ORIGINAL ARTICLES

UDC: 616.89-008.441.44-02:364.63-053.2
https://doi.org/10.2298/VSP170826142D

Victimization in childhood as a suicide risk factor in adults

Viktimizacija u detinjstvu kao faktor suicidnog rizika kod odraslih

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Abstract

Background/Aim. There is a burgeoning literature on the association between childhood victimization and the risk of suicidal behavior in early adolescence, while there is significantly less research showing this association in adults. The aim of our study was to examine whether victimization in childhood increased the likelihood of suicide attempt in adults. **Methods.** The sample consisted of 90 patients, 71 females and 19 males, aged 37.92 ± 11.04 years on average, hospitalized in the Day Hospital of the Clinic of Psychiatry Military Medical Academy, Belgrade, Serbia. The Juvenile Victimization Questionnaire (JVQ), Defense Style Questionnaire (DSQ-40) and Beck Depression Inventory were used for 50 patients following suicide attempt and in 40 patients who were on psychotherapeutic treatment due to various life crises not resulting in suicide attempt. According to the indications, we excluded the patients with psychosis (F20-F29, F30-31 and F 32.3), substances abuse (F10-F19) and dementia (F00-F09), satisfying International Classification of Diseases-10 version (ICD-10) (the World Health Organization criteria). The examinees of both groups were matched by age, education and marital status. Comparison of the patient groups was done by the Students' *t*-test for the parametric features and Mann-Whitney U test for non-parametric data. **Results**. The suicide attempters had moderate depression (19.76 ± 10.52) and used immature defense mechanisms ($p < 0.001$). The JVQ established statistical differences in the Total score ($p < 0.005$) and in two modules: Peer and Sibling Victimization ($p < 0.005$) and Sexual victimization ($p < 0.005$). **Conclusion**. The adults who were more likely to attempt suicide during their lifetime were more often victims of peer and sexual abuse in their childhood. Data on victimization in early childhood provide opportunities for early detection of persons with suicide risk that could help in the psychotherapeutic work with these patients, but also in the suicide prevention in a wider population.

Key words:
crime victims; child; suicide, attempted; adults; psychotherapy.

Apstrakt

Uvod/Cilj. Postoje istraživanja o povezanosti između viktimizacije deteta i rizika od samoubilačkog ponašanja u ranoj adolescenciji, dok je značajno manje istraživanja koja pokazuju ovu povezanost kod odraslih osoba. Cilj našeg istraživanja je bio da se ispita da li viktimizacija u detinjstvu povećava rizik od pokušaja suicida kod odraslih osoba. **Metode.** Istraživanje je sprovedeno na grupi od 90 pacijenata, 71 žene i 19 muškaraca, prosečne životne dobi od 37,92 ± 11,04 godina, hospitalizovanih u Dnevnoj bolnici Klinike za psihijatriju Vojnomedicinske akademije, Beograd, Srbija. U istraživanju su korišteni: Upitnik viktimizacija (*The Juvenile Victimization Questionnaire* – JVQ), Upitnik mehanizama odbrane (*Defense Style Questionnaire* – DSQ-40) i Bekova skala depresije (*Beck Depression Inventory* – BDI). Ispitanici su bili podeljeni u dve grupe: grupa pacijenata koji su pokušali suicid (N = 50) i grupa pacijenata koji su bili na psihoterapijskom tretmanu zbog različitih životnih kriza koje nisu imale za posledicu pokušaj samoubistva (N = 40). Iz ispitivanja su isključeni pacijenti sa psihotičnim poremećajem (F20-F29, F30-31 i F 32.3), bolestima zavisnosti (F10-F19) i demencijom (F00-F09), prema Međunarodnoj klasifikaciji bolesti 10 verzija (ICD 10) (*World Health Organization criteria*). Ispitanici obe grupe su bili ujednačeni prema godinama života, obrazovanju i bračnom statusu. Za statističku obradu korišten je Studentov *t*-test za parametarsku i Mann-Whitney U test za neparametarsku analizu podataka. **Rezultati**. Pacijenti koji su pokušali suicid ispoljavali su depresiju umerenog stepena (19.76 ± 10.52) i koristili su nezrele mehanizme odbrane ($p < 0.001$). Upitnikom JVQ utvrđene su statistički značajne razlike na Ukupnom skoru viktimizacije ($p < 0.005$), kao i na dva modula: Vršnjačko zlostavljanje ($p < 0.005$) i Seksualno zlostavljanje ($p < 0.005$). **Zaključak.** Odrasle osobe koje su

