PHYSICAL VERSUS PSYCHOLOGICAL MALTREATMENT: HOW INTERVENTION ATTITUDES ARE AFFECTED BY MALTREATMENT TYPE

by

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ABSTRACT

The present study examined how perception of maltreatment type and participant sex impact attitudes toward intervention. Included in the final analyses were 89 (46 men and 43 women) undergraduate college students. Participants read vignettes depicting either physical or psychological maltreatment and completed a survey of their perceptions of the maltreatment severity and attitudes toward intervention. Collected data were analyzed with a series of 2 (maltreatment type: physical versus psychological) x 2 (participant sex: male versus female) ANOVAs. Results showed that participants who read the physical maltreatment vignette were more likely to say that they would personally intervene than those who read the psychological maltreatment vignette and that women were more likely than men to rate maltreatment as severe, to believe intervention was necessary, to say that they would personally intervene, and to try getting others involved.

TABLE OF CONTENTS

LIST OF TABLES.....v

CHAPTER I: INTRODUCTION.....1

Bystander Apathy.....1

Child Maltreatment.....8

Summary.....14

Hypotheses.....15

CHAPTER II: METHOD.....17

Participants.....17

Measures.....17

Procedure.....20

CHAPTER III: RESULTS.....21

Descriptive Statistics.....21

Hypotheses Testing.....21

CHAPTER IV: DISCUSSION.....33

REFERENCES.....37

APPENDICES.....43

Appendix A: IRB Exemption Determination Notice.....44

Appendix B: Demographic Questions.....46

Appendix C: Survey of Attitudes Regarding Intervention in Physical Maltreatment.....47

Appendix D: Survey of Attitudes Regarding Intervention in Psychological Maltreatment.....49

Appendix E: Informed Consent.....51

Appendix F: Debriefing Information.....54

LIST OF TABLES

1. Demographic Information..... 18
2. Descriptive Statistics for Severity..... 22
3. Descriptive Statistics for Intervention Necessity..... 23
4. Descriptive Statistics for Personal Intervention..... 24
5. Descriptive Statistics for Given Actions..... 25
6. Descriptive Statistics for Fear of Given Barriers..... 27

CHAPTER I

INTRODUCTION

Bystander Apathy

Research on "bystander apathy" began after the case of Catherine "Kitty" Genovese in 1964. Genovese, who was attempting to return to her Queens, New York apartment after finishing an early morning shift, was the victim of two brutal attacks that resulted in her death (Lurigio, 2015). Numerous neighbors heard Genovese's cries for help and did nothing. Some heard her screams during the first attack, which occurred on the streets of her seemingly safe Kew Gardens neighborhood, and one neighbor had even yelled down to her perpetrator, Winston Moseley, to leave her alone. Moseley did flee the scene, leaving Genovese time to make it into the lobby of her apartment building, but he soon returned to pursue a second attack, during which Genovese was stabbed continuously and then raped (Lurigio, 2015).

Two bystanders were fully able to intervene at this point, but neither did; the janitor for a nearby apartment building did nothing, and a friend of Genovese's, who watched a portion of the occurrences inside, sought help too late. Others had eventually called police, but none arrived early enough to keep Genovese from dying (Lurigio, 2015). The mindset that left numerous individuals psychologically incapable of intervention because they were relying on other bystanders to aid Genovese became known as bystander apathy (i.e., a psychological phenomenon in which witnesses to an event find themselves paralyzed to react; Darley & Latané, 1968).

The Genovese case prompted numerous studies on the psychological phenomenon of bystander apathy (e.g., Darley & Batson, 1973; Darley & Latané, 1968; Latané & Darley, 1968). Many of these initial studies were either led by or based off the work of social psychologists Bibb Latané and John Darley; the two created a five-step decision making model in which a potential intervener must notice that an event is occurring, interpret that event as an emergency that requires intervention, assume responsibility for intervention, know how to intervene, and accept the costs that could result from intervention (Latané & Darley, 1968). According to Latané and Darley, bystanders must progress through each of these steps successfully for intervention to occur (Latané & Darley, 1968); unfortunately, additional studies have discovered numerous other factors that may block this progression (e.g., Fischer et al., 2011; Moriarty, 1975; Obermaier, Fawzi, & Koch, 2016; Simons & Chabris, 1999).

In noticing an event, bystanders must see a situation occurring and attend to it. Research shows, however, that this is quite difficult due to the great amount of stimuli individuals continuously encounter (Simons & Chabris, 1999). Because not all stimuli can be given full attention, psychologists suggest that a phenomenon called inattentional blindness renders individuals unlikely to notice any occurrence that is not the current focus of their attention (Mack & Rock, 1998). One study on inattentional blindness required participants to see and mentally note the number of times a basketball was passed among one of two teams on a basketball court; this required such focused attention that the majority of participants failed to notice a man dressed in a gorilla suit

pass across the court (Simons & Chabris, 1999). More recent variations of this study produce similar results (Oktay & Cangoz, 2018).

What individuals pay attention to may be strongly affected by societal assumptions and societally defined suspicious behavior. In a study comparing numerous shoplifting scenarios, it was found that shoplifters dressed in ragged clothing were more likely to be noticed and reported than shoplifters dressed in nicer clothing (Gelfand, Hartmann, Walder, & Page, 1973). Also, those who reported shoplifting were more likely to be from upper-income, rural areas, than lower-income, urban areas. These findings, which are reflective of the stereotypes associated with those from varying socioeconomic backgrounds, suggest that what is learned from the social environment is an additional factor in the noticing of an event (Gelfand et al., 1973).

In a more recent study, Lukacena, Reynolds-Tylus, and Quick (2019) surveyed 186 college students to examine the effects of attitude, norms, capacity, and autonomy on intervention in sexual assault situations. Results related to norms indicated that participants' perceptions of how they believed their peers would intervene was an influencing factor on their own intervention intentions (Lukacena et al., 2019). Together, research by Gelfand et al. (1973) and Lukacena et al. (2019) suggests that the social environment, and what is learned from it, is influential at various stages of the intervention process.

Events that are noticed by bystanders must then be deemed as emergencies. This, however, is challenging, as the general nonresponsiveness of a bystander group often prevents any single bystander from interpreting an event as an emergency that requires

immediate action (Latané & Darley, 1968). One study, conducted to explore the responsiveness of individuals versus groups, placed undergraduate participants in rooms either alone, with fellow participants, or with confederates who were instructed to not react. As staged smoke poured into the rooms, 75% of participants sought help when alone, 38% sought help when in a group with other participants, and less than 10% sought help when in a group of nonreacting confederates (Latané & Darley, 1968). In effect, individual participants based their interpretation of the ambiguous situation on the behaviors of others, and groups of participants became pluralistically ignorant (i.e., they did not deem intervention in the situation necessary if no one else was responding).

Many scenarios go unnoticed or uninterpreted as emergencies by bystanders, but scenarios that are interpreted as emergencies require bystanders to take responsibility for intervention. Unfortunately, in the same way that it decreases the likelihood that a situation will be interpreted as an emergency, the presence of numerous bystanders decreases the likelihood that any individual bystander will take responsibility for intervention (Darley & Latané, 1968). This diffusion of responsibility, or avoidance of intervention by placing the responsibility to intervene on other bystanders, was shown to be present among college students who heard confederates feign epileptic seizures. Participants acted quickly to intervene if they believed they were the only one hearing the event; participants who believed others in adjoining rooms also were hearing the event, however, were slower to act, if they acted at all (Darley & Latané, 1968). In the latter scenario, believing that others were capable of intervention decreased the likelihood that any one individual felt responsible to help. Diffusion of responsibility appeared to be a

primary factor in the decision to intervene, with sex of the students and their feelings towards the victim having little to no correlation with their helping behavior (Darley & Latané, 1968).

A more recent variation of this study examined the effect of bystanders and scenario severity on intervention in cyberbullying (Obermaier et al., 2016). The researchers conducted two studies in which participants were presented with a fictitious cyberbullying scenario on social media. In study one, they examined the correlation between number of bystanders and likelihood of intervention; unlike previous studies (e.g., Darley & Latané, 1968), the results did not suggest that diffusion of responsibility had occurred. In study two, they examined the correlation between scenario severity and likelihood of intervention. Results suggested that scenario severity did significantly increase intervention intentions; these intentions, however, were inhibited by the presence of numerous bystanders, suggesting that the number of bystanders indirectly decreases the likelihood of intervention occurrence (Obermaier et al., 2016).

