point Mike approaches her again, but this time offers her a shot of vodka. She drinks it, and he grabs her hand and leads her out of the party towards his car.

You had a roommate come to your room with a guy and you notice that your roommate was so drunk that she was stumbling over her own feet. As she stumbled into the room, she mumbled, "Can you get out of here for a while so we can hang out?" You can tell by looking at the guy that he has no intention of just innocently hanging out. What do you think you would actually do in this situation?

Conclusion

A Safe Sister...Helps Survivors: Supportive, Compassionate, Knowledgeable about resources, Does not blame victim for assault, Supports victim in making her/his own decisions, Confidential/Trustworthy, Takes action as a bystander!

Make a commitment to: Practice Bystander Intervention and Support Survivors, Encourage others to attend trainings and Wellness sponsored events : Take Back the Night & Rock Out the RedZone

Sorority Door Decorations



Alpha Delta Pi

We Look Out For Each Other

We Live For Each Other

Safe Sisters 2014

Listen. Believe. Connect.



Alpha Gamma Delta

Love her for her Womanhood

Protect her Womanhood

Safe Sisters 2014

Listen. Believe. Connect.



Alpha Chi Omega

REAL. STRONG. **SAFE.** WOMEN.

Safe Sisters 2014

Listen. Believe. Connect.



Kappa Delta Sorority

keeping sisters safe.

making great things happen.

Safe Sisters 2014

Listen. Believe. Connect.

Phi Sigma Sigma



*building to the walls of our pyramid.
keeping our sisters safe.*

Safe Sisters 2014

Listen. Believe. Connect.

VITA

Alicia Cambron

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Education

DOCTOR OF PHILOSOPHY | DECEMBER 2014 | THE UNIVERSITY OF MISSISSIPPI

- Major: Health and Kinesiology
- Focus: Health Behavior
- Dissertation: Pilot Study of Safe Sisters: A sexual violence prevention program for sorority women

MASTER OF SCIENCE | MAY 2011 | THE UNIVERSITY OF MISSISSIPPI

- Major: Health Promotion

BACHELOR OF SCIENCE | AUGUST 2009 | AUBURN UNIVERSITY

- Major: Exercise Science
- Minor: Business

Experience

HEALTH EDUCATOR | UNIVERSITY OF WEST FLORIDA | DECEMBER 2012-CURRENT

- Program planning targeting the 8 dimensions of wellness
- Development and implementation of strategic plans to meet university plans and initiatives using Strategic Planning Online
- Develop, implement, and evaluate evidence based events, programs, and social marketing for the student population related to multiple areas of health and wellness promotion
- Advisor for UWF Peer Health Educators
- Supervise and mentor graduate assistants, interns, student workers, and support staff to meet the demands Wellness Services
- Insure adherence to Title IX and Campus Save Act
- Develop and implement training programs for campus partners on health and wellness
 - Housing and Residence Life
 - Student Transition Programs
 - Dean of Students
 - Judicial Council
- Develop and present at national and state health promotion and education conferences

INSTRUCTOR-HSC 2990 | UNIVERSITY OF WEST FLORIDA | DECEMBER 2012-PRESENT

- Instructor for HSC 2990, Sex, Booze, and Peer Education (3 credits)
- Utilize active learning approach to train students on health promotion theories, social norming, sexual health, alcohol and other drugs, sexual assault prevention, interpersonal violence, media literacy, and college health promotion
- Train students on public speaking, leadership development, professionalism, and best practices for peer education

VIOLENCE PREVENTION COORDINATOR | UNIVERSITY OF MISSISSIPPI | AUGUST 2012-DECEMBER 2012

- Assist in the implementation of Department of Justice, Office on Violence Against Women Campus Grant to reduce sexual assault, domestic violence, dating violence, and stalking on campus
- Develop campus-wide bystander intervention training programs for students, faculty, and staff
- Implement training for all incoming students
- Assist survivors in the reporting process
- Serve as a liaison between the Violence Prevention Office, Title IX investigators, Dean of Students Office
- Grant writing

HEALTH EDUCATOR | GENERAL ELECTRIC AVIATION | JANUARY 2011-AUGUST 2012

- Aid employee development in personal wellness plans
- Develop plant wide health initiatives and wellness events
- Group fitness class instructor
- Strategic planning for long-term healthy plant goals

GRADUATE ASSISTANT | UNIVERSITY OF MISSISSIPPI | AUGUST 2009-JANUARY 2011

- Aerobics Instructor
- Jogging Instructor
- Tennis Instructor
- Body Conditioning Instructor
- HP 191: Foundations to Health Instructor
- Plan and implement employee health fair
- Develop sexual health outreach for university student body

HEALTH COUNSELOR | NEW BEGINNINGS | MAY 2010-AUGUST 2010

- Motivational interviewing
- Healthy goal setting and one on one health counseling
- Develop and disseminate worksite health materials for university employees

CARDIAC REHAB INTERN | EAST ALABAMA MEDICAL CENTER | JANUARY 2009-MAY 2009

- Patient health education sessions on nutrition and physical activity for rehabilitation participants
- Exercise demonstrations for in session treatment as well as in home activity
- Heart Rate Monitoring during physical activity

Certifications & Trainings

- Certified Health Education Specialist (CHES)
- American Council on Exercise (ACE) group fitness instructor
- CPR and AED for Adults
- FC2 Provider Training Program
- Multicultural Competence Training
- QPR-Suicide Prevention Training

- Green Dot Training Institute
- NASPA: New Professionals Institute

Campus and Community Involvement

- Escambia County Syphilis Task Force-December 2012-present
- Junior League of Pensacola Training Committee-March 2013-present
- Student Affairs Fitness and Health Committee-April 2013-present
- Social Values and Experiences Greek and Athlete Research Team-January 2014-present

Conference Presentations

- NASPA-Bacchus and Gamma Conference, November 2014-Using Harry Potter as a Stress Reduction Technique.
- NASPA-Bacchus and Gamma Conference, November 2014-Expect Respect: Relationship Check.
- APHA Annual Conference, November 2014-A qualitative evaluation of BASICS training at a public southeastern college.
- NASPA-Bacchus and Gamma Conference, November 2014-Relationship Ref: Coaching students on red flags of relationship violence.
- NASPA-Bacchus and Gamma Conference, November 2014-Stressed..At Hogwarts: An interactive way to address stress for college students.
- ATIXA/SCOPE Conference, October 2014-Media Literacy: A crucial component of sexual violence prevention programs
- Student Affairs Symposium, December 2013-Click into the norm: Utilizing technology when addressing wellness topics for Greek students.
- Southern Criminal Justice Association Conference, October 2012-Barriers to reporting sexual violence: College students' perspectives.