Risk events associated with suicide behavior

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ABSTRACT

Objective: Analyze risk events associated with suicidal behavior in individuals seen in general emergency care. **Methods:** Exploratory, descriptive research, qualitative approach. Data were collected from December 2017 to November 2019 with people who attempted suicide through an interview with a semi-structured questionnaire. Data reviewed with thematic Content Analysis. **Results:** This survey interviewed 113 participants, 86 (76.1%) female, 57 (50.4%) aged between 18 and 30 years, 103 (91.2%) heterosexual, and 49 (43.4%) single. According to the data analysis, the content was grouped into one category with four thematic units that emphasized traumatic family relationships, the presence of a history of traumatic experiences beyond the family, socioeconomic conditions, impulsive behavior, and the perception of the nonexistence of protective factors. It is known that suicidal behavior is influenced by relationships with family members, friends, and other people with whom there is an important emotional relationship. Good family bonds, thus, take on a protective role against suicidal behavior, while conflicting family bonds are potential risk factors. **Final remarks:** Results disclosed the experience of the multiplicity of events that influenced the decision to commit suicide, emphasizing damaged affective and family relationships and traumatic experiences.

Descriptors: Suicide, Attempted suicide, Risk factors, Association, Qualitative research.

INTRODUCTION

The impact of suicide on families, friends, and communities is devastating and far-reaching and may last long after the event. An estimated 804,000 people died from suicide worldwide in 2016, with a worldwide rate of death from the suicide of 10.6 per 100,000 inhabitants[1].

About 3,000 individuals commit suicide every day, and 60,000 attempts it but fail. These figures represent almost 50% of all violent deaths; however, since suicide is a sensitive and even illegal issue in some countries, it is very likely to be underreported[2].

There is no single reason or cause capable of explaining how suicide occurs because suicide results from a complex interaction of biological, genetic, psychological, social, cultural, and environmental factors. Suicide, thus, deserves a multidimensional understanding. One can then state that suicide is caused by the final link of a chain of factors, which will vary for each individual[3].

As for the complexity of suicidal behaviors, there are several contributing factors and several paths that can lead to suicide, in addition to a series of actions for preventing it. In general, suicide does not occur due to a single cause or a single stressor; however, several accumulated risk factors increase the individual's vulnerability to suicidal behavior[2].

However, even considering the significant variation of risk factors and situations for suicidal behavior, some are frequently associated with its occurrence. Any effective response in suicide prevention should start by identifying these risk factors, thus leading to appropriate interventions[2-4].

The World Health Organization defined three categories of risk factors for suicide: sociodemographic factors, which contain male gender, age range between 15 and 35 years and over 75 years, extreme economic strata, single or separated, migrant, social isolation, residents in urban areas, unemployed; the psychiatric factors, which refer to depression, bipolar disorder, schizophrenia, and anxiety disorder; and the psychological factors, which point out to recent loss, important dates, and personality with traits of impulsiveness and aggressiveness[5].

In this context, this research aims to analyze the risk events associated with suicidal

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behavior in individuals seen in a general emergency care unit.

METHODS

Type of study

This is an exploratory descriptive research with a qualitative approach, guided by the Equator network's COREQ[7] tool, conducted from December 2017 to November 2019 in an Emergency Care Unit of a city in the center-west of the state of São Paulo.

Study setting

The study was carried out in the Emergency Care Unit, a component of the Urgent Care Network within the Unified Health System. This is the health unit where psychiatric urgency and emergency care is provided, including suicide attempts, in the municipality of Assis/SP.

Data source

The research was carried out with individuals who had attempted suicide including those being treated at the Emergency Care Unit in the city of Assis/SP.

It interviewed 113 patients, characterizing a non-probabilistic random sample by convenience, and all of them agreed to participate in the research. The participant had been admitted to the Emergency Care Unit during the aforementioned period proposed for data collection.

Participants included those who were in health care due to a suicide attempt, who were cognitively able to participate in the interview, and who were older than 14. Patients 14 to incomplete 18 years old could only participate with the authorization of their tutors, as well. The cognitive condition was assessed by the researcher by an interview with analysis of attention, concentration, memory, judgment, reasoning, and understanding to look for alteration in the state of lucid consciousness that would make participation impossible. It was based on the Mini Mental State Examination (*Mini Exame do Estado Mental*, MMSE). The non-inclusion criterion was when the patient had been discharged from the hospital before the researcher arrived at the unit and invited them to participate in the research.

Data collection and organization

Data were collected using interviews carried out by the authors of this article, both nurses, post-graduated, with expertise in suicidal behavior, using a semi-structured questionnaire prepared by the authors. Interviews took place in a private environment so that the privacy of the information provided by participants was maintained. In order to provide fluidity to the interview, an audio recorder was used, and the content was transcribed in its entirety.

The semi-structured questionnaire contained sociodemographic information: sex, age, sexual orientation, skin color, marital status, number of children, education, religion, housing conditions, source of income, participation in social groups, diagnosis of physical pathology, diagnosis of mental disorder and use of psychoactive substances, as well as information about the events that culminated in the suicide attempt in the context of the participant's life.

Data analysis

To process and analyze the qualitative data, the methodological referential of Content Analysis was used, according to the steps proposed by Bardin, working the speech, specifically the practice of language, trying to know what is behind the words expressed at a given moment. It is the search for other realities through messages. Three chronological poles guide the different phases of content analysis: pre-analysis; exploration of the material; and processing of results, inference and interpretation[8].

Thus, speeches were grouped into a Category: Risk events for suicidal behavior, with four Thematic Units: 1- Traumatic family relationships; 2 - History of traumatic experiences; 3 - Socioeconomic conditions; 4 - Impulsive behavior and the perception of the nonexistence of protective factors.

Ethical aspects

The norms that rule ethics in research with human beings, outlined in Resolution 466/2012[6] of the National Health Council, were assured. The research project was submitted and approved by the Research Ethics Committee of the Federal University of São Paulo, with opinion No. 2,314,347 in 2017.

After the approach, identification of potential participants, explanations about the research, its objectives, forms of participation, and consent in participation, the Informed Consent Form was delivered, signed in two copies by the researcher and the participant, and one copy was delivered for each of them.

OUTCOMES

In total, there were 113 (100.0%) participants, with a majority of females 86 (76.1%), aged between 18 and 30 years, 57 (50.4%), heterosexual 103 (91.2%), with white skin color 62 (54.9%), single 49 (43.4%), and with high school education 71 (62.8%).

According to the methodological framework of Content Analysis, data were grouped into a category with four thematic units presented below.

Category 1 - Risk events for suicidal behavior

Thematic Unit 1- Traumatic family relationships

In this research, negative family relationships lead to fights, family violence, isolation, and betrayal. The following statements demonstrate this family environment:

> *The family doesn't help at all. The family doesn't help with moral or financial support. It gets in the way. I feel very alone. I'm talking about my mother, my sisters. I live with my husband. We fight a lot, he likes to hit me, you know? But when he leaves, I am alone and I feel despair (I1).*
>
> *I have no family; I live by myself (E3).*
>
> *It is very hard, very complicated. In fact, I am single, but I have a relationship, currently, I am with a person, but this person has already been my boyfriend in the past. We did not work out in the beginning, then we resumed the relationship, and everything went wrong; he cheated on me with my daughter (I12).*
>
> *... my problem is more related to my family; I feel a lot of indifference to certain things until I take drugs and everything (I17).*
>
> *My husband drinks, mistreats me... ah, I take care of my sister-in-law. My sister-in-law has problems, she curses me, mistreats me a lot. Yeah... My son is also very angry. He is married. He is living with me. I have another nephew who has cancer, and I have to take care of him... so it is very tiring for me (E21).*
>
> *It was my parents that triggered everything, right? Because... I am very attached to my father... my father was that guy who always cheated on my mother, and my mother in that abusive relationship since forever (E23).*
>
> *Yeah... We have a lot of disagreements, a lot of fights. In general. (E25).*
>
> *I get apart from everyone. I live with my husband. My children don't, they live with their father, my first husband (I33).*
>
> *A lot of fights with the mother and the husband, which are the causes of suicide (E38).*
>
> *... I feel that nobody likes me. Son has been a drug user for 14 years, husband cheated on me with the maid and married her (E53).*
>
> *I fight a lot with my mother (E84).*
>
> *My mother and I, we don't get along. I left home when I was 16. I want to be right and so does she. We didn't get along, I wanted to run away, I left home when I was 16 to live with an ex-boyfriend of mine, it didn't work out. Then I got together with the one I am with now, the father of my son, and I don't know... He cheated on me, made me suffer a lot in the beginning, you know? But, even so, I loved him and when you love someone, you don't think, you forgive. It's like everything that happened back there, like I told my mother, there are things that happened to me that she doesn't know. My grandfather tried to abuse me, her father, and she doesn't know. But I don't have the courage to tell her, he had cancer, suffered a lot, and I forgave him. My mother drank, my father drank, they fought all the time. My brothers were also alcoholics, you know? I think a lot of things happened (E100).*
>
> *With my daughter, it is not good (E112).*