Also affecting whether any individual bystander will assume responsibility is his or her commitment to being responsible (Moriarty, 1975). Two similar field experiments, one at a New York beach and another in a café, examined the responses of bystanders as they watched either a radio or suitcase be stolen while the owner, a confederate, stepped away. Observers who had verbally committed to watch the confederate's belongings prior to the confederate leaving the belongings unattended were more likely to recognize and intervene in the attempted theft than those who had not committed to watch or protect the items (Moriarty, 1975). Another study found that 95% of participants who were asked by

a confederate to watch a grocery cart intervened when a second confederate attempted to move the cart, whereas only 10% of participants who were not asked to watch the cart intervened (Guéguen, 2014). These results suggest that committing to be responsible prior to an event occurring makes it easier for a bystander to decide to intervene.

Having assumed responsibility for intervention, a potential bystander must know how to intervene effectively. One study, illustrating the importance of bystander competence, involved participants coming to the aid of a fallen confederate (Cramer, McMaster, Bartell, & Dragna, 1988). Similar to previously discussed studies (e.g., Darley & Latané, 1968; Latané & Darley, 1968), participants, who were alone when they heard a confederate fall in the distance, were likely to intervene, and their decisions to help were made despite their intervention competencies. Contrarily, grouped participants were unlikely to help due to pluralistic ignorance and diffusion of responsibility. If an individual among the grouped participants, however, was highly competent (i.e., medically trained), he or she was as likely as a lone participant to aid the confederate (Cramer et al., 1988). This suggests that the ability to comfortably and capably intervene may override the influence of multiple bystanders being present. A more recent study supports this suggestion by showing a negative correlation between perceived self-efficacy and fear of intervention in workplace bullying (Hellemans, Dal Cason, & Casini, 2017),

In another study demonstrating the importance of bystander competence, effective responses to simulated bleeding injuries resulted from the intervening bystander having expertise in the necessary area (Shotland & Heinold, 1985). In this study, however, Red

Cross training, which was the expertise held by some, only increased the effectiveness of those who had already chosen to intervene; it did not encourage intervention (Shotland & Heinold, 1985). Together, these studies (i.e., Cramer et al., 1988; Hellemans et al., 2017; Shotland & Heinold, 1985) suggest that lacking the knowledge and competence necessary for intervention further decreases the likelihood that intervention will occur, while possessing aptitude and competence can increase the occurrence and/or success of intervention.

If bystanders successfully progress through the first four steps, they must accept the costs that could result from their intervention before providing help. Situational variables such as time constraints and discomfort, for example, have been shown as factors in cost assessment (Darley & Batson, 1973; Fritzsche, Finkelstein, & Penner, 2000). In one study, seminary students, who were rushed in getting from one location to another, failed to aid confederates dressed in ragged clothing and slumped down on the sidewalk (Darley & Batson, 1973). In a more recent study (i.e., Fritzsche et al., 2000), the costs of helping (e.g., time required to help, being uncomfortable with involvement) had to be less than the costs of not helping (e.g., the victim would not receive help if no other bystanders intervened). These results suggest that high costs of intervention (e.g., being late) can prevent it and that high costs of nonintervention can promote it.

A systematic meta-analysis (i.e., Fischer et al., 2011) examined additional factors affecting bystander intervention (e.g., dangerous situations, the presence of perpetrators, the physical costs of intervention). Resulting analyses suggested that situations presenting imminent danger were more quickly recognized as emergencies requiring intervention

than situations that were seemingly less dangerous; dangerous situations also produced higher levels of arousal, overriding concerns of possible physical consequences, and increased the rate of helping. An increase in the rate of intervention also was shown when individuals felt physically supported by other bystanders, which occurred most often when bystander groups were composed primarily of men, when fellow bystanders were naïve rather than passive (i.e., fellow bystanders were unaware that intervention was necessary rather than recognizing intervention as necessary and choosing not to act), and when familiarity among bystanders created a supportive environment to intervene (Fischer et al., 2011).

Child Maltreatment

Numerous researchers (e.g., Cramer et al., 1988; Fritzsche et al., 2000; Gelfand et al., 1973; Lukacena et al., 2019; Shotland & Heinold, 1985) have examined the factors preventing intervention throughout the stages of Latané and Darley's five-step decision making model (Latané & Darley, 1968). Fewer, however, have examined the model's applicability to child maltreatment and any specific predictors that may affect intervention in these cases. Those who have examined the model's application have found characteristics of the bystander (e.g., Fledderjohann & Johnson, 2012; Hoefnagels & Zwikker, 2001) and victim (e.g., Vanderfaeillie, De Ruyck, Galle, Van Dooren, & Schotte, 2018), to be predictors of intervention.

Bystander characteristics acting as predictors that increase intervention in cases of child neglect included participants being female rather than male and widowed rather than married; participants with higher levels of education rather than lower levels of

education and those believing there should be limits to parents' freedoms in raising their children rather than believing parents should raise their children as they see fit also reported more frequent intervention (Fledderjohann & Johnson, 2012). Regardless of maltreatment type, being certain of maltreatment occurrence was a predictor of intervention (Hoefnagels & Zwikker, 2001).

Victim characteristics also acted as predictors of intervention in all types of maltreatment (Vanderfaeillie et al., 2018; Webster, O'Toole, O'Toole, & Lucal, 2005). Child characteristics most related to intervention occurrence were ethnicity, gender, and age. Cases involving children from ethnic minorities and/or boys were more likely to be reported than those involving children from the ethnic majority and/or girls (Vanderfaeillie et al., 2018). In addition, younger children were more likely to receive aid than older children (Vanderfaeillie et al., 2018).

In addition to the predictors identified in previous studies (e.g., Fledderjohann & Johnson, 2012; Hoefnagels & Zwikker, 2001; Vanderfaeillie et al., 2018), type of maltreatment and bystander sex may affect intervention occurrence. Both physical and psychological maltreatment have been shown to be prevalent (e.g., Finkelhor, Vanderminden, Turner, Hamby, & Shattuck, 2014; Shi, 2013). The perception of their severity, though, may not be equal much like the perceived severities of physical and sexual abuse are not equal (Bornstein, Kaplan, & Perry, 2007). In their study of 99 undergraduate college students and 100 nonstudent adults, Bornstein et al. (2007) found that physical abuse was perceived as more likely than sexual abuse to occur/reoccur and was, thus, perceived as more severe than sexual abuse; they also found that women

perceived abuse as more severe and more likely to reoccur than men. Despite the perceived severity difference between men and women, Ashton (2004) found no significant correlation between participant sex and reporting in a sample of 276 undergraduate college students majoring in health and social service fields.

The definitions of child maltreatment types vary as much as the perceived severity of each. Operationally defining and researching child maltreatment, especially psychological maltreatment, has been difficult due to the absence of a societal consensus on how maltreatment is differentiated from suboptimal parenting (Trickett, Mennen, Kim, & Sang, 2009). Conceptual definitions, however, do exist for both physical and psychological maltreatment. Physical maltreatment can be defined as an act (e.g., hitting, kicking, shaking) that results in injury or risk of injury (Sedlak et al., 2010), while psychological maltreatment can be defined as "a repeated pattern of caregiver behavior or extreme incident(s) that convey to children that they are worthless, flawed, unloved, unwanted, endangered, or only of value in meeting another's needs" (American Professional Society on the Abuse of Children [APSAC], 1995, p. 2).

Both physical and psychological maltreatment are comprised of many possible actions and are, thus, broken down into subcategories of similar behaviors. Actions constituting physical maltreatment can be further divided into "shaking, throwing, [or] purposefully dropping;" hitting with the hand or an object; "pushing, grabbing, dragging, or pulling; [and] punching or kicking" (Sedlak et al., 2010, p. 72). Actions constituting psychological maltreatment can be further divided into spurning (i.e., hostile rejection or degrading; e.g., belittling or shaming the child), terrorizing (e.g., threatening or

committing violence against the child), isolating (e.g., refusing to interact with the child or restricting the child's physical environment), exploiting and/or corrupting (e.g., engaging in antisocial acts around a child or requiring the child to engage in the antisocial acts), denying emotional responsiveness (e.g., failing to express affection and love), and unwarrantedly denying health care or education (APSAC, 1995; Hart, Binggeli, & Brassard, 1997).

Despite their differing definitions, both physical and psychological maltreatment are associated with numerous negative outcomes. Physical maltreatment has been correlated with outcomes such as aggression (Teisl & Cicchetti, 2008), childhood behavioral and conduct disorders, depressive disorders, anxiety disorders, post-traumatic stress disorder, eating disorders, substance use and abuse, risky sexual behaviors and increased rates of sexually transmitted infections, health concerns (e.g., obesity, arthritis, ulcers, and headaches), and suicidal behavior (Norman et al., 2012).

Psychological maltreatment, alternatively, has been correlated with outcomes such as low self-esteem, anxiety, and depression (Kuo, Goldin, Werner, Heimberg, & Gross, 2011); similarly, it has been associated with decreased quality of life (Bruce, Heimberg, Blanco, Schneier, & Liebowitz, 2012). It also has been correlated with eating disorders, substance use and abuse, risky sexual behaviors and increased rates of sexually transmitted infections, health concerns, and suicidal behavior (Norman et al., 2012).

The perpetrators of child maltreatment are most frequently the biological parents of child victims, as parents were responsible in approximately 71% of reported physical maltreatment cases and 73% of reported psychological maltreatment cases (Sedlak et al.,

2010). Alcohol use, drug use, and the presence of mental illness, while influential in approximately 5 to 10% of reported maltreatment cases, were most influential in cases where the perpetrator was a biological parent (Sedlak et al., 2010). Mothers and other women were slightly more likely to be perpetrators of child maltreatment than men; of those who were reported to be maltreated, 68% were maltreated by women, while 48% were maltreated by men (some children were maltreated by both women and men) (Sedlak et al., 2010). Also, those over the age of 26 years were responsible for maltreatment in 89% of reported cases (Sedlak et al., 2010). Another study found parental perpetrators of physical and emotional abuse, when compared to foster parents, to be more narcissistic and impulsive (Wiehe, 2003).

Considering victim characteristics, reported maltreatment is more prevalent among African American children, and serious harm and injury resulting from maltreatment is more prevalent among younger children and children with disabilities (Sedlak et al., 2010); those with characteristics of a difficult temperament also may be at increased risk for maltreatment by their mothers (Lowell & Renk, 2017). Out of reported cases, children with unemployed parents were two to three times more likely to experience maltreatment than those with employed parents, and those in low socioeconomic status households were three to seven times more likely to experience maltreatment than those in higher socioeconomic status households (Sedlak et al., 2010). Also out of reported cases, children living with married biological parents were the least likely to be maltreated, while those living with a single parent and his or her live-in

partner were eight to ten times more likely to experience maltreatment (Sedlak et al., 2010).

Child maltreatment, overall, is a prevalent issue (e.g., Dias, Sales, Hessen, & Kleber, 2015; Shi, 2013; U. S. Department of Health & Human Services [USHHS], 2015). According to information gathered by the USHHS (2015), more than 3,000,000 children across the United States are the subjects of one or more maltreatment case(s) each year, with 683,487 children (approximately 1% of the U. S. child population) being victims of confirmed abuse. Other research has shown that between 70% and 90% of sampled individuals have experienced some form of maltreatment in their lifetime (Dias et al., 2015; Shi, 2013).

One retrospective study found that 340 (74.4%) out of 497 individuals sampled at a marriage and family counseling clinic had experienced some form of child maltreatment; from responses to the Childhood Trauma Questionnaire, it was determined that 31.2% of those who were maltreated had been subjected to physical abuse, 52.1% had been subjected to emotional abuse, and 54.9% had been subjected to emotional neglect (Shi, 2013). Another retrospective study found that 1,064 (88.7%) out of 1,200 individuals in a community sample had experienced some form of child maltreatment; from responses to the Childhood Trauma Questionnaire-Short Form, it was determined that 21.8% of maltreated participants had been subjected to physical abuse, 44% had been subjected to physical neglect, 57.6% had been subjected to emotional abuse, and 80.5% had been subjected to emotional neglect (Dias et al., 2015).

In a study examining only individual types of maltreatment, it was found that physical maltreatment, emotional maltreatment, and neglect each occurred in similar percentages of the sample (Finkelhor et al., 2014). Through endorsement of physical assault survey questions answered by 4,503 caregivers of children ages 1 month to 10 years and youth aged 10 to 17 years, it was found that 4% of children and youth had been subjected to physical maltreatment in the past year, and 8.9% had been subjected to physical maltreatment at some point in their lifetime (Finkelhor et al., 2014). To determine the prevalence of emotional maltreatment, children/youth or their caregivers responded to the question "Did you/your child get scared or feel really bad because grown-ups in their/your life called this child/you names, said mean things to this child/you, or said they didn't want this child/you?" (Finkelhor et al., 2014, p. 1425); through answers to this question, it was found that 5.6% had been subjected to emotional maltreatment in the past year and 10.3% had been subjected to emotional maltreatment at some point in their lifetime (Finkelhor et al., 2014). By using neglect screeners, it also was determined that 4.7% had been subjected to some type of neglect in the past year and 11.6% had been subjected to neglect at some point in their lifetime (Finkelhor et al., 2014).

Summary

Much research exists on child maltreatment (e.g., APSAC, 1995; Dias et al., 2015; Finkelhor et al., 2014; Hart et al., 1997; Shi, 2013). Similarly, much research exists on Latané and Darley's (1968) five-step decision making model and the factors that affect progression through its steps (e.g., Cramer et al., 1988; Fritzsche et al., 2000;

Gelfand et al., 1973; Lukacena et al., 2019; Shotland & Heinold, 1985). Little research, however, has examined the application of the five-step decision making model to child maltreatment and the factors affecting intervention decisions in these cases.

The research that has focused on the model's application to the area of child maltreatment has found bystander characteristics (e.g., being female rather than male and/or believing there should be limits to parents' freedoms in raising their children; Fledderjohann & Johnson, 2012), situational characteristics (e.g., feeling that it is acceptable to intervene and/or being certain of maltreatment occurrence; Hoefnagels & Zwikker, 2001) and victim characteristics (e.g., ethnicity; Vanderfaeillie et al., 2018) to be predictors of intervention occurrence. The aim of the current research was to determine if maltreatment type (i.e., physical versus psychological) and participant sex (i.e., male versus female) additionally affect proposed intervention occurrence. Some research (e.g., Bornstein et al., 2007) has shown that perceived severity is affected both by maltreatment type and participant sex (i.e., women perceive all types of abuse as more severe), so it was hypothesized that the difference in perceived severity between the two types of maltreatment and between men and women would affect attitudes toward intervention.

Hypotheses

1. There would be significant main effects for maltreatment type. Specifically, participants who read the physical maltreatment vignette would respond with higher severity ratings and intervention necessity ratings than those who read the psychological maltreatment vignette. Additionally, participants who respond to

the physical maltreatment vignette would endorse higher ratings for the likelihood that they would take specific actions to intervene and lower ratings for the likelihood that specific barriers would prevent them from intervening.

2. There would be significant main effects for participant sex. Overall, women would respond with higher severity ratings and intervention necessity ratings regardless of which vignette they read. Additionally, women would respond with higher ratings for the likelihood they would take specific actions to intervene. Men, however, would respond with lower ratings for the likelihood that specific barriers would prevent them from intervening.
3. There would be significant interactions between maltreatment type and participant sex; no specific predictions are proposed.

CHAPTER II

METHOD

Participants

Students at a university in the southeast United States were recruited from undergraduate psychology courses through an online psychology research pool. A total of 100 participants (50 men and 50 women) participated in the study, but 11 were eliminated because of uncompleted items. Included in the final analyses were 89 participants (46 men and 43 women); only 59 participants were included in the analysis of perceived severity because of missing data. All participants were at least 18 years of age, and the sex and race/ethnicity of each participant were collected. Demographic information is shown in Table 1. Participants received research or extra credit as compensation for their participation. Before data collection began, approval was obtained from the Institutional Review Board (see Appendix A).

Measures

Demographic questions. Participants responded to questions about their sex (male or female), age (18 to 21 years, 22 to 25 years, 26 to 29 years, 30 years and older, or prefer not to answer), and race/ethnicity (Caucasian, African American, Other, or prefer not to answer) in a multiple-choice format (see Appendix B). The age variable was divided into groups to help preserve the anonymity of participants and prevent those representing the extreme from being easily identifiable.

Table 1

Demographic Information

Variable	*n*	*%*
Sex		
Male	46	51.69
Female	43	48.31
Age		
18 to 21 years	77	86.52
22 to 25 years	7	7.87
26 to 29 years	1	1.12
30 years and older	4	4.49
Prefer not to answer	0	0
Race/Ethnicity		
Caucasian	48	53.93
African American	16	17.98
Other	24	26.97
Prefer not to answer	1	1.12

Note. $N = 89$.

Maltreatment vignettes. Each participant was presented with a vignette documenting either physical (see Appendix C) or psychological maltreatment (see Appendix D). Each vignette included the term for the maltreatment type and the phrase "on multiple occasions." No descriptions of the acts parents were engaging in that constituted maltreatment were included.