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češće tokom života pokušale samoubistvo su bile žrtve vršnjačkog i seksualnog zlostavljanja u detinjstvu. Podaci o zlostavljanju u ranom detinjstvu pružaju mogućnosti rane detekcije osoba sa suicidnim rizikom što može pomoći u psihoterapijskom radu sa ovim osobama, kao i u prevenciji suicida u široj populaciji.

Ključne reči:
žrtve zločina; deca; samoubistvo, pokušaj; odrasle osobe; psihoterapija.

Introduction

Suicide risk factors are estimated on the basis of the presence or absence of a number of specific factors that are presumed to be significant in order to have a suicide occurring within the statistical probability. Bearing in mind all these characteristics and regularity as well as belonging to certain risk groups and knowing the specific life situations in which an individual can be found and attempt suicide, more or less reliable estimates of the degree of risk can be made as well as the basic motives of a person willing to attempt suicide [1].

In recent years, an increasing importance in investigations of the distal sucide risk factors has been given to the problem of child victimization. In prospective family studies of suicide risk monitoring across many generations, some data on the early childhood experiences of physical and sexual abuse and child neglect in the family were encountered, and they represent significant risk factors for suicidal behavior in adolescence [2–5].

Investigations show that the childhood maltreatment is frequent among western societies, with an estimated prevalence of 10% to 15% [2].

Data obtained from the national study among the U.S. adults who attempted suicide showed that the prevalence of reported childhood abuse was 4.60% for physical abuse, 7.83% for emotional abuse and 10.20% for sexual abuse. Approximately 18% of adults reported some form of violent behavior in their childhood [6].

The results from a representative sample of 5,960 students (aged 17) from high schools in Sweden showed that 84.1% (83.0% young men and 85.2% young women) of the students had experienced victimization during their lifetime, and 10.3% were categorized as poly-victims (8.1% young men and 12.5% young women) [7].

The results from the South Australian population-based observational study suggest that there is a strong association between a history of childhood bullying victimization and current suicidal ideation that persists across all ages [8]. In a random probability sample comprising 7461 respondents in Great Britain interviewed on psychiatric morbidity of adults, recalled of being bullied in childhood decreased with age from 25% of 16-24 year old subjects to 4% among those of 75 or over, with few differences in proportions between men and women. Adults who reported bullying in childhood were still more than twice as likely as other adults to attempt suicide later in life [9].

Some investigations estimated differences in gender in childhood abuse. An investigation among Swedish students showed that the adolescents living with both parents were at lower risk of any form of victimization for both genders. But, females living with both parents were at higher risk of maltreatment, peer victimization, and most significantly, sexual victimization [7].

Childhood maltreatement is a risk factor for the development of mental disorders in adulthood [10]. Suicide attempts are more often seen in young people from dysfunctional families characterized by divorce, psychopathology in parenting, data on sexual, physical and emotional abuse or neglect, poor parent-child relationships, quarrels and violent behavior among parents. The problem is even more dramatic if disturbed family relationships last for a long time, with the tendency of accumulation and the occurrence of multiple child abuse, which include socioeconomic problems, alcohol abuse in the family, or frequent relocation.

The data obtained from the British National Child Development Study, from 7,771 participants, a 50-year prospective cohort of births in 1958 suggested that maltreatment in childhood and early adolescence increased levels of psychological distress at ages 23 and 50 [9]. The victims of frequent bullying had higher rates of depression, anxiety disorders and suicidality than their nonvictimized peers. Childhood bullying victimization was associated with a lack of social relationships, economic hardship and perceived quality of life at age 50 as poor [10].

In the individuals hospitalized at the Clinic for Toxicology at the Military Medical Academy (MMA), Belgrade, following suicide attempt by self-poisoning, 86.7% of suicide attempters had a history of bullying just preceding the suicide attempt: 53.3% by their mother or father (emotionally mistreated and/or physically bullied), 23,3% by their conjugal partner (sexually neglected and/or emotionally harassed, or physically bullied), and 10% by persons in their social network (emotionally neglected and/or bullied) [11, 12].

The largest number of studies show that there is an association between childhood abuse (victimization) and the risk of suicidal behavior in early adolescence, while significantly less studies show this association in adulthood. This is one of the reasons for our interest in the relationship between the two types of behavior.

The objective of our study was to determine whether a history of childhood victimization is associated with suicide attempt in adult life.

Methods

The cross-sectional study was performed on a sample consisting of 90 consecutively recruited patients, 71 females and 19 males, who were on psychotherapeutic treatment in the Day Hospital of the Clinic of Psychiatry MMA, Belgrade, Serbia. The investigation was conducted during 3-year period (2014 to 2017.).

The majority of patients were recruited directly after the inpatient treatment in the Clinic of Psychiatry, MMA, where they were admitted after the treatment at the Clinic for Toxicology, MMA, following a suicide attempt by self-poisoning. A few patients admitted after an outpatient examination at the Department of Psychiatry, MMA, and self-reported that they had a lifetime suicide attempt.

The most common reasons for suicide attempt were separation problems and problems with interpersonal communication with emotional partners. The patients with diagnosis F32-F33, F40-F48 were included into the control group. According to the indications, the patients who were excluded from our investigation suffered from: dementia (F00-F09), substance abuse/dependence (F10-F19) and psychotic disorders (F20-F29, F30-31, 32.3) satisfying International Classification Disease-10th version (ICD 10) [13].

This study was conducted according to the approval by the Ethics Committee of the Military Medical Academy Belgrade. The written informed consent after receiving the information about the study was obtained from all patients prior to their inclusion into the study. Confidentiality of the responses was assured.

Patients

The patients were divided into two groups. The first group consisted of 50 suicide attempters (38.76 ± 10.26 years old with 13.51 ± 2.16 years of education). The control group (non-suicide attempters) consisted of 40 patients who were on psychotherapeutic treatment due to various life crises, not resulting in suicide attempt (37.55 ± 11.63 years old with 13.70 ± 2.31 years of education). A half of all patients of both groups were married and had children, and about 20% came from uncomplete primary family. The patients of both groups were matched by age, education, and characteristics of primary and secondary family (marital status, children and primary family completed).

Instruments

The demographic data were collected from medical records.

The following was used in the investigation: The Juvenile Victimization Questionnaire (Adult Retrospective Questionnaire – JVQ) [14], Defense Style Questionnaire (DSQ-40) [15] and Beck Depression Inventory (BDI) [16].

The Juvenile Victimization Questionnaire (Adult Retrospective Questionnaire) is a comprehensive questionnaire designed to gather information for a variety of important forms of victimizations experiences during their childhood, including community violence and other conventional crime, bullying and other peer and sibling violence and witnessing all types of violence, including domestic violence. The JVQ is a self-report questionnaire adapted for the retrospective reporting of childhood events starting from infancy to 17 years of age, which is assessed from the perspective of an adult. It contains 34 types of abuse that adults experienced during their childhood and adolescence. It covers five general areas of concern (modules): Conventional crime, Child maltreatment, Peer and Sibling victimization, Sexual victimization and Witnessing and indirect victimization. Every victimization-screening question includes the number of times a child was victimized, who victimized the child, whether the child was hurt and questions specific to the victimization reported [14]. The Juvenile Victimization Questionnaire is free for public to use. We translated it in Serbian for our investigation.

The Defense Style Questionnaire (DSQ-40) consists of 40 claims of personal attitudes. It includes 20 defense mechanisms; each mechanism is represented by two questions. Mature and the neurotic defence mechanisms include 8 questions and the immature include 24 questions. Using the scale of 9 numbers, each respondent is asked to indicate how much he agree or disagree with the given statements. The defense mechanism score represents the sum of all items of the same set. The score of each defense mechanism is calculated as the average response to items that make this defense mechanism [15].

The Beck Depression Inventory is a scale for assessing depression. There are 21 questions with 4 answer options graduaded from four point Likert scale from 0–3. The total score is the sum of all answers. The cut-off score for clinically significant depression is 10. The higher score indicates more severe depressiveness [16].

Statistical analysis

The one-sample Kolmogorov-Smirnov test was used for the testing the normal distribution of data. *P*-value 0.005 was considered to be significant and *p*-value of 0.001 to be highly significant.

Results

Defense mechanisms (DSQ-40) and Depression BDI are shown in Table 1.

Table 1

Defense mechanisms (DSQ-40) and Depression (BDI) in suicide and non-suicide attempters

Variable	Suicide attempter (n = 50) mean ± SD	Non-suicide attempter (n = 40) mean ± SD	*p*
Depression	19.76 ± 10.52	17.08 ± 11.89	0.470
Defense mechanisms			
neurotic	5.23 ± 1.36	4.82 ± 1.55	0.602
immature	4.80 ± 0.92	4.50 ± 1.44	0.001**
mature	5.62 ± 1.15	5.39 ± 1.43	0.198

DSQ – Defense Style Questionnaire; BDI – Back Depression Inventory; $p < 0.005$*; $p < 0.001$; SD – standard deviation.**

The patients who attempted suicide and the patients from the control group had depression of moderate level, and there were no statistically significant differences between the groups of patients.

The patients who attempted suicide had the higher values of the total score of mature, immature and neurotic defense mechanisms than the patients from the control group. But, there were highly statistically significant differences in the immature defense mechanisms between two groups of patients ($p < 0.001$).

The Juvenile Victimization Questionnaire showed that there was a high statistically significant difference beetween the suicide attempters and the control group in the Total score of the Questionnaire ($p < 0.005$).

In the module related to Peer and Sibling victimization, all values were higher in the suicide attempters than in the control group. There were statistically significant differences in the subscale of Bullying and in the Total score ($p < 0.005$).

In the module of Sexual Victimization all values were higher in the suicide attempters than in the control group. There was a statistically significant difference in the subscale of Statutory Rape & Sexual Misconduct ($p < 0.005$) and in the Total score ($p < 0.005$) (Table 2).

Table 2

Results of Juvenile Victimization Questionnaire (JVQ) in suicide and non-suicide attempters

