

Study number:

PSYCHOLOGY QUESTIONNAIRE

A1 ID Number _____

A2 Name _____

A3 Date of Birth / /
dd/mm/yy

A4 Hospital Number _____

A5 Today's date / /

Place for Cleft identification sticker
if available

A6 Psychology questionnaire

Self completed at clinic ₁

Completed at clinic with assistance ₂

Self completed at home ₃

Study number:

B1A. Do you feel your son/daughter's self confidence has been affected by the cleft?

0	1	2	3	4	5	6	7	8	9	10

Has a very negative effect

Makes no difference

Has a very positive effect

B1B. Comments:

B2A. Is teasing/bullying a current problem for your son/daughter?

YES ₁

NO ₂

B2B) If yes, what's happening?

B2C) How much is it happening?

- Sometimes ₁
- Once a week ₂
- Every few days ₃
- Every day ₄

B2D) What does your child do in response to the teasing/bullying? Please tick ✓ all that apply:

Response	✓	Comments	Does this work?	
Gets upset	<input type="checkbox"/> _{1A}	_{1B}	YES _{1C} <input type="checkbox"/> ₁	NO <input type="checkbox"/> ₂
Gets angry	<input type="checkbox"/> _{2A}	_{2B}	YES _{2C} <input type="checkbox"/> ₁	NO <input type="checkbox"/> ₂
Ignores it	<input type="checkbox"/> _{3A}	_{3B}	YES _{3C} <input type="checkbox"/> ₁	NO <input type="checkbox"/> ₂
Tells someone	<input type="checkbox"/> _{4A}	_{4B}	YES _{4C} <input type="checkbox"/> ₁	NO <input type="checkbox"/> ₂
Uses anti-bullying strategies	<input type="checkbox"/> _{5A}	_{5B}	YES _{5C} <input type="checkbox"/> ₁	NO <input type="checkbox"/> ₂
Other	<input type="checkbox"/> _{6A}	_{6B}	YES _{6C} <input type="checkbox"/> ₁	NO <input type="checkbox"/> ₂

Study number:

B2E) How much do you think the teasing/bullying bothers your son/daughter?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0	1	2	3	4	5	6	7	8	9	10

Bothers my son/daughter a great deal

Does not bother my son/daughter at all

B3A. Does your son/daughter avoid any things because of their nose/scar/lip/speech/teeth? (Please underline which)

B3B YES ₁ NO ₂

B3C If yes, what does s/he avoid? (e.g. being in public; socialising; having photos/videos taken)

.....

.....

B4A Do you think it would be helpful for your son/daughter to talk to somebody who could help them to deal with any cleft-related problems?

- Yes ₁
- No ₂
- Perhaps at a later date ₃
- Seeing someone already ₄

B4B comments

.....

.....

B5 Do you have any anxieties about your son/daughter's future?

.....

.....

B6A Do you feel you are getting enough support outside of the cleft team?

YES ₁ NO ₂

B6B comments

.....

.....

Study number:

B7A Does the cleft make any difference to your life at the moment?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0	1	2	3	4	5	6	7	8	9	10
Makes life much worse			Makes no difference					Makes life much better		

B7B) If yes, in what way does the cleft make a difference?

B8 Would you like to talk to somebody who could help you to deal with any cleft related problems?

- Yes ₁
- No ₂
- Perhaps at a later date ₃
- Seeing someone already ₄

Thank you

How do you feel about the way your son / daughter / patient looks?
(Please tick one box for each question)

C1A. How their face looks:

Very happy ☺ ☹ Very unhappy

10 0

C2A. The whole of their appearance:

Very happy ☺ ☹ Very unhappy

10 0

C3A. Side view / profile:

Very happy ☺ ☹ Very unhappy

10 0

C4A. How good-looking do you think they are?

Very good-looking ☺ ☹ Not at all good-looking

10 0

How do you feel about these parts of their face?

C5A. Nose:

Very happy ☺ ☹ Very unhappy

10 0

C6A. Lips:

Very happy ☺ ☹ Very unhappy

10 0

C15A. Do they wear a hearing aid? Yes₁ No₂

C16A. If yes, are they happy wearing it?

Very happy 😊 😞 Very unhappy

10 0

C17A. Do they have braces? Yes₁ No₂

C18A. If yes, how happy are you with the way they look?

Very happy 😊 😞 Very unhappy

10 0

C19A. Overall how noticeable do you feel the cleft is to other people?

Not at all noticeable 😊 😞 Very noticeable

10 0

C20A. Do you think their appearance affects how they get on with other people?

Makes it easier 😊 😞 Makes it harder

10 makes no difference 0

Thank you