Sexual abuse was added to family conflicts, a significantly frequent event in the lives of the respondents. The statements are shown below.

> *... sexual abuse... and my father was there with me, giving support. I didn't know what it was... It was a man, older than my father... My father took me to that place because of money. I was 14 years old, I can't forgive my father. I lived with this person until I was 33 years old... he was very stupid, very cruel... I wasn't married to him, I wasn't married, we just lived together... My father used to hurt my mother. I asked my mother not to see her dead, I said: "Mom, go away. I prefer leaving you, but knowing that you are alive" (I9).*
>
> *Sexual abuse happened a long time ago. I prefer not to talk about it, may I? Because it hurts a lot. Emotional abuse affects me a lot, it is as if the person judges me a lot, because I am very emotional, criticizes me, I am wrong, and that hurts me a lot... (E41).*
>
> *Moral harassment. My ex-husband's family is always bothering me... Physical violence from a relative, my uncle. Sexual abuse with him, I was 13 years old. At the time, they didn't do anything. I was young, he had a small child and I got along very well with his wife, so I helped him take care of my cousins, then the day she left, and it was just me and my older cousin, my cousin slept and he came at me (a lot of crying). I can't stand looking at his face... (E42).*
>
> *In my mother's house we went hungry. I am facing a lawsuit because of my ex-wife. Sexual abuse, by a man when I was little, after a few years, now, I decided to talk to my mother. I think the only thing that affected me was this... I keep remembering. Ill treatment, yes, by my mother's husband, it always involved a fight (E45).*
>
> *Sexual abuse when I was five, six, 13 years old, by different people. They were men, lived nearby, were family, very close people. Each time a different one. One was a second cousin. I never said anything to anyone. But at the time I didn't really understand. I was ill-treated by my stepfather. At the time he... I believe he sexually abused my sister. While he was having sex with her in the living room, he would beat me and ground me in the bedroom. This became very clear when she became pregnant and ran away with him. But my mother is dating him again...at the age of five, I started living with a lot of different kinds of violence (E65).*
>
> *Bullying. I was very short, and everybody beat me... I had a stepfather who beat my mother, had sex with the dog, with men, at home. I've seen that. My mother, after a while, she separated from him. I had a judicial problem with drug trafficking. I was arrested for two months... Sexual abuse yes, when I was a child. We lived on the same street. It happened several times, I can't say. I was about eight years old... ah, of course, this affected me. Nobody knows about it until today. I never saw this guy again... (E76).*

Thematic Unit 2 - History of traumatic experiences

The great majority of participants had multiple experiences with traumatic situations. The presence of physical, psychological, and sexual violence, in addition to family life that was cited as striking by the respondents. The speeches are shown below.

> *I suffered bullying with image exposure when I was 15 years old at school. I was attacked, recorded, and it became viral, and it still affects me (E11).*
>
> *Bullying and physical violence. Bullying at school, but I always dealt with it jokingly, but it affected me a lot, it became strong (I15).*
>
> *... sexual harassment, I was 13, a boy abused me, he just tried, I ran away. Everyone made fun of me, the neighbors. I think it affected me a little. I have a lawsuit for contempt. Problems at work, several. Small town, everybody knew and pointed out: "That one over there was abused." In my mind, it is revenge (I20).*
>
> *Bullying my whole life for being overweight. I always felt inferior to other people, to other children. I had some friends, but the ones you*

thought were friends, you found out that they gossiped too... And it was always the struggle with the scale, you know? Or the hair. There was always... it hurt me... at night, it hurt me. I often slept crying because of it. Today it still affects me, for sure (crying). I had financial problems. I went hungry in my childhood. When my father was unemployed, we asked others for money to eat. It also hurts, right? No one forgets... My mother passed away four years ago, and my pivot is there. My father is alive and is already in another family, you know? My greatest problem started there after my mother passed away... everything was my mother, and my worst problem is this because she was ground, it was all my mother... and I can't let go. That is what harms me the most (crying) (E48).

Bullying at school, on the street, because of my name, long hair, tall, thin. I always had financial problems. Moral harassment every day I go through this. A lot of people say that I am useless. People don't realize it, but this hurts (E62).

I was bullied, but it wasn't called bullying. It affected me. I was expelled from school... I was always a balanced and unbalanced person (I insist you put that there). When someone offended me, I didn't care how many were there to hit me, I didn't care. I just wanted to hit the first one. Problems at work I had a lot, considering... a part of it affects me, alcoholism was largely due to work. (E64).

Sexual abuse, I worked with a guy there, he took me by force and raped me, I didn't like it. Nobody saw. I felt demeaned, you know? Sad (I74).

Sexual abuse, yes. I was sleeping, they touched me down there. I don't like talking about it. I lost count. How many people abused me? Quite a lot. I don't want to talk (crying) (E78).

Bullying, sexual and emotional abuse...I don't want talk. I was small (a lot of crying) (E81).

I was bullied because I was thin. Financial problems at home. My mother prostituted herself to take care of us. Problems at work, I took money once, I was afraid, the guy fought with me. Physical violence, rape also (I84).

Bullying at school. There were two big kids that waited for me at the school gate and beat me, hit me on my head... Financial problems, I lacked the money to pay the bills, I didn't have enough to have food, I even starved sometimes... (E111).

Thematic Unit 3 - Socioeconomic conditions

Socioeconomic conditions, with a change in economic power, were events associated with suicidal behavior. In this research, 47 (41.6%) participants said to have experienced a negative change in economic power, as we can see in the following transcripts:

It gets in the way a little bit because I'm dependent and I don't like to ask anyone for anything. I feel bad (I1).

Quite a lot. I worked at the market and at the garage. I earned well; I lost my job (E4).

With psychiatric treatment, I was on leave from the INSS and was paid. Then the benefit was cut by the INSS, but I couldn't return to work. I haven't earned anything. The household is supported by the salary of the other family members (E13).

It changed a lot. After the death of my parents, it changed a lot, everything, everything (E17).

Very representative. Four years of difficulty (E19).

Because of unemployment. It was of big value. Very big value... (E25).

I lost about 100 thousand. I had a lot of money; I lost everything. Have no car. Lost everything. Business went all wrong. Everything in drugs and the vultures came and got it too (E34).

I lost some material goods. It is a little difficult (E47).

I lost everything. I lost my job (E49).

I lost my car; my husband lost his job. We are living in rent (E62).

Actually, I never had much, only that I lost (E76).

I used to earn well, I could buy whatever I wanted, do whatever I wanted, but now I no longer have this. I have no income (E94).

It's been a long time...I have many problems, and I can't solve them (E105).

I was robbed when I was married. They stole all my things (I110).

Thematic Unit 4 - Impulsive behavior and the perception of the nonexistence of protective factors

For those who did not plan suicide, we can observe impulsive behavior in the suicide attempt, so that the thought of suicide as a possibility resulted in the suicide attempt in a short period of time. The following speeches express this matter.

I didn't plan it, it was on the spot, it was out of nowhere (E6).

No. I said: "I'm going to do it". I went and did it (E13).

Nothing, it was on the spot, spontaneous (E14).

No, no. It was all at the moment (E25).

No. I was very sad, and I did it. It was of the moment (E34).

No. I never wanted that in my life (E37).

I didn't plan it. My boyfriend started sending me a lot of messages that he didn't want to do it anymore, that he didn't trust me anymore, I took them and said: "Okay, so what am I going to live for?" (E43).

No. It was an argument, and they started making fun of me, I said: "That's it! (E83).

No. I got in my head, I wanted to go there, take medicine, and I did. I didn't want to live anymore... (E94).

Another form of risk is the nonexistence of the perception of protection against suicidal behavior. The following statements unveil an environment of rigid thinking, which hinders and even impairs noticing something that can protect you.

Nothing, nothing can keep me from doing it. And it still hasn't gone out of my mind, I still have it in my mind. If it gets to the point where I can't take it anymore, I'll probably try again (E11).

Nothing can protect me; I will kill myself (E69).

There is nothing, because many people got away. A lot of people that I was connected got away. I don't even have faith. For about five years, by choice, I have no faith in anything (E76).

There is nothing (E97).

Nothing protects me (E111).

DISCUSSION

It is known that suicidal behavior is influenced by relationships with family members, friends, and other people with whom there is an important emotional relationship. Good family bonds, thus, take on a protective role against suicidal behavior, while conflicting family bonds are potential risk factors[2,9].

The family, considering the structural and functional changes that have occurred in recent years, maintains the trait of being the main base for the safety and well-being of its members. Thus, it can be defined as a special social group in which intimacy, affection, and intergenerationality sustain the bonds[10].

It is in the family environment that deep and long-lasting relationships are conceived, integrate positive communication, coherent and flexible rules, democratic leadership, self-esteem, and the preservation of its members' individuality. These links ground the healthy development of its members and the learning toward living in a group aimed at the social interaction and maintenance of both physical and psychological integrity. It is in this context that the family is classified as a supporting system[11].

However, it is important to note the ambiguity of the family's position as a risk factor and a protective factor for suicide. It is known that suicidal behavior is influenced by relationships with family members, friends and other people with whom there is an important emotional relationship. Good family bonds, thus, take on a protective role against suicidal behavior, while conflicting family bonds are potential risk factors[2,9].

In other words, if, on the one hand, the family is understood as a protective factor against suicidal behavior, on the other hand, when family relationships are maladjusted and unhealthy, it becomes a risk factor. The lack of family support, with precarious social relationships, makes the family environment unpleasant and intolerable[12].

Notably, the relationships between family members and the family structure make clear the association with suicidal behavior. In the negative perception of these variables, there is vulnerability related to social support, which, when scarce, can exacerbate risk behaviors in daily activities[13].

Misfit and conflicting family relationships are described as consisting of relationship and communication difficulties, absence of affection, and lack of support. It is a situation that promotes suicidal behavior in adolescents, youngsters, and the elderly, who start experiencing feeling like an outsider and the feeling of not belonging to the family context[14].

This situation was observed in research carried out with adolescents that, when they were exposed to an environment of low family cohesion and disruption, characterized by the inability to develop the promotion of support and emotional support, reported an increase in suicidal behavior[13].

In addition to caring for adolescents and youth, it should be emphasized that the proximity of parents and children with open and frequent communication, and the promotion of educational training, including protective actions, the definition of obligations, and behavior control, play a preventive role in suicidal behavior, as they result in healthy and responsible growth and maturation. On the other hand, there are losses in the growth and development of adolescents and youth who live in an environment of neglected care by their parents, with excessive permissiveness[15-16].

To the elderly, the feeling of not belonging, and loss of autonomy and identity generated by recurrent attempts to control their actions and behavior by their children are frequent narratives associated with family conflicts and the consequent development of suicidal behavior[17].

At this point, it is important to emphasize that when analyzing family behavior and its relationships, a product of the functional or dysfunctional bond between members, there is no relation between the nonexistence of personal or collective problems or the exclusive existence of pleasant situations or both, because it would be utopia, but the key point resides in the ability to understand, react, and face the situations experienced[18].

The pathological effects caused on the psychic structures of individuals who experience dysfunctional bonds are perceptible, in a negative way, with intensity to influence the manifestation of negative feelings as responses to events considered traumatic in their lives, with a view to the occurrence of these events at any time of the vital cycles: children, young adults, and the elderly[19].

The reaction to a traumatic event is marked by feelings of helplessness and the impossibility of solving and overcome it so it becomes a disturbance to the individual. Other remarkable characteristics are the experiences of death or danger of death and risk to physical integrity, either of the individual or of others, as long as the situation involved fear, horror, and powerlessness[20].

Among the traumatic events associated with suicidal behavior, a study conducted in Puerto Rico listed psychological violence, physical abuse, and sexual assault as events with higher occurrence in college students with a history of suicidal behavior when compared to the total sample. It is noteworthy that one-fifth of these events referred to domestic violence, therefore occurring in the personal residence and perpetrated by family members[21].

Sexual violence was also a frequent experience pointed out by the respondents. It is a public health problem, a violation of human rights. It is understood as an act or attempted sexual act or unwanted comments against a person's sexuality, based on coercion[22].

Sexual violence is present in and associated with suicidal behavior[23-24]. A study devoted to estimating the prevalence of sexual risk behavior and sexual assault and measuring their association with suicide in adolescents revealed that forced sex was a risk factor for depression and suicide. Moreover, the earlier sexual activity was initiated, and the multiplicity of partners increased the risk of developing suicidal behavior[25].

During childhood and adolescence, situations such as neglect, manifested by deprivation of food, clothing, shelter, and protection, and sexual abuse are events present in the life histories of people with suicidal behavior[26].

In sexual abuse, very frequent in the speeches of participants in this research, most of the abusers were family members or people from the family circle. Literature states a strong association between sexual abuse and suicidal behavior due to the psychological disorders caused by this violence[27].

In Brazil, intra-family sexual violence is an unfortunate reality. The ones who would have the social role of protectors assume the position of

rapists[28]. Epidemiological analysis with data from the Notifiable Diseases Information System showed that 58.7% of sexual violence between 2011 and 2017 occurred at home[29].

Bullying was cited as an event that influences the development of suicidal behavior, and it should be noted that it is a widespread correlation in the literature[30].

The relationship between bullying and suicidal behavior is due to the negative impacts on the victim's mental health. Victims may develop other symptoms such as headaches, abdominal pain, decreased school performance, depression, anxiety, and school absenteeism. In addition to suicidal behavior, victims of bullying tend to present other health risk behaviors, such as careless and unprotected sexual intercourse and tobacco use[31].

In addition to traumatic experiences, unemployment, a condition observed among participants, can lead to poverty, social decline, domestic difficulties, and hopelessness and is thus strongly associated with suicide. According to the World Health Organization, unemployment rates and suicide rates make up a complex association[32].

Also, the change in economic status is presented as a significant risk factor for suicidal behavior, as part of the multifactorial factors for suicide[33].

This situation of financial difficulty is associated with the feeling of lack of control over the environment in which one lives and the powerlessness to change one's own reality. It is marked by interference and even interruption in the accomplishment of life projects[34].

The feeling of lack of control over one's environment that contributes to the psychological vulnerability toward suicidal behavior includes impulsiveness/aggressiveness, a situation characterized by the loss of behavioral control, spontaneously or reactively, when faced with a controversial situation[35].

Thus, there is a correlation between impulsivity and suicidal behavior in the sense that in impulsive behavior, the possibility of a self-extermination reaction in the face of despair over the suffering experienced, allied to hopelessness and helplessness, is real[2].

Vulnerability to the development of impulsive and self-harmful behavior may be related to the fragility or even absence of skills to deal with unknown situations. Added to this lack of ability is the inability to analyze and plan the consequences of their actions. With the experience of a sense of relief, even if momentary, through self-injury, the probability of impulsive action with self-injury is high[36].

At this point, impulsive action is observed in the occurrence of current situations, such as interpersonal conflicts, so that the anger toward the moment experienced generates an impulsive and aggressive reaction[37].

We also highlight the degree of involvement with suicidal behavior to the point that hopelessness dominates the thoughts and does not allow one to see the possibility of resolving the situation that causes suffering. This situation is perceived in the participants' statements about the absence of protective factors for suicidal behavior.

We highlight that 15 participants affirmed that there is no protection for suicidal behavior, a fact that refers to worsening and rigid thoughts, besides future plans for suicide, and 21 could not identify what protects them from this behavior.

When considering the potentiality of suicide prevention by protective factors, one should employ actions that improve and sustain these factors; however, when considering the statement of some participants in this research about the nonexistence of protective factors, and the difficulty in identifying any protective factor, there is a risk of death from suicide, due to the absence of help before situations difficult to be faced and supported[38].

STUDY LIMITATIONS

This research is limited by the geographic scope, which describes a local situation of suicidal behavior in a municipality of an administrative region of the state of São Paulo, making it impossible to generalize the data presented.

Another limitation is the data collection format selected to meet the ethical requirements of the research participants, which made it difficult to approach and interview all the individuals assisted with attempted suicide during the research period.

FINAL REMARKS

The interviews revealed the experience of a multiplicity of events pointed out by participants as influencing the decision for suicide. It is important

to emphasize the frequency of the experience of situations such as damaged affective and family relationships and the history of traumatic experiences.

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