JVQ	Suicide attempter mean ± SD	Non-suicide attempter mean ± SD	z	*p*
Conventional crime				
robbery	1.24 ± 1.88	0.75 ± 1.48	1,582	0,114
personal theft	0.96 ± 1.37	0.60 ± 0.93	1,208	0,227
vandalism	1.18 ± 1.55	0.90 ± 1.71	1,816	0,069
assault with weapon	1.22 ± 1.93	0.45 ± 0.81	1,705	0,088
assault without weapon	1.76 ± 2.19	1.48 ± 2.04	0,731	0,465
attempted assault	1.20 ± 1.77	0.45 ± 0.99	2,291	0,022
kidnapping	0.20 ± 0.14	0.00 ± 0.00	0,894	0,371
bias attack	0.58 ± 1.49	0.23 ± 1.00	1,842	0,065
total score	8.16 ± 7.78	4.77 ± 5.27	2,277	0,023
Child maltreatment				
physical abuse by caregiver	2.68 ± 2.58	2.23 ± 2.47	0,830	0,407
psychological/emotional abuse	2.22 ± 2.65	1.88 ± 2.52	0,485	0,628
neglect	0.58 ± 1.60	0.18 ± 0.96	1,412	0,158
custodial interference/family abduction	0.32 ± 1.19	0.23 ± 0.97	0,255	0,799
total score	5.80 ± 5.48	4.50 ± 5.35	1,359	0,174
Peer and sibling victimization				
gang or group assault	0.74 ± 1.51	0.35 ± 1.23	1,961	0,050
peer or sibling assault	3.06 ± 2.46	1.88 ± 2.02	2,238	0,025
nonsexual genital assault	0.18 ± 0.52	0.02 ± 0.22	1,421	0,155
bullying	2.16 ± 2.41	0.72 ± 1.50	3,132	0,002*
emotional bullying	1.76 ± 2.48	0.72 ± 1.61	1,484	0,138
dating violence	0.24 ± 0.87	0.17 ± 0.54	0,023	0,981
total score	8.14 ± 6.95	3.97 ± 4.63	3,100	0,002*
Sexual victimization				
sexual assault by known adult	0.28 ± 0.90	0.25 ± 0.77	0,587	0,557
nonspecific sexual assault	0.16 ± 0.42	0.02 ± 0.22	1,421	0,155
sexual assault by peer	0.20 ± 0.83	0.00 ± 0.00	1,819	0,069
rape: attempted or completed	0.42 ± 1.19	0.02 ± 0.26	1,527	0,127
flashing/sexual exposure	0.48 ± 1.26	0.27 ± 1.01	1,929	0,054
verbal sexual harassment	0.96 ± 2.06	0.20 ± 0.96	1,952	0,051
statutory rape & sexual misconduct	0.34 ± 1.11	0.00 ± 0.00	2,633	0,005*
total score	2.84 ± 5.70	0.90 ± 2.79	2,960	0,003*
Witnessing and indirect victimization				
witness to domestic violence	1.06 ± 1.82	0.97 ± 1.79	0,590	0,555
witness to parent assault of sibling	0.78 ± 1.86	0.02 ± 0.34	2,131	0,033
witness to assault with weapon	1.34 ± 1.99	0.67 ± 1.59	1,822	0,068
witness to assault without weapon	1.64 ± 2.04	1.12 ± 1.96	1,727	0,084
burglary of family household	0.74 ± 1.13	0.37 ± 0.66	1,458	0,145
murder of family member or friend	0.46 ± 1.19	0.52 ± 1.35	0,308	0,758
witness to murder	0.56 ± 1.43	0.27 ± 0.98	0,774	0,439
exposure to random shootings, terrorism, or riots	0.90 ± 1.66	0.40 ± 1.33	2,101	0,036
exposure to war or ethnic conflict	0.85 ± 1.92	0.20 ± 0.56	1.301	0.193
total score	8.32 ± 9.48	4.67 ± 6.01	2.301	0.021
Total score	33.60 ± 26.73	18.77 ± 16.49	3.022	0.003*

Z – Mann-Whitney U test; $p < 0.005$*; $p < 0.001$; SD – standard deviation.**

Discussion

Victimization is a complex concept with elements ranging from the more purely physical up to the emotional and sexual abuse. The majority of types of victimization occur in some form during the childhood.

There is the burgeoning literature on the association between the childhood victimization and the risk of suicidal behavior in the adolescence, but little is known about the association between children victimization and suicidal behaviors in the adulthood.

Differences can be explained by the fact that in adults, compared to young ones, early childhood experiences have lesser impact on suicidal behavior because of the greater flow of time and because unpleasant experiences from the childhood are deeply suppressed and replaced by other life experiences [17].

In our study, we examined the association between the childhood victimization and lifetime suicide attempts in a sample of patients hospitalized in the Day Hospital. The respondents of both groups were the patients on a psychotherapeutic treatment in the Day Hospital, who can recall long forgotten memories and suppressed the memories of traumatic events. So, in our survey, the children and adolescents were asked about suicidal attempts and whether they were abused in the childhood. The adult respondents, unlike the young respondents, were able to answer the questions about several forms of childhood abuse, including emotional and sexual and peer victimization.

The life-history data obtained from our patients who attempted suicide and received the psychotherapeutic treatment, pointed to the presence of victimization in their childhood. Our investigation showed that the experience of childhood abuse was a factor of suicidal risk in the adulthood. One of the reason the childhood abuse remains unrecognized has to do with the immature defensive systems that generate experiences of victimization during the childhood, where children are simultaneously the victims of violence of the same person (parents), who are also the people they rely on, which gives a false picture of real relationship, while psychotherapy provides the possibility of reminiscence of these events.

One of the common explanations for this relationship has to do with the immature defensive systems that generate experiences of victimization from the childhood. Injuries come from those who are trusted, which produces a tendency to believe that those who are trusted will be also those who will hurt him/her. This issue is particularly true in a small family system. When a child is abused by someone important to him/her, the child will have to give some explanation as to why this event happened. Given the fundamental nature of the parent-child relationship, the main purpose of the explanation will be to protect the perpetrator from liability. To this end, the child feels that the reason for the abuse has occurred. Many victims would say things like "Dad cannot make a mistake, but me." The result of these defenses is creation of guilt and shame. Attempts to commit suicide can be the act of acting out of guilt and shame [17, 18].

One possibility is that children do not have the ability to reduce their anxiety in ways that are available to adults, such as alcohol or cigarette, exercise in the gym, or excessive consumption of food. Frequent exposure to such victimization and physical maltreatment by adults, as well as bullying by peers, can lead the child to a critical attitude toward himself and use self-promotion as a means of self-indulgence [19–22].

Early exposure to victimization had results in a reduction of individual ability to cope with stressful situations, which increased their vulnerability and inability to deal with difficulties of life, when they chose maladaptive forms of behavior, including suicidal behavior [23–25].

Even after controlling for lifetime factors known to increase the suicide risk behavior, the adults who reported peer and sexual victimization in childhood were still more likely to attempt suicide later in life than other adults.

There are two explanations of dynamics of these relationships. The first reflects on the causal chain, where exposure to family and peer abuse increases the risk of problems in psychological and social functioning and the emergence of adolescent problems, or vice versa, the adolescent problems lead to an increased risk of suicidal behavior. Also, the childhood abuse results in a reduction in the individual ability to cope with stressful situations and adolescent problems, which can affect subsequent susceptibility to suicidal behavior [17, 18].

The persons who were victims later in adulthood can become violent, or (again) victims or both. Pain and anger over abuse can direct him\her to himself/herself or to someone else. With a good treatment and support they do not have to become either. When anger stays inside, a person can be self-destructive (self-inflicting, trying a suicide or other way to cause pain) or being injured by others. For those people, the self-destruction or suffering of pain inflicted by other people is more than necessary to make them feel powerful [18].

Our observations of childhood abuse show gender differences. In the childhood, male respondents were more often exposed to peer and sibling victimization, but women to sexual ones. The highest score on module of peer victimization had male respondents, while the highest values on module of sexual victimization had female respondents, which is in accordance with the literature data [23].

The statistical differences in the module of peer victimization were observed in bullying. The most current research findings shows that being involved in bullying in any way (as a person who bullies, a person who is bullied, or a person who both bullies and is bullied, i.e., bully-victim) is one of several important risk factors that appears to increase the risk of suicide among adults [6, 18].

Bullying and suicide-related behavior are both complex public health problems. There is evidence of a strong correlation between the childhood bullying with the risk of suicide later in life. Controlling for lifetime factors known to increase the risk of suicidal behaviour, adults who reported bullying in childhood were still more than twice as likely as other adults to attempt suicide later in life [6].

Bullying is associated with negative consequences. Circumstances that can affect a person’s vulnerability to either

or both of these behaviors exist at a variety of levels of individual, family, community and social influence. Being the victim of bullying involved them in the experience of suffering a defeat and humiliation that in turn could lead to hopelessness, entrapment, depression and suicidal behaviour [26]. Bullying co-occurred with several victimisation experiences including exposure to violence, sexual abuse, emotional distress, relationship problems, family conflict, and lack of connectedness to school as well as alcohol and drug use, physical disabilities, severe beatings and running away from home [27].

