UNIVERSITÉ DU QUÉBEC À MONTRÉAL

SUICIDALITY, BULLYING AND SEXUAL HARASSMENT IN ADOLESCENT GIRLS WITH A HISTORY OF SEXUAL ABUSE

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LE SUICIDE, L'INTIMIDATION ET L'HARCELEMENT SEXUEL CHEZ LES ADOLESCENTES VICTIMES D'AGRESSION SEXUELLE

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In loving memory of my grandmother, Mémé Anna.

DEDICATION

To my parents, Danielle & Gerry,
for always pushing me to succeed, and to Howard, the love of my life.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ABBREVIATIONS AND SYMBOLS

AAUW	American Association of University Women
ACT	Acceptance and Commitment Therapy (Hayes, Strosahl, & Wilson, 1999)
β	Beta
CBT	Cognitive-Behaviour Therapy (Allen, McHugh, & Barlow, 2008)
CI	Confidence Interval
CITES II	Children's Impact of Traumatic Events Scale II (Wolfe et al., 2002)
DBT	Dialectical Behaviour Therapy (Linehan, 1993)
DSM	Diagnostic and Statistical Manual of Mental Disorders
HVF	History of Victimization Form (Wolfe, Gentile, & Bourdeau, 1987)
SA	Sexual abuse

SEQ	The Sexual Experiences Questionnaire (Fitzgerald, Geldland, & Drasgow, 1995)
SH	Sexual harassment
N	Sample size
p	Probability
ϕ	Phi
PTSD	Post-traumatic stress disorder
Exp(B)	Exponents of the Beta coefficient
R^2	Nagelkerke R Square
SE	Standard error
US	United States
W	Wald criteria
WCQ	Ways of Coping Questionnaire (Folkman & Lazarus, 1988)

WHO	World Health Organization
$\chi 2$	Chi-square

RÉSUMÉ

Cet essai doctoral avait pour objectif de mieux saisir les liens entre la suicidalité et la victimisation par les pairs chez les adolescentes victimes d'agression sexuelle. Les adolescentes avec une histoire d'agression sexuelle sont 4.3 fois plus susceptibles d'avoir des idées suicidaires et 15 fois plus à risque d'avoir fait une tentative de suicide que les autres adolescents (Brabant, Hébert, & Chagnon, 2014). Cet essai considère les écrits scientifiques portant sur l'intimidation et le harcèlement sexuel par les pairs. La présente étude a été réalisée auprès d'un échantillon de 195 adolescentes (âgées de 12 à18 ans) consultant des centres d'intervention suite à un dévoilement d'agression sexuelle. Les participantes ont rempli des questionnaires sur la suicidalité (idéations et tentatives), et les expériences d'intimidation et de harcèlement sexuel vécues au cours des 12 derniers mois. Différents facteurs associés (symptômes de stress post-traumatique, stratégies d'adaptation ou « coping » et soutien social) ont également été mesurés. La majorité des adolescentes (82%) a vécu des agressions sévères. Environ 37% des adolescentes ont rapporté des incidents d'intimidation répétés (en personne ou par voie électronique) et 27% ont rapporté des situations de harcèlement sexuel par les pairs dans la dernière année. Les résultats des analyses de régressions hiérarchiques suggèrent que la présence de stress post-traumatique et un faible soutien maternel contribuent à la prédiction du risque de suicidalité. En contrôlant pour ces variables, l'intimidation était associée à une augmentation du risque d'idéations suicidaires, alors que le harcèlement sexuel n'était pas associé à la suicidalité. À notre connaissance, cette étude est la première à mettre en évidence l'importance d'aborder l'intimidation et le harcèlement sexuel de façon distincte dans la prévention et l'intervention auprès des adolescentes ayant vécu une agression sexuelle.

Mots clés: suicide, agression sexuelle, intimidation par les pairs, cyberintimidation, harcèlement sexuel, adolescente

ABSTRACT

The objective of this thesis is to advance knowledge on suicidality and peer victimization in adolescents with a history of sexual abuse. Adolescents with a history of sexual abuse are 4.3 times more likely to have suicidal ideation and 15 times more likely to attempt suicide than other adolescents (Brabant, Hébert, & Chagnon, 2014). This thesis reviews the literature on risk factors associated with suicidality in this population, with particular emphasis on bullying and sexual harassment. A cross-sectional study analyzes responses to questionnaires for 195 sexually abused girls aged 12-18 years presenting at intervention centres in Quebec, Canada. The participants filled out questionnaires on suicidality over their lifetime (ideation and attempt) and on experiences of bullying and sexual harassment over the past 12 months. Other factors associated with suicidality (social support, coping skills and symptoms of PTSD) were also measured in the questionnaires. Most participants (82%) had experienced "severe" penetrative sexual behaviour. About 37% of participants reported incidents of repeated bullying (online/offline) in the past year; 27% reported repeated sexual harassment by peers. Hierarchical logistic regressions revealed that symptoms of post-traumatic stress disorder and lower maternal support were predictors of suicidality. After controlling for social support, coping skills and symptoms of PTSD, bullying was associated with increased risks of suicidal ideation, whereas sexual harassment was not. To our knowledge, this is the first study to highlight the importance of considering peer victimisation in prevention and treatment programs aimed at reducing suicide risk among teenage girls with a history of sexual abuse.

Keywords: suicide, sexual abuse, bullying, cyberbullying, sexual harassment, adolescent girls

CHAPTER I

GENERAL INTRODUCTION

Sexual abuse (SA) is recognized as a global problem with known negative consequences on adolescents' psychological well-being (Stoltenborgh, Van Ijzendoorn, Euser, & Bakermans-Kranenburg, 2011). Suicide represents one of the most alarming consequence of SA (Alvarez-Alonso et al., 2016). Indeed, suicide is the ultimate avoidance strategy (Briere & Elliott, 1994) and the leading cause of death in adolescent girls (Serafini et al., 2015).

Recently, cases of suicides have been highlighted in the media as being linked to episodes of peer victimization (Hinduja & Patchin, 2010). Bullying and sexual harassment (SH) are two forms of interpersonal violence commonly reported in adolescence (Li, 2014). In the general population, both bullying and sexual harassment have individually been associated with suicidality (Van Geel, Vedder, & Tanilon, 2014). SA has an important impact on social functioning and interpersonal skills and may be associated with dysfunctional peer relationships, including the risk of interpersonal violence and suicidality (Dube, Anda, & Felitti, 2001). Examining victimization of sexually abused girls in the context of peer relationships could offer relevant data to inform detection of suicidality risk and treatment.

In the empirical literature to date there is a dearth of information concerning peer victimization in adolescent girls who have been sexually abused. Yet, the limited research available indicates a significant relationship between SA and bullying (Benedini, Fagan, & Gibson, 2016; Hébert, Cénat, Blais, Lavoie, & Guerrier, 2016a) and between SA and SH (Das & Otis, 2016; Senécal, Hébert, Lavoie, Tremblay, & Vitaro, 2006). Data is still missing, however, on the rate of SH and on the co-occurrence of bullying and SH in adolescent girls with a history of SA, as well as on the impact of peer victimization and SA on suicidality to understand if there is a relationship between these factors.

The objective of this thesis is to advance knowledge about suicidality and peer victimization in victims of SA. Specifically, the study's objectives are to document the rate and co-occurrence of bullying and SH in a clinical sample of adolescent girls with a history of SA. Identifying whether bullying and SH are prevalent in this population and whether they co-occur could inform practice by highlighting whether there would be a need for specific prevention strategies. It would also be crucial to determine whether peer victimization is associated with an increased risk of suicidality in sexually abused girls. Such an understanding would help tailor preventive measures and design optimal intervention strategies for adolescent girls, as well as help practitioners identify youth at risk of suicidality.

This thesis is divided into the following sections. The Literature review highlights the knowledge to date on SA, suicidality and peer victimization. Other possible Interpersonal-Psychological Factors leading to suicidality are described. The Introduction concludes with our objectives and hypotheses. As part of an article submitted for publishing, the Methods section provides information on the questionnaires and statistical analyses used and the Results are presented in detail and

then put into context in the Discussion section. Considerations for future research directions and Practical Implications for assessment, intervention and prevention are presented in the Conclusion of this thesis.

LITERATURE REVIEW

1.1 Sexual Abuse (SA)

The World Health Organization (WHO) defines SA during childhood and adolescence as "the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and could not give consent, or that violate the laws or social taboos of society" (Murray, Nguyen, & Cohen, 2014, p.2). Compared to boys, girls are more at risk for SA, particularly for intrafamilial SA (Murray et al., 2014; Pérez-Fuentes, Olfson, Villegas, Morcillo, Wang, & Blanco, 2013). In addition, girls are also more likely than boys to disclose the abuse to someone (Hébert, Tourigny, Cyr, McDuff, & Joly, 2009) and to seek treatment (Easton, Saltzman, & Willis, 2013).

In a meta-analysis conducted in 2011, Stoltenborgh et al. reported an overall estimated worldwide prevalence of 11.8% for SA occurring before the age of 18

years. In Quebec, the prevalence of SA is 22% for women and 10% for men (Tourigny, Hébert, Joly, Cyr, & Baril, 2008). Prevalence rates may vary from one study to another due to differences in definitions and methodology, such as particular inclusions of sexual acts, sample selection, survey methods, and screening questions (Murray et al., 2014). Further, estimates may differ by country, as reports reflect cultural norms and values affecting the willingness of individuals to disclose. What is clear is that SA is a global issue. Understanding the risk factors and consequences of SA would be helpful to aid those already affected and to prevent future abuse.

1.2 Consequences of Sexual Abuse

Positive developmental experiences in childhood establish the groundwork for lifetime health and well-being. Many children, however, face hardships that destabilise their development and increase the risk of later problems (Herrenkohl et al., 2016). While traumatic events in adulthood could cause potential immediate harm, childhood trauma disrupts and distorts personal development, such that its impact lasts a lifetime (Williams, 2006). Sex acts imposed on children, too immature to fully grasp their significance, are associated with significant cognitive, emotional and social impairments (McConnell, 2015). Maladaptive behaviours elicited by trauma include: distrust of others, anger or fear of authority figures, fear of abandonment, passivity, avoidance and sexualized behaviour (Blanchard-Dallaire & Hébert, 2014; Briere & Elliot, 1994). A review of the literature shows that 10-58% of children with a history of SA suffered setbacks in both academic performance and

psychosocial adaptation (Daigneault & Hébert, 2004). Children with a history of abuse have lower concentration capacity, obtain lower grades, perform worse on standardized exams of academic achievement, are less engaged in school programs, and are absent more often than children who have not been abused (Raby et al., 2018).

SA is also associated with a plethora of adverse effects on psychological well-being. Symptoms of anxiety, depression, borderline personality disorder, and dissociation are documented after SA (Collin-Vézina, Daigneault, & Hébert, 2013). Adolescents with a history of SA are more likely to use drugs and alcohol to cope with the trauma (Alvarez-Alonso et al., 2016; Mandavia, Robinson, Bradley, Ressler, & Powers, 2016).

Of these effects on psychological well-being, post-traumatic stress disorder (PTSD) is the most noteworthy psychiatric disorder affected by SA (Hébert, Lavoie, & Blais, 2014). The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5; American Psychiatric Association, 2013) classifies PTSD as a trauma- and stress- related disorder. To meet criteria, victims must have been directly involved in, witness to or repeatedly exposed to aversive details of "actual or threatened death, serious injury or sexual violation". The four distinct clusters of diagnostic criteria include: intrusive symptoms (nightmares, flashbacks, prolonged distress); avoidance of stimuli (cognitions, emotions, external reminders), changes in cognitions and mood (dissociative amnesia, constricted affect, alienation); and changes in arousal and reactivity (aggression, reckless behaviour). Bal, De Bourdeaudhuij, Crombez, and Van Oost (2004a) found that in 50% of adolescents seeking treatment for SA, symptoms matched diagnostic criteria for PTSD. Six months after disclosure, 46% of these adolescents persevered with significant trauma symptoms (Bal et al., 2004b).

1.3 Sexual abuse and Suicidality

Adolescents with a history of SA are 4.3 times more likely to have suicidal ideation and are almost 15 times more likely to have attempted suicide than those without a history of SA (Mansbach-Kleinfeld et al., 2015). Suicide is recognized as a critical public health issue: it is the leading cause of death for adolescent girls (Serafini et al., 2015) and the ninth leading overall cause of death in Canada (Canadian Association for Suicide Prevention). It is the foremost cause of untimely, preventable death (Statistics Canada, 2015). Identifying the factors that contribute to the likelihood of suicidality in adolescents with a history of SA would help prevent future suicides. This section will provide an overview of the definition, prevalence and associated risks for suicidality in victims of SA.

The term *suicidality* encompasses suicidal ideation, self-harming behaviour, suicidal attempt and completed suicide (Meyer et al., 2010). Our study focuses primarily on *suicidal ideation*, the "presence of passive and active suicidal thoughts, intention and plans" (Florez, Allbaugh, Harris, Schwartz, & Kaslow, 2018, p. 50) and *suicidal attempt*, "potentially self-injurious behavior with a nonfatal outcome, for which there is evidence that the person intended to kill herself" (O'Carroll et al., 1996, p. 247). The presence of suicidal ideation indicates a higher likelihood of suicidal attempt, which in turn could lead to a higher likelihood of suicidal death (Brabant et al., 2014).

Amongst the Canadian general population, 84 suicidal deaths of teenage girls were reported in 2015, with a rate of 6.2 for 15- to 19-year-olds (per 100,000; Statistics Canada, 2015). About 14% of Canadian teens report a lifetime prevalence of suicidal ideation and 3.5% of attempted suicide (Statistics Canada, 2012).

Elevated risk for suicidality includes demographic factors, psychological vulnerabilities, adverse life events and interpersonal difficulties (Serafini et al., 2015). Girls are more at risk of suicidal behaviour, while boys are more likely to commit suicide (James, Abrutyn, & Levin, 2015). Girls are more likely to seek professional help than are boys (Meyer et al., 2010). Psychiatric diagnoses of depression, borderline personality disorder, antisocial personality disorder, substance use and anxiety are more likely to increase the risk of suicidality in adolescence (Gournellis et al., 2018; Orri et al., 2018; Soloff & Chiappetta, 2018). Extreme psychological pain, known as *psychache,* contributes to the likelihood of suicidal behaviours (Campos, Holden, & Santos, 2018). Impulsivity is a risk for suicidal attempts in adolescence (Brezo et al., 2008).

There is a clear link between SA and suicidality (Miller, Esposito-Smythers, Weismoore, & Renshaw, 2013; Wherry, Baldwin, Junco, & Floyd, 2013). A recent meta-analysis by Ng, Yong, Ho, Lim, and Yeo (2018) demonstrated that sexually abused adolescents are more likely to attempt suicide than non-abused peers. Brezo et al. (2008) found that the odds of non-fatal suicidal behaviours are higher in women reporting a childhood history of either SA or physical abuse than those without a history of abuse. Noll et al. (2003) reported that sexually abused women were four times more likely to partake in self-harming behaviour than comparison participants.

Martin, Bergen, Richardson, Roeger, and Allison (2004) found that girls who have experienced SA have a three-fold risk of suicidal ideation. In Quebec, Brabant et al. (2014) stated that 64% of adolescent girls with a history of SA have suicidal ideations and of those, 25% have attempted suicide. Earlier onset, repeated abuse and closer proximity to the perpetrator are correlated with higher degree of associated risk of suicidality (Serafini et al., 2015; Soylu & Alpaslan, 2013). Various factors are found to mediate the relationship between SA and suicidality, such as PTSD, coping skills, and family dynamics (Brabant et al., 2014).

1.4 The Interpersonal-Psychological Theory of Suicidal Behaviour (Joiner, 2005)

The interpersonal-psychological theory of suicidal behaviour proposed by Joiner (2005) attempts to explain how people develop the desire for self-destruction and how this desire could overcome the need for self-preservation. According to Joiner, "an individual will not die by suicide unless s/he has both the desire to die by suicide as well as the ability to do so" (Joiner et al., 2009, p.2). The theory hypothesizes that three types of factors contribute to suicidal behaviour: thwarted belongingness, burdensomeness, and fearlessness. The first two, thwarted belongingess and burdensomeness, may lead to suicidal ideation, the desire to die by suicide, while the addition of fearlessness may give the adolescent the capacity to die by suicide, and completing a suicidal attempt.

The relationship between social isolation and suicidality has been clearly established, and social isolation seems to be one of the strongest factor related to suicidality (Joiner et al., 2009). An adolescent may have feelings of thwarted belongingness

when she feels alienated from her peer group, when she feels different than others, or when she doesn't feel like an integral part of her community. For example, after an experience of SA or peer victimization, the adolescent may feel as though she no longer belongs in the peer group, like she is an outsider, or like she is targeted as different from her peers, in line with the stigmatization dynamic proposed by Finkelhor and Browne (1985). Traumatic experiences in childhood, such as SA, have been associated with loneliness and decreased satisfaction in relationships (Merz & Jak, 2013; Kearney, Zeligman, Brack, & Payne, 2018) and Opperman, Czyz, Gipson, and King (2015) found that low family and school connectedness were correlated with suicidal ideation in bullied adolescents. Further research is required to understand the relationship between interpersonal victimization and suicidal ideation.

Past research has shown a strong association between higher levels of perceived burdensomeness and suicidal ideation, even after controlling for other variables such as hopelessness (Van Orden, Lynam, Hollar, & Joiner, 2006). These feelings of thwarted belonging and burdensomeness may fester over time and increase the adolescent's desire for suicide. An adolescent may also feel like a burden on her friends, family or community. She may feel like others believe they would be better off if she was dead. She may feel low self-worth and believe that she is not worth their time or energy. SA, bullying and SH have each been associated with low self-esteem in past studies (Cenat et al., 2014; Morrow & Sorell, 1989). For example, after an experience of peer victimization, she may feel ashamed or like a burden on those friends who tried to protect her. She may feel that she would be better off dead, so that those friends would have an easier life if they didn't have to protect her. Opperman et al. (2015) found that low family connectedness combined with a high sense of perceived burdensomeness in bullied adolescents was associated with more severe suicidal ideation.

