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FAMILY FINANCIAL SITUATION, PARENTAL MARITAL STATUS AND SELF-HARM AMONGST ADOLESCENTS IN CROATIA

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SUMMARY – The aim of this study was to determine the level of self-harm behaviors among adolescents in the general population (students of secondary schools in Zagreb, Croatia), as well as to determine if the level of self-harm behaviors differed according to financial circumstances of the family and marital status of the parents. The study was conducted in 701 adolescents (male and female, age range 14 to 19 years). A specially designed questionnaire that included family and demographic data was used to determine the family financial circumstances. The Scale of Auto-Destructiveness measuring instrument was used to assess the level self-harm. Study results revealed that 87.3% of adolescents indicated average levels of self-harm, whereas above-average and high above-average self-harm was indicated in 12.7% of the adolescents. Results also showed that single-parent families significantly differentiated the level of self-harm among adolescents of both genders, whereas financial deprivation (perception of financial stress) partially differentiated these levels. Practical implications of this study emphasize the importance of social support to parents of adolescents grown up in single-parent and/or financially challenged families.

Key words: *Adolescent; Adolescent behavior; Aggression; Single-parent family; Social support; Croatia*

Introduction

Adolescence presents many developmental challenges for the individual and the family in which these adolescents grow up. The manner in which an adolescent overcomes this psychologically demanding period will depend on many factors of their personal development, but also on the characteristics of the family and the society in which they grow up. The focus of this study were self-harm behaviors in the adolescents in Croatia, in relation to their family financial circumstances and parental marital status.

Although each adolescent has his/her own peculiarities and his/her own pace of development, environmental and social factors are partly responsible for mental disorders in adolescence[1]. Namely, the economic power of the family affects the health, emotional stability, school success, educational status, employment, and general economic success in adulthood[2,3]. One of the most important findings in the social sciences in recent decades is confirmation that economic hardship harms families and children who are growing up in such families. Economic poverty is a form of stress that can be likened to unforeseen difficulties such as sudden unemployment, serious illness, war, or even death[1-4].

Numerous studies emphasize the importance of a family process that is influenced by economic stress and subjective experience of economic disadvantage[5]. In some sociological articles, the term social exclusion is used relating to the impossibility to participate in the financial and cultural events offered by modern life

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(housing, transportation, participation in sports, culture, social life, etc.)[5,6]. In many of these studies, families affected by economic hardship and consequent social exclusion are exposed to an increased risk of depression, poor health, early adolescent pregnancies, and generally unfavorable younger years[5,7].

The impact of altered social conditions, especially deep political and economic crisis and war destruction, and their long-term effects on family structure in Croatia is reflected in the increasing rate of single-parent families and in changing internal family dynamics and division of family roles[1]. In Croatia, the number of single-parent families where one parent alone takes care of the children has increased significantly in the past three decades. Some studies have revealed that such parents are under greater economic burden and greater efforts are to be invested both at work and at home[1]. These parents also take greater mental and physical burden of responsibility for their children as compared with parents from two-parent families. Single parents also report lower life satisfaction, poorer health, and greater incidence of depression[1].

Although the professional and general public emphasizes the importance of family environment in raising children and facing difficulties and challenges imposed on modern family, there is a lack of systematic knowledge about the types of social support expected from parents. On the other hand, it is not clear how the absence of social support is associated with different characteristics of family functioning[7-9]. One of the disorders that is distinctive for children and adolescents is self-harm behavior, which is largely mediated by the features of family functioning[8,10,11].

Few studies show the extent to which self-harm behavior can appear or disappear in adolescence[12]. The most comprehensive study of self-harm forms of behavior in young people from Europe, the Child & Adolescent Self-harm in Europe (CASE) study included 30 000 adolescents[12]. This study revealed that 3 out of 10 girls and 1 out of 10 young men examined had been self-harmed or had thoughts about self-harming. The most disturbing finding is that 59% of those who were self-harmed reported that they wanted to die[12]. Deliberate self-harm is associated with suicidal ideation and previous attempted suicide, and there is a significant relationship between social factors and occasional deliberate self-harm[13,14]. Self-harm behaviors are common in families where psychosocial problems are present, especially early trauma of any kind[15]. Many studies confirm that self-harm, especially that which is frequently repeated by adolescents, is associated with an increased risk of suicide[16-18].

