Identifying the pathways to suicide in child sexual abuse victims

Ross S Kalucy

New findings highlight that child sexual abuse is a major risk factor for future illness

Child sexual abuse is a social issue but, because of its association with psychological and other problems, it is of special concern to the medical profession.[1] An article by Cutajar and colleagues in this issue of the Journal (*page 184*) shows a greatly increased risk of suicide among people who have experienced sexual abuse in childhood.[2] The findings are somewhat stunning: compared with the general population, those with a record of experiencing child sexual abuse had a relative risk of suicide of 18.09 (14.20 for males and 40.38 for females). The relative risk of accidental fatal drug overdose was 88.42 for females and 38.46 for males. Such relative risks are high and of the same order of magnitude as those that link cigarette smoking to lung cancer and chronic obstructive airways disease.[3]

The study by Cutajar et al, from the School of Psychology, Psychiatry and Psychological Medicine at Monash University, was made possible by the authors' use of established but underutilised resources, including the Victorian Psychiatric Case Register, the National Coroners Information System, the Victorian Coronial Information Database and records of the Victorian Institute of Forensic Medicine. Although such databases underestimate the prevalence of child sexual abuse and adverse outcomes, they provide a means of extracting data on mental health status and rates of suicide and death from drug overdose for a population in which child sexual abuse had been notified.

Increased suicide rates in people who have experienced child sexual abuse are not due to the abuse alone, and suicide is not an inevitable, or even a common, outcome. Just as the great majority of people who smoke cigarettes do not develop cancer of the lung, the great majority of people with a history of child sexual abuse do not commit suicide.

Much work needs to be done in examining the intermediary variables in development for victims of child sexual abuse who develop psychological problems in adolescence and young adulthood. Although child sexual abuse is a marker for later psychosocial problems, it may not be the critical formative experience — many patients who become disturbed in adolescence and young adulthood report child sexual abuse but also have a history of other disruptive factors during childhood which centre on such issues as rejection, abandonment, problems regarding trust and an inner sense of chaos often associated with dissociation.[1]

It is also fascinating that Cutajar et al found that the most common background psychiatric disorder recorded for patients who experienced child sexual abuse and died from self-harm was anxiety rather than depression, which is usually perceived as the background psychopathological experience for those who ultimately commit suicide.[4] This needs further research and explication.

In clinical practice, it is common to meet women aged in their 50s and 60s who will tell you about a child sexual abuse experience. Despite this, many appear to have led otherwise "normal" lives. Some identify experiences that surround the circumstances of child sexual abuse, such as failure to feel protected, and say that they have always been sensitive about personal safety and trust, lack of order, and unpredictability.

On the other hand, psychiatrists see many women during their 30s who have had childhoods that were disorganised and damaging on multiple levels (eg, involving physical and verbal abuse, a pervasive feeling of being unprotected, and chaotic parental relationships) and have included child sexual abuse, and who describe themselves as "complete ratbags in their teens and 20s who got their act together in their early 30s". None whom I have seen can satisfactorily explain this transformation.

One of the findings in the article by Cutajar et al was that the average age at time of suicide for those who experienced child sexual abuse (about 31 years) was similar to the average ages at time of suicide and accidental fatal overdose for the population as a whole. Many doctors and nurses recognise this as the age at which the worst excesses of personality disorder and borderline personality disorder begin to abate. This area of developmental research has been neglected.

Patients with borderline personality disorder often report child sexual abuse among myriad insults during childhood development.[5,6] These patients often begin to "settle" during their late 20s and late 30s. At my institution, the Emergency Mental Health team has developed modestly successful programs for patients with borderline personality disorder. In general, such programs do not include an extensive or in-depth investigation of the details of child sexual abuse, which many of our patients would be reluctant to discuss but are grateful to have acknowledged. Most of the time is spent discussing their pressing need to feel safe and their feelings of rejection and abandonment. I regularly see patients in a state of crisis and decompensation, apparently because their therapist feels that it is important that the details of their sexual abuse are fully revealed. However, it is not at all convincing that talking through the actual details of the abuse helps. Recently, dialectical behaviour therapy has been shown to be promising for patients with borderline personality disorder.[5,7] This therapy does not emphasise revelation of past events related to child sexual abuse as part of the therapeutic exercise.

Our understanding of the role and importance of child sexual abuse in disorders of adolescence and early adulthood is incomplete, and our present approach for treating patients with a history of such abuse is therapeutically eclectic. Research is lacking on whether our present approach will reduce the incidence of suicide and fatal overdose among people in their 30s.

The moral and cultural complexities of child sexual abuse are appreciated and shared throughout the medical profession, and we are in a good position to provide special leadership. The complex psychopathological conditions that are associated with disorders of adolescence and young adulthood need more investigation, and their association with child sexual abuse needs explanation.

The study by Cutajar and colleagues reveals important findings from a study in a complex area. These point to the need for a great deal of work in dissecting issues involved in the pathways to suicide in child sexual abuse victims, including why some patients are vulnerable and others are resilient. Additionally, preventing

ongoing child sexual abuse requires improving resources for child protection services and a massive public health response.

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References

1 Dinwiddie S, Heath AC, Dunne MP, et al. Early sexual abuse and lifetime psychopathology: a co-twin control study. *Psychol Med* 2000; 30: 41-52.
2 Cutajar MC, Mullen PE, Ogloff JRP, et al. Suicide and fatal drug overdose in child sexual abuse victims: a historical cohort study. *Med J Aust* 2010; 192: 184-187.
3 Doll R, Peto R, Wheatley K, et al. Mortality in relation to smoking: 40 years' observations on male British doctors. *BMJ* 1994; 309: 901-911.
4 Goldney RD. Depression and suicidal behavior: the real estate analogy. *J Crisis Interv Suicide Prev* 2003; 24: 87-88.
5 Lieb K, Zanarini MC, Schmahl C, et al. Borderline personality disorder. *Lancet* 2004; 364: 453-461.
6 Johnson JG, Cohen P, Brown J, et al. Childhood maltreatment increases risk for personality disorders during early adulthood. *Arch Gen Psychiatry* 1999; 56: 600-606.
7 Robins CJ, Chapman AL. Dialectical behavior therapy: current status, recent developments, and future directions. *J Pers Disord* 2004; 18: 73-89. ❑