While thwarted belonging and burdensomeness may increase the desire for suicide, Joiner's interpersonal-psychological theory suggest that these are not enough to lead to the attempt at suicide (Van Orden et al., 2006). The addition of fearlessness of physical injury must be present for the adolescent to have the acquired ability to commit suicide (Joiner, 2005). Research has shown that a history of suicide attempts is a strong predictor of future suicidal behaviour, including death by suicide (Joiner, 2005). In theory, "the body is generally not designed to cooperate with its own early demise; therefore, suicide entails a fight with self-preservation motives" (Joiner et al., 2009, p. 3). An adolescent may develop this sense of fearlessness after having repeated exposure to adverse experiences in her lifetime. She may feel that life is not worth living, that it is too difficult for her to continue living under these conditions, or she may feel that the pain of continuing to live in these conditions is worse than the act of suicide. For example, she may feel a heightened sense of fearlessness after experiencing both SA and peer victimization or symptoms of PTSD may heighten her tolerance for pain. Smith et al. (2016) found that interpersonal trauma exposure and the PTSD symptoms of reexperiencing and anxious arousal were associated with the acquired capacity for suicide.

This study will examine how factors related to SA such as *peer victimization, social support, coping strategies* and *PTSD* contribute to the likelihood of suicidal behaviour.

1.4.1 Interpersonal Factors Associated with Suicidality

In adolescence, social relationships become increasingly important and group interactions more complex. A history of SA could impair adolescents' ability to navigate these important social changes. Adolescents with a history of SA may be socially withdrawn and may have feelings of betrayal, shame, powerlessness and stigmatisation (Murray et al., 2014), which impact interpersonal functioning. They may experience less satisfactory friendships and greater conflicts in peer relations (Raby et al., 2018). Research found that a history of SA is associated with internalizing and externalizing mental health problems during adolescence, such as anxiety, depression, and behavioural issues, which may significantly impact on the ways of relating to others (Petersen, Joseph, & Feit, 2014). Misconceptions about sexual morality and inappropriate sexual behaviour may result from SA, spurring inappropriate sexual repertoires, confusing sexual self-concepts, and creating unusual emotional associations to sexual activities (Finkelhor & Browne, 1985). Adolescents exposed to sexuality at an earlier age may be more likely to participate in increased consensual sexual behaviour (Kaltiala-Heino et al., 2018). Das (2009) argued that increased sexualization may be interpreted as cues for receptivity to sexual attention, inadvertently leading to SH. Inappropriate sexual behaviour could also incur wrath from peers, perhaps leading to distance from the peer group and vulnerability to bullying. A major consequence of SA therefore is impaired interpersonal skills. These factors may lead to possible vulnerability for peer victimization.

As peer victimization has been linked with suicidality in adolescence, it would be important to further explore the impact of peer victimization on suicidality in sexually abused girls. In the current study, two forms of interpersonal victimization are studied, bullying and sexual harassment (SH). This section will explain the definition, associated risk factors, consequences and previous study of bullying and SH, apart

and together, in the general population as well as in victims of SA. Distinguishing between these two forms of peer victimization could be important to determine prevention and treatment protocols for teenage girls with a history of SA.

1.4.1.1 Bullying

Bullying, or repeated interpersonal aggressive behaviour over time, is the most common modality of peer victimization (Alavi, Robert, Sutton, Axas, & Repetti, 2015). Bullying includes direct and indirect forms of aggression, with both face-to-face interactions (traditional) and electronic communications (cyber) designed to establish dominance and control over the victim. Traditional bullying is mostly contained to school premises during school hours, peaking around grades 7-8 and decreasing with later school grades (Jeong, Kwak, Moon, & San Miguel, 2013; Merrill & Hanson, 2016). On the other hand, cyberbullying is boundless in time, space and audience, perpetrators may remain anonymous (Cénat, Hébert, Blais, Lavoie, Guerrier, & Derivois, 2014; Hébert et al., 2016a) and it peaks somewhat later in adolescence (Pablan & Vandebosch, 2014). About 23% of adolescents in the general population experience traditional or cyberbullying (Merrin, Espelage, & Hong, 2016). Several risk factors are identified in the literature for bullying in the general population. Being female, being overweight, having low socioeconomic status and belonging to a minority group (Alavi et al., 2015) are factors for increased risk of bullying, whereas school belonging and family connectedness are protective factors (Duggins, Kupermine, Henrich, Smalls-Glover, & Perilla, 2016). Social

isolation increases the likelihood of eliciting peer aggression due to lack of perceived social support and protection (Pouwels, Lansu, & Cillessen, 2016). Consequences of bullying include psychosomatic problems, psychiatric illness, poor academic performance and self-harming behaviours (Alavi et al., 2015; Van Geel et al., 2014). Bullying has also been associated with suicidal ideation and attempts. More specifically, about 30% of adolescents who are bullied report suicidal ideation (Kessel Schneider, O'Donnell, Stueve, & Coulter, 2012). Victims of bullying are also almost twice as likely to attempt suicide as non-victimized peers (Hinduja & Patchin, 2010).

Given the impact of SA on social functioning (Blanchard-Dallaire & Hébert, 2014; Hébert et al., 2016b), teens with a history of SA could be particularly at risk for bullying. However, to our knowledge, few studies have previously examined this relationship. Hébert et al. (2016b) found that over half (60%) of children with a history of SA are being bullied in elementary school. In a sample of high school girls, those with a history of SA were almost twice more likely to be bullied than girls without a history of abuse (Hébert et al., 2016a). Benedini et al. (2016) found that adolescents with a history of SA have a greater risk of physical assault by peers but not of intimidation when compared to victims of physical abuse. After an examination of the existing literature of the general population, Lereya et al. (2013) found that victims of bullying (aged 4-25 years) are significantly more likely to have been sexually abused, neglected or exposed to maladaptive parenting. Similarly, in a retrospective study of college freshmen, Duncan (1999) found that those who have been bullied by peers in childhood are more likely to have experienced childhood SA than those who have not been bullied. Although a clear link between bullying and SA has been established, further exploration is needed to understand whether bullying increases vulnerability to suicidality in sexually abused teenage girls.

1.4.1.2 Sexual Harassment (SH)

A second form of peer victimization, SH, is most commonly defined as "persistent, unwanted and unwelcome sexual behaviour that interferes with your life" (Espelage & Holt, 2007) and includes verbal and physical behaviours such as crude jokes, sexual comments and inappropriate touching. It does not include sexual acts of penetration (American Association of University Women (AAUW), 2001).

In the general population, prevalence of SH varies based on the frequency, occurrence and inclusion of behaviours measured. The AAUW study in 2001 measured a lifetime prevalence of SH in the general population and found that 83% of girls report at least one occurrence while 30% describe that they "often" feel harassed. In 2011, the AAUW national US study assessed online and offline SH over the past year and found that 56% of girls experience SH at least once (Hill & Kearl, 2011). Two or more incidents of SH are reported by 44% of high school girls (Chiodo, Wolfe, Crooks, Hughes, & Jaffe, 2009) while 37% girls indicated three or more incidents of SH over the past year (Clear et al., 2014). Racial differences are also reported across studies and affect the rate of SH. For instance, African American female students are more likely to report SH than their Caucasian peers (Goldstein, Malanchuk, Davis-Kean, & Eccles, 2007). A national investigation of Quebecois

adolescents indicates that 11.5% of girls (N = 3151) report three or more instances of physical and verbal SH occurring in the past year (Hébert, Blais, & Lavoie, 2018).

Research shows that SH emerges as early as grade five, coinciding with the biological and psychosocial changes which occur around puberty (Petersen & Hyde, 2009). The physical changes associated with pubertal development, combined with the psychosocial changes in peer group composition (from same-gender to mixed-gender groups) and the addition of new social interactions such as dating may elicit increased feelings of self-consciousness and unwanted sexual attention from peers (Li, 2014). Unlike SA, SH often occurs in both mixed-and same-gender interactions (Petersen & Hyde, 2009). Girls with advanced pubertal status are more likely to be victims of same-gender SH (Hill & Kearl, 2011). While most (85%) experiences of SH at school involve peers, 38% of victims report that teachers and other school employees are involved (AAUW, 2001).

Risk factors of SH include physical attractiveness, perceived power and family characteristics. Girls who are more physically attractive gain more sexual attention from their peers (Li, 2014). Contrary to the power dynamics seen in bullying, girls with increased perceived power are more likely to be targeted for SH, mostly by the opposite gender (Petersen & Hyde, 2009). Since powerful peers have increased influence and are more likely objects of romantic interest, inappropriate sexual passes may be made to get their attention rather than to cause distress (Land, 2003). Kaltialal-Heino, Frojd, and Marttunen (2016) found that parental unemployment, not living with both parents, and low parental education may be associated with higher risk of SH, whereas parental involvement seems to act as a protective factor. Fineran and Bolen (2006) found that a history of family violence is associated with an

increased risk of SH: the internalized message of weakness and the belief that they deserve to be treated as inferior may increase vulnerability to SH at school.

Consequences of SH include low self-esteem, isolation, risky sexual behaviour, poor academic functioning, delinquent traits and school absenteeism (Gruber & Fineran, 2008). Most importantly, SH may be associated with an increased risk of suicidal ideation and attempt (Kaltiala-Heino, Savioja, Frojd, & Marttunen, 2018). Chiodo et al. (2009) found that adolescent girls who are sexually harassed are five times more likely to have suicidal thoughts and six times more likely to have self-harming behaviour.

In the literature, the relationship between SA and SH is considered within the broader construct of sexual revictimization (Messman-Moore & Long, 2000). Consequently, little research exists on SH specific to those having experienced SA. An investigation of Quebecois young adults (aged 20-22) determined that for young women, SA predicts the experience of SH at work and at school (Senécal et al., 2006). Although an association between SA and SH has been established, the rate and implication of this relationship on suicidality has yet to be investigated.

1.4.2 Psychological Factors Associated with Suicidality

The aim of this thesis is to examine the relationship between suicidality and SA in adolescence. Past studies have shown that various psychological factors have been found to influence the outcome of suicidality in adolescent girls, so it would be important to understand how these factors affect sexually abused girls. Pertinent factors explored in this study include social support, coping strategies and PTSD.

1.4.2.1 Social support

Social support is defined as "information leading the individual to believe that they are cared for, loved, esteemed, and valued, and are a member of a network of communication" (Cobb, 1976, p. 300). Belongingness refers to the adherence to a social group, consisting of family, friends or community members. Support from a non-offending parent(s) is shown to influence the psychological consequences in abuse survivors and their ability to manage later adverse life events (Godbout, Briere, Sabourin, & Lussier, 2014). Maternal support is associated with decreased psychological distress, high self-esteem and decreased suicidal ideations (Hébert et al., 2016a). Thus, social support could be associated with a decreased risk of suicidal behaviour.

1.4.2.2 Coping Strategies

Coping strategies are defined as "constantly changing cognitive and behavioral efforts to manage specific external or internal demands that are appraised as taxing or exceeding the resources of the person" (Lazarus & Folkman, 1984, p. 141). Effective coping strategies approach the problem directly to change its course and its effect on the level of stress experienced (Hébert et al., 2007). These adaptive strategies include problem-solving and social support seeking. Avoidance strategies could alleviate immediate distress (Daigneault et al., 2006), but avoiding the problem may ultimately result in negative symptoms, low self-esteem and feelings of guilt and anger (Hébert, Parent, & Daignault, 2007); this is defined as a maladaptive coping strategy.

Victims of SA may experience feelings of shame derived from perceived responsibility of the abuse and they may believe that they are a burden on others. Perceived burdensomeness is described as the notion that "my death will be worth more than my life to family, friends, society, etc." (Joiner et al., 2009, p. 2). This may produce a grave misperception of the individual's self-worth and may lead to a greater reliance on maladaptive coping strategies (Alix, Cossette, Hebert, Cyr, & Frappier, 2017). Maladaptive coping strategies in survivors of SA would likely predict suicidal ideation.

On the contrary, adaptive coping strategies may protect against suicidality. Adaptive coping strategies are associated with positive functioning and may serve to properly negotiate interpersonal relationships and rally support (Hébert et al., 2007). Adequate

interpersonal functioning would help reduce the feeling of being a burden and would protect against the likelihood of suicidality.

1.4.2.3 PTSD

PTSD may be a consequence of trauma. Chu (1992) explained that PTSD symptoms such as dissociation, avoidance and numbing are conditioned to react to stimuli resembling the initial traumatic experience in a way that may cause the person to misinterpret future events as dangerous. These symptoms may limit judgement and response in their daily life, causing them to overreact to perceived threats. Further, these symptoms may decrease fear of death, as "repeated exposure and habituation to painful and provocative events move an individual from mere desire to death by suicide" (Ng et al., 2018). Post-traumatic hyperarousal is shown to mediate the relationship between the extent of trauma exposure and the degree of suicidal thoughts (Briere, Godbout, & Dias, 2015). PTSD is found to mediate the relationship between SA and suicidal ideation (Ford & Gomez, 2015) as higher rates of PTSD contribute to suicidal ideation and attempts in adolescent victims of SA (Brabant, Hébert, & Chagnon, 2014). PTSD may also mediate the relationship between bullying and suicidality in sexually abused girls, as rates of PTSD showed a three-fold increase after bullying in children with a history of SA (Hébert et al., 2016b). Thus, symptoms of PTSD would likely be associated with a decreased risk of suicidality in sexually abused girls.

OBJECTIVES AND HYPOTHESES

After an examination of the existing literature on SA, suicidality and peer victimization, several gaps are identified. While a significant relationship between SA and peer victimization is recognized, the rate of SH and the co-occurrence of bullying and SH in adolescent females with a history of SA is missing. Thus, our first objective aims to measure the rate and co-occurrence of bullying and SH in sexually abused teenage girls. The second objective is to determine whether peer victimization would be associated with suicidality in adolescent girls' victims of SA. We predict that bullying and SH would be associated with an increased risk of suicidality in a clinical population of sexually abused girls over and above the effect of the other psychological factors examined (i.e., social support, coping strategies and symptoms of PTSD). We believe that social support and adaptive coping strategies would be associated with a decreased risk of suicidality while avoidance and symptoms of PTSD would be associated with an increased risk of suicidal ideation and attempt.

Identifying the rate and co-occurrence of bullying and SH in girls with a history of SA and assessing the risk of suicidality will help in the prevention of future trauma and in the design of adequate tools to aid the mental health professional for optimal intervention.

CHAPTER II

BULLYING AND SEXUAL HARASSMENT AS PREDICTORS OF SUICIDALITY IN SEXUALLY ABUSED ADOLESCENT GIRLS

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RÉSUMÉ

La présente étude vise à documenter la prévalence et la cooccurrence de l'intimidation et du harcèlement sexuel chez les adolescentes victimes d'agression sexuelle, tout en explorant les associations avec la suicidalité. La présente étude a été réalisée auprès d'un échantillon de 195 adolescentes (12-18 ans) consultant des centres d'intervention suite à un dévoilement d'agression sexuelle. Les participantes ont rempli des questionnaires sur le suicidalité (idéations et tentatives), et les expériences d'intimidation et le harcèlement sexuel vécues au cours des 12 derniers mois. Différents facteurs associés (symptômes de stress post-traumatique, stratégies d'adaptation ou « coping » et soutien social) ont également été mesurés. Environ 37% des adolescentes ont rapporté des incidents d'intimidation répétés (en personne ou cyberintimidation) et 27% ont rapporté des situations d'harcèlement sexuel par les pairs dans la dernière année. Les résultats des analyses de régressions hiérarchiques suggèrent que la présence de stress post-traumatique et un faible soutien maternel contribuent au risque de suicidalité. En contrôlant pour ces variables, l'intimidation était associée à une augmentation du risque d'idéations suicidaires. Le harcèlement sexuel n'était pas associé à la suicidalité. À notre connaissance, cette étude est la première à mettre en évidence l'importance d'aborder l'intimidation et le harcèlement sexuel de façon distincte dans la prévention et intervention pour les adolescentes ayant vécu une agression sexuelle.

Mots clés: suicide, agression sexuelle, intimidation par les pairs, cyberintimidation, harcèlement sexuel, adolescente

ABSTRACT

This study aimed to document the rate and co-occurrence of bullying and sexual harassment in sexually abused teens while examining their association with suicidality. The sample consisted of 195 teenage girls aged 12-18 consulting intervention centres in Quebec, Canada following disclosure of sexual abuse. Participants completed questionnaires on suicidality (ideation and attempt) and experiences of bullying and sexual harassment over the past 12 months. Other associated factors (symptoms of post-traumatic stress disorder, coping strategies and social support) were equally measured. About 37% of adolescents reported incidents of repeated bullying (online/offline) and 27% reported repeated sexual harassment by peers in the past year. Results of the hierarchical logistic regressions suggest that greater symptoms of post-traumatic stress disorder and insufficient presence of maternal support contributed to the prediction of suicidality. Controlling for these, bullying was associated with an increased risk of suicidal ideation. Sexual harassment was not associated with suicidality. To our knowledge, this is the first study to highlight the importance of distinguishing between bullying and sexual harassment in prevention and treatment programs for teenage girls with a history of sexual abuse.

Keywords: suicide, sexual abuse, bullying, cyberbullying, sexual harassment, adolescent girls

INTRODUCTION

Sexual abuse (SA) is a worldwide phenomenon with negative effects on adolescents' psychological well-being (Stoltenborgh, Van Ijzendoorn, Euser, & Bakermans-Kranenburg, 2011). Girls are more likely to experience SA (Murray, Nguyen, & Cohen, 2014), to disclose the abuse (Hébert, Tourigny, Cyr, McDuff, & Joly, 2009) and to seek treatment (Easton, Saltzman, & Willis, 2013) than are boys. The numerous consequences of SA include post-traumatic stress disorder (PTSD), substance use, decreased self-esteem, feelings of distress and diminished academic performance (Paolucci, Genuis, & Violato, 2001). However, of all the consequences linked to SA, suicide is considered the most devastating (Alvarez-Alonso et al., 2016). The leading cause of death during adolescence for girls (Serafini et al., 2015), suicide is the ultimate avoidance strategy and a means of escape from extreme psychological pain (Briere & Elliott, 1994).

Previous studies show that SA survivors are highly vulnerable to suicidal ideations (Devries et al., 2014; Wherry, Baldwin, Junco, & Floyd, 2013). Adolescents with a history of SA are more likely to have attempted suicide than those without a history of abuse (Ng, Yong, Ho, Lim, & Yeo, 2018) and sexually abused girls have a three-fold risk of suicidal ideation (Martin, Bergen, Richardson, Roeger, & Allison, 2004). Brezo et al. (2008) and Miller, Esposito-Smythers, Weismoore, and Renshaw (2013) propose that SA may be relatively more significant in explaining suicidal behaviours than any other forms of abuse. Noll et al. (2003) suggest that girls with a history of

SA may use suicidal behaviours to communicate extreme psychological pain, to help regulate emotion, to reclaim power of their own body or to re-enact feelings of worthlessness, shame or guilt.