When explaining this phenomenon, we would see that the problem between the perpetrator and the victim is not a simple diadic relationship. Violence is a complex form of interpersonal aggression, which has many forms, serves to different functions and manifests itself in different ways. It is recognized as a phenomenon of the group, which occurs in a social context that promotes, supports or suppresses such behavior. Consequently, the behavior of the perpetrator is not only the result of the individual characteristics of the victim, but also under the influence of multiple connections with peers, family, teachers, neighbors and under the influence of the society as a whole. Cultural competence implies society's sensitivity to various factors affecting minority groups and immigrants such as stress migration, acculturation, history, poverty, language barriers, discrimination, taboos, values, beliefs and spirituality [28].

In peer and sibling victimization, the group chooses one person that is the most vulnerable, and he/she becomes a "scapegoat". It is the bearer of unconscious group guilt or malice, and its punishment releases members of the group of their sin through the release from aggravated aggression and the manifestation of that aggression towards those in whom such a manifestation will not have detrimental consequences for the perpetrators [29]. Thus, when a child hits or attacks, it becomes a victim of social violence. The attack follows various verbal statements, gossip, the spread of rumors, and finally the exclusion of a child from society [24].

In Sexual victimization module, there are high statistical differences in Statutory Rape & Sexual Misconduct. Results of our investigation are in accordance with the reseaches by other authors that show that in childhood, girls were more often exposed to sexual abuse than boys [30], and that sexual abuse increased the risk of multiple suicide attempts in adulthood [31]. Also, the women who had been sexually abused in the childhood were at a greater risk of committing suicide in adulthood [32].

And a few years after the sexual abuse, or the rape, women feel dirty, helpless, ruined, present with disgust toward themselves. Also, there is a shame, anger and feeling of guilt. Such a woman feels that she have done something different**,** and therefore she feels guilty. Or, she thinks something is wrong with her and the perpetrator was made to attack her because she deserved it. Self-indulgence prevents the process of healing of mental wounds after rape, which does not help recovery [13, 30–35].

Sexual abuse is not transmitted directly from the victim to the next generation, but rather relates to the dynamics of family functioning against sexual abuse [33, 36–39]. A girl or a woman who was raped, expected support from her closest ones. However, many of them were not always ready to provide this support, or some may not be willing to accept reality, and even women can blame, or abandon her and she then lose confidence in themselves and others. When a raped or a sexually abused woman does not have the ability to reduce her / emotions, she can attempt a suicide after her attempts to talk to others about her problems which were not successful overcame, and even more drastically, because she did not get the attention she needed. When anger stays inside, it can be self-destructive (self-inflicted, may try to commit a suicide or inflict pain to herself in other way), or be further harmed by others. For her self-destruction, or the suffering from pain inflicted on her by others, it is necessary to make her feel less guilty. When the anger is directed towards themselves, an attempted suicide can be a mechanism for acting out for guilt and shame. Self-discipline is a way of self-indulgence, but her pain would never heal [40–42].

Limitations of the study

Our investigation was done on a relatively small sample. In the Day Hospital of the Clinic of Psychiatry of the MMA in Belgrade approximately 110 patients were annually hospitalized which reflected to the number of patients involved in our investigation during the 3-year observation period.

This research could be continued and extended to a larger number of respondents, but in accordance with already mentioned, it requires many years of work on this problem.

It is necessary to conduct a national study, using the JVQ, on a large sample of adolescents in Serbia, to estimate the presence of various forms of victimization in childhood and early adolescents.

Conclusion

Significant suicide risk factors for commiting a suicide in adulthood are history of childhood peer and sibling and sexual victimization.

The ultimate goal of our prevention efforts is to reduce the suicide risk factors and increase the protective factors as much as possible.

Early recognition of the victims of children abuse could help them to adopt the effective strategies for overcoming maladaptive forms of behavior, which increases the ability to help a person successfully to overcome them and to prevent fatal consequences.

Learning the strategies of persons` experience, the opposite of some of the circumstances (family support rather than family conflict; strong school connectedness rather than lack of connectedness) are some of several “protective factors” that decrease suicide risk. In psychotherapy with patients following suicide attempt, the work on maturing defense mechanisms is very important.

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Received on August 26, 2017.
Revise on September 14, 2017.
Accepted on September 25, 2017.
Online First October, 2017.