Longitudinal studies show that problematic relationships within the family, including early attachment difficulties and reduction in the ability of parental care, increase the risk of suicide and suicide attempts in children and adolescents[19].

Results of research on deliberate self-harm in adolescents conducted in Croatia show how family dynamics, interpersonal relationships and the family financial situation are all associated with psychological difficulties, but this research was conducted on a relatively small sample from a clinical setting[20].

The large number of individuals affected by post-traumatic stress disorder in Croatia, as well as the long-term adverse effects of war trauma on direct descendants of those affected can have a strong impact on family functioning. It is clear from many studies[10,21] that self-harm behavior and suicidal phenomena in adolescence are associated with parental involvement in the war in Croatia.

The first aim of this study was to determine the level of self-harm behaviors in adolescents from the general population of the students in Zagreb high schools. The second aim was to determine if the level of self-harm behaviors differed according to financial circumstances of the family in which the adolescents grew up. The third aim was to determine if the level of self-harm behaviors differed according to marital status of their parents. According to the findings of previous studies[10,11], it could be assumed that the level of self-harm behaviors in adolescents could be higher in families with worse financial circumstances. Moreover, it could be assumed that the level of self-harm behaviors in adolescents could be higher in single-parent families, which have reported lower life satisfaction, poorer health, and greater incidence of depression[1].

Subjects and Method

Subjects

The study included a stratified sample of 697 high-school students, by gender 395 boys and 302 girls. The participant mean age (± SD) was 16.5±1.0 years. The subjects attended 35 classes in various Zagreb high schools (vocational and regular), where the ratio of vocational and regular classes was kept in accordance

with the actual population ratio (1:3 in favor of vocational classes). The subjects' structure followed the actual ratio of school types (1/3 regular and 2/3 vocational), while gender distribution was in favor of boys due to the type of vocational schools involved. None of the participants refused to take part in the study, making the 100% turnout.

Upon the obtained written permission from the Ministry of Science, Education and Sports, the headmasters of the schools involved were informed about the research. A written notice was sent to adolescents' parents, while the students were briefly informed about the general issue, and the methods and procedure of the research. If both the parents and the student agreed to take part in the research, they both signed a consent form. The survey was conducted in groups, in the classroom, during school class, lasting for two classes. Data collection was anonymous and the subjects had the right to withdraw at any moment. They were offered a possibility to talk to the examiner or to get help at any time during or after the examination.

Materials

The following instruments and variables were used on data collection:

- the Scale of Auto-destructiveness (SAD), a standardized questionnaire, was used to measure self-harmness[22]. SAD is the instrument for measuring self-destructive tendencies in the individual's personality, which is used in scientific studies and diagnostic practice in subjects older than 14 years. It consists of 107 grouped statements that make 4 subscales (suicidal depression, anxiety, aggression, and borderline). The participants' task was to answer with a "yes" or "no" depending on whether the statement was true for them. The application of SAD can be conducted individually or in a group, and it takes 15-20 minutes on average[22]. In this study, the reliability type internal consistency (Cronbach's alpha) was very high, yielding the following values: Total score in SAD (α=0.97); Suicidal depression (α=0.92); Anxiety (α=0.91); Aggression (α=0.88); and Borderline (α=0.85);

- to obtain basic demographic data used in this study, a structured questionnaire with demographic and family data was used, containing questions on marital and employment status of parents, socioeconomic status of parents, presence of serious illness, alcoholism and mental illness in the family, corporal punishment in the family, etc.).

Statistical analysis

Descriptive statistics methods were used on statistical analysis (mean and standard deviation) when distribution of data for certain variables was normal or at least symmetric. Differences between groups were assessed by tests for independent samples (Kruskal-Wallis test for more than two samples and median test for comparison of two samples of participants). Namely, not all prerequisites for using parametric statistical analysis were met, therefore nonparametric tests were used. Data analysis was performed by using the Statistical Package for Social Sciences for Windows v. 23.0 (SPSS Inc., Chicago, IL, USA)[23,24].

Results

The overall score in the SAD (Total SAD) was defined as the sum of "yes" responses in all 107 items of the SAD. Then, the overall score on the SAD was grouped according to the clinical setting limit and further divided into 25% of the participants with the lowest score and 25% with the highest and average level of destructiveness. The results showed that 87.3% of the participants demonstrated low/average self-harm, 8.8% demonstrated above-average self-harm, and 3.9% demonstrated highly above-average self-harm. Distribution of the results is shown in Table 1.

Differences in the number of participants within certain categories of scores in the SAD according to

Table 1. Distribution of results on the Scale of Auto-Destructiveness (SAD) according to clinical guidelines[22]

Total SAD	n	(%)	SAD (upper and lower quartile)	n	(%)
Low/average	496	(87.3%)	Low auto-destructiveness (25%)	150	(26.4%)
Above average	50	(8.8%)	Average	278	(48.9%)
High above average	22	(3.9%)	High auto-destructiveness (25%)	140	(24.6%)
Total	568	(100.0%)	Total	568	(100.0%)

Table 2. Differences in number of participants within particular categories of scores in the Scale of Auto-Destructiveness (SAD) according to categories of financial situation of the child's parents (stratified by gender)

Total SAD males	Financial situation of child's parents			Total	χ^2 (df=4)
	Below average	Average	Above average		
Low/average	22	183	65	270	5.601
Above average	4	15	3	22	
High above average	1	4	4	9	
Total	27	202	72	301	
Total SAD females	Financial situation of child's parents			Total	χ^2 (df=4)
	Below average	Average	Above average		
Low/average	20	160	29	209	1.381
Above average	3	23	2	28	
High above average	1	7	2	10	
Total	24	190	33	247	
Total SAD males (recorded with 2% upper and lower)	Financial situation of child's parents			Total	χ^2 (df=4)
	Below average	Average	Above average		
Low auto-destructive	6	66	23	95	5.338
Average autodestructive	11	95	37	143	
High auto-destructive	10	41	12	63	
Total	27	202	72	301	
Total SAD females (recorded with 2% upper and lower)	Financial situation of child's parents			Total	χ^2 (df=4)
	Below average	Average	Above average		
Low auto-destructive	2	37	8	47	6.878
Average autodestructive	10	100	18	128	
High auto-destructive	12	53	7	72	
Total	24	190	33	247	

financial situation of the child's parents were calculated (Table 2). Two different criteria for defining categories of scores in the SAD were used, i.e. total and upper/lower quartile, following clinical guidelines proposed by Dautović in 2000[22]. Adolescents living in below-average financial conditions appeared to show slightly higher self-harm behavior as compared with the other two groups, but these differences were not statistically significant, either in male or female subjects.

Differences in the results in the SAD and its subscales according to financial situation of the child's parents were determined separately for male and female subjects (Table 3). The results revealed the suicidal risk to be highest in adolescents with below-average financial situation, both in male and female subjects. Only in female subjects, the highest score in borderline was recorded in the adolescents with below-average financial situation as compared with those with average or above-average financial situation.

Most statistically significant differences were found in the results recorded in the SAD and its subscales (using two different criteria, proposed by Dautović[22]) according to parental marital status (Table 4). In male subjects, differences were statistically significant in all variables except for the borderline subscale and total SAD score, indicating a higher level of auto-destructiveness in single-parent families. In females, a higher level of auto-destructiveness was found in single-parent families in all variables, except for the anxiety subscale.

Discussion

Study results showed a high incidence of various self-harm behaviors in the adolescent population in-

Table 3. Differences in results in the Scale of Auto-Destructiveness (SAD) and its subscales according to financial situation of the child's parents (stratified by gender)

Males: Financial situation		Mean	SD Lower bound	95% Confidence interval for mean		Kruskal-Wallis test (p)
				Upper bound		
Total SAD	Below average	32.407	20.298	24.378	40.437	0.063
	Average	24.253	18.769	21.649	26.856	
	Above average	23.333	21.053	18.386	28.281	
Suicidal risk	Below average	6.655	5.253	4.657	8.653	0.042*
	Average	4.846	5.520	4.133	5.558	
	Above average	4.829	6.310	3.443	6.216	
Anxiety	Below average	12.107	7.218	9.308	14.906	0.062
	Average	9.927	7.115	9.011	10.844	
	Above average	8.720	7.283	7.119	10.320	
Aggressiveness	Below average	6.536	5.309	4.477	8.594	0.679
	Average	5.694	4.647	5.106	6.283	
	Above average	5.595	4.837	4.546	6.645	
Borderline	Below average	6.586	4.363	4.927	8.246	0.055
	Average	4.813	4.066	4.296	5.330	
	Above average	4.671	4.497	3.683	5.659	
Females: Financial situation		Mean	SD Lower bound	95% Confidence interval for mean		Kruskal-Wallis test (p)
				Upper bound		
Total SAD	Below average	37.667	17.547	30.257	45.076	0.071
	Average	30.221	19.553	27.423	33.019	
	Above average	28.758	19.408	21.876	35.640	
Suicidal risk	Below average	8.679	5.382	6.592	10.766	0.043*
	Average	6.735	5.930	5.930	7.539	
	Above average	6.139	6.086	4.080	8.198	
Anxiety	Below average	15.536	5.966	13.222	17.849	0.191
	Average	13.521	7.003	12.575	14.467	
	Above average	12.757	6.974	10.432	15.082	
Aggressiveness	Below average	5.571	3.511	4.210	6.933	0.105
	Average	4.608	4.462	4.011	5.205	
	Above average	5.143	4.615	3.557	6.728	
Borderline	Below average	7.875	3.938	6.212	9.538	0.015*
	Average	5.667	4.187	5.101	6.232	
	Above average	5.306	3.624	4.079	6.532	

*statistically significant at the 5% level; SD = standard deviation

cluded. Above-average self-harm was recorded in 8.8% of the participants, whereas 3.9% of the participants demonstrated high above-average self-harm. These results are consistent with the research in other European countries and with the findings reported from the CASE study as the most comprehensive study of self-harming children and adolescents in Europe conducted to date, which included 30 000 adolescents[12,25].

Our results revealed that family financial circumstances had an impact on self-harm in adolescents,

Table 4. Differences in results in the Scale of Auto-Destructiveness (SAD) and its subscales (using two different criteria) according to parental marital status (stratified by gender)

Males	Marital status	Mean	SD	Median test
Total SAD	Two-parent, married single, divorced	23.531 31.359	19.227 21.538	0.002**
Suicidal risk	Two-parent, married single, divorced	4.783 6.579	5.620 6.665	0.008**
Anxiety	Two-parent, married single, divorced	9.437 11.893	7.129 7.541	0.008**
Aggressiveness	Two-parent, married single, divorced	5.526 6.828	4.722 4.867	0.034*
Borderline	Two-parent, married single, divorced	4.769 5.966	4.174 4.611	0.103
Total SAD recorded	Two-parent, married single, divorced	1.116 1.226	0.391 0.542	0.089
Total SAD recorded with 2% upper and lower	Two-parent, married single, divorced	1.855 2.094	0.719 0.687	0.026*
Females	Marital status	Mean	SD	Median test
Total SAD	Two-parent, married single, divorced	28.714 43.079	17.376 25.073	0.046*
Suicidal risk	Two-parent, married single, divorced	6.401 9.698	5.395 7.683	0.049*
Anxiety	Two-parent, married single, divorced	13.057 16.674	6.505 8.263	0.054
Aggressiveness	Two-parent, married single, divorced	4.284 7.409	3.879 5.868	0.011**
Borderline	Two-parent, married single, divorced	5.406 8.116	3.909 4.742	0.009**
Total SAD recorded	Two-parent, married single, divorced	1.136 1.526	0.408 0.725	0.000**
Total SAD recorded with 2% upper and lower	Two-parent, married single, divorced	2.049 2.421	0.668 0.683	0.002**

*statistically significant at the 5% level; **statistically significant at the 1% level; SD = standard deviation

which was statistically significant in particular SAD subscales. Concerning suicidal risk, higher scores were recorded in adolescents of both genders with below-average financial situation, whereas in the borderline subscale, the same trend was only found in female subjects. Adolescents living in below-average financial conditions appeared to show higher levels of self-harm behaviors, as compared with adolescents living in average and above-average financial family circumstances. These findings are in line with the results of a longitudinal study, which indicated that socioeconomic problems during childhood continued to be a predictive factor for self-harm at a later age[26], regardless of mental problems and stressful life events[27,28]. On the other hand, findings of our previous study using the same data suggested that neither the mother's or father's

employment status, nor residence status of the adolescent (own house, apartment, rent a flat) did affect the level of self-harm significantly. Our previous findings also suggested that low socioeconomic status, low level of education, low income, and poverty were socioeconomic risk factors for self-harm[29]. A study on Economic Vulnerability and Social Welfare, conducted by the World Bank in Croatia, revealed that the unemployed were largely affected by long-term poverty[30]. Croatian studies point out that financial deprivation, as well as the perception of financial stress is more associated with mental health than with all other aspects of health[31].

Parents and generally adults whose parents' financial position is not based on an appropriate social status may have difficulty in expressing authority. If this is combined with the lack of recognition or respect from those who also have power and authority over their children, such as teachers or social workers, their ability to express their respect as parents is even lower. Then some of them may resort to authoritarianism and become violent towards their children, or give an impression that they are not handled properly or, conversely, may become passive as it is often interpreted as a reduced parental responsibility[32]. These authors found that adolescents who tended towards self-harm had more problems with their family, friends, partners, and at school. In their families, they experienced less understanding when compared to the adolescents who were not prone to self-harm[32].

Problems in interpersonal relationships play an important role in the emergence of self-harm at all ages, but for children and adolescents relationships with parents are of utmost importance. Difficult relationships with parents, particularly in relation to the mother, are significantly associated with depression and suicidal ideation in the adolescent. Results of a meta-analysis of self-harm in adolescents indicate the importance of good communication, support and acceptance within the family[33-35].

Successfully passing through a crisis of identity in adolescence is conditioned by the fact that children develop in a warm and safe atmosphere, that parents satisfy their basic needs, stimulate them to be independent, encourage them, and so enable development initiatives. Children growing up in dysfunctional families, especially if they also are of poor social status, will find it difficult to successfully resolve the crisis of identity, which can be associated with a tendency towards self-harm and negative identity or unsuccessful attempts of young people to get proof of their value by parents[36].

The transitional changes in Croatia and the post-war period, as well as operational and financial uncertainty certainly have profound effects on all family members, family dynamics and family systems as a whole. Abundant literature clearly indicates that stress in a family member causes suffering of other family members and undermines communication with each other, and that such families may struggle with the subsequent burnout and compassion fatigue. All this together can interfere with the psychological development of children and adolescents that grow up in such families[37,38].

Limitations of this study derived mainly from the methodology. The study population on which data were collected was an urban population, so the results of this research can only be applied to a similar population. By using self-assessment techniques, adolescents do not necessarily reflect an accurate state of affairs. The questionnaire examines the propensity to self-harm along a continuum. Data on specific procedures and their frequency were obtained by a relatively small number of participants, so we suggest a more detailed examination of self-harm by translating and standardizing some of the international measurement instruments for testing self-harm, such as Deliberate Self-Harm Inventory[39] or Self-Harm Behavior Questionnaire[40].

Conclusion

The highest suicidal risk (in males and females) and the highest score in borderline subscale (in females) were recorded in the adolescents with the family financial situation below the average. In male and female adolescents, differences indicated a higher level of auto-destructiveness in single-parent families in all variables (except for the borderline subscale and Total SAD recorded for males and in anxiety subscale in females). These findings, along with the generally high incidence of self-harm behavior in adolescents included in this study, indicate that social support is an important factor to the families of adolescents. Social support is a key preventive intervention measure related to work with these families. It is important to

point out that the insight in the social and family factors that are associated with self-harm is important for future understanding, prevention and therapeutic work with adolescents.

References

1. Pećnik N, Raboteg Šarić Z. Neformalna i formalna podrška jednoroditeljskim i dvoroditeljskim obiteljima. Rev Soc Polit. 2005;12(1):1-21. (in Croatian)
2. Brunner R, Kaess M, Parzer P, Fischer G, Carli V, Hoven ChW, Wassermann C, Sarchiapone M, Resch F, Apter A, Balazs J, Barzilay S, Bobes J. Life time prevalence and psychosocial correlates of adolescent direct self-injurious behavior: a comparative study of findings in 11 European countries. J Child Psychol Psyhiatry. 2014;55(4):337-48. doi: 10.1111/jcpp.12166
3. Čudina-Obradović M, Obradović J. Psihologija braka i obitelji. Zagreb: Tehnička knjiga, 2006. (in Croatian)
4. Nikolić S, *et al*. Dječja i adolescentna psihijatrija. Zagreb: Školska knjiga; 2004:14-5. (in Croatian)
5. Wagner Jakab A. Obitelj – sustav dinamičnih odnosa u interakciji. Hrvatska revija za rehabilitacijska istraživanja. 2008;44 (2):119-28. (in Croatian)
6. Consoli A, Cohen D, Bodeau N, Guile JM, Mirkovic B, Knafo A, Mahe V, Laurent C, Renaud J, Labelle R, Breton JJ, Gerardin P. Risk and protective factors for suicidality at 6-month follow-up in adolescent inpatients who attempted suicide: an exploratory model. Can J Psychiatry. 2015;60(2 Suppl 1):S27-S36. PMID:25886668 PMCID:pmc4345845
7. Carli V, Mandelli L, Zaninotto L, Iosue M, Hadlaczky G, Wasserman D, Hegerl U, Värnik A, Reisch T, Pfuhlmann B, Maloney J, Schmidtke A, Serretti A, Sarchiapone M. Serious suicidal behaviors: socio-demographic and clinical features in a multinational, multicenter sample. Nord J Psychiatry. 2014; 68:44-52. doi: 10.3109/08039488.2013.767934
8. Petak A. Obitelj u promjenama: rezultati istraživanja u Hrvatskoj. Sociologija sela. 2004;163-164:5-10. (in Croatian)
9. Serafini G, Muzio C, Piccinini G, Flouri E, Ferrigno G, Pompili M, Amore M. Life adversities and suicidal behavior in young individuals: a systematic review. Eur Child Adolesc Psychiatry. 2015;24(12):1423-46. doi: 10.1007/s00787-015-0760-y
10. Marčinko D. Suicidologija. Zagreb: Medicinska naklada, 2011. (in Croatian)
11. Hamza ChA, Stewart L, Willoughby T. Evaluating the link between nonsuicidal self injury and suicidal behaviour: a review of the literature and an integrated model. Clin Psychol Rev. 2012;32:482-95. doi: 10.1371/journal.pone.0153760
12. Madge N, Hewitt A, Hawton K, De Wilde EJ, Corