

Q 5 : Have your parents ever talked with you about child sexual abuse ?

no

yes



If they have, please answer questions 5b to 5d:

Q 5b : Which parent ?

father

mother

both

Q 5c : Did they explain that children may be sexually abused by family friends or family members ?

yes

no

I don't remember

Q 5d : Did they tell you to let an adult know if it happened to you ?

yes

no

I don't remember

Q 6 a : Did you take part in the information session before today's questionnaire ?

yes

no

6 b : Before the information session, were you ever told about sexual abuse at school, for example during Facts of Life classes, or in a play, a movie or an exhibit ?

yes

no

I don't remember

Q 7 : Were you told about sexual abuse somewhere else (i.e., outside of home and school) ?

yes

no

I don't remember

If so, please specify who told you about it (e.g., friend, scout, doctor, etc.) :

.....
.....

Q8 : Has an adult or an older child ever not respected you by demanding you or forcing you to...

	<u>Yes</u>	<u>No</u>	<u>I don't want to answer</u>
a) look at his/her genitals ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) undress and show him/her your genitals ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) watch him/her masturbate ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) undress with another child and fondle each other in front of him/her ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) <u>be fondled</u> (caresses, rubs, kisses on the whole body and/or your genitals) ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) <u>fondle</u> him/her (caresses, rubs, kisses on the whole body and/or his/her genitals) ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) look at pornographic pictures, drawings, films, videotapes or magazines ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) be naked and to expose your genitals for picture taking or filming ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) submit to full sexual intercourse with penetration ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) submit to having his/her fingers or an object introduced in your body ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

You may wish to give a more detailed answer. Here is some space you may use to comment...

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Q9 : If you experienced several of the situations described in question 8, one of them may have affected you far more than the others. If so, please indicate which one stands out by providing the corresponding letter in the list, i.e., "a" to "j"

If you were subjected to *several* situations described in question 8, answer the following question (Q 10) with the situation that affected you most in mind, i.e., the one you just provided for question 9.

Q 10 : If you were subjected to one (or more) situation/s described in question 8, it happened to you :

- | | |
|---|--|
| <input type="checkbox"/> once | <input type="checkbox"/> I can't remember |
| <input type="checkbox"/> between 2 and 5 times | <input type="checkbox"/> it never happened to me |
| <input type="checkbox"/> between 6 and 10 times | |
| <input type="checkbox"/> over 10 times | |

Q 11 : How old were you when it happened the first time ?

- | | |
|--|--|
| <input type="checkbox"/> under 6 years old | <input type="checkbox"/> between 12 and 14 years old |
| <input type="checkbox"/> between 6 and 8 years old | <input type="checkbox"/> between 14 and 16 years old |
| <input type="checkbox"/> between 8 and 10 years old | <input type="checkbox"/> I can't remember |
| <input type="checkbox"/> between 10 and 12 years old | <input type="checkbox"/> it never happened to me |

Q 12 : Are you still subjected presently to any of these situations ?

- | | | |
|--------------------------|--------------------------|--------------------------|
| yes | no | it never happened to me |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Q 13 : If not, how old were you the last time it happened to you ?

- | | |
|--|--|
| <input type="checkbox"/> under 6 years old | <input type="checkbox"/> between 12 and 14 years old |
| <input type="checkbox"/> between 6 and 8 years old | <input type="checkbox"/> between 14 and 16 years old |
| <input type="checkbox"/> between 8 and 10 years old | <input type="checkbox"/> I can't remember |
| <input type="checkbox"/> between 10 and 12 years old | <input type="checkbox"/> it never happened to me |

If you were subjected to *several* situations described in question 8, answer the following question (Q 14) with the situation that affected you most in mind, i.e., the one you provided for question 9.

Q 14 :

	<u>yes</u>	<u>no</u>	<u>it never happened to me</u>
At the time it happened, did you feel...			
a) threatened or in danger ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) unable to say no out of embarrassment/shame/fear ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) forced to go along for other reasons ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) neither forced nor threatened ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were you...			
e) subjected to physical abuse ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) able to avoid the situation/s, e.g., by refusing to go along, running away, etc. ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you wish, use the space below to complete your answers freely.

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Q 15 a : What was the gender of the person (or people) who got you in this (or these) situation/s ? (*several answers possible*) :

male

female

it never happened to me

Q 15 b : How old would you say s/he was (or they were) ?

1st person year old

2nd person year old

3rd person year old

Q 16 : This person (or these people) was (or were) a : *(several answers possible)*

- | | |
|---|---|
| <input type="checkbox"/> stranger | <input type="checkbox"/> mother's or father's friend |
| <input type="checkbox"/> baby-sitter | <input type="checkbox"/> brother or sister |
| <input type="checkbox"/> family friend | <input type="checkbox"/> half brother or half sister |
| <input type="checkbox"/> neighbour | <input type="checkbox"/> uncle or aunt |
| <input type="checkbox"/> teacher | <input type="checkbox"/> grandfather or grandmother |
| <input type="checkbox"/> instructor | <input type="checkbox"/> someone else <i>(specify without giving the person's name)</i> |
| <input type="checkbox"/> peer | |
| <input type="checkbox"/> father or mother | |
| <input type="checkbox"/> stepfather or stepmother | <input type="checkbox"/> it never happened to me |

Q 17 : Did you ever talk to anyone about this (or these) event/s ?

- | | | |
|--------------------------|--------------------------|--------------------------|
| yes | no | it never happened to me |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

If you did : *(several answers possible)*

- I was helped
- I was not believed
- nothing changed
- I asked that it be kept secret
- I asked that nothing be done

Q 18 : Who did you talk to about this (or these) event/s ? *(several answers possible)*

- | | |
|--|---|
| <input type="checkbox"/> father | <input type="checkbox"/> someone teaching a Fact of Life class |
| <input type="checkbox"/> mother | <input type="checkbox"/> school nurse |
| <input type="checkbox"/> brother or sister | <input type="checkbox"/> doctor |
| <input type="checkbox"/> grandparent/s | <input type="checkbox"/> friend |
| <input type="checkbox"/> other family member | <input type="checkbox"/> another person outside the family
<i>(specify without providing a name)</i> |
| | |
| | |
| | <input type="checkbox"/> it never happened to me |

Q 19 : Do you know of another youngster who experienced similar events and who spoke to you about them ?

yes	no
<input type="checkbox"/>	<input type="checkbox"/>

Q 20 : How did you find this questionnaire ?

	<u>yes</u>	<u>no</u>
useful	<input type="checkbox"/>	<input type="checkbox"/>
boring	<input type="checkbox"/>	<input type="checkbox"/>
clear	<input type="checkbox"/>	<input type="checkbox"/>
too difficult	<input type="checkbox"/>	<input type="checkbox"/>
embarrassing	<input type="checkbox"/>	<input type="checkbox"/>
interesting	<input type="checkbox"/>	<input type="checkbox"/>
too long	<input type="checkbox"/>	<input type="checkbox"/>

If you wish, please add comments here :

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You got to the end of the questionnaire.

You have time to read it over and check if you answered all the questions.

Please, remain seated at your desk, we will collect all the questionnaires at the same time.

Thank you once again for your help!