Survey of Attitudes Regarding Intervention. The survey was a compilation and adaptation of surveys from both Bensley et al. (2004) and Walsh, Rassafiani, Mathews, Farrell, and Butler (2010). In Bensley et al. (2004), the Washington State Department of Health contracted out the conduction of focus groups and pilot interviews within a community sample to collect data for the development of a survey that would determine what actions people take when maltreatment is occurring, what barriers prevent these actions, and the beliefs people held about the effects of their actions. In Walsh et al. (2010), the Teacher Reporting Attitude Scale for Child Sexual Abuse (TRAS-CSA) was developed by performing a systematic examination of the literature, then validating and conducting preliminary testing to assess the attitudes of teachers toward reporting child sexual abuse; the resulting survey had moderate internal consistency reliability ($\alpha = .75$) and adjusted alpha coefficient ($\alpha = .81$) when tested in a small sample of teachers (Walsh et al., 2010).

The designed surveys (see Appendices C and D) assessed attitudes regarding maltreatment severity, necessity of intervention, likelihood of intervention, methods of intervention, and barriers to intervention on a 5-point scale. Perceived severity of maltreatment was rated on a scale of 1 (*not severe*) to 5 (*very severe*); perceived necessity

of intervention was rated on a scale of 1 (*very unnecessary*) to 5 (*very necessary*); likelihood that the participant will intervene was rated on a scale of 1 (*very unlikely*) to 5 (*very likely*). Participants also rated how likely they were to use five possible methods of intervention and how likely they were to be stopped from intervening by five possible barriers on a scale of 1 (*very unlikely*) to 5 (*very likely*). In total, the identical surveys had five questions each, with one of those questions having five parts and one of those questions having six parts; thus, the survey included 14 items.

Procedure

Approval was obtained from the Institutional Review Board before research began. Participants were recruited from undergraduate psychology courses through a psychology research pool to participate in the online study. Participants were first prompted to provide their informed consent (see Appendix E), which detailed the procedure, potential benefits, and potential risks of the study. Once participants consented to engage in the study, they electronically completed demographic questions (see Appendix B). Using random assignment by participant sex, participants either read a vignette depicting physical maltreatment and completed a survey to assess their attitudes toward intervention in that maltreatment (see Appendix C) or read a vignette depicting psychological maltreatment and completed a survey to assess their attitudes toward intervention in that maltreatment (see Appendix D). After completing the study, participants were presented debriefing information (see Appendix F), which they could print to keep for their records, and were awarded research or extra credit.

CHAPTER III

RESULTS

Descriptive Statistics

Collected data were analyzed with a series of 2 (maltreatment type: physical versus psychological) x 2 (participant sex: male versus female) ANOVAs. The sample sizes were unequal, so the SPSS mixed procedure was used to conduct the two-way ANOVAs without the assumption of equal population variances. A familywise alpha of .05 was used for all analyses. Severity, overall intervention necessity, and likelihood of personal intervention were all tested for significance using an alpha of .05, which resulted in a 95% confidence interval for these items. Given actions and barriers both had subitems, so they were tested for significance using an alpha of approximately .01, which resulted in a 99% confidence interval for these items. Descriptive statistics for ratings of severity are shown in Table 2; due to missing responses, only 59 participants were included in this analysis. Descriptive statistics for overall intervention necessity are shown in Table 3. Descriptive statistics for likelihood of personal intervention are shown in Table 4. Descriptive statistics for likelihood of taking given actions are shown in Table 5. Descriptive statistics for likelihood of given barriers preventing actions are shown in Table 6.

Hypotheses Testing

The first hypothesis was that participants who read the physical maltreatment vignette would respond with higher severity ratings and intervention necessity ratings

Table 2

Descriptive Statistics for Severity

Maltreatment Type	Participant Sex	*n*	*M* (*SD*)	95% Confidence Interval	
				Lower Bound	Upper Bound
Physical	Male	16	3.81 (0.84)	3.37	4.26
	Female	14	4.57 (0.65)	4.20	4.95
	Total	30	4.19 (0.83)	3.91	4.47
Psychological	Male	14	3.43 (1.28)	2.69	4.17
	Female	15	4.33 (0.82)	3.88	4.79
	Total	29	3.88 (1.15)	3.46	4.30

Note. Item rated on a scale of 1 (*not severe*) to 5 (*very severe*).

Table 3

Descriptive Statistics for Intervention Necessity

				95% Confidence Interval	
Maltreatment Type	Participant Sex	*n*	*M* (*SD*)	Lower Bound	Upper Bound
Physical	Male	23	4.35 (0.83)	3.99	4.71
	Female	22	4.86 (0.35)	4.71	5.02
	Total	55	4.61 (0.69)	4.41	4.80
Psychological	Male	23	4.30 (0.88)	3.93	4.68
	Female	21	4.57 (0.68)	4.26	4.88
	Total	44	4.44 (0.79)	4.20	4.68

Note. Item rated on a scale of 1 (*very unnecessary*) to 5 (*very necessary*).

Table 4

Descriptive Statistics for Personal Intervention

				95% Confidence Interval	
Maltreatment Type	Participant Sex	*n*	*M* (*SD*)	Lower Bound	Upper Bound
Physical	Male	23	4.09 (0.67)	3.80	4.38
	Female	22	4.36 (0.58)	4.11	4.62
	Total	55	4.23 (0.64)	4.04	4.41
Psychological	Male	23	3.61 (0.84)	3.25	3.97
	Female	21	4.14 (0.73)	3.81	4.47
	Total	44	3.88 (0.82)	3.64	4.11

Note. Item rated on a scale of 1 (*very unlikely*) to 5 (*very likely*).

Table 5

Descriptive Statistics for Given Actions

	Physical Maltreatment			Psychological Maltreatment		
	Male	Female	Total	Male	Female	Total
	(*n* = 23)	(*n* = 22)	(*n* = 45)	(*n* = 23)	(*n* = 21)	(*n* = 44)
Report to DCS						
M	3.70	3.77	3.73	3.48	4.05	3.76
SD	1.12	1.07	1.07	1.24	0.81	1.08
99% CI	3.05, 4.35	3.13, 4.42	3.30, 3.34	2.75, 4.21	3.55, 4.55	3.34, 4.19
Talk to Parent						
M	3.65	3.32	3.49	3.61	3.43	3.52
SD	1.15	1.39	1.27	1.12	1.03	1.07
99% CI	2.89, 4.33	2.48, 4.16	2.97, 4.00	2.95, 4.27	2.79, 4.07	3.08, 3.96
Befriend Child						
M	3.83	3.91	3.87	3.83	4.33	4.08
SD	0.94	1.23	1.08	1.23	0.80	1.07
99% CI	3.28, 4.38	3.17, 4.65	3.43, 3.66	3.10, 4.31	3.84, 4.83	3.66, 4.50

(continued)

Table 5 (continued)

Descriptive Statistics for Given Actions

	Physical Maltreatment			Psychological Maltreatment		
	Male	Female	Total	Male	Female	Total
	(*n* = 23)	(*n* = 22)	(*n* = 45)	(*n* = 23)	(*n* = 21)	(*n* = 44)
Get Others Involved						
M	3.78	4.50	4.14	3.91	4.29	4.10
SD	1.20	0.86	1.10	1.04	0.64	0.88
99% CI	3.08, 4.49	3.98, 5.02	3.72, 4.56	3.30, 4.53	3.89, 4.69	3.75, 4.45
Report to Police						
M	3.83	4.05	3.94	3.39	4.10	3.74
SD	1.19	1.25	1.21	1.31	0.77	1.13
99% CI	3.13, 4.53	3.29, 4.80	3.44, 4.43	2.62, 4.16	3.62, 4.57	3.31, 4.18

Note. Items rated on a scale of 1 (*very unlikely*) to 5 (*very likely*).
CI = Confidence Interval.

Table 6

Descriptive Statistics for Fear of Given Barriers

	Physical Maltreatment			Psychological Maltreatment		
	Male	Female	Total	Male	Female	Total
	(*n* = 23)	(*n* = 22)	(*n* = 45)	(*n* = 23)	(*n* = 21)	(*n* = 44)
Physical Confrontation						
M	2.87	2.86	2.87	2.61	3.71	3.16
SD	1.36	1.32	1.33	1.37	1.27	1.42
99% CI	1.51, 4.23	1.50, 4.23	2.00, 3.74	1.23, 3.99	2.35, 5.08	2.29, 4.03
Verbal Confrontation						
M	2.30	2.46	2.38	2.57	2.76	2.66
SD	1.15	1.41	1.27	1.20	1.48	1.33
99% CI	1.16, 3.45	1.00, 3.91	1.54, 3.22	1.36, 3.77	1.17, 4.35	1.77, 3.56
Being Sued						
M	2.61	2.41	2.51	2.74	2.52	2.63
SD	1.08	1.37	1.22	1.29	1.37	1.31
99% CI	1.53, 3.69	0.99, 3.83	1.70, 3.32	1.45, 4.03	1.06, 3.99	1.76, 3.51

(continued)

Table 6 (continued)

Descriptive Statistics for Fear of Given Barriers

	Physical Maltreatment			Psychological Maltreatment		
	Male	Female	Total	Male	Female	Total
	(*n* = 23)	(*n* = 22)	(*n* = 45)	(*n* = 23)	(*n* = 21)	(*n* = 44)
Worsening the Situation						
M	3.78	4.05	3.91	3.78	4.33	4.06
SD	1.35	1.25	1.29	1.20	0.86	1.07
99% CI	2.43, 5.13	2.75, 5.34	3.07, 4.76	2.57, 4.99	3.41, 5.25	3.37, 4.74
Being Wrong						
M	3.61	3.32	3.46	3.83	3.91	3.97
SD	1.16	1.46	1.31	0.89	1.09	0.98
99% CI	2.45, 4.77	1.80, 4.83	2.60, 4.33	2.94, 4.72	2.73, 5.08	3.20, 4.53
Family Life is Private						
M	2.44	1.96	2.20	2.78	2.14	2.46
SD	1.34	1.33	1.34	1.00	1.20	1.13
99% CI	1.09, 3.78	0.58, 3.33	1.33, 3.06	1.78, 3.78	0.86, 3.43	1.73, 3.20

Note. Items rated on a scale of 1 (*very unlikely*) to 5 (*very likely*).
CI = Confidence Interval.

than those who read the psychological maltreatment vignette. The two-way ANOVAs, however, indicated that there was no significant main effect of maltreatment type on perceived severity, $F(1, 39.56) = 1.64$, $p = .207$, $\omega^2 = .01$, or overall intervention necessity, $F(1, 70.56) = 1.24$, $p = .269$, $\omega^2 = .00$. Likelihood of personal intervention did differ by maltreatment type, $F(1, 79.90) = 5.40$, $p = .023$, $\omega^2 = .04$. Participants reading the physical maltreatment vignette ($M = 4.23$) reported that they would be more likely to personally intervene than those who read the psychological maltreatment vignette ($M = 3.88$).

Additionally, it was hypothesized that participants who responded to the physical maltreatment vignette would endorse higher ratings for the likelihood that they would take specific actions to intervene and lower ratings for the likelihood that specific barriers would prevent them from intervening. The two-way ANOVAs indicated, however, that the main effect for maltreatment type was not significant for any of the given actions or barriers. Participant responses were similar when asked the likelihood that they would report the incident to the Department of Children's Services, $F(1, 81.04) = 0.02$, $p = .899$, $\omega^2 = .00$, talk to the parent who was maltreating the child, $F(1, 80.21) = 0.02$, $p = .894$, $\omega^2 = .00$, befriend the child to help him or her, $F(1, 77.11) = 0.89$, $p = .349$, $\omega^2 = .00$, try to get others involved, $F(1, 75.32) = 0.04$, $p = .836$, $\omega^2 = .00$, and report the incident to the police, $F(1, 78.57) = 0.63$, $p = .430$, $\omega^2 = .00$.

Participant responses were also similar when asked the likelihood that fear of physical confrontation, $F(1, 84.97) = 1.09$, $p = .299$, $\omega^2 = .00$, fear of verbal confrontation, $F(1, 78.50) = 1.03$, $p = .313$, $\omega^2 = .00$, fear of being sued, $F(1, 80.53) =$

0.20, p = .654, ω^2 = .00, fear that the situation would worsen for the child, $F(1, 80.33)$ = 0.33, p = .565, ω^2 = .00, fear of being wrong about what was happening, $F(1, 74.26)$ = 2.63, p = .109, ω^2 = .01, and the belief that family life is private and those outside of the family should not get involved, $F(1, 80.77) = 1.07$, p = .305, ω^2 = .00, would stop them from intervening.

The second hypothesis was that women would respond with higher severity ratings and intervention necessity ratings than men regardless of which vignette they read. The two-way ANOVAs indicated that the main effect of participant sex was significant for perceived severity, $F(1, 39.56) = 11.75$, p = .001, ω^2 = .16, overall intervention necessity, $F(1, 70.56) = 6.75$, p = .011, ω^2 = .06, and likelihood of personal intervention, $F(1, 79.90) = 7.26$, p = .009, ω^2 = .06. Higher severity ratings were reported by women (M = 4.45), while lower severity ratings were reported by men (M = 3.62); intervention was rated as more necessary by women (M = 4.72), while it was rated less necessary by men (M = 4.33); and higher likelihoods of personal intervention were reported by women (M = 4.25), while lower likelihoods of personal intervention were reported by men (M = 3.85).

Additionally, it was hypothesized that women would respond with higher ratings for the likelihood they would take specific actions to intervene but that men would respond with lower ratings for the likelihood that specific barriers would prevent them from intervening. The two-way ANOVAs indicated that the main effect for participant sex was not significant for most of the given actions. Participant responses were similar when asked the likelihood that they would report the incident to the Department of

Children's Services, $F(1, 81.04) = 2.07$, $p = .154$, $\omega^2 = .01$, talk to the parent who was maltreating the child, $F(1, 80.21) = 1.05$, $p = .308$, $\omega^2 = .00$, befriend the child to help him or her, $F(1, 77.11) = 1.72$, $p = .194$, $\omega^2 = .00$, and report the incident to the police, $F(1, 78.57) = 3.62$, $p = .061$, $\omega^2 = .03$. Trying to get others involved was the only action that differed by participant sex, $F(1, 75.32) = 7.27$, $p = .009$ $\omega^2 = .06$; higher likelihoods of trying to get others involved were reported by women ($M = 4.39$), while lower likelihoods were reported by men ($M = 3.85$).

There was no main effect for participant sex on any of the given barriers. Participant responses were similar when asked the likelihood that fear of physical confrontation, $F(1, 84.97) = 3.80$, $p = .055$, $\omega^2 = .03$, fear of verbal confrontation, $F(1, 78.50) = 0.39$, $p = .537$, $\omega^2 = .00$, fear of being sued, $F(1, 80.53) = 0.58$, $p = .448$, $\omega^2 = .00$, fear that the situation would worsen for the child, $F(1, 80.33) = 2.67$, $p = .106$, $\omega^2 = .02$, fear of being wrong about what is happening, $F(1, 74.26) = 0.18$, $p = .671$, $\omega^2 = .00$, and the belief that family life was private and those outside of the family should not get involved, $F(1, 80.77) = 4.65$, $p = .034$, $\omega^2 = .04$, would stop them from intervening.

The third hypothesis was that there would be a statistically significant interaction between maltreatment type (i.e., physical or psychological) and participant sex (i.e., male or female). The two-way ANOVAs indicated that there was not a significant interaction between maltreatment type and participant sex for perceived severity, $F(1, 39.56) = 0.09$, $p = .765$, $\omega^2 = .00$, overall intervention necessity, $F(1, 70.56) = 0.68$, $p = .412$, $\omega^2 = .00$, or likelihood of personal intervention, $F(1, 79.90) = 0.73$, $p = .395$, $\omega^2 = .00$.

Similarly, there was not a significant interaction between maltreatment type and participant sex for any of the given actions. Participant responses were similar when asked the likelihood that they would report the incident to the Department of Children's Services, $F(1, 81.04) = 1.20$, $p = .277$, $\omega^2 = .00$, talk to the parent who was maltreating the child, $F(1, 80.21) = 0.09$, $p = .759$, $\omega^2 = .00$, befriend the child to help him or her, $F(1, 77.11) = 0.89$, $p = .349$, $\omega^2 = .00$, try to get others involved, $F(1, 75.32) = 0.73$, $p = .397$, $\omega^2 = .00$, and report the incident to the police, $F(1, 78.75) = 1.00$, $p = .321$, $\omega^2 = .00$.

The interaction also was not significant concerning barriers to intervention. Participant responses were similar when asked the likelihood that fear of physical confrontation, $F(1, 84.97) = 3.88$, $p = .052$, $\omega^2 = .03$, fear of verbal confrontation, $F(1, 78.50) = 0.01$, $p = .934$, $\omega^2 = .00$, fear of being sued, $F(1, 80.53) = 0.00$, $p = .977$, $\omega^2 = .00$, fear that the situation would worsen for the child, $F(1, 80.33) = 0.33$, $p = .565$, $\omega^2 = .00$, fear of being wrong about what is happening, $F(1, 74.26) = 0.56$, $p = .459$, $\omega^2 = .00$, and the belief that family life was private and those outside of the family should not get involved, $F(1, 80.77) = 0.09$, $p = .730$, $\omega^2 = .00$, would stop them from intervening.

CHAPTER IV

DISCUSSION

Overall, the type of child maltreatment occurring (i.e., physical or psychological) only impacted the likelihood of personal intervention, as those who read the physical maltreatment vignette were more likely than those who read the psychological maltreatment vignette to report that they would intervene. Participant sex, however, impacted how severe the maltreatment was perceived to be, how necessary intervention was perceived to be, and how likely the participant said he or she was to personally intervene, as women were more likely than men to perceive maltreatment as severe, perceive intervention as necessary, and say they would personally intervene. Women were also more likely than men to try to involve others (e.g., witnesses, relatives, friends) as an intervention attempt. The interaction between maltreatment type and participant sex did not affect perceived severity, perceived intervention necessity, likelihood of personal intervention, likelihood of taking given actions, or likelihood of having given barriers decrease intervention.

The results of this study comparing physical and psychological maltreatment contradict results from previous studies comparing physical and other forms of maltreatment (e.g., sexual abuse). For example, Bornstein et al. (2007) found that physical abuse was perceived as more severe than sexual abuse, but the current study does not show that this perceived difference exists when physical and psychological maltreatment are compared. Similarly, Ashton (2004) found no significant correlation between participant sex and reporting, but this study found participant sex to affect both

the perceived need for intervention and the self-reported likelihood of actual intervention, as women were more likely to see intervention as necessary and report that they would take actions to personally intervene than men. The difference in women and men shown in this study is similar to the results of studies looking at other forms of maltreatment (e.g., Bornstein et al., 2007), which have shown that women may perceive maltreatment as more severe, and, therefore, intervene more often because of how they process evidence (i.e., the more empathetic nature of women may make them more likely to perceive maltreatment as severe and take actions to intervene).

Many factors could have influenced the differences in the results of this study compared to others, though. Types of maltreatment compared, for example, likely affected perceived severity and intervention necessity, as there is already lacking societal consensus on the differentiation between some forms of maltreatment (e.g., psychological maltreatment) and suboptimal parenting (Trickett et al., 2009). Similarly, use of the term "maltreatment" rather than "abuse" may have predisposed participants to perceive the vignettes as less severe.

Other factors within the study limit the generalizability of results. A specific limitation was due to numerous missing responses to the severity item. Only 59 participants were included in the analyses for the severity item, which likely created an issue with power, meaning those results should be interpreted with much caution.

More broad factors affecting the generalizability of the results included the sample and the vignettes used. The sample, for example, consisted only of college students, and the responses given may be reflective only of the college population. The

results may be limited in generalizability even within the college population because the majority of participants were aged 18 to 21 years and most were either Caucasian or identified their race/ethnicity as "Other." Furthermore, the results may be more generalizable to college populations in the Southeast geographical region than other regions in the United States and other countries. Considering this limitation, further research in this area would benefit from larger, more diverse samples.

The author constructed vignettes used, which were intentionally created to be neutral and not predispose participants to any particular way of thinking, also limit the generalizability of results. Real situations would likely never be this vague, so the vignettes were possibly ineffective in gathering responses similar to those that would be elicited by a true maltreatment scenario. Creating vignettes that more closely resemble real scenarios would allow the results of future research to be more meaningful, and research designed to thoroughly explore the response differences to varying vignette scenarios (e.g., varying perpetrator sex, varying victim sex, perpetrator-victim relationship, bystander relationship to the perpetrator and victim) would aid understanding of the factors affecting real responses to intervention.

Despite the discussed limitations, the results of this study provide meaningful information on the processes underlying bystander intervention in child maltreatment. By examining the influence of maltreatment type (i.e. physical and psychological) and participant sex (i.e., male and female) on participant responses to perceived severity and intervention necessity, it was found that both maltreatment type and participant sex are additional factors affecting intervention in child maltreatment. This study, ultimately,

showed that children enduring physical maltreatment may be more likely to receive help than those enduring psychological maltreatment and that children who are helped, regardless of maltreatment type, are more likely to be helped by women than men.

REFERENCES

American Professional Society on the Abuse of Children. (1995). *Psychosocial evaluation of suspected psychological maltreatment in children and adolescents: Practice guidelines*. Chicago, IL: APSAC.

Ashton, V. (2004). The effect of personal characteristics on reporting child maltreatment. *Child Abuse & Neglect, 28*, 985-997. doi:10.1016/j.chiabu.2004.03.012

Bensley, L., Simmons, K. W., Ruggles, D., Putvin, T., Harris, C., Allen, M., & Williams, K. (2004). Community responses and perceived barriers to responding to child maltreatment. *Journal of Community Health, 29,* 141-153. doi:10.1023/B:JOHE.0000016718.37691.86

Bornstein, B. H., Kaplan, D. L., & Perry, A. R. (2007). Child abuse in the eyes of the beholder: Lay perceptions of child sexual and physical abuse. *Child Abuse & Neglect, 31*, 375-391. doi:10.1016/j.chiabu.2006.09.007

Bruce, L. C., Heimberg, R. G., Blanco, C., Schneier, F. R., & Liebowitz, M. R. (2012). Childhood maltreatment and social anxiety disorder: Implications for symptom severity and response to pharmacotherapy. *Depression and Anxiety*, *29*, 131-138. doi:10.1002/da.20909

Cramer, R. E., McMaster, M. R., Bartell, P. A., & Dragna, M. (1988). Subject competence and minimization of the bystander effect. *Journal of Applied Social Psychology, 18*, 1133-1148. doi:10.1111/j.1559-1816.1988.tb01198.x

Darley, J. M., & Batson, C. D. (1973). 'From Jerusalem to Jericho': A study of situational and dispositional variables in helping behavior. *Journal of Personality and Social Psychology, 27*, 100-108. doi:10.1037/h0034449

Darley, J. M., & Latané, B. (1968). Bystander intervention in emergencies: Diffusion of responsibility. *Journal of Personality and Social Psychology, 8*, 377-383. doi:10.1037/h0025589

Dias, A., Sales, L., Hessen, D. J., & Kleber, R. J. (2015). Child maltreatment and psychological symptoms in a Portuguese adult community sample: The harmful effects of emotional abuse. *European Child & Adolescent Psychiatry, 24*, 767-778. doi:10.1007/s00787-014-0621-0

Finkelhor, D., Vanderminden, J., Turner, H., Hamby, S., & Shattuck, A. (2014). Child maltreatment rates assessed in a national household survey of caregivers and youth. *Child Abuse & Neglect, 38*, 1421-1435. doi:10.1016/j.chiabu.2014.05.005

Fischer, P., Krueger, J. I., Greitemeyer, T., Vogrincic, C., Kastenmüller, A., Frey, D., . . . Kainbacher, M. (2011). The bystander-effect: A meta-analytic review on bystander intervention in dangerous and non-dangerous emergencies. *Psychological Bulletin, 137*, 517-537. doi:10.1037/a0023304

Fledderjohann, J., & Johnson, D. (2012). What predicts the actions taken toward observed child neglect? The influence of community context and bystander characteristics. *Social Science Quarterly, 93*, 1030-1052. doi:10.1111/j.1540-6237.2012.00859.x

Fritzsche, B. A., Finkelstein, M. A., & Penner, L. A. (2000). To help or not to help: Capturing individuals' decision policies. *Social Behavior and Personality, 28,* 561-578. doi:10.2224/sbp.2000.28.6.561

Gelfand, D. M., Hartmann, D. P., Walder, P., & Page, B. (1973). Who reports shoplifters? A field-experimental study. *Journal of Personality and Social Psychology, 25*, 276-285. doi:10.1037/h0033953

Guéguen, N. (2014). Commitment and the responsive bystander: A field evaluation with a less problematic request. *Psychological Reports*, *115*, 607-611. doi:10.2466/17.07.PR0.115c18z9

Hart, S. N., Binggeli, N. J., & Brassard, M. R. (1997). Evidence of the effects of psychological maltreatment. *Journal of Emotional Abuse, 1*, 27-58. doi:10.1300/J135v01n01_03

Hellemans, C., Dal Cason, D., & Casini, A. (2017). Bystander helping behavior in response to workplace bullying. *Swiss Journal of Psychology, 76*, 135-144. doi:10.1024/1421-0185/a000200

Hoefnagels, C., & Zwikker, M. (2001). The bystander dilemma and child abuse: Extending the Latané and Darley model to domestic violence. *Journal of Applied Social Psychology, 31*, 1158-1183. doi:10.1111/j.1559-1816.2001.tb02668.x

Kuo, J. R., Goldin, P. R., Werner, K., Heimberg, R. G., & Gross, J. J. (2011). Childhood trauma and current psychological functioning in adults with social anxiety disorder. *Journal of Anxiety Disorders, 25*, 467-473. doi:10.1016/j.janxdis.2010.11.011

Latané, B., & Darley, J. M. (1968). Group inhibition of bystander intervention in emergencies. *Journal of Personality and Social Psychology, 10,* 215-221. doi:10.1037/h0026570

Lowell, A., & Renk, K. (2017). Predictors of child maltreatment potential in a national sample of mothers of young children. *Journal of Aggression, Maltreatment & Trauma, 26,* 335-353. doi:10.1080/10926771.2017.1299825

Lukacena, K. M., Reynolds-Tylus, T., & Quick, B. L. (2019). An application of the reasoned action approach to bystander intervention for sexual assault. *Health Communication, 34,* 46-53. doi:10.1080/10410236.2017.1384356

Lurigio, A. J. (2015). Crime narratives, dramatizations, and the legacy of the Kitty Genovese murder: A half century of half truths. *Criminal Justice and Behavior*, *42*, 782-789. doi:10.1177/0093854814562954

Mack, A., & Rock, I. (1998). *Inattentional blindness*. Cambridge, MA: MIT Press.

Moriarty, T. (1975). Crime, commitment, and the responsive bystander: Two field experiments. *Journal of Personality and Social Psychology, 31,* 370-376. doi:10.1037/h0076288

Norman, R. E., Byambaa, M., De, R., Butchart, A., Scott, J., & Vos, T. (2012). The long-term health consequences of child physical, emotional abuse, and neglect: A systematic review and meta-analysis. *PLoS Medicine, 9(11):* e1001349. doi:10.1371/ journal.pmed.1001349

Obermaier, M., Fawzi, N., & Koch, T. (2016). Bystanding or standing by? How the number of bystanders affects the intention to intervene in cyberbullying. *New Media & Society, 18,* 1491-1507. doi:10.1177/1461444814563519

Oktay, B., & Cangoz, B. (2018). I thought I saw "Zorro": An inattentional blindness study. *Archives of Neuropsychiatry, 55,* 59–66. doi:10.29399/npa.19227

Sedlak, A. J., Mettenburg, J., Basena, M., Petta, I., McPherson, K., Greene, A., & Li, S. (2010). *Fourth National Incidence Study of Child Abuse and Neglect (NIS-4): Report to Congress*. Washington, DC: U. S. Department of Health and Human Services, Administration for Children and Families. Retrieved from: https://www.acf.hhs.gov/sites/default/files/opre/nis4_report_congress_full_pdf_jan2010.pdf

Shi, L. (2013). Childhood abuse and neglect in an outpatient clinical sample: Prevalence and impact. *American Journal of Family Therapy*, *41*, 198-211. doi:10.1080/01926187.2012.677662

Shotland, R. L., & Heinold, W. D. (1985). Bystander response to arterial bleeding: Helping skills, the decision-making process, and differentiating the helping response. *Journal of Personality and Social Psychology, 49,* 347-356. doi:10.1037/0022-3514.49.2.347

Simons, D. J., & Chabris, C. F. (1999). Gorillas in our midst: Sustained inattentional blindness for dynamic events. *Perception, 28,* 1059-1074. doi:10.1068/p2952

Teisl, M., & Cicchetti, D. (2008). Physical abuse, cognitive and emotional processes, and aggressive/disruptive behavior problems. *Social Development, 17,* 1-23. doi:10.1111/j.1467-9507.2007.00412.x

Trickett, P. K., Mennen, F. E., Kim, K., & Sang, J. (2009). Emotional abuse in a sample of multiply maltreated, urban young adolescents: Issues of definition and identification. *Child Abuse & Neglect, 33*, 27-35. doi:10.1016/j.chiabu.2008.12.003

U. S. Department of Health & Human Services. (2015). *Child maltreatment*. Retrieved from https://www.acf.hhs.gov/sites/default/files/cb/cm2015.pdf

Vanderfaeillie, J., De Ruyck, K., Galle, J., Van Dooren, E., & Schotte, C. (2018). The recognition of child abuse and the perceived need for intervention by school personnel of primary schools: Results of a vignette study on the influence of case, school personnel, and school characteristics. *Child Abuse & Neglect, 79*, 358-370. doi:10.1016/j.chiabu.2018.02.025

Walsh, K., Rassafiani, M., Mathews, B., Farrell, A., & Butler, D. (2010). Teachers' attitudes toward reporting child sexual abuse: Problems with existing research leading to new scale development. *Journal of Child Sexual Abuse, 19*, 310-336. doi:10.1080/10538711003781392

Webster, S. W., O'Toole, R., O'Toole, A. W., & Lucal, B. (2005). Overreporting and underreporting of child abuse: Teachers' use of professional discretion. *Child Abuse & Neglect, 25*, 1281-1296. doi:10.1016/j.chiabu.2004.02.007

Wiehe, V. R. (2003). Empathy and narcissism in a sample of child abuse perpetrators and a comparison sample of foster parents. *Child Abuse & Neglect, 27*, 541-555. doi:10.1016/S0145-2134(03)00034-6

APPENDICES

APPENDIX A

IRB Exemption Determination Notice

IRB
INSTITUTIONAL REVIEW BOARD
Office of Research Compliance,
010A Sam Ingram Building,
2269 Middle Tennessee Blvd
Murfreesboro, TN 37129

MIDDLE TENNESSEE STATE UNIVERSITY

IRBN007 – EXEMPTION DETERMINATION NOTICE

Thursday, February 14, 2019

Principal Investigator	**Jensen Still** (Student)
Faculty Advisor	David B. Kelly
Co-Investigators	NONE
Investigator Email(s)	*jms2e@mtmail.mtsu.edu; david.kelly@mtsu.edu*
Department	Psychology
Protocol Title	***How intervention attitudes are affected by maltreatment type***
Protocol ID	**19-1167**

Dear Investigator(s),

The above identified research proposal has been reviewed by the MTSU Institutional Review Board (IRB) through the **EXEMPT** review mechanism under 45 CFR 46.101(b)(2) within the research category *(2) Educational Tests* A summary of the IRB action and other particulars in regard to this protocol application is tabulated as shown below:

IRB Action	**EXEMPT from furhter IRB review*** **	Date	**2/14/19**
Date of Expiration	NOT APPLICABLE		
Sample Size	100 (ONE HUNDRED)		
Participant Pool	**Healthy Adults (18 or older) - MTSU students**		
Exceptions	Online consent and online data collected allowed		
Mandatory Restrictions	1. Participants must be 18 years or older 2. Informed consent must be obtained from the participants 3. Identifying information must not be collected		
Restrictions	**1. All restrictions for exemption apply.** **2. Mandatory inclusion/exclusion criteria**		
Comments	NONE		

***This exemption determination only allows above defined protocol from further IRB review such as continuing review. However, the following post-approval requirements still apply:

- Addition/removal of subject population should not be implemented without IRB approval
- Change in investigators must be notified and approved
- Modifications to procedures must be clearly articulated in an addendum request and the proposed changes must not be incorporated without an approval
- Be advised that the proposed change must comply within the requirements for exemption
- Changes to the research location must be approved – appropriate permission letter(s) from external institutions must accompany the addendum request form
- Changes to funding source must be notified via email (irb_submissions@mtsu.edu)

- The exemption does not expire as long as the protocol is in good standing
- Project completion must be reported via email (irb_submissions@mtsu.edu)
- Research-related injuries to the participants and other events must be reported within 48 hours of such events to compliance@mtsu.edu

Post-approval Protocol Amendments:

The current MTSU IRB policies allow the investigators to make the following types of changes to this protocol without the need to report to the Office of Compliance, as long as the proposed changes do not result in the cancellation of the protocols eligibility for exemption:

- Editorial and minor administrative revisions to the consent form or other study documents
- Increasing/decreasing the participant size

Only THREE procedural amendment requests will be entertained per year. This amendment restriction does not apply to minor changes such as language usage and addition/removal of research personnel.

Date	Amendment(s)	IRB Comments
NONE	NONE.	NONE

The investigator(s) indicated in this notification should read and abide by all applicable post-approval conditions imposed with this approval. Refer to the post-approval guidelines posted in the MTSU IRB's website. Any unanticipated harms to participants or adverse events must be reported to the Office of Compliance at (615) 494-8918 within 48 hours of the incident.

All of the research-related records, which include signed consent forms, current & past investigator information, training certificates, survey instruments and other documents related to the study, must be retained by the PI or the faculty advisor (if the PI is a student) at the sacure location mentioned in the protocol application. The data storage must be maintained for at least three (3) years after study completion. Subsequently, the researcher may destroy the data in a manner that maintains confidentiality and anonymity. IRB reserves the right to modify, change or cancel the terms of this letter without prior notice. Be advised that IRB also reserves the right to inspect or audit your records if needed.

Sincerely,

Institutional Review Board
Middle Tennessee State University

Quick Links:

Click here for a detailed list of the post-approval responsibilities.
More information on exmpt procedures can be found here.

APPENDIX B

Demographic Questions

Please complete the following questions regarding demographics.

1. What is your sex?
    - Male
    - Female
2. What is your age?
    - 18 to 21 years
    - 22 to 25 years
    - 26 to 29 years
    - 30 years and older
    - I prefer not to answer.
3. What is your race/ethnicity?
    - Caucasian
    - African American
    - Other
    - I prefer not to answer.

APPENDIX C

Survey of Attitudes Regarding Intervention in Physical Maltreatment

You witness one of your neighbors physically maltreating his or her child on multiple occasions.

1) Please rate how severe you perceive this situation to be on a scale of one to five, with one being not severe and five being very severe:

Not Severe				Very Severe
1	2	3	4	5
○	○	○	○	○

2) Please rate how likely you are to take each of the following actions:

	Very Unlikely	Somewhat Unlikely	Unsure	Somewhat Likely	Very Likely
a) Report the incident to the Department of Children's Services.	○	○	○	○	○
b) Talk to the parent who is maltreating the child.	○	○	○	○	○
c) Befriend the child and try to help him/her.	○	○	○	○	○
d) Try to get others (e.g., witnesses, relatives, friends) involved.	○	○	○	○	○
e) Report the incident to the police.	○	○	○	○	○

3) Please rate how likely each of the following are to stop you from taking action:

	Very Unlikely	Somewhat Unlikely	Unsure	Somewhat Likely	Very Likely
a) Fear of physical confrontation.	○	○	○	○	○
b) Fear of verbal confrontation.	○	○	○	○	○
c) Fear of being sued.	○	○	○	○	○
d) Fear that the situation would worsen for the child.	○	○	○	○	○
e) Fear of being wrong about what is happening.	○	○	○	○	○
f) The belief that family life is private and those outside of the family should not get involved.	○	○	○	○	○

4) Please rate how necessary you feel it is that some action be taken to stop the parent's behavior:

Very Unnecessary	Somewhat Unnecessary	Unsure	Somewhat Necessary	Very Necessary
○	○	○	○	○

5) Please rate how likely you are to take some action to stop the parent's behavior:

Very Unlikely	Somewhat Unlikely	Unsure	Somewhat Likely	Very Likely
○	○	○	○	○

APPENDIX D

Survey of Attitudes Regarding Intervention in Psychological Maltreatment

You witness one of your neighbors psychologically maltreating his or her child on multiple occasions.

1) Please rate how severe you perceive this situation to be on a scale of one to five, with one being not severe and five being very severe:

Not Severe				Very Severe
1	2	3	4	5
○	○	○	○	○

2) Please rate how likely you are to take each of the following actions:

	Very Unlikely	Somewhat Unlikely	Unsure	Somewhat Likely	Very Likely
a) Report the incident to the Department of Children's Services.	○	○	○	○	○
b) Talk to the parent who is maltreating the child.	○	○	○	○	○
c) Befriend the child and try to help him/her.	○	○	○	○	○
d) Try to get others (e.g., witnesses, relatives, friends) involved.	○	○	○	○	○
e) Report the incident to the police.	○	○	○	○	○

3) Please rate how likely each of the following are to stop you from taking action:

	Very Unlikely	Somewhat Unlikely	Unsure	Somewhat Likely	Very Likely
a) Fear of physical confrontation.	○	○	○	○	○
b) Fear of verbal confrontation.	○	○	○	○	○
c) Fear of being sued.	○	○	○	○	○
d) Fear that the situation would worsen for the child.	○	○	○	○	○
e) Fear of being wrong about what is happening.	○	○	○	○	○
f) The belief that family life is private and those outside of the family should not get involved.	○	○	○	○	○

4) Please rate how necessary you feel it is that some action be taken to stop the parent's behavior:

Very Unnecessary	Somewhat Unnecessary	Unsure	Somewhat Necessary	Very Necessary
○	○	○	○	○

5) Please rate how likely you are to take some action to stop the parent's behavior:

Very Unlikely	Somewhat Unlikely	Unsure	Somewhat Likely	Very Likely
○	○	○	○	○

APPENDIX E

Informed Consent

IRBF024 – Participant Informed Consent (ONLINE)

Primary Investigator: Jensen Still
PI Department & College: Department of Psychology; College of Graduate Studies
Faculty Advisor (if PI is a student): Dr. David B. Kelly
Protocol Title: How Intervention Attitudes are Affected by Maltreatment Type
Protocol ID: 19-1167 **Approval Date:** 02/14/2019 **Expiration Date:** N/A

Information and Disclosure Section

1. Purpose: This research project is designed to help us evaluate how the perception of maltreatment type impacts attitudes toward intervention.

2. Description: There are several parts to this project. They are:

- completing a demographic form;
- reading a short vignette that uses the term of a maltreatment type (no graphic descriptors or details are included); and
- completing a survey to assess your thoughts about the vignette.

Here are your rights as a participant:

- Your participation in this research is voluntary.
- You may skip any item that you don't want to answer, and you may stop the experiment at any time (but see the note below).
- If you leave an item blank by either not clicking or entering a response, you may be warned that you missed one, just in case it was an accident. But you can continue the study without entering a response if you didn't want to answer any questions.

3. Risks & Discomforts: There is less than minimal risk and discomfort expected to result from participation in this study.

4. Benefits: There will be no direct benefit to you, the participant. A potential benefit to science and humankind that may result from this study is furthered understanding of intervention or lack of intervention in child maltreatment.

5. Identifiable Information: You will NOT be asked to provide identifiable personal information.

6. Compensation: The participants will be compensated as described below:

- Participants will receive 1 research or extra credit.
    - *Compensation Requirements:*
        - *The qualification to participate in this research is: to be 18 years of age or older. If you do not meet this qualification, you will not be included in the research and you will not be compensated.*
        - *After you complete this consent form you will answer screening questions. If you fail to qualify for the research based on these questions, the research will end, and you will not be compensated.*
        - *Please do not participate in this research more than once. Multiple attempts to participate will not be compensated.*
        - *To be compensated, you must receive a completion code. That requires clicking on the final screen of the study. If you choose to stop for any reason, you will still need to click through until the end to receive compensation (just leave the items blank and click through until the end).*

7. Confidentiality. All efforts, within reason, will be made to keep your personal information private but total privacy cannot be promised. Your information may be shared with MTSU or the government, such as the Middle Tennessee State University Institutional Review Board, Federal Government Office for Human Research Protections, if you or someone else is in danger or if we are required to do so by law.

8. Contact Information. If you should have any questions about this research study or possibly injury, please feel free to contact Jensen Still by email at jms2et@mtmail.mtsu.edu OR my faculty advisor, Dr. David B. Kelly, at David.Kelly@mtsu.edu or (615) 898-2584. You can also contact the MTSU Office of Compliance via telephone at (615) 494-8918 or by email at compliance@mtsu.edu. This contact information will be presented again at the end of the study.

Participant Response Section

☐No ☐Yes I have read this informed consent document pertaining to the above identified research
☐No ☐Yes The research procedures to be conducted are clear to me
☐No ☐Yes I confirm I am 18 years or older
☐No ☐Yes I am aware of the potential risks of the study

By clicking below, I affirm that I freely and voluntarily choose to participate in this study. I understand I can withdraw from this study at any time without facing any consequences.

- ☐ NO, I do not consent
- ☐ Yes, I consent

APPENDIX F

Debriefing Information

Please save or print this for your own use.

Physical maltreatment can be defined as an act that results in injury or risk of injury and may include behaviors such as hitting, kicking, and shaking. Psychological maltreatment can be defined as acts that are emotionally damaging to a child; these acts may include behaviors such as terrorizing or isolating, which convey to the child that he or she is worthless, flawed, unloved, unwanted, endangered, or only of value in meeting another's needs.

This study was designed to examine how perception of maltreatment type (physical versus psychological) and participant sex impact attitudes toward intervention. Specifically, perceptions of severity and intervention necessity, as well as the likelihood of taking specific action and not taking action due to specific barriers, were examined.

If you would like more information about this study or your rights as a participant, please feel free to contact me at jms2et@mtmail.mtsu.edu or my faculty advisor, Dr. David B. Kelly, at David.Kelly@mtsu.edu. You can also contact the MTSU Office of Compliance via telephone at (615) 494-8918 or by email at compliance@mtsu.edu. The results of this study will not be immediately available, but arrangements for you to obtain the results once they are available can be made by contacting me at jms2et@mtmail.mtsu.edu or my faculty advisor, Dr. David B. Kelly, at David.Kelly@mtsu.edu.

Thank you for your participation!

Jensen Still
Graduate Student, Clinical Psychology
jms2et@mtmail.mtsu.edu