Research suggests that many interpersonal-psychological variables may be related to both suicidality and SA as either risk or protective factors. Specifically, this study will examine the role of coping strategies, social support, PTSD and social difficulties. Coping strategies may play an important part in an adolescent's overall well-being. Avoidance coping strategies may alleviate immediate distress (Daigneault, Hébert, & Tourigny, 2006) but may ultimately result in negative symptoms, lowered self-esteem and feelings of guilt and anger (Hébert, Tremblay, Parent, Daignault, & Piché, 2006). Adolescents who engage in suicidal behaviours are more likely to rely on avoidance than problem-solving strategies as compared to those without suicidal tendencies (Evans, Hawton, & Rodham, 2005). Adolescents who actively seek social support are less likely to have suicidal ideation than those who withdraw or avoid the problem (Meehan, Peirson, & Fridjhon, 2007). In adolescence, support from the peer group appears to provide a protective function and decrease vulnerability to suicidality (Kostenuik & Ratnapalan, 2010). In survivors of abuse, support from a non-offending parent may influence the psychological effects of the trauma and the adolescent's ability to cope with later adverse life events (Godbout, Briere, Sabourin, & Lussier, 2014). Maternal support may also serve to protect against the risk of suicide by decreasing psychological distress and increasing self-esteem (Hébert, Cénat, Blais, Lavoie, & Guerrier, 2016). Finally, symptoms of PTSD are also associated with increased likelihood of suicidal behaviour (Ford & Gomez, 2015). Intruding stimuli from the trauma may induce a post-traumatic hyperaroused state to blunt fear and may increase the desire to escape the pain (Brabant, Hébert, & Chagnon, 2013; Briere, Godbout, & Dias, 2015).

Social difficulties may also play an important role between SA and suicidality (Brezo et al., 2008). SA may impact adolescents' social functioning and interpersonal skills (Postmus, 2013). During adolescence, social relationships become increasingly important and group interactions more complex. Adolescents become more self-aware and seem to be more influenced by peer opinion (Choudhury, Blakemore, & Charman, 2006). Social withdrawal and feelings of betrayal, powerlessness and stigmatisation resulting from SA could lead to increased vulnerability for personal conflicts and various forms of peer victimization in high school (Blanchard-Daillaire & Hébert, 2014).

The most common form of adolescent peer victimization is bullying, repeated interpersonal aggressive behaviour over time (Alavi, Robert, Sutton, Axas, & Repetti, 2015). It includes face-to-face interactions (traditional bullying) and electronic communications (cyberbullying) to establish dominance and control over the victim. Traditional bullying is contained to school premises during school hours, peaking around grades 7-8 and decreasing in later years (Jeong, Kwak, Moon, & San Miguel, 2013; Merrill & Hanson, 2016). On the contrary, cyberbullying peaks later in adolescence and is boundless in time, space and audience, as perpetrators can remain anonymous (Cénat, Hébert, Blais, Lavoie, Guerrier, & Derivois, 2014). Studies indicate that in the general population, 23% of adolescents' experience bullying (Merrin, Espelage, & Hong, 2018). Psychosomatic problems, psychiatric illnesses, poor academic performance and self-harming behaviours have been associated with bullying (Alavi et al., 2015; Copeland, Wolke, Angold, & Costello, 2013). Suicidality is also identified as an important consequence of bullying in the general population (Kessel Schneider, O'Donnell, Stueve, & Coulter, 2012). Adolescents who were

bullied are twice as likely to have suicidal ideation than non-bullied peers (Hinduja & Patchin, 2010).

Another common form of peer victimization is sexual harassment (SH), "persistent, unwanted and unwelcome sexual behaviour that interferes with your life" (Espelage & Holt, 2007). These verbal and physical behaviours include crude jokes, sexual comments and inappropriate touching but not sexual acts of penetration (AAUW, 2001). In the general population, prevalence of SH varies according to the inclusion of behaviours, the frequency and the population measured. For example, according to a national US study conducted by AAUW in 2001, 83% of girls ($N = 1094$) report at least one episode of lifetime prevalence of physical, non-verbal and verbal acts while 30% described that these behaviours happened "often". In a sample of adolescents in high schools across Quebec, 11.5% of girls ($N = 3151$) report three or more instances of physical and verbal SH occurring in the past year (Hébert, Blais, & Lavoie, 2018). SH emerges at the onset of pubertal development, as psychosocial and biological changes begin to occur (Petersen & Hyde, 2009) and may elicit unwanted sexual attention from peers (Li, 2014). SH is also a strong predictor of suicidality in the general population: sexually harassed girls are five times more likely to have suicidal thoughts and six times more likely to have self-harming behaviour than their peers (Chiodo, Wolfe, Crooks, Hughes, & Jaffe, 2009). To date, it has not been determined whether peer victimization is associated with suicidality in survivors of SA.

Only a few studies have investigated peer victimization in sexually abused adolescent girls. This limited research suggests a significant association between SA and bullying (e.g., Benedini, Fagan, & Gibson, 2016; Espelage, Low, & De La Rue, 2012; Lereya, Samara, & Wolke, 2013) and between SA and SH (Das & Otis, 2016). In a community sample of adolescents, girls with a history of SA are almost twice as

likely to be cyberbullied as girls without a history of SA (Hébert et al., 2016). Victims of SA also appear to be more vulnerable to SH than non-victims (Espelage & Holt, 2007). Studies also demonstrate an association between bullying and SH in the general population (e.g. Clear et al., 2014; Espelage, Low, Anderson, & De la Rue, 2014; Gruber & Fineran, 2016) but have yet to explore the co-occurrence of these peer victimization subtypes in adolescent girls with a history of SA. To our knowledge, this is the first study to examine the effect of bullying and SH on suicidality in sexually abused teens.

Objectives

The study's first objective was to document the rate and co-occurrence of bullying and SH in a clinical sample of sexually abused adolescent girls. The second objective was to identify whether bullying and SH were associated with suicidal behaviour in adolescents with a history of SA. The analysis was conducted while controlling for other interpersonal-psychological factors, coping strategies, social support and symptoms of PTSD. Identifying the effect of peer victimization on suicidality in teen victims of SA could help in the prevention of future suicide and in the design of adequate tools to aid the mental health professional for optimal intervention.

METHOD

Participants and Procedure

Data was collected as part of the longitudinal Youth Romantic Relationships Project. The current analysis used data from the first wave of the four-wave study ($n = 195$). The study was approved by the ethics committee of Centre Hospitalier Universitaire Ste-Justine. Adolescents were invited to participate if they were between 12-18 years old ($M = 15$, $SD = 1.34$) and were consulting at one of four specialized intervention centres in SA in Quebec, Canada. Adolescents were excluded from the study if they presented with severe developmental delays or disorders, or if they spoke neither French nor English. Information about the study was given by a trained graduate student research assistant and consent was obtained from the adolescent or guardian (for those under 14 years). Questionnaires were administered by the research assistant in a 90-minute structured interview.

Of the 195 adolescents, about 37% lived with a single mother, 20% with both parents, 7.5% lived in shared custody, 10% with a single father and 7% with another family member, while 18.5% lived with a foster family or in a youth shelter. While 43% did not adhere to any religious affiliation, 38% identified as Catholic, 9% as Protestant and 10% identified as another religion.

Table 1 presents the characteristics of the sexual abuse and shows that most girls (82%) suffered severe SA, as defined by an act of penetration. About 56% of the girls describe a single episode of SA, while 14% describe a few episodes and 30% describe chronic SA. Most of the girls (69%) were over the age of 13 years at the time of the first episode of SA. While describing the abuse, most of the girls (63%) reported experiencing extrafamilial SA, most describing that the abuser was an acquaintance (42%). Others described the abuser as an immediate (31%) or extended (6%) family member, a stranger (15%) or a romantic partner (6%). The majority of participants reported the abuser was an adult aged between 20-59 years old (59%) or over 60 years old (3%).Other participants reported the abuse involved a youth aged under 15 years (5%) or aged between 15-19 years old (33%)..

Measures

Adolescents completed all questionnaires, except for the items documenting the characteristics of SA experienced, which were completed by the caseworker. The questionnaires were administered in French or English, depending on the adolescent's language preference. In addition to sociodemographic information, the following variables were assessed:

Abuse-related variables were evaluated with the *History of Victimization Form* (HVF; Wolfe, Gentile, & Bourdeau, 1987) completed by the caseworker. This questionnaire, translated into French by Parent and Hébert (2006), assessed the characteristics of abuse, such as severity, duration, age at onset, as well as the characteristics of the perpetrator. Severity of SA was coded according to Russell's (1986) definition: less severe (non-physical sexual experiences or physical sexual contact over clothing; sexual contact without penetration) and very severe (sexual penetration; Finkelhor, Hotaling, Lewis, & Smith, 1990). The questionnaire probed for the perpetrator's gender, age, and relationship with the victim. The questionnaire also inquired about the adolescent's experience of disclosure of abuse. Based on a subset of 30 records, this measure showed high inter-rater reliability with a median intra-class correlation of 0.86 and a median inter-rater agreement of 92.8% (Hébert et al., 2006). Descriptive Frequencies regarding the characteristics of SA are presented in Table 1.

Bullying/cyberbullying. Two items were adapted for the present study from the *National Longitudinal Survey of Children and Youth, Cycle 7 Survey Instruments* (Statistics Canada, 2006-07). Participants were asked whether they had experienced incidents of cyberbullying, defined as electronic harassment, and traditional bullying, which occurred at school and excluded electronic forums in the twelve months prior to the survey (Statistics Canada, 2006-07). These two items were answered on a Likert scale indicating how many times they had experienced an incident (0 = *never*, 1 = *1-2 times*, 2 = *3-5 times*, 3 = *6 or more times*) and were combined to form the bullying construct for the analyses. A dichotomous variable was created according to Solberg and Olweus' definition of repeated bullying (2003). Therefore, to be

considered bullying by a peer, incidents had to occur repeatedly over time; hence, 0 = *under 2 times* and 1 = *3 times or more*.

Sexual Harassment was evaluated with two items derived from the definition of SH used in *The Sexual Experiences Questionnaire* (SEQ; Fitzgerald, Geldland, & Drasgow, 1995). Verbal harassment included unwanted sexual comments, jokes or gestures; physical harassment included touching, grabbing, and pinching in a sexual way (excluding sexual penetration) in the twelve months prior to the survey. These two items were answered on a Likert scale indicating how many times participants had experienced an incident (0 = *never*, 1 = *1-2 times*, 2 = *3-5 times*, 3 = *6 or more times*). A dichotomous variable was created for the regression and repeated occurrences of SH by a peer over time was defined by 0 = *under 2 times* and 1 = *3 times or more* (Clear et al., 2014).

PTSD was measured by the *Children's Impact of Traumatic Events Scale II* (Cites II; Wolfe, Gentile, Michienzi, Sas, & Wolfe, 2002). The PTSD subscale included 40 items based on symptoms identified by the *Diagnostic and Statistical Manual of Mental Disorders Fourth Edition* (DSM-IV; American Psychiatric Association, 1994): intrusive thoughts, avoidance, hyperarousal and sexual anxiety. Each item was rated on a 3-point Likert scale (0 = *not true* to 2 = *very true*). A total score (0-40) indicated the presence and severity of symptoms. The PTSD scale had a good internal consistency in our sample (α = .88) similar to past research (α = .89; Crouch, Smith, Ezzell, & Saunders, 1999). The instrument has shown good discriminant validity for

children who have been abused (Chaffin & Shultz, 2001) and good construct validity as scores on the abuse attributions and social reactions scales predicted symptoms in the PTSD subscales (Chaffin & Shultz, 2001).

Social support was measured with items from the *Children's Impact of Traumatic Events Scale II* (Cites II; Wolfe et al., 2002) for both mother and community. The three items for maternal support in our sample (α = .88) asked whether the adolescent perceived that her mother would protect her so that a situation like this would not re-occur; whether she believed the mother took good care of her when she disclosed the abuse; and whether she believed her mother would listen to her if she needs to talk about what happened. Each item was rated on a 3-point Likert scale (0 = *not true* to 2 = *very true*) and a score was computed (0-6) to indicate the perceived strength of the maternal support. General support in our sample (α = .53) included three items measuring the adolescent's experience with members of the community. It asked whether the adolescent felt believed and understood by their community after disclosing the trauma, and whether they received help from social workers or police officers. Each item was rated on a 3-point Likert scale (0 = *not true* to 2 = *very true*) and a score was computed (0-6) to indicate the perceived support.

Coping Strategies were identified by the *Ways of Coping Questionnaire* (WCQ; Folkman & Lazarus, 1988). A 20-item abbreviated measure (Bouchard, Sabourin, Lussier, Richer, & Wright, 1995) examined three dimensions of coping strategies. Each item was rated on a 4-point Likert-scale (0 = *Never used,* 1 = *Used once,* 2 =

Used sometimes, 3 = *Used often*). The problem-solving scale was assessed by six items such as "I changed something so things would turn out all right". The seeking social support scale included six items such as "I talked to someone to find out more about the situation". Finally, the avoidance scale included eight items, such as "I hoped a miracle would happen". The items in the three scales had good internal consistency (α = ranged from .76 - .85) and low to moderate intercorrelations between the scales (.05 - .31), similar to the original version (Lundqvist & Ahlstrom, 2006).

Suicidal Ideation and Attempt. Suicidal ideation was assessed by the question "Have you ever seriously thought of committing suicide?" (Statistics Canada, 2007) and a dichotomous variable (yes/no) was computed. If the participant answered positively for suicidal ideation, they were then asked, "Have you ever attempted suicide?" (Statistics Canada, 2007). A dichotomous variable (yes/no) was then also computed for suicidal attempt.

Statistical Analyses

The study's first objective was to explore the rate and co-occurrence of bullying and SH in teen girls with a history of SA, with frequencies and cross-tabulations. Phi

coefficients were calculated to measure the degree of association between bullying and SH. The second objective was to assess whether bullying and SH contributed to the likelihood of suicidal ideation and attempt in adolescent girls with a history of SA after controlling for other interpersonal-psychological factors. Two separate hierarchical logistic regressions (forced entry) were carried out to examine whether bullying and SH predicted suicidal ideation and attempt after controlling for coping strategies, social support and symptoms of PTSD.

RESULTS

Rate and Co-Occurrence of Peer Victimization

Figure 1 shows the frequencies of bullying and SH in the adolescent clinical sample. Roughly 37% of the sample reported having been bullied three times or more in the past year, and 27% of the girls reported repeated SH. Figure 2 showed how co-occurrence of repeated peer victimization was frequent as 15% of respondents reported experiencing both forms of victimization. Results of a chi-square test indicated a significant association between repeated bullying and SH ($\chi 2$ (1, $N = 195$) $= 9.895$, $p = .002$, $\phi = .225$), suggesting that participants reporting a history of bullying were more likely to report SH than participants not reporting bullying.

Hierarchical Regressions

Two hierarchical logistic regressions were conducted to test whether bullying or SH contributed to the prediction of either suicidal ideation or attempt, while controlling for coping strategies, social support and symptoms of PTSD in a clinical population. The regressions were conducted in three steps using the forced entry method, to assess the possible contribution of bullying and SH over and above the contribution of the interpersonal-psychological factors. Thus, the psychological factors (coping strategies and symptoms of PTSD) were entered the model first, followed by the interpersonal factors (general and maternal support) in the second step, and finally the two forms of peer victimization (bullying and SH) in the third step.

Suicidal Ideation. In the sample, 67% of girls reported having had suicidal ideations in their lifetime. Overall, the logistic regression model was significant ($\chi 2$ (8) = 42.53; $p < .001$). The model explained 28% of the variance and correctly identified 72% of adolescents as having had suicidal thoughts. Table 2 illustrates the test of significance at each step and provided summary statistics for the final step of the regression analysis. In the final model, symptoms of PTSD and low levels of maternal support contributed significantly to higher rates of suicidal ideation. Presence of PTSD in adolescent girls with a history of SA contributed to the prediction of suicidal ideation (Exp(B) = 1.04) while presence of maternal support was associated with a reduction in the likelihood of suicidal ideation (Exp(B) = 0.83). Peer victimization factors showed that for adolescent girls with a history of SA,

bullying increased the odds of suicidal ideation more than two-fold (Exp(B) = 2.68). This effect held while controlling for the factors included in the first and second step of the model. SH did not significantly contribute to the prediction of suicidal ideation.

Suicidal Attempt. Of the girls who reported suicidal ideation, 43% had attempted suicide in their life. The logistic regression model was significant for suicidal attempt ($\chi 2$ (8) = 34.83; $p < .001$). The model explained 21% of the variance and correctly classified 71% of adolescents as having attempted suicide. Table 3 illustrates the test of significance at each step and provided summary statistics for the final step of the regression analysis. In the final model, having PTSD symptoms increased the odds of suicidal attempt (Exp(B) = 1.03), while a higher level of perceived maternal support decreased suicidal attempt (Exp(B) = 0.82). When the peer victimization factors were entered in the third step, having experienced bullying was marginally associated with an increase in suicidal attempt for adolescent girls with a history of SA (Exp(B) = 1.84, $p = .07$). SH did not significantly contribute to the model.

DISCUSSION

Data from a clinical sample of Quebec adolescent girls with a history of SA was analyzed to examine whether peer victimization was prevalent and whether it was

associated with a risk of suicidality over and above known interpersonal-psychological factors linked to SA. To our knowledge, this was the first study to examine the association between peer victimization and suicidality in sexually abused adolescent girls.

The first objective of this study was to assess whether girls with a history of SA were likely to be targeted for bullying and SH and whether these two forms of peer victimization co-occurred. Rates in our study indicated that a significant percentage of girls with a history of SA were targeted repeatedly (three times or more) for bullying (37%) and for SH (27%) in the past 12 months. The marked rate of bullying in this population confirmed results from previous research indicating that 33% of sexually abused girls reported being bullied in the past 12 months (Hébert et al., 2016). In the Quebec general population, 20% of girls reported bullying and 11.5% of girls reported SH (Hébert et al., 2016; Hébert, Blais, & Lavoie, 2018). While we cannot directly compare the results of our study, it appeared that sexually abused girls were more likely to report SH than girls in the general population.

In addition, our results corroborated the hypothesis that experiences of victimization were often inter-related (Finkelhor, Shattuck, Turner, & Hamby, 2015). Indeed, co-occurrence of peer victimization was frequent in the sample with 15% of adolescents who reported experiencing both bullying and SH. This was corroborated by Clear et al. (2014) where they found that adolescents in the general population who reported bullying also showed significantly higher rates of SH.

Finkelhor and Browne's Model of Traumagenic Dynamics (1985) could explain the possible underlying mechanisms of how SA would lead to increased vulnerability of

peer victimization. The four traumagenic dynamics that categorized the effects of SA – *traumatic sexualization*, *betrayal*, *stigmatization*, and *powerlessness* – demonstrated how SA can misshape the child's feelings, attitudes and behaviours towards others. These may impact the adolescent's ability to relate to others and to seek support (Finkelhor & Browne, 1985). Victimization by peers may occur when others perceive the adolescent's impaired judgement for trustworthiness and overdependence on others as weakness (Blanchard-Dallaire & Hébert, 2014). The likelihood of being targeted by peers for victimization may also be increased by feelings of alienation and powerlessness that result from stigmatization (Blanchard-Dallaire & Hébert, 2014). While self-disclosure of the abuse in adolescence could serve to elicit support, end the abuse, and decrease symptoms of distress (Hébert et al., 2009; McConnell, 2015), negative societal attitudes may provoke disbelief of the abuse, leading to shame, rejection, and isolation (Lyon & Ahern, 2010; McConnell, 2015), which may also serve to increase vulnerability to peer victimization. Future research should examine the effect of self-disclosure on peer victimization in sexually abused girls. The high rate of bullying and SH found in this population indicated a dire need for awareness programs and psychological support to promote positive peer relationships in vulnerable youths.

The second objective was to examine whether bullying and SH were associated with suicidal behaviour in sexually abused teens. In our sample, 67% of the girls reported a lifetime prevalence of suicidal ideation, and of those, 43% reported suicidal attempt. Our results corroborated those of other studies which showed that girls who have been sexually abused were associated with an elevated risk of suicidal behaviour (e.g., Brabant et al., 2014; Ng et al., 2018), as 14% of Canadian teens reported a lifetime prevalence of suicidal ideation and 3.5% of attempted suicide (Statistics Canada, 2012). Hierarchical logistic regressions demonstrated that while bullying was associated with suicidal ideation and marginally associated with suicide attempt,

SH was not. Bullying led to more than a two-fold increase in suicidal ideation over and above the effects of other interpersonal-psychological factors. Joiner (2005) speculated that factors which contribute to feelings of alienation, burdensomeness and fearlessness could increase the likelihood of suicidality. Perhaps these adolescents felt ostracized by their peers and re-traumatized by the bullying, thereby increasing feelings of alienation and burdensomeness and increasing the likelihood of suicidality.

Our results may not have found an individual association of SH with the risk of suicidality due to the observed overlap between SH and bullying in this population. Or, perhaps physical and psychological effects of SH are minimal when compared to those of severe SA in teen victims, which may explain why SH did not seem to have an impact on suicidality in this population. Or, perhaps these girls were popular with their peers, as Petersen and Hyde (2009) demonstrated that girls with increased power were more likely to be targeted for SH and that inappropriate sexual advances may be used to get their attention, not to cause distress (Land, 2003). Thus, these girls may have increased feelings of belongingness that would not have contributed to the emergence of suicidal behaviour as hypothesized by Joiner (2005).

Of the interpersonal-psychological factors considered, both symptoms of PTSD and maternal support were found to be significant predictors of suicidal ideation and attempt. These results are consistent with past studies (Eisenberg, Ackard, & Resnick, 2007; Krysinska & Lester, 2010). For instance, Ford and Gomez (2015) demonstrated that PTSD mediated the relationship between SA and suicidal ideation. PTSD may increase vulnerability to suicidality as symptoms of dissociation, avoidance and numbing are conditioned to react to stimuli resembling the initial traumatic experience. The triggered shock or helplessness could impair appropriate response in

a potentially dangerous situation (Chu, 1992). Support from a non-offending parent, primarily the mother, has been associated with a secure attachment in other relationships (Godbout et al., 2014) which may buffer against isolation and alienation from the peer group; this could explain the decrease in the likelihood of suicidality. None of the coping strategies had a significant effect on the likelihood of suicidality. It is possible that the effect of avoidance measured as a symptom of PTSD may have been stronger and might have overlapped with the avoidance coping strategy, masking its effect.

Limitations

There were several limitations in this study. Other forms of child maltreatment were not evaluated in our sample, so we could not postulate regarding other forms of trauma and impact on suicidality. In addition, the chronological order of experiences of peer victimization, SA and suicidality was not measured, so we could not infer a causal relationship between these variables. Future studies should use a longitudinal design to help determine the temporal sequence between experiences of peer victimization and SA to be able to assess direction and causality of consequences.

Girls with a history of SA may have been more likely to disclose incidents of peer victimization than girls in the general population due to an increased sensitivity to perceived acts of perpetration of abuse. Or, perhaps disclosure of peer victimization could seem less psychologically threatening and more socially acceptable after

disclosure of SA. Our measure for general support had a moderate reliability; future studies should use a more comprehensive measure with stronger inter-item correlations to further assess whether peer and community support affected suicidality. Finally, since boys do not typically disclose and seek treatment for SA as often as girls did (Hébert et al., 2009), we could not collect sufficient data from adolescent boys to have included in our sample. Therefore, future studies should also examine whether male victims of SA shared similar experiences and consequences.

Practical Implications

Our results showed that bullying and SH were prevalent in sexually abused teens, demonstrating a need for prevention programs for peer victimization and SA. Prevention programs aimed at the general population should provide psychoeducation regarding the associations between SA and peer victimization to increase awareness and decrease stigmatisation. Specifically, prevention programs for bullying should target earlier school grades as Merrill and Hanson (2016) found that bullying generally decreased with later school grades. Programs for SH should start as early as puberty and target both same- and opposite-gender perpetration (Petersen & Hyde, 2009). Our finding that bullying was a predictor of suicidal ideation and attempt further emphasized the need to decrease the rate of bullying in sexually abused teens. Prevention programs of peer victimization for sexually abused adolescents should foster positive peer relationships, as Dion et al. (2016) demonstrated that support from friends served as a protective factor against distress in victims of abuse.

Hébert et al. (2016) demonstrated that maternal support was protective against cyberbullying and Lereya et al. (2013) indicated that positive parenting behaviours protected against traditional bullying, our results linked maternal support as a protective factor against suicidal attempt and ideation. Prevention programs should target mothers of teenage girls to encourage involvement in their daughter's lives and to increase awareness of possible victimization.

Our results highlight the need to provide clinical care for adolescents with a history of SA having experienced bullying or SH to decrease the likelihood of negative effects. Intervention programs should provide adequate psychoeducation for non-offending parents of adolescents who have been abused to nurture parental support and decrease the likelihood of suicidality. In line with our finding that PTSD was associated with a risk of suicidal ideation and attempt, clinical interventions should aim to decrease PTSD symptoms after initial trauma to decrease the likelihood of suicidality in this population.

Conclusion

To our knowledge, this was the first study to examine bullying and SH simultaneously in a sample of adolescent girls with a history of SA. Unlike previous

research with adult samples, our study did not rely on retrospective reports regarding past childhood experiences; adolescent participants were asked about their current experiences of bullying and SH. Results of this study demonstrated that adolescents with a history of SA were vulnerable to other forms of interpersonal victimization experienced in the peer context which contribute to the risk of suicidality. It is clear from our results that SA has harmful effects on the global psychosocial well-being of adolescent's. Thus, it would be crucial for clinicians to evaluate for suicidality, bullying, SH and SA and to develop the adolescent's social skills to decrease suicidal ideation and isolation and to promote positive peer relationships. It would also be important for school prevention programs aimed at the general population to provide psychoeducation on SA to decrease stigma and to endorse inclusiveness. This would help prevent bullying and SH to ensure the welfare of vulnerable teenage girls and decrease the risk of suicidality.

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Table 1

Description of the Characteristics of Abuse (SA)

Severity	No Penetration	18%
	Penetration	82%
Duration	Single Episode	56%
	A Few Episodes	14%
	Chronic	30%
Age at First Episode	Under 12 Years	31%
	Over 13 Years	69%
Age of Abuser	Under 15 Years	5%
	15-19 Years	33%
	20-59 Years	59%
	60+ Years	3%
Relationship with the Abuser	Immediate Family	31%
	Extended Family	6%
	Romantic Partner	6%
	Acquaintance	42%
	Stranger	15%
Intrafamilial Abuse	No	63%
	Yes	37%

Table 2

Results from the Hierarchical Logistic Regression for Suicidal Ideation

Step and Predictor Variables	X^2	β	SE	W	*p*	Exp(B)	95% CI for Exp(B)
Step One	30.93				.000		
Problem resolution		-.098	.073	1.810	.178	.907	[.786 – 1.046]
Avoidance coping		-.035	.070	.246	.620	.966	[.842 – 1.108]
Seeking social support		.070	.069	1.050	.306	1.073	[.938 – 1.228]
Symptoms of PTSD		.042	.010	17.133	.000	1.043	[1.023 – 1.064]
Step Two	5.38				.068		
Maternal support		-.176	.090	3.863	.049	.838	[.703 – 1.000]
General support		-.074	.128	.336	.562	.928	[.722 – 1.194]
Step Three	6.136				.047		
Sexual Harassment[a]		-.062	.432	.020	.886	.940	[.403 – 2.191]
Bullying[a]		.945	.395	5.717	.017	2.573	[1.186 – 5.583]

Note. Model ($\chi 2$ (8) = 42.533; p <.001; R^2 = .281). Abbreviations: β, Beta; SE, Standard error; W, Wald Criteria; CI, Confidence Interval, R^2 = Nagelkerke R Square. [a] Dichotomized score.

Table 3

Results from the Hierarchical Logistic Regression for Suicidal Attempt

Step and Predictor Variables	χ^2	β	SE	W	*p*	Exp(B)	95% CI for Exp(B)
Step One	21.264				.000		
Problem resolution		.012	.064	.034	.854	1.012	[.893 – 1.146]
Avoidance coping		.034	.069	.238	.626	1.034	[.904 – 1.183]
Seeking social support		.094	.064	2.175	.140	1.099	[.970 – 1.245]
Symptoms of PTSD		.028	.010	7.877	.005	1.028	[1.008 – 1.048]
Step Two	8.867				.012		
Maternal support		-.194	.077	6.313	.012	.824	[.708 – .958]
General support		-.103	.120	.726	.394	.902	[.713 – 1.143]
Step Three	3.271				.195		
Sexual Harassment[a]		-.202	.383	.279	.598	.817	[.386 – 1.730]
Bullying[a]		.610	.340	3.228	.072	1.841	[.946 – 3.582]

Note. Model ($\chi 2$ (8) = 31.957; $p < .001$; $R^2 = .209$). Abbreviations: β, Beta; SE, Standard error; W, Wald Criteria; CI, Confidence Interval, R^2 = Nagelkerke R Square. [a] Dichotomized score.

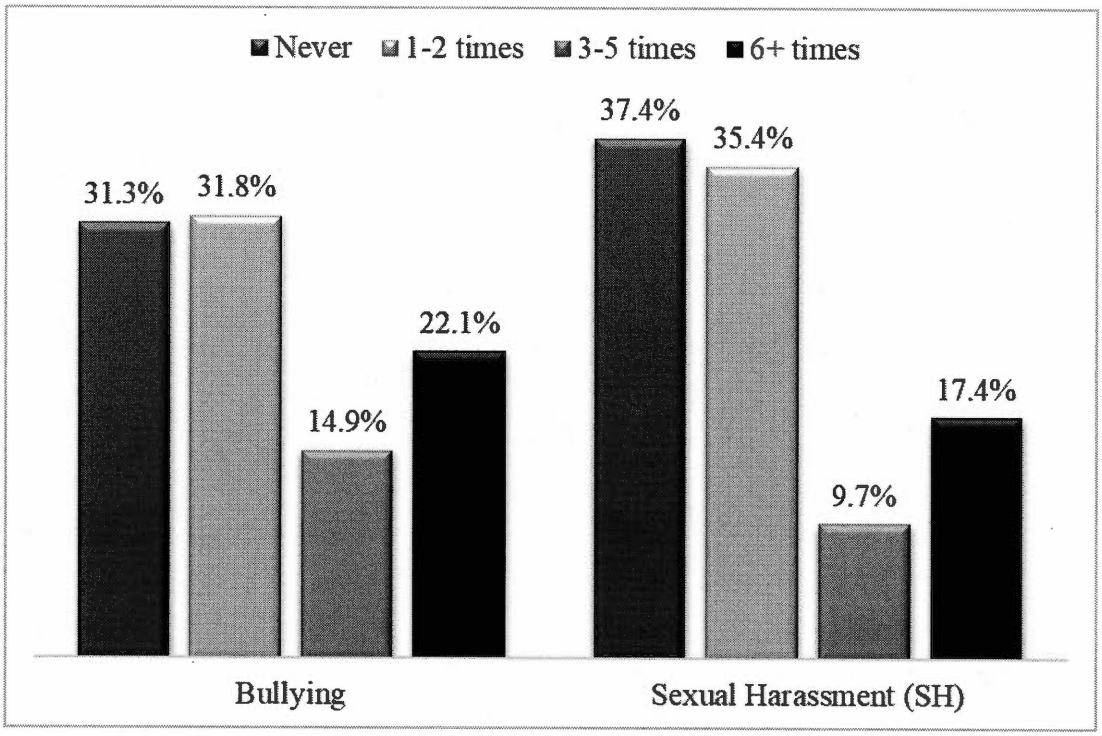

Figure 1. Rate of Peer Bullying and Sexual Harassment in the Clinical Sample. *Note*. Abbreviations, SH, Sexual Harassment.

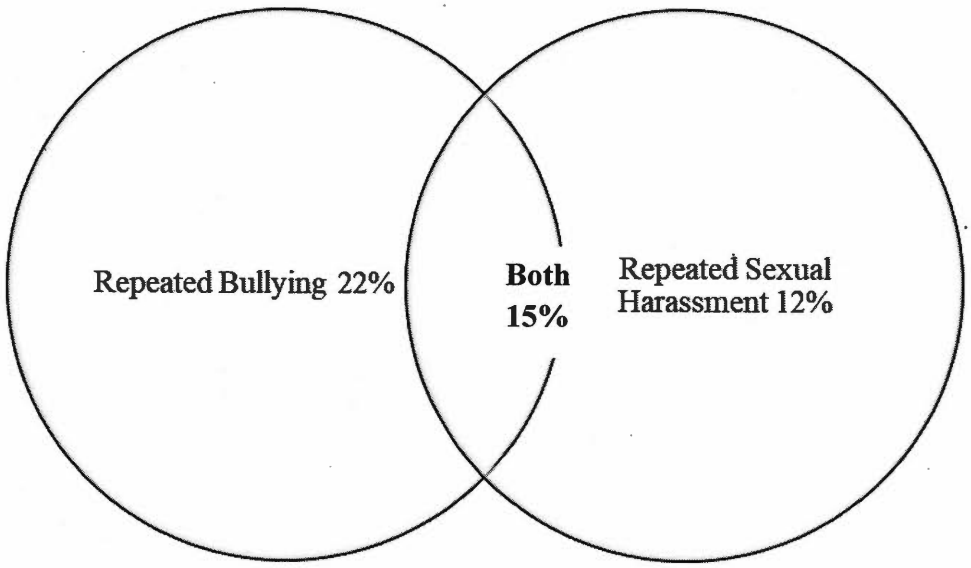

Figure 2. Co-Occurrence of Repeated (three times or more) Peer Bullying and Sexual harassment.

CHAPTER III

GENERAL DISCUSSION

3.1 General objectives

The main objective of this doctoral essay was to provide better documentation on factors related to SA, suicidality and peer victimization. We aimed to measure the rate and co-occurrence of bullying and sexual harassment in sexually abused girls. Then, we examined their association with suicidality while controlling for other interpersonal-psychological factors such as social support, coping strategies and PTSD symptoms. Our research is crucial as it pertains to several difficult experiences which could shape an adolescent's global well-being.

SA is a critical traumatic experience, as in Quebec, 1 out of 5 girls report experiencing SA before the age of 18 years (Tourigny et al., 2008). The most important and frequent consequence associated with SA (Ng, Yong, Ho, Lim, & Yeo, 2018), suicide is the most alarming health concern for adolescents (Meyer et al., 2010). Suicide is the leading cause of untimely and preventable death for girls (Serafini et al., 2015). We explored factors related to suicidality with a sample consisting of a clinical population of sexually abused adolescent girls consulting for treatment in three centers in Quebec, evaluated at intake. Most of the girls in our sample (82%) experienced "severe" penetrative sexual abuse. About 30% of the girls

experienced chronic episodes of SA and 37% had been abused by a family member. About 67% of the girls reported having had a lifetime prevalence of suicidal ideation, and of those, 43% reported that they had attempted suicide. It was crucial to understand how the relationship between SA and suicidality functions to identify crucial targets for intervention and to provide better treatment for teenage girls, in the hopes of preventing future suicides.

Past studies have shown that greater risks of suicidal behaviour have been associated with psychological vulnerabilities, family adversity, interpersonal functioning and adverse life events (Gournellis et al., 2018). Joiner (2005)'s theory of suicidal behaviour hypothesized that interpersonal-psychological factors which contribute to an adolescent's feelings of thwarted belongingness, burdensomeness and fearlessness were associated with an increased risk of suicidal behaviour.

In the present thesis, we aimed to explore more specifically the contribution of peer relations in the prediction of suicidality in SA girls. SA may have an impact on lifetime cognitive, emotional and social well-being (Williams, 2006), such that affected individuals could exhibit maladaptive behaviours across the lifespan. Maladaptive behaviours could include distrust of others, anger, fear of abandonment, helplessness, avoidance and sexualized behaviour (Blanchard-Dallaire & Hébert, 2014) which could heighten vulnerability to other forms of victimization (Finkelhor & Browne, 1985). Further, social withdrawal, feelings of betrayal, shame and stigmatisation related to SA could impede the development of friendships (Raby et al., 2018) and could be associated with an increased the risk of peer victimization. In this thesis, two forms of peer victimization were examined, bullying and SH.

Our study examined peer victimization and key interpersonal-psychological factors as associated with risk of suicidal behaviour in sexually abused girls. Bullying entails direct and indirect forms of aggression meant to establish dominance over the victim (Jeong et al., 2013). Social isolation and perceived helplessness were recognized as predictors of bullying (Pouwels et al., 2016). Previous research established a positive association between SA and bullying (Hébert et al., 2016a, 2016b). SH, another form of peer victimization, is defined as inappropriate sexual advances causing distress (AAUW, 2011). Unwanted sexual attention from peers may ensue from physical pubertal changes along with new romantic inclinations and psychosocial changes in peer group composition (Li, 2014). Recently, there have been highlighted cases of suicide associated with peer victimization (Mueller & Abrutyn, 2015). The other factors we examined were social support, coping strategies and symptoms of PTSD.

The Discussion section will expand on results of the main objectives of our study. First, our findings on the rate and co-occurrence of peer victimization in sexually abused girls will be discussed in context of past studies in the general population. Second, we will examine the factors associated with the risk of suicidality in sexually abused girls, such as peer victimization and other key interpersonal-psychological factors. Then, we will highlight the limits of the study and provide recommendations for future research. Finally, we will conclude with the practical implications of our findings, indicating potential assessment, intervention and prevention tools.

3.2 Rate and Co-Occurrence of Peer Victimization

We examined whether girls with a history of SA were at risk of both forms of peer victimization and whether these two forms of victimization co-occurred. The rate of SH in a clinical sample of Quebecois adolescents was still missing from the literature to date. Repeated experience of SH (three times or more) in the past 12 months was reported by 27% of the girls in our sample. This is almost double the rate of girls who did not experience SA, as reported by a study of an equivalent Quebecois population, where only 11.5% of girls in the general population reported repeated SH (Hébert, Blais, & Lavoie, 2018). However, contrary to the data found in Quebec, the AAUW national US study found that roughly 30% of adolescents in the US general population aged 12-18 years reported being victims of repeated SH, similar to our rate in a clinical population. Perhaps data from Quebec cannot be directly compared to the US because of differences in measures. Or, it is possible that racial or cultural differences could account for the difference between the general population in Quebec and that of the US. For instance, Clear et al. (2014) noted that the African Americans in their sample experienced higher rates of SH than their Caucasian peers; most of the adolescents in our Quebecois sample were Caucasian, which may account for the variance observed. It may be that Quebecois cultural norms discourage SH, as the prevalence in the general population appeared to be much lower than the prevalence in similar US studies (11.5% vs. 30%). Thus, there appears to be an increased vulnerability for SH in adolescent girls with a history of SA in Quebec, and perhaps the rate of SH in sexually abused girls elsewhere than Quebec would be much higher too. This justifies the need to pursue this line of research.

Repeated instances of bullying (three times or more) in the past 12 months were reported by 37% of the girls in our sample. In the general population, a cross-cultural

study by Craig et al. (2009) found that bullying was a universal problem even while individual characteristics, social values and dynamics varied across cultures. In their study, around 12.6% of adolescents (n = 24, 919) across 40 countries reported being involved in bullying and 17% of Canadian girls (n = 3051) reported being victims. Although we could not directly compare our results with Craig et al (2009)'s meta-analysis due to differences in measures, our findings seemed to indicate that girls with a history of SA were associated with an increased risk of bullying. Our result confirmed previous investigations, where girls who were sexually abused were twice as likely to report repeated bullying than non-abused peers (Hébert et al., 2016a) and where victims of bullying were more likely to have been sexually abused (Lereya et al., 2013). Thus, a significant relationship between SA and bullying was established by our study, furthering the need to examine this more closely.

Our findings gave evidence that girls who experienced SA were vulnerable to peer victimization (Finkelhor et al., 2015). Several interpretations can be offered to explain this finding. Briere (2002) suggested that SA negatively impacted the individual's attachment style, emotion regulation skills, coping strategies and cognitive understanding of the self in relation to others, thereby accruing risk of victimization by peers. Taboos surrounding SA may elicit feelings of shame and fear, low self-esteem, and decreased confidence for sustaining viable friendships (Lyon & Ahern, 2010). Feelings of loneliness and alienation may be associated with an increased risk of peer victimization (Murray et al., 2014). Vulnerability to bullying may stem from feelings of betrayal accrued by SA, which could impair judgement for trustworthiness and could cause disengagement from social groups (Blanchard-Daillaire & Hébert, 2014). Powerlessness associated with the violation of the intimate self may be perceived as a weakness by peers and may also be associated with an increased risk of bullying. Feminist theories have also conceptualized SH as a reinforcement of perceived powerlessness (Espelage & Holt, 2007). An increased risk

of SH may be accrued from exposure to sexuality at a young age, from inappropriate sexual behaviour conveyed by the perpetrator of SA, from misconceptions about sexual morality, and from participation in risky sexual behaviour associated with SA (Kaltiala-Heino et al., 2018).

Also, the question of whether bullying and SH were related was addressed by examining the co-occurrence and strength of the association in our sample. We found that girls who reported bullying were also more likely to report SH in the past 12 months than girls who did not report bullying. This result confirmed the hypothesis that experiences of victimization are often inter-related and that perhaps having experienced one victimization is associated with an increased risk of experiencing other forms of victimization (Finkelhor et al., 2015). Previous studies in the general population found that teens who experienced bullying were also likely to experience SH (Clear et al., 2014; Doty et al., 2017; Gruber & Fineran, 2016). Our findings gave further evidence that SH and bullying may be on a continuum of aggressive behaviour in adolescence.

3.3 Predictors of Suicidality

The second objective of this thesis was to assess whether peer victimization and other key interpersonal-psychological factors were associated with an increased risk of suicidality in sexually abused girls. Identifying the factors which are associated to the

risk of suicidal behaviour is crucial for prevention of future adolescent vulnerabilities to suicidal ideations and attempts. The relationship between SA and suicidality has been ascertained. A meta-analysis by Ng et al. (2018) found that suicidal attempt was more likely in SA victims than in non-abused adolescents. Mansbach-Kleinfeld et al (2015) demonstrated that sexually abused girls were four times more likely to exhibit suicidal thoughts than those without a history of SA. In our sample, 67% of girls reported a lifetime prevalence of suicidal ideation and of those, 43% had attempted suicide at least once. These results are similar to those found in another clinical sample of Quebec SA adolescents (Brabant et al., 2014), where 64% of girls with a history of SA reported suicidal ideations and of those, 25% had attempted suicide, much higher than those found in the general population. In the general population, about 14% of Canadians have reported suicidal ideation in their lifetime and 3.5% have attempted suicide (Statistics Canada, 2015). Given this high rate, it is essential to understand which SA girls are vulnerable to suicidality. Past research has highlighted multiple victimization as associated with heightened risk of negative outcomes (Dube et al., 2004). The following subsections will expand on the findings from the logistic regressions used to identify whether the experience of bullying and SH affected suicidality while controlling for other interpersonal-psychological factors in a clinical population of sexually abused girls.

3.3.1 Bullying

In our study, bullying was significantly associated with over a two-fold increase in suicidal ideation even after controlling for other factors, namely social support, coping strategies and symptoms of PTSD Bullying was also marginally associated with an increase of suicidal attempt. In line with our findings, previous research has demonstrated that bullying was associated with an increased risk of suicidality: in the general population, 30% of bullied teens reported suicidal ideation (Kessel Schneider et al., 2012) and were almost twice as likely to have attempted suicide than those who were not bullied (Hinduja & Patchin, 2010). Brezo et al. (2008) also found that social difficulties were an important mediator between SA and suicidality.

Joiner (2005) hypothesized that factors which influence feelings of thwarted belongingness, burdensomeness, and fearlessness would impact suicidal behaviour. It is possible that experiencing bullying may amplify feelings of thwarted belongingness from psychological distress, stigmatisation, betrayal and distrust of others stemming from SA. This may further impede social relationships and cause alienation and isolation (Benedini et al., 2016). Burdensomeness may be triggered when victims of bullying underestimate their own self-value and worth and believe that others wished they were dead. They may have become more submissive and dependent from being bullied, causing difficulties expressing personal boundaries and feeling ashamed of these inadequacies (Cloitre et al., 2005). Finally, perhaps fearlessness was triggered by the additive effect of bullying and SA, as repeated exposure to different types of painful events increased the desire of death (Ng et al., 2018).

3.3.2 Sexual Harassment (SH)

SH was not associated with a risk of suicidal behaviour in our clinical sample. Our results were contrary to previous research, which identified an association between SH and suicidality in the general population. For instance, in one study, girls who were sexually harassed were five times more likely to exhibit suicidal ideation and six times more likely to have attempted suicide (Chiodo et al., 2009). While bullying may have contributed to feelings of isolation, perhaps experiencing SH strengthened feelings of belongingness. Girls who are considered physically attractive and powerful by their peers have been found more likely to be sexually harassed (Petersen & Hyde, 2009). Perhaps SH was misconstrued by the girls in our sample as an expression of fun/play, an acknowledgement of their attractiveness or as evidence of peer acceptance (Land, 2003). Or, if the girls in our sample were disgusted or distressed by inappropriate sexual advances, perhaps the experience of SH seemed mild when compared to the severe SA experienced in our population. Then, SH would not have added value as a different type of trauma than SA and could not have contributed to feelings of fearlessness for suicidal behaviour.

3.3.3. Other Interpersonal-Psychological Factors

In the literature, coping strategies, social support and symptoms of PTSD have been identified as important interpersonal-psychological factors which are influenced by the experience of SA. Of the other factors examined, PTSD and maternal support were significant predictors of suicidal behaviour while coping strategies and general support were not. Previous research corroborated our finding that the presence of PTSD is associated with an increased risk of suicidal behaviour in sexually abused girls (Ford & Gomez, 2015). To understand the link between PTSD and suicidality, Joiner's (2005) theory explains how PTSD affects underlying feelings of thwarted belongingness, burdensomeness and fearlessness to impact suicidal feelings. PTSD may thwart efforts of belongingness due to symptoms of disruptive behaviour, constricted affect and psychosocial impairment which interfere with social relationships (Paolucci et al., 2001). PTSD symptoms of amnesia and helplessness may amplify feelings of burdensomeness when adolescents feel overly dependent on others (Bal et al., 2004a). Finally, symptoms of dissociation, avoidance and numbing may trigger fearlessness (Briere et al., 2015), which limits judgement and response in a potentially dangerous situation (Chu, 1992).

As predicted, presence of maternal support was associated with a decreased risk of suicidal behaviour. Belief and protection of the victim may have been signalled by the presence of maternal support after disclosure of abuse (Cyr, McDuff, & Hébert, 2013), leading to better overall adjustment (Van Toledo & Seymour, 2013) and increased feelings of belongingness (Elliott & Carnes, 2001). Secure maternal attachment may have increased trust in others and esteemed self-worth (Godbout et al., 2014), which may have alleviated feelings of burdensomeness. Maternal support has been shown to buffer the effect of psychological distress after trauma (Hébert et al., 2016a), thereby decreasing the feeling of fearlessness.

In our study, general support had no effect on suicidality. Perhaps the effect of general support on suicidality was eclipsed by the influence of maternal support: regardless of whether authority figures in the community believed the disclosure of abuse or helped out, perhaps it was not as important as the belief and protection from the caregiver.

It proved important to distinguish between a supportive presence, measured by social support, and social seeking skills, measured by adaptive coping in our study. The perceived presence of support affected suicidal behaviour after trauma while the coping strategy of seeking social support did not. Perhaps this was indicative of the victim's need to be believed and protected during disclosure of abuse rather than sometime in the future. Or, perhaps thinking of an already established family support network helps keep the adolescent grounded and prevents her from idealising suicide as an escape. On the contrary, perhaps thinking of the tools required to build a supportive network in the future makes her feel hopeless and is useless in the moment (Canton-Cortes & Canton, 2010). Or, perhaps the abuse questioned belief in the adolescent's ability to seek social support, so she doesn't place worth on this skill and so it could not impact suicidality.

Neither adaptive nor maladaptive coping strategies had an effect on the likelihood of suicidality in our study. Past research found that, for adolescents in the general population, while fantasising about death as a way for their problems to disappear was a mediator between life stress and suicidality, avoidance coping was not (Zhang, Wang, Xia, Liu, & Jung, 2012). Perhaps the presence of avoidance as a symptom of PTSD had a stronger effect on suicidality than the use of avoidance as a cognitive strategy (Pineles, Mostoufi, Ready, Street, Griffin, & Resick, 2011). Alix et al. (2017) also noted that although avoidance coping was associated with negative symptoms, it

did not act as a mediator between PTSD, depressive symptoms and suicidal ideation once self-blame and shame were introduced to the model. Regarding problem-solving, perhaps it was not a predictor of suicidality because opting for suicide did not incorporate a rational decision-making process. As in, perhaps adolescents won't even acknowledge their capacity for problem-solving at all when thinking of suicide. Studies have shown that suicidal children failed to produce cognitive mediational strategies to deal with stressful events (Rosenbaum Asarnow, Carlson, & Guthrie, 1987). Further, perhaps problem-solving efforts were ineffective in situations of extreme stress, such as traumatic experiences (Grover et al., 2009). Our result was in line with past research where problem-solving had no effect on suicidality (Yoon, Cederbaum, & Schwartz, 2018).

3.4 Study Limitations and perspectives for further studies

Our study had several limitations which could guide the path for future research. First, perhaps due to racial or methodological differences, the overall rate of SH seemed lower in Quebec than in other countries and ethnicities. For example, a brief measure was used to examine SH in Quebec, whereas more comprehensives measures were used in the US or elsewhere. As well, since we used a clinical sample where most girls had experienced severe SA, the rate of SH found in our study may not be generalizable to other populations. Future studies should assess SH rates of sexually abused girls across various countries and ethnicities using the same measure,

the Sexual Experiences Questionnaire (SEQ) (Fitzgerald, Magley, Drasgow, & Waldo, 1999).

Second, other forms of adolescent trauma, such as neglect, physical abuse and dating violence were not measured in our study, so we could not postulate on their effects on suicidality in sexually abused girls. As other studies have ascertained relationships between bullying and dating violence (Espelage & Holt, 2007), and between SA, neglect, physical abuse and suicidality (Yoon et al., 2018), it would be necessary to evaluate the risk of suicidality when adolescents experience more than one of these types of trauma or when the traumas are cumulative. Future studies should investigate other possible influences on suicidality.

Third, a causal relationship between SA, peer victimization and suicidality could not be inferred as the chronological order of experiences was not measured. A longitudinal design would be necessary to determine the direction and causality between victimization experience and outcome. It would also be useful to determine a timeline of victimizations for the planning and implementation of specific assessment, intervention and prevention programs to dictate when strategies would best be employed.

Fourth, while maternal support was associated with a risk of suicidality in our study, general support was not. However, due to the moderate reliability of the measure used for general support these results must be interpreted with caution. As well, the measure did not ask about friendships. In adolescence, peer relationships are crucial

for developmental well-being, and a lack of peer support may have harmful effects (Choudhury, Blakemore, & Charman, 2006). Future studies may choose to use more specific measures of the presence of existing peer and community support to assess whether positive peer relationships and/or guidance from authoritative community figures protect against suicidality after victimization.

Fifth, while it was crucial to evaluate the impact of peer victimization and SA on suicidal behaviour, it would also be important to evaluate other negative consequences associated with victimization in adolescence, such as school adaptation and use of substances.

Further, longitudinal studies should assess whether the impact of peer victimization and SA on suicidal behaviour has a lasting effect into adulthood. It would be important to understand the repercussions of these on social development into adulthood and whether the consequences affect their future.

Finally, there was insufficient data collected to examine the issue of suicidality in male adolescents in this study. Boys' experiences of SA is a relatively unexplored topic as most studies focus on girls' experiences, since girls typically disclose and seek treatment for SA more often than boys (Hébert et al., 2009). As well, society has a misconstrued belief that SA doesn't exist for boys or that the consequences are not as harmful (Miller, Smith, Caldwell, Mathews, & Wegner, 2018). Therefore, future studies should make a concerted effort to find male participants to assess whether boys share similar experiences and consequences to the girls in our study.

3.5 Practical Implications

The need for clinical care for adolescents having experienced SA and peer victimization has been highlighted by the results of our study. The impact of our results will be discussed in three domains: assessment, intervention and prevention. Proper assessment of SA, peer victimization and other interpersonal-psychological factors associated with suicidality is necessary to detect whether an adolescent is at risk and in need of clinical care. Practitioners must be skilled in therapeutic components of intervention aimed at reducing trauma-induced symptoms and in fostering positive parental support. Finally, prevention programs for suicidality, SA and peer victimization should be implemented nationwide to promote awareness and decrease occurrence of these in adolescence for the future.

3.5.1 Assessment

As we have ascertained our results with a clinical population of girls who have been sexually abused, it is necessary to first assess whether girls have experienced SA. The

victim's experience during disclosure of abuse should be recounted to gain knowledge of perceived belief and protection from caregivers, peers and community members. An accurate portrayal of the quality of current relationships with family, friends, peers and community members should be done.

Next, as our study demonstrates that SA is related to peer victimization, it would be important for practitioners offering services to victims to systematically assess whether these girls have been victimized by their peers. For an accurate history of peer victimization, detailed accounts of bullying and SH should include modality, types of behaviour, frequency, duration, characteristics of the perpetrator and reactions from others. Clinician knowledge that girls who have been bullied can be associated with a higher risk of suicidality can be crucial for properly signalling critical cases.

Most importantly, clinicians should ask specifically about current and lifetime suicidal ideation, intention, plans and past attempts. As our research shows that PTSD and maternal support are associated with the risk of suicidality in sexually abused girls, it is crucial to observe for difficulties in emotional regulation, establishment of personal boundaries and interpersonal support networks. Traumatized girls should be screened for possible symptoms of PTSD and psychological distress. Relationships with non-offending parents should be assessed to determine whether support is present.

3.5.2 Intervention

Our research has shown that in sexually abused girls, peer victimization in the form of bullying and an outcome of SA, PTSD, is associated with an increased risk of suicidality. As well, maternal support is associated with a decreased risk of suicidality. Thus, treatment for this population should target these factors. Treatment with victimized girls should include intervention strategies from empirically validated therapies. These include Trauma-Focused Cognitive-Behaviour Therapy (TF-CBT; Cohen, Mannarino, & Deblinger, 2006), Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999) and Dialectical Behaviour Therapy (DBT; Linehan, 1993). Self-help books with guided exercises such as "Mind and Emotions: A Universal Treatment for Emotional Disorders" (McKay, Fanning, & Zurita Ona, 2011) would be helpful to assign to these teens. Family therapy or dyadic sessions with the adolescents' mothers would be important to increase parental support. Time-limited same-gender groups are helpful for intervening on interpersonal factors (Underwood, Stewart, & Castellanos, 2007). Other modalities include art therapy, eye movement desensitization and reprocessing, psychophysiological trauma-work (Corder, 2000; Murphy, 2001; Bagley and LaChance, 2000) and mode deactivation treatment (Apsche & Ward, 2004).

Therapy should be a safe place for adolescents to understand how they feel about themselves and the actors in their environment after upsetting or confusing events (Kirkbride, 2018). The five core elements of the TF-CBT model include: psychoeducation, coping strategies, gradual exposure, cognitive processing and caregiver participation (Ramirez de Arellano et al., 2014). Psychoeducation on

traumatic experiences should be done to normalize feelings of fear, confusion, anger, hopelessness and numbness and answer questions on rate, meaning and treatment for sexually abused girls (Underwood et al., 2007). Rationale for relaxation and grounding techniques should be given and exercises should be done in session and practiced at home to improve coping strategies. Through gradual exposure, adolescents learn how to visualize their own safe place to intervene with symptoms of distress. Non-offending parents should be included in therapy with traumatized adolescents to nurture parental support and improve parenting skills. Therapists should conduct parenting skills training, where they "collaborate on developing family rituals, routines and structure that will enhance children's feelings of safety and security" (Cohen et al., 2006, p. 12). Psychoeducation for parents should help parents to understand the impact of trauma on their children. Finally, parents should be included in dyadic therapy sessions with their child to promote positive parent-child communications skills and understanding.

Improving interpersonal effectiveness skills would be crucial for fostering healthy relationships that could offer protection from victimization in the future (Card & Hodges, 2008). Targeting interpersonal effectiveness skills could help reduce feelings of thwarted belongingness to decrease suicidal ideations (Brabant, 2012). Clinicians should focus on cultivating communication and assertiveness skills, such as active listening, vocalisation of needs and establishment of personal boundaries without passivity or aggression. Identifying core values and addressing barriers to goals could give life meaning, direction, power and motivation (Brown & Ryan, 2003). This could buffer against negative outcomes and empower to make important decisions in the future (Horesh & Gordon, 2018).

Psychoeducation on the nature of emotions and coping strategies should be provided to intervene for suicidal behaviours, as indicated by an adaptation of DBT for adolescent girls and suicidality (Miller, Rathus, & Linehan, 2007). An explanation of the characteristics of emotions should be given. The rationale for how to observe emotions and how to decide whether to act on emotion-driven urges in an appropriate way should be specified. Therapy should teach how to regulate emotion and how to do the opposite of emotion-driven behaviours (McKay et al., 2011). Adolescents should be guided to alternative solutions when faced with extreme emotions or destructive flashbacks, to decrease potential for self-harming behaviours (Brabant, Chagnon, & Hébert, 2008). Research has shown that mindfulness and emotion awareness is effective with traumatized adolescents (Horesh & Gordon, 2018). To reduce the potential for catastrophizing or judgemental thoughts and to appropriately situate emotion in the overall context, teens should use Mindfulness to bring the focus to the present moment instead of dwelling in the past. Defusion exercises should help to detach from negative thoughts and reduce the intensity of their painful emotions. This could be particularly useful when feeling the urge to act on suicidal thoughts evolved from negative emotion such as thwarted belongingness.

Our results demonstrated that a key feature of PTSD, avoidance, could be associated with an increased risk of suicidality. A number of different strategies could be used to reduce or prevent the development of avoidance symptoms. First, psychoeducation could highlight the potential negative outcomes stemming from avoidance strategies. Exercises to identify and analyze avoidance strategies could also be assigned. Cognitive flexibility training could expand the cognitive repertoire of expectations and perceptions of events (McKay et al., 2011). A coping plan worksheet could be assigned to help improve the adolescent's ability to cope in future stressful situations. Learning distress tolerance skills, such as self-care, relaxation and distraction may help to reduce stress appropriately. Imagery-based emotion exposure could be used to

observe, label and experience negative feelings in a safe setting to reduce reliance on avoidance. Finally, desensitization from in-vivo exposure could allow for habituation to sensations of distress in a safe or controlled environment to decrease fear and learn to adequately behave in future stressful situations.

Our finding that the presence of maternal support protected against suicidality warrants intervention for caregivers of victimized adolescent girls. Through schools and community centers, appropriate information should be provided in written and visual formats (Van Toledo & Seymour, 2013). Parents, teachers, school administrators, and even camp counsellors need to be made aware that SA, bullying and SH are interrelated and that girls who have been sexually abused and bullied may be more vulnerable to suicide. Training for caregivers should be given to increase sensitivity and knowledge to reduce taboo of SA, bullying and suicidality to promote a positive rapport with adolescent girls who may be at risk. Support groups for caregivers would be helpful to build successful social networks in the community, to provide relief from hearing about shared experiences and to normalize their traumatised child's experiences (Van Toledo & Seymour, 2013).

3.5.3 Prevention

The Canadian Association for Suicide Prevention has created programs that should be implemented in schools nation-wide and we advocate that they should be adapted to

specifically target girls who have been sexually abused. Formal training to recognize possible warning signs that girls who have been abused or bullied may be thinking of committing suicide should be mandatory to provide help. Training should include safe and appropriate information about suicide to encourage positive dialogue with students to reduce stigma and raise awareness. Further resources should be made available for the parents, the adolescent or their friends.

Our study detailing high rates of peer victimization has underscored the importance of universal prevention programs. Anti-bullying policies and initiatives should be formally introduced throughout Canadian schools. Student anti-bullying programs should be arranged for when the behaviour emerges at lower school grades, when the risk is more salient (Merrill & Hanson, 2016) and should have long-term prevention strategies. Schools should assess the students' bullying behaviour to understand why the bullying occurs, should implement individualized support plans for positive behaviour and should nurture students' social and emotional skills. Students should be provided with age-appropriate materials and discussions that are relevant to reduce bullying at school.

In the prevention of SA, an ecological approach is the most promising avenue for the prevention of future victimization. Sexual education programs should be introduced at the start of puberty to better prepare adolescents to learn healthy dating and sexual norms. In addition to STI and pregnancy prevention, sexual education programs in schools should include modules on normative dating and sexual scripts, and protocols on how to give and receive consent to sexual behaviour. Information should be given for resources where adolescents can ask for help when needed. Programs should teach girls how to deal with a risky situation to prevent negative outcomes.

Finally, nation-wide media campaigns should target cultural norms and beliefs about adolescent SA and peer victimization. Educational commercials may help reduce stigma and provide resources. Media blitzes such as the "#MeToo" movement may have helped propagate recognition of the harmful effects of SA and peer victimization to prevent future victimization. Shows on popular TV networks could serve to raise awareness of the struggles adolescents face with their peers to promote open discussions and to share experiences. They should emphasize the importance of seeking help and provide information of important resources in the community.

CONCLUSION

To our knowledge, this was the first thesis to examine SA, suicide, bullying, and SH simultaneously in a female adolescent sample. Results of this study demonstrated that adolescents were vulnerable to multiple forms of interpersonal victimization, such as SA, bullying and SH. This study confirmed previous investigations, where girls who were sexually abused were also likely to report bullying. Our study uncovered new information, that girls who were sexually abused were also likely to experience SH, and that co-occurrence of bullying and SH was high in this population. Most importantly, our findings show that bullying was associated with the risk of suicidality in sexually abused girls, over and above the effects of other interpersonal-psychological factors.

It is clear from our study that SA and peer victimization have harmful repercussions on the adolescent's global psychosocial well-being. Thus, it would be crucial for clinicians to properly evaluate for SA, peer victimization, PTSD symptoms, maternal support and suicidality. Intervention strategies should aim to develop the adolescent's social skills and to promote positive peer relationships. It would also be important for school and community prevention programs to provide psychoeducation on SA and peer victimization to decrease stigma and endorse inclusiveness. This would prevent future peer victimization and suicidality in adolescents with a history of SA to ensure their welfare. Future research is needed to inform the design of such programs.

APPENDIX A

SOCIODEMOGRAPHIC CHARACTERISTICS

Section *** Informations générales DDN : __ __

1. Quel est ton sexe? 1 Fille 2 Gars

2. Quel est le mois de ta naissance? 1 Janvier 4 Avril 7 Juillet 10 Octobre
2 Février 5 Mai 8 Août 11 Novembre
3 Mars 6 Juin 9 Septembre 12 Décembre

3. Quelle est l'année de ta naissance? __ __ __ __

4A. En ce moment, avec qui habites-tu?

1 Mes 2 parents sous le même toit (mes parents sont ensemble)
2 Mes 2 parents séparés (mes parents ont ma garde partagée)
3 Ma mère
4 Mon père
5 Un membre de ma famille élargie (oncle, cousine, grands-parents, etc.)
6 Une famille d'accueil
7 Un centre d'accueil
8 Mon chum ou ma blonde
9 Autre (précise) : _____

4B. J'ai des parents de même sexe.

1 Oui **Tu as répondu oui? Tu répondras aux questions sur ta mère et ton père en pensant à chacun d'eux.*
2 Non

5. Quel niveau de scolarité <u>ta mère</u> a-t-elle complété?

1 Études primaires
2 Études secondaires
3 Études collégiales ou professionnelles
4 Études universitaires
5 Autre (précise) : _____
9 Je ne sais pas

7. Concernant <u>ta mère</u>, actuellement elle :

1 Travaille
2 Est aux études

3 Est à la retraite
4 Reçoit des allocations de bien-être social
5 Est au chômage ou en recherche d'emploi 6 N'a aucun revenu (à la maison)
7 Est décédée
8 Autre (précise) : _____
9 Je ne sais pas

6. Quel niveau de scolarité <u>ton père</u> a-t-il complété?
1 Études primaires
2 Études secondaires
3 Études collégiales ou professionnelles
4 Études universitaires
5 Autre (précise) : _____
9 Je ne sais pas

8. Concernant <u>ton père</u>, actuellement il :
1 Travaille
2 Est aux études
3 Est à la retraite
4 Reçoit des allocations de bien-être social
5 Est au chômage ou en recherche d'emploi
6 N'a aucun revenu (à la maison)
7 Est décédé
8 Autre (précise) : _____
9 Je ne sais pas

9. Es-tu né/e au Canada de parents nés <u>tous les deux</u> au Canada?
1 Oui **Tu as répondu oui? Passe à la question 11 de la page suivante.*
2 Non **Tu as répondu non? Réponds à la question suivante.*

10. Nous aimerions savoir quelle situation te représente le mieux. Tu es…
1 …né/e à l'étranger. Alors dis-nous quel âge tu avais lorsque tu es arrivé/e au Canada : _____ ans
2 …né/e au Canada d'un parent né à l'étranger et d'un parent né au Canada.
3 …né/e au Canada de parents nés tous les deux à l'étranger.

11. Est-ce que tu t'identifies à l'une des religions suivantes?
1 Catholique
2 Protestante
3 Chrétienne orthodoxe
4 Musulmane
5 Juive
6 Bouddhiste
7 Hindoue
8 Sikh
9 Autre (précise) : _____
10 Non, à aucune

12. En ne comptant pas les mariages, les funérailles, les bar/bat mitsvas, etc., à quelle fréquence assistes-tu à des services religieux ces

temps-ci?

1 Plus d'une fois par semaine
2 Une fois par semaine
3 Une fois par mois
4 À l'occasion des fêtes religieuses seulement (ex : Noël, Pâques, Hanouka, etc.)
5 Une fois par année
6 Moins d'une fois par année
7 Jamais ou pratiquement jamais

13. À quel/s groupe/s ethnique/s ou culturel/s <u>tes parents</u> appartiennent-ils? Tu peux choisir plus d'une réponse.

1 Québécois ou canadien
2 Premières Nations, Inuits, Métis, Autochtones, etc.
3 Latino-Américain (Amérique centrale ou Amérique du Sud)
4 Afro-Américain / Afrique noire
5 Asiatique (Chine, Japon, Laos, Philippines, Inde, etc.)
6 Européen de l'Ouest (France, Espagne, Allemagne, Grèce, etc.)
7 Européen de l'Est (Hongrie, Roumanie, Ukraine, etc.)
8 Caribéens / Antillais
9 Afrique du Nord (Maghreb) / Moyen-Orient
10 Autre (précise) : _____

14. Quelle langue parlez-vous le plus souvent à la maison? Tu peux choisir plus d'une réponse.

1 Français 2 Anglais 3 Autre (précise) : _____

15. Quels sont les trois premiers items de ton code postal? (exemple : **H2S** pour H2S 3A4) __ __ __

15A. Quelle est ton occupation <u>principale</u>? Tu peux choisir plus d'une réponse.

1 Je vais à l'école à temps plein
2 Je vais à l'école à temps partiel
3 Je travaille à temps plein
4 Je travaille à temps partiel
5 Je ne vais pas à l'école
6 Je suis en recherche d'emploi
7 Autre (précise) : _____

16. Quel type d'études complètes-tu actuellement?

1 Formation générale (FG)
2 Formation préparatoire au travail (FPT)
3 Diplôme d'études professionnelles (DEP)
4 Formation à un métier semi-spécialisé (FMS)
5 Attestation de spécialisation professionnelle (ASP)
6 Formation aux adultes
7 Attestation d'études collégiales (AEC)
8 Diplôme d'études collégiales (DEC)
9 Je ne suis pas aux études présentement. (Indique la dernière année scolaire que tu as complétée _____ et passe aux questions de la page 5.)

17. Es-tu dans un profil ou une concentration particulière (arts, sports, sciences, etc.)?

1 Oui

2 Non

18. En quelle année scolaire es-tu?

1 Secondaire 1
2 Secondaire 2
3 Secondaire 3
4 Secondaire 4
5 Secondaire 5
6 CÉGEP
7 Autre (précise : _____)

19. Dans l'ensemble, quel degré de réussite dirais-tu que tu as dans ton travail scolaire, y compris tes bulletins?

1 Très bon
2 Bon
3 Dans la moyenne
4 Faible
5 Très faible

APPENDIX B

HISTORY OF VICTIMIZATION FORM (HVF; WOLFE, GENTILE, & BOURDEAU, 1987).

HISTOIRE DE VICTIMISATION – ADOLESCENT/E

Veuillez compléter ce formulaire pour chacune des situations d'agression sexuelle rapportées concernant l'adolescent/e.

Nombre total de situations d'AS vécues ou rapportées: _____

☐ Première situation d'AS (la plus récente)
☐ Deuxième situation d'AS
☐ Troisième situation d'AS

Date de naissance: ____/____/_____ (jj/mm/aaaa) # dossier: _____

Date de l'évaluation: ____/____/_____ (jj/mm/aaaa) Code recherche: _____

1. Description de la situation d'agression sexuelle

a. Gestes vécus par l'adolescent/e : _____

_____

_____

_____

Coter la sévérité de l'agression sexuelle: ① Moins sévère ② Sévère ③ Très sévère ⑨ ?

SVP Coter la sévérité de l'agression telle que définie selon la codification de Russel (inversée)

1. **Agression sexuelle moins sévère:** Expérience sexuelle impliquant un contact physique par-dessus les vêtements (sans déshabillage); expérience sexuelle n'impliquant pas de contact physique comme incitation à une activité sexuelle ou exhibitionnisme
2. **Agression sexuelle sévère:** Expérience sexuelle impliquant un contact physique sous les vêtements ou avec déshabillage, sans pénétration ou force comme des caresses ou frottements
3. **Agression sexuelle très sévère:** Expérience sexuelle impliquant un contact physique avec pénétration / tentative de pénétration ou force comme pénétration digitale, sexe oral, sexe anal, actes bizarres tels que bestialités ou acte sexuel impliquant plus d'un agresseur

b. Est-ce que l'agression sexuelle a été faite dans le cadre d'une exploitation sexuelle (distribution de matériel pornographique, prostitution)? ⓪ Non ① Oui ⑨ ?

c. Durée de l'agression: ① Épisode unique ② Quelques événements ③ Répétitif ou chronique ⑨ ?
   ↳ Durée, si plus d'un épisode: _____ mois

d. Âge de l'adolescent/e lors du premier épisode d'agression sexuelle: _____ ans

e. L'agresseur a procédé à l'agression:
   ⓪ Sans menace ou violence
   ① En utilisant des menaces verbales ou en faisant peur à l'adolescent/e
   ② En utilisant de la force ou violence physique
   ③ En offrant des cadeaux ou des récompenses à l'adolescent/e
   ④ Lorsque l'adolescent/e avait consommé alcool ou drogue

f. Autres victimes dans l'entourage de l'adolescent/e:
   1. Fratrie: ⓪ Non ① Oui
   2. Enfant du conjoint: ⓪ Non ① Oui
   3. Famille élargie: ⓪ Non ① Oui
   4. Connaissance: ⓪ Non ① Oui
   5. Autre: ⓪ Non ① Oui
   (si autre, précisez) _____

g. Présence d'amnésie (perte de mémoire) :
   ⓪ Aucune ① Partielle ② Totale

2. Caractéristiques de l'agresseur (au moment des AS)

S'il y a plusieurs agresseurs (précisez): _____

a. Sexe: ① Femme ② Homme

b. Âge approximatif: _____ ans (pour cette question, deux réponses sont requises, l'une en chiffre et l'autre en catégorie)
   ① Moins de 15 ans ② 15-19 ans ③ 20-59 ans ④ 60 ans et plus ⑨ ?

c. Lien avec l'adolescent/e (précisez): _____

À catégoriser par l'équipe de recherche:

- 10 Un membre de la famille immédiate
  - 11 Parent biologique (père, mère)
  - 12 Fratrie (frère, sœur)
  - 13 Conjoint d'un des parents (beau-père, belle-mère)
  - 14 Enfant du conjoint ou de la conjointe
- 20 Un membre de la famille élargie
  - 21 Oncle, tante
  - 22 Cousin, cousine
  - 23 Grand-parent
- 30 Une personne de l'entourage
  - 31 Gardien/ne
  - 32 Conjoint du gardien/ne
  - 33 Enfant du/de la gardien/ne
  - 34 Parent d'accueil
  - 35 Enfant de la famille d'accueil
  - 36 Professeur/e ou entraîneur/e
  - 37 Ami/e de la famille
  - 38 Ami/e de l'adolescent/e
  - 39 Voisin/e
- 40 Une personne inconnue
- 50 Autre
- 60 Partenaire
  - 61 Chum / blonde
  - 62 Fréquentation
  - 63 Partenaire sexuel occasionnel

d. Réside avec l'adolescent/e au moment des agressions: ⓪ Non ① Oui ⑨ ?

3. Dévoilement de la situation d'agression sexuelle

a. Est-ce que l'adolescent/e a lui-même dévoilé la situation d'agression sexuelle: ⓪ Non ① Oui ⑨ ?

(Attention! À moins qu'il y ait plusieurs personnes présentes lors de la première confidence de l'adolescent/e, il ne peut y avoir plus d'un confident. Choisir la personne la plus significative pour l'adolescent/e.)

b. *Si oui*, quel est le lien avec le confident (précisez): _____

Sexe du confident: ① Femme ② Homme

À catégoriser par l'équipe de recherche:

10 Un membre de la famille immédiate
- 11 Parent biologique (père, mère)
- 12 Fratrie (frère, sœur)
- 13 Conjoint d'un des parents (beau-père, belle-mère)
- 14 Enfant du conjoint ou de la conjointe

20 Un membre de la famille élargie
- 21 Oncle, tante
- 22 Cousin, cousine
- 23 Grand-parent

30 Une personne de l'entourage
- 31 Gardien/ne
- 32 Conjoint du gardien/ne
- 33 Enfant du/de la gardien/ne
- 34 Parent d'accueil
- 35 Enfant de la famille d'accueil
- 36 Professeur/e ou entraîneur/e
- 37 Ami/e de la famille
- 38 Ami/e de l'adolescent/e
- 39 Voisin/e

40 Un professionnel (médecin, travailleur social, infirmier, etc.)
- 41 Médecin
- 42 Travailleur social, infirmière, etc.
- 43 Policier

50 Autre

60 Chum / blonde

c. *Si non*, quel est la source du dévoilement/signalement:
- ① Quelqu'un a soupçonné l'agression
- ② L'agresseur (soit que l'agresseur s'est dévoilé, qu'il a été pris sur le fait ou matériel pornographique)
- ③ Des amis/es ou la fratrie ont verbalisé leur propre agression ainsi que celui de l'adolescent/e en question

d. Première date à laquelle l'AS a été dévoilée ou signalée: ___/___/_____ (jj/mm/aaaa)

e. Nombre approximatif de mois entre le dernier épisode d'agression et le dévoilement/signalement: _____ mois

f. Nombre approximatif de mois entre le dernier épisode d'agression et la première entrevue pour l'administration des questionnaires (i.e. temps 1/prétest de l'étude): _____ mois

4. Sources d'informations menant à la description de la situation d'AS

a. Verbalisations de l'adolescent/e: ② Précises ① Vagues ⓪ Aucune verbalisation
(précédant ou suivant le signalement ou l'investigation)

b. Verbalisations crédibles d'autres personnes: (plus d'un choix possible)
③ L'agresseur sexuel de l'adolescent/e
② Un témoin de l'AS qu'a vécue l'adolescent/e
① Une autre victime du présumé agresseur
⓪ Aucune verbalisation crédible d'autres personnes

c. Preuves médicales: Source(s) d'information: ① DPJ ② Police ③ Autre:_____

② Preuves physiques fortes qui corroborent l'AS (p.ex.: sperme, ITS, grossesse)
① Indices physiques présents mais non concluants (anomalies décelées, soupçon d'AS sans confirmation)
⓪ Examen physique normal qui ne permet pas d'éliminer la possibilité de l'AS
⑧ Ne s'applique pas – l'adolescent/e n'a pas eu d'examen médical

d. Indice(s) supplémentaire(s) (plus d'un choix possible): ⓪ Aucun indice supplémentaire

① Comportements de l'adolescent/e qui suggèrent la possibilité d'AS (précisez) _____

_____

_____

② Circonstances qui incitent l'entourage à soupçonner une AS (précisez) _____

_____

_____

Pour les besoins de la recherche, à partir des informations recueillies dans le dossier clinique et des constats faits par les différents intervenants au dossier (DPJ, service de police, pédiatre, etc.) qui ont rencontré l'adolescent/e:

① ... la situation d'agression sexuelle est fondée
② ... la situation d'agression sexuelle est probable
③ ... il y a soupçon d'agression sexuelle
④ ... la situation d'agression sexuelle n'est pas fondée

Veuillez compléter cette section une seule fois sur le document HVF de la première situation d'AS (la plus récente)

5. Autres épisodes de victimisation

Veuillez indiquer tout autre épisode de victimisation en spécifiant s'ils sont arrivés en même temps, avant ou après l'agression sexuelle la plus récente (ne pas compléter pour les autres situations). Dans le cas où l'on sait qu'il y a eu d'autres mauvais traitements mais qu'on ne peut spécifier à quel moment ils ont eu lieu indiquer "Moment non spécifié". Vous pouvez inscrire plus d'un choix de réponse.

	Aucune	Concomitante à l'AS	Antérieur à l'AS	Ultérieur à l'AS	Moment non spécifié	?
1. Abus physique	⓪	①	②	③	⑧	⑨
2. Abus psychologique	⓪	①	②	③	⑧	⑨
3. Négligence	⓪	①	②	③	⑧	⑨
4. Exposition à la violence familiale	⓪	①	②	③	⑧	⑨
5. Intimidation ou rejet à l'école / travail	⓪	①	②	③	⑧	⑨

* Pour l'entrée des données dans la banque:
④ Concomitante et antérieure à l'AS; ⑤ Concomitante et ultérieure à l'AS; ⑥ Antérieure et ultérieure à l'AS; ⑦ Concomitante, antérieure et ultérieure à l'AS

6. Revictimisation

Est-ce que l'adolescent/e a vécu une nouvelle situation d'agression sexuelle depuis son recrutement pour l'étude (soit la période entre le T1 et T2)? ⓪ Non ① Oui ⑨ ?

Si plus d'une situation d'AS

Dans le cas où l'adolescent/e a vécu plus d'une situation d'AS, laquelle de ces situations a eu le plus d'impacts ou de répercussions dans la vie de l'adolescent/e?

① La première situation d'AS (la plus récente)
② La deuxième situation d'AS (la deuxième plus récente)
③ La troisième situation d'AS (la troisième plus récente)
④ La quatrième situation d'AS (la quatrième plus récente)

À titre informatif

Votre réponse devrait être une combinaison de votre perception (en tant qu'intervenant/e) et de la perception de l'adolescent/e. Vous pouvez élaborer votre réflexion à l'aide de ce que l'adolescent/e a rapporté dans les rencontres, ou encore selon votre observation des symptômes.

La situation d'AS la plus importante (situation ayant le plus d'impacts dans la vie de l'adolescent/e ou qui semble être la plus traumatique, traumatisante, bouleversante, etc.) peut être liée aux caractéristiques de la situation (sévérité, durée, caractère récent, première situation d'AS, etc.) ou encore aux caractéristiques de l'agresseur (lien qui les unit, âge, etc.).

APPENDIX C

TRADITIONAL & CYBER BULLYING AND SEXUAL HARASSMENT

Section *** Expériences difficiles

31. Pour les questions suivantes, indique si la situation t'est arrivée, et si oui, qui était la personne impliquée.

Au cours des 12 derniers mois, environ combien de fois…	**Jamais**	**1 à 2 fois**	**3 à 5 fois**	**6 fois et plus**	**Qui était la personne impliquée?**	**Élève/s**	**Ex-chum ou ex-blonde**	**Ami/es**	**Intervenant sportif (ex.: entraîneur, coach, assistant-coach)**	**Autre adulte**	
A. … quelqu'un t'a fait te sentir exclu/e ou laissé/e de côté?	0	1	2	3		1	2	3	4	5	6
B. … quelqu'un t'a harcelé/e (rumeurs, intimidation, menaces, etc.) par voie électronique (Facebook, MySpace, MSN, courriel, texto, etc.)?	0	1	2	3		1	2	3	4	5	6
C. … quelqu'un t'a harcelé/e (rumeurs, intimidation, menaces, etc.) à l'école ou ailleurs (excluant par voie électronique)?	0	1	2	3		1	2	3	4	5	6
D. … as-tu personnellement été traité/e de façon injuste à cause de ton orientation sexuelle?	0	1	2	3		1	2	3	4	5	6
E. … as-tu été la cible de commentaires, de blagues ou de gestes à connotation sexuelle (l'autre siffle, imite une fellation, etc.)?	0	1	2	3		1	2	3	4	5	6
F. … une autre personne que ton chum ou ta blonde t'a touché/e, agrippé/e ou s'est frotté/e contre toi d'une manière sexuelle (en sachant que tu ne serais probablement pas	0	1	2	3		1	2	3	4	5	6

d'accord)?

***N'oublie pas de remplir les 2 colonnes!

APPENDIX D

WAYS OF COPING QUESTIONNAIRE (WCQ; FOLKMAN, & LAZARUS, 1988)

32. Les jeunes utilisent différentes stratégies pour faire face aux problèmes qu'ils rencontrent. Indique si tu as déjà utilisé les stratégies suivantes pour gérer des situations stressantes. Il n'y a pas de bonne ou de mauvaise réponse.	**Jamais utilisée**	**Utilisée une seule fois**	**Utilisée à quelques reprises**	**Utilisée à plusieurs reprises**
A. J'essaie de ne pas y penser.	0	1	2	3
B. J'essaie de résoudre le problème avec l'aide de mes amis.	0	1	2	3
C. Je pense au problème et j'essaie de trouver différentes solutions.	0	1	2	3
D. J'essaie d'oublier le problème avec de l'alcool ou des drogues.	0	1	2	3
E. Je me blesse volontairement (par exprès) (ex : me couper ou me brûler, m'arracher des cheveux, etc.).	0	1	2	3
F. Je pleure.	0	1	2	3
G. Je laisse sortir ma colère en frappant ou en faisant une crise.	0	1	2	3
H. Je souhaite que ça ne soit jamais arrivé.	0	1	2	3
I. J'abandonne parce que je ne peux rien y changer de toute façon.	0	1	2	3
J. Je discute du problème avec mes parents ou avec d'autres adultes.	0	1	2	3
K. J'essaie de me faire aider par des personnes qui sont dans une situation semblable.	0	1	2	3
L. Je me comporte comme si rien n'était arrivé.	0	1	2	3

APPENDIX E

CHILDREN'S IMPACT OF TRAUMATIC EVENTS SCALE. (CITES II; WOLFE, GENTILE, MICHIENZI, SAS, & WOLFE, 1991)

Section *** À PROPOS DE CE QUI EST ARRIVÉ

68. Voici des affirmations qui servent à connaître tes pensées et tes sentiments à propos de l'agression sexuelle que tu as vécue. Pour chacune des phrases, indique si pour toi, elle est fausse, un peu vraie ou très vraie. Il n'y a pas de bonne ou de mauvaise réponse aux questions. Il est possible que certaines questions te rappellent des événements désagréables. Si une question te rend mal à l'aise, passe à la suivante.

	Faux	Un peu vraie	Très vraie
1. Des images de ce qui est arrivé apparaissent dans ma tête.	⓪	①	②
2. Lorsque quelque chose me rappelle ce qui est arrivé, j'essaie de penser à autre chose.	⓪	①	②
3. Je fais des rêves ou des cauchemars à propos de ce qui est arrivé.	⓪	①	②
4. Je tente d'oublier ce qui est arrivé.	⓪	①	②
5. J'ai de la difficulté à m'endormir parce que je pense à ce qui est arrivé.	⓪	①	②
6. Je me fâche pour des choses qui ne sont pas très importantes.	⓪	①	②
7. J'ai peur lorsque je me rappelle ce qui est arrivé.	⓪	①	②
8. Je fais comme si ça n'est jamais arrivé ou bien que c'était un rêve.	⓪	①	②
9. Je me sens en colère sans raison.	⓪	①	②
10. J'ai de la difficulté à me concentrer parce que je pense à ce qui est arrivé.	⓪	①	②
11. Je suis contrarié/e pour des petites choses.	⓪	①	②
12. Plusieurs choses me rappellent ce qui s'est passé.	⓪	①	②
13. Je sens que je dois faire très attention pour demeurer en sécurité.	⓪	①	②

	Faux	Un peu vraie	Très vraie
14. J'ai arrêté de faire les choses qui me rappellent ce qui est arrivé.	⓪	①	②
15. Je pense à ce qui m'est arrivé même lorsque je ne veux pas.	⓪	①	②
16. J'ai de la difficulté à contrôler mes émotions.	⓪	①	②
17. Des sons bruyants ou soudains me font sursauter ou me font peur.	⓪	①	②
18. Je me sens tellement agité/e que je ne peux pas me concentrer.	⓪	①	②

19. J'essaie de ne pas être en contact avec ce qui me rappelle ce qui est arrivé.	⓪	①	②
20. Les autres me dérangent facilement.	⓪	①	②
21. J'ai répété ce qui s'est passé en jouant.	⓪	①	②
22. J'ai peur quand je pense à ce qui est arrivé.	⓪	①	②
23. J'ai eu l'impression que l'événement se reproduit.	⓪	①	②
24. Je me demande si j'aurai un avenir.	⓪	①	②
25. Je souhaite ne jamais plus penser à ce qui est arrivé.	⓪	①	②
26. Je ne suis plus autant intéressé/e par des choses que j'aimais avant.	⓪	①	②
27. J'ai des souvenirs très intenses de ce qui arrivé de sorte que je peux ressentir, entendre ou voir les choses qui sont arrivées.	⓪	①	②
28. J'ai l'impression de devoir vérifier des choses pour que rien de mauvais ne se produise.	⓪	①	②
29. Je trouve difficile de faire confiance aux gens.	⓪	①	②
30. J'évite les endroits qui me rappellent ce qui est arrivé.	⓪	①	②
31. Je me sens souvent agité/e ou nerveux/se.	⓪	①	②
32. Je préfère être seul/e plutôt qu'avec des gens.	⓪	①	②
33. J'ai de la difficulté à me souvenir les détails de ce qui s'est passé.	⓪	①	②
34. Penser à ce qui est arrivé me dérange.	⓪	①	②
35. J'ai envie de pleurer lorsque je pense à ce qui est arrivé.	⓪	①	②
36. Je ne pense pas me marier, avoir des enfants ou un travail.	⓪	①	②
37. Je suis resté/e assis/e tranquille sans rien faire.	⓪	①	②
38. Je ne file pas pour jouer ou être avec d'autres jeunes.	⓪	①	②
39. Je fais des rêves épeurants mais je ne me souviens pas des détails.	⓪	①	②
40. Quand je pense à ce qui est arrivé, j'ai mal au ventre ou à la tête.	⓪	①	②
41. C'est plus difficile pour moi d'aimer les gens.	⓪	①	②
42. Je m'inquiète que la même chose ou un autre mauvais événement puisse m'arriver.	⓪	①	②
43. J'ai l'impression que l'événement se reproduit.	⓪	①	②
44. J'évite les gens qui me rappellent ce qui est arrivé.	⓪	①	②
45. J'évite de parler de ce qui est arrivé.	⓪	①	②
46. Je reste dans mon lit sans pouvoir m'endormir même si je suis fatigué/e.	⓪	①	②
47. Ce qui est arrivé est de ma faute.	⓪	①	②
48. J'ai l'impression que j'ai causé des problèmes à plusieurs personnes.	⓪	①	②
49. Je me sens coupable de ce qui est arrivé.	⓪	①	②
50. La plupart des gens me croient lorsque je parle de ce qui est arrivé.	⓪	①	②
51. Je connais quelqu'un avec qui je me sens à l'aise de parler de ce qui m'est arrivé.	⓪	①	②
52. Depuis que j'ai parlé de la situation, je sens que les travailleurs sociaux, les policiers ou les médecins que j'ai rencontrés m'ont aidé.	⓪	①	②
53. Ma mère me protégera afin qu'une telle situation ne m'arrive plus.	⓪	①	②
54. Quand j'ai parlé de ce qui est arrivé à ma mère, je trouve qu'elle s'est bien occupée de moi.	⓪	①	②
55. Si j'ai besoin de parler de ce qui est arrivé, ma mère m'écoutera.	⓪	①	②

APPENDIX F

SUICIDAL IDEATION AND ATTEMPT

Il peut être difficile de répondre à la question qui suit.

Si tu sens que tu as besoin d'aide, nous t'encourageons à en parler à un adulte en qui tu as confiance ou à te servir des ressources qui te sont fournies. Fais signe à l'assistant/e de recherche présent/e sur place si tu désires avoir de l'AIDE IMMÉDIATE.

35. As-tu déjà <u>sérieusement</u> pensé à essayer de te suicider?

1 Non **Tu as répondu non? Passe à la question de la page suivante.*
2 Oui **Tu as répondu oui? Passe à la question suivante.*

36. As-tu déjà essayé de te suicider?

1 Non
2 Oui [redacted] **de fois as-tu essayé de te suicider?**
1 Une fois
2 Plus d'une fois

APPENDIX H

CERTIFICATE FROM THE ETHICS COMMITTEE

CHU Sainte-Justine
Le centre hospitalier universitaire mère-enfant

Pour l'amour des enfants

Université de Montréal

Comité d'éthique de la recherche
ethiques@recherche-ste-justine.qc.ca
Tél. : 514-345-4931 poste 5819
Téléc. : 514- 345-4808

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Le 16 juin 2015

Docteur Jean-Yves Frappier
Médecine adolescents
Étage 7 Bloc 2

OBJET: Titre du projet: Équipe des IRSC sur les traumas interpersonnels - Volet 2: Étude auprès des adolescentes et adolescents issus de populations vulnérables (victimes d'agression sexuelle)

No. de dossier: 3322

Responsables du projet: Jean-Yves Frappier M.D., chercheur responsable au CHU Sainte-Justine. Chercheur principal: Martine Hébert, UQAM. Collaboratrice: Mireille Cyr

Cher Docteur,

L'approbation éthique de votre projet cité en rubrique a été renouvelée et votre amendement (ajout du site CJMCQ) a été accepté par le comité d'éthique de la recherche en date du 26 mai 2015. Vous trouverez ci-joint la liste des documents approuvés ainsi que votre formulaire d'information et de consentement estampillé dont nous vous prions de vous servir d'une copie pour distribution.

Tous les projets de recherche impliquant des sujets humains doivent être réexaminés annuellement et la durée de l'approbation de votre projet sera effective jusqu'au **26 mai 2016**. Notez qu'il est de votre responsabilité de soumettre une demande au Comité pour le renouvellement de votre projet avant la date d'expiration mentionnée. Il est également de votre responsabilité d'aviser le Comité de toute modification à votre projet et/ou tout événement pouvant toucher à la sécurité des participants.

Nous vous souhaitons bonne chance dans la continuité de votre projet et vous prions de recevoir nos meilleures salutations.

Carolina Martin, éthicienne
Responsable du suivi annuel du Comité d'éthique de la recherche

CM/sa
c.c. : BER

3175, Côte-Sainte-Catherine
Montréal (Québec)
H3T 1C5

APPENDIX I
INFORMATION, CONSENT AND CONTACT FORMS

CHU Sainte-Justine
Le centre hospitalier universitaire mère-enfant
Pour l'amour des enfants

Université de Montréal

APPROUVÉ PAR LE COMITÉ D'ÉTHIQUE #3320 26 MAI 2015 CHU SAINTE-JUSTINE

UQÀM
Université du Québec à Montréal

FORMULAIRE D'INFORMATION ET DE CONSENTEMENT

ÉVOLUTION DES JEUNES AYANT DÉVOILÉ UNE AGRESSION SEXUELLE

CHERCHEURS/ES : MARTINE HÉBERT, Ph.D., DÉPARTEMENT DE SEXOLOGIE, UNIVERSITÉ DU QUÉBEC À MONTRÉAL
Dr. JEAN-YVES FRAPPIER, M.D., CHU SAINTE-JUSTINE
MIRELLE CYR, Ph.D., DÉPARTEMENT DE PSYCHOLOGIE, UNIVERSITÉ DE MONTRÉAL

Ce projet est financé par les Instituts de recherche en santé du Canada (IRSC).

Nous sollicitons ta participation à une étude menée par des chercheurs/es de l'Université du Québec à Montréal (UQAM) et du Centre hospitalier universitaire (CHU) Sainte-Justine en collaboration avec quatre milieux d'intervention : la Clinique de médecine de l'adolescence du CHU Sainte-Justine de Montréal, le Centre d'intervention en abus sexuels pour la famille (CIASF) de Gatineau, l'Organisme Parents-Unis (PU) de Lanaudière et le Centre jeunesse de la Mauricie et du Centre-du-Québec (CJMCQ).

Cette étude porte sur les facteurs et les interventions qui aident les jeunes âgés de 14 à 18 ans à surmonter des événements difficiles, comme une agression sexuelle, et sur leur évolution pendant deux ans. Les objectifs de ce projet sont d'identifier l'évolution des adolescents/es ayant dévoilé une agression sexuelle et les éléments qui influencent cette évolution. Nous nous intéressons également aux parcours amoureux des jeunes, à leurs perceptions concernant les relations amoureuses et aux défis de ces relations. Tu n'as pas besoin d'être actuellement en couple ni d'avoir déjà eu des relations amoureuses : nous voulons connaître les perceptions et les opinions de tous les jeunes. Les informations recueillies nous aideront à identifier les besoins des jeunes comme toi et à mettre en place des services mieux adaptés.

EN QUOI CONSISTE TA PARTICIPATION AU PROJET?

Ce projet comprend deux volets:

1) Collecte de données effectuée directement auprès des participantes et participants
Ta collaboration consistera en 4 rencontres individuelles d'une durée de 75 minutes avec une assistante ou un assistant de recherche. Tu répondras à des questionnaires portant sur ta situation personnelle, psychologique, familiale, relationnelle et amoureuse. La première rencontre aura lieu lors de ta visite dans le milieu d'intervention (CHU Sainte-Justine, CIASF, PU ou CJMCQ). Les autres rencontres auront lieu à des intervalles de 6 mois suivant la première rencontre. Il sera alors possible pour toi d'effectuer les autres rencontres à l'endroit de ton choix : au milieu d'intervention (CHU Sainte-Justine, CIASF, PU ou CJMCQ), à ton domicile, dans un local de l'UQAM, ou encore par le biais du web, selon ta préférence.

2) Collecte d'informations par le biais du dossier clinique ou médical des participantes et participants
Ici, ta participation consiste à autoriser que l'équipe de chercheurs/es recueille des informations contenues dans ton dossier clinique ou médical du milieu d'intervention (CHU Ste-Justine, CIASF, PU ou CJMCQ), comprenant entre autres la description des services que tu as reçus et de l'information sur ton évolution psychosociale. Cette autorisation ne te demandera aucune participation supplémentaire.

☐ Copie des participants/es ☐ Copie de l'équipe de recherche
Révision : 24.01.2014 – IRSC ADOS

AVANTAGES DE L'ÉTUDE
En complétant les questionnaires, tu auras la possibilité de faire le point sur différents aspects de ta vie ainsi que sur ton adaptation aux événements difficiles que tu peux avoir vécus. Le fait de recueillir ces informations sur l'ensemble des adolescents/es nous permettra de mieux définir les caractéristiques des jeunes ayant vécu une agression sexuelle, de mieux saisir les besoins d'intervention et d'adapter les services.

INCONVÉNIENTS ET RISQUES
Un possible inconvénient est le temps que tu nous accorderas pour compléter les questionnaires. Un autre désavantage possible serait de te rappeler des épisodes désagréables de ta vie familiale, sociale ou amoureuse. Toutefois, l'assistante ou l'assistant de recherche te renseignera après l'entrevue sur les personnes-ressources disponibles si tu ressens le besoin de parler d'une expérience difficile. Par ailleurs, si tu le désires, tu pourras discuter avec l'intervenant/e que tu rencontres dans le milieu d'intervention (CHU Sainte-Justine, CIASF, PU ou CIMCQ). De plus, à aucun moment il ne te sera demandé de décrire ce que tu as vécu. Il est également possible de faire une pause, selon tes besoins, ou de mettre un terme à l'entrevue, si tu le désires. Les assistants/es de recherche sont des étudiantes et étudiants de niveau universitaire inscrits dans un programme d'étude en lien avec le projet de recherche. Ils et elles ont déjà mené des entrevues auprès d'adolescents/es.

CONFIDENTIALITÉ ET UTILISATION DES DONNÉES RECUEILLIES
Les données recueillies par cette étude sont ***entièrement confidentielles***, à moins d'une autorisation de ta part ou d'une exception de la loi (par exemple, en vertu de l'article 39 de la loi sur la Protection de la Jeunesse[1]). La confidentialité sera assurée par l'utilisation d'un code numérique pour identifier les questionnaires et les informations recueillies dans ton dossier clinique ou médical. Seuls l'équipe de chercheurs/es et leurs assistants/es auront accès aux formulaires de consentement. Ces personnes sont toutefois tenues à la confidentialité des informations consultées. En plus des chercheurs/es impliqués/es dans ce projet, des étudiants de maîtrise et de doctorat, supervisés par ces chercheurs, pourraient avoir accès au fichier de traitement statistique de données dénominalisées (c'est-à-dire que ton nom n'y apparaîtra jamais). Les résultats des recherches effectuées avec ces données ne permettront pas non plus d'identifier les personnes participantes. Les résultats seront diffusés dans des articles de revues scientifiques, des présentations lors de congrès et colloques, et des travaux d'étudiants/es. Les questionnaires et les informations recueillies dans le dossier clinique ou médical seront conservés sous clé dans les locaux de la chercheure principale (Martine Hébert - UQAM). Les seules personnes qui y auront accès sont les chercheurs/es associés au projet et les assistants/es de recherche. Ces documents seront détruits 5 ans après la dernière rencontre. Le comité d'éthique du CHU Sainte-Justine ainsi que l'organisme subventionnaire (IRSC) pourront avoir accès aux données.

RESPONSABILITÉ DES CHERCHEURS
En acceptant de participer à cette recherche, tu ne renonces à aucun de tes droits prévus par la loi. De plus, tu ne libères pas les chercheurs/es de leur responsabilité légale et professionnelle advenant une situation qui te causerait préjudice.

COMPENSATION
Si tu acceptes de compléter le questionnaire, une somme de 30$ sous forme de certificat cadeau te sera remise lors de chaque rencontre. C'est une compensation pour ton temps ou les coûts relatifs à ton déplacement.

EST-IL OBLIGATOIRE DE PARTICIPER?
Tu es entièrement libre de participer ou non, en partie ou en totalité. Tu es libre de te retirer du projet à tout moment; toutes les données recueillies sur toi seraient alors détruites. Sache que la décision de participer ou non à cette étude n'affectera en rien les services qui te sont offerts dans les différents milieux d'intervention impliqués dans le projet de recherche.

PERSONNES DISPONIBLES POUR RÉPONDRE À TES QUESTIONS:
Si tu as des questions concernant ce projet de recherche, n'hésite pas à communiquer avec nous aux coordonnées indiquées ci-dessous :

Martine Hébert, Ph.D. — (514) 987-3000 (poste 5697)
Professeure titulaire au département de sexologie, UQAM

Dr. Jean-Yves Frappier, M.D. — (514) 345-4722
CHU Sainte-Justine

Mireille Cyr, Ph.D. — (514) 343-2285
Professeure titulaire au département de psychologie, Université de Montréal

Nous te remercions pour ta collaboration.

MARTINE HÉBERT, Ph.D., DÉPARTEMENT DE SEXOLOGIE, UNIVERSITÉ DU QUÉBEC À MONTRÉAL
Dr. JEAN-YVES FRAPPIER, M.D., CHU SAINTE-JUSTINE
MIREILLE CYR, Ph.D., DÉPARTEMENT DE PSYCHOLOGIE, UNIVERSITÉ DE MONTRÉAL

Si tu as des questions au sujet de tes droits ou une plainte à formuler, contacte le commissaire local aux plaintes et à la qualité des services du CHU Sainte-Justine au (514) 345-4749.

FORMULAIRE D'INFORMATION ET DE CONSENTEMENT

ÉVOLUTION DES JEUNES AYANT DÉVOILÉ UNE AGRESSION SEXUELLE

En signant le présent formulaire, je certifie que:

- J'ai lu le formulaire d'information et de consentement du projet de recherche ci-haut mentionné.
- J'ai compris les conditions, les risques et les bienfaits de ma participation.
- J'ai eu l'occasion de poser des questions auxquelles on m'a donné des réponses. Je sais que je peux poser d'autres questions en tout temps.
- Je comprends que je peux me retirer de l'étude en tout temps sans conséquence sur les services qui me sont offerts.
- Je comprends qu'en signant ce document, je ne renonce pas à mes droits.
- Je comprends que je vais recevoir une copie signée du présent formulaire de consentement.

J'accepte librement de participer au projet de recherche qui implique la passation de questionnaires à 4 reprises.	☐ Oui	☐ Non
J'accepte que les données recueillies dans mon dossier clinique ou médical soient transmises à l'équipe de chercheurs/es pour qu'elles soient utilisées à des fins de recherche.	☐ Oui	☐ Non
J'accepte qu'un/e assistant/e de recherche communique avec moi dans 4 mois pour prévoir une 2ième rencontre.	☐ Oui	☐ Non
J'accepte que des informations sommaires soient présentées sous forme de tableau résumé à mon intervenant/e du milieu d'intervention visité.	☐ Oui	☐ Non

Nom du participant (Lettres moulées) Consentement du participant (Signature) Date (jj/mm/aaaa)

SI TU AS ACCEPTÉ DE PARTICIPER À CE PROJET DE RECHERCHE, COMPLÈTE LA SECTION SUIVANTE:

( ) _____ ( ) _____ _____

Téléphone résidence Cell. ou Autre Courriel

_____

Adresse Numéro Rue Appartement

_____

Municipalité Province Code postal

Coordonnées de deux personnes qui pourraient nous aider à te rejoindre :

_____ ( )

Nom et prénom du contact (Lettres moulées) Lien du contact avec le participant N° de téléphone

_____ ( )

Nom et prénom du contact (Lettres moulées) Lien du contact avec le participant N° de téléphone

J'ai expliqué au participant et/ou à son parent/tuteur tous les aspects pertinents de la recherche et j'ai répondu aux questions qu'ils m'ont posées. Je leur ai indiqué que la participation au projet de recherche est libre et volontaire et que la participation peut être cessée en tout temps.

Le centre hospitalier universitaire sainte-justine

Pour l'amour des enfants

Université de Montréal

LETTRE D'INFORMATION ET D'ACCORD

AFIN QUE NOUS PUISSIONS PRENDRE CONTACT AVEC TOI DANS 6 MOIS POUR UNE 3ième RENCONTRE

ÉVOLUTION DES JEUNES AYANT DÉVOILÉ UNE AGRESSION SEXUELLE

Ce projet est financé par les Instituts de recherche en santé du Canada (IRSC).

Tu as collaboré à un projet de recherche auprès des adolescents/es ayant vécu une agression sexuelle qui ont reçu des services dans un des milieux d'intervention avec lesquels nous sommes en étroite collaboration (Clinique de médecine de l'adolescence du CHU Sainte-Justine de Montréal, Centre d'intervention en abus sexuels pour la famille de Gatineau, Organisme Parents-Unis de Repentigny et Centre jeunesse de la Mauricie et du Centre-du-Québec). Cette étude implique une 3ième entrevue qui se tiendra dans 6 mois. Si tu es d'accord, nous te demandons de l'indiquer et d'inscrire le nom et le numéro de téléphone de deux personnes qui pourraient nous aider à te rejoindre. Cette recherche est sous la direction de Martine Hébert (docteure en psychologie), professeure à l'UQAM. Toute question ou commentaire peut lui être adressé au numéro (514) 987-3000, poste 5697.

J'accepte qu'un/e assistant/e de recherche communique avec moi dans 6 mois pour prévoir une 3ième rencontre. ☐ Oui ☐ Non

Nom du participant/e (Lettres moulées) Consentement du participant/e (Signature) Date (jj/mm/aaaa)

SI TU AS ACCEPTÉ DE PARTICIPER À LA RELANCE, COMPLÈTE LA SECTION SUIVANTE:

( ) Téléphone ou domicile ( ) Cell. ou Autre: Courriel

Adresse Numéro Rue Appartement

Municipalité Province Code postal

Coordonnées de deux personnes qui pourraient nous aider à te rejoindre :

Nom et prénom du contact (Lettres moulées) Lien du contact avec le participant ( ) # de téléphone

Nom et prénom du contact (Lettres moulées) Lien du contact avec le participant ( ) # de téléphone

Quelles sont les mesures prévues au plan éthique?

Cette enquête a reçu l'approbation du Comité institutionnel d'éthique de la recherche avec des êtres humains (CIER) de l'Université du Québec à Montréal (UQAM) et par le Comité d'éthique de la recherche du CHU Sainte-Justine. La participation à cette enquête se fait sur une base volontaire. Les adolescents/es sont entièrement libres de participer au projet ou non, en partie ou en totalité. Ils ont également la liberté de se retirer du projet à tout moment. La confidentialité des participants/es sera assurée par l'utilisation d'un code numérique pour identifier les questionnaires et seuls l'équipe de chercheurs/es et leurs assistantes auront accès aux formulaires de consentement.

Qui sont les chercheurs/es de l'équipe?

Martine Hébert, Ph.D., responsable de l'Équipe et professeure à l'UQAM
hebert.m@uqam.ca / 514.987-3000 poste 5697

Dr. Jean-Yves Frappier, M.D. CHU Sainte-Justine
(514) 345-4722

Mireille Cyr, Ph.D., Professeure titulaire à l'Université de Montréal
mireille.cyr@umontreal.ca / 514-343-2285

Pour plus d'informations, n'hésitez pas à communiquer avec nous :

Janèle Boivin
Professionnelle de recherche
Université du Québec à Montréal
boivin.janele@uqam.ca
514-987-3000 poste 4754

Projet de recherche sur l'évolution des jeunes ayant dévoilé une agression sexuelle

UQÀM
Université du Québec à Montréal

CHU Sainte-Justine
Le centre hospitalier universitaire mère-enfant
Pour l'amour des enfants

Université de Montréal

Aperçu de votre participation à nos projets de recherche

L'équipe de recherche sur les traumas interpersonnels

L'Équipe de recherche sur les traumas interpersonnels mène actuellement un projet aux multiples volets sur la violence dans les relations amoureuses (VRA) des adolescentes et adolescents âgés de 14 à 18 ans. L'Équipe est financée par les Instituts de Recherche en Santé du Canada (IRSC) et implique des chercheurs/es provenant de l'Université du Québec à Montréal, l'Université de Montréal, l'Université Laval et du CHU Ste-Justine. Plusieurs milieux d'interventions et partenaires contribuent également au projet.

La programmation de recherche du projet, présentée en quatre volets, vise les objectifs généraux suivants

Volet I : Enquête longitudinale représentative auprès des jeunes Québécois fréquentant l'école secondaire

Documenter le phénomène de la VRA chez les jeunes âgés de 14 à 18 ans: sa prévalence, ses formes, les facteurs de risque associés, les conséquences à court et moyen terme sur la santé (blessures physiques et psychologiques) ainsi que les facteurs de protection et les profils de résilience.

Volet II : Enquête longitudinale quantitative auprès de sous-groupes spécifiques

Volet II a : Étude d'une population clinique : Les victimes d'agression sexuelle prises en charge par les services hospitaliers ou spécialisés

Volet II b : Sur-échantillonnage d'une population minoritaire à risque : Les jeunes de minorités sexuelles

Documenter le phénomène de la revictimisation: sa prévalence, ses formes, les facteurs de risque associés et les variables liées aux trajectoires de résilience (en comparant les trajectoires à épisode unique de victimisation et celles à épisodes répétés) ainsi que ses conséquences à court et moyen termes sur la santé physique et mentale.

Volet III : Étude sur la dyade adolescente et analyse des interactions de couples en laboratoire

Décrire les interactions de couples chez les adolescents et leurs modes de résolution violents et non violents des conflits tout en contrastant les patrons d'interaction des couples adolescents en regard des expériences de victimisation.

Volet IV : Analyse qualitative chronologique (longitudinale) des trajectoires amoureuses et sexuelles d'adolescents

Dégager les significations subjectives accordées aux relations amoureuses, à la sexualité et à la VRA.

Les caractéristiques du volet IIa sur les victimes d'agression sexuelle

Cette étude longitudinale prévoit 4 rencontres avec les participants (intervalle de 6 mois) afin de documenter leur évolution psychosociale. Les deux premières rencontres ont habituellement lieu dans le milieu d'intervention de l'adolescent/e afin de lui administrer un questionnaire d'une durée approximative de 90 minutes, tandis que les deux dernières rencontres prévues se feront par la poste ou en personne selon les disponibilités de l'adolescent/e.

Nous aimerions demander la collaboration de votre organisme afin de nous aider à recruter des sujets pour ce volet IIa et ainsi aider à l'avancement des connaissances dans le domaine du traitement des victimes d'agression sexuelle.

En quoi consiste votre collaboration?

La participation de votre organisme en termes de ressources et de temps consiste simplement à présenter le projet de recherche aux adolescents/es de 14 à 18 ans, ayant été victimes d'agression sexuelle, qui bénéficient de vos services. Lorsque l'adolescent/e a donné son consentement verbal ou écrit, à votre convenance, vous pouvez directement prendre contact avec Janèle Boivin, coordonnatrice principale du projet, au 514-987-3000 x 4754 afin de lui transmettre les coordonnés du sujet potentiel. L'adolescent/e sera appelé par une assistante de recherche afin de lui expliquer plus en détails les implications reliées à la participation au projet de recherche.

Merci de votre précieuse collaboration !

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