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Bullying and Sexual Harassment as Predictors of Suicidality in Sexually Abused Adolescent

Intimidation et harcèlement sexuel comme prédicteurs de suicide chez les adolescentes victimes d'agression sexuelle

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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 (14-18 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 le manque de 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 : Déficience intellectuelle ; Enfants ; Agression sexuelle dans l'enfance ; Bien-être de l'enfance ; Services de protection de l'enfance ; Maltraitance.

Abstract :

This study aimed to document the prevalence 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 teenagers 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

Bullying and Sexual Harassment as Predictors of Suicidality in Sexually Abused Adolescent Girls

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 prevalence 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 predictors of 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. Teenagers 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.

About 37% of participants 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, in a youth shelter or elsewhere. While 43% did not adhere to any religious affiliation, 38% identified as Catholic, 9% as Protestant and 10% identified as another religion. Most of the girls (82%) suffered very severe SA, as defined by an act of penetration.

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.

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%

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 prevalence 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

Prevalence and Co-Occurrence of Peer Victimization

Figure 1 showed 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 1 also 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, ϕ = .225), suggesting that participants reporting a history of bullying were more likely to report SH than participants not reporting bullying.

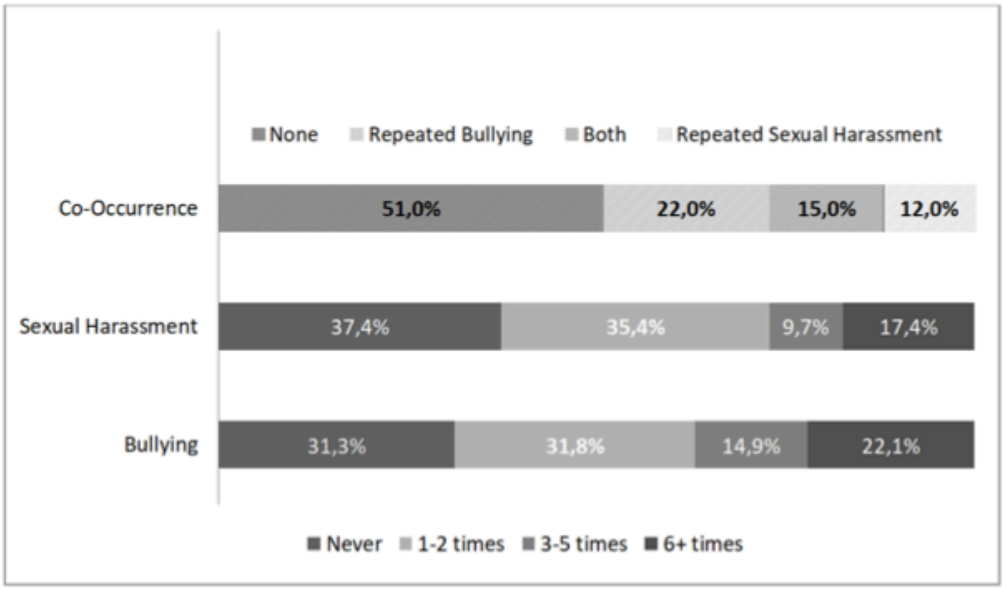

Figure 1. Prevalence and Co-Occurrence of Peer Bullying and Sexual Harassment in the Clinical Sample. *Note*. Abbreviations, SH, Sexual Harassment. Co-Occurrence of repeated (three times or more) peer bullying and sexual harassment.

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 into 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 illustrated 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.

Table 2
Results from the Hierarchical Logistic Regressions 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 (χ2 (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.

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 illustrated 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.

Table 3
Results from the Hierarchical Logistic Regressions 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 (χ2 (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.

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 contributed to the risk of suicidality over and above known interpersonal-psychological factors linked to suicidality. 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. Prevalence 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 prevalence 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 prevalence 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 predictors of 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 at an elevated risk of suicidal behaviour (Brabant et al., 2014; Brezo et al., 2008; Martin et al., 2004; Ng et al., 2018; Noll et al., 2003), 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 contribution of SH to 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 prevalence 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 a risk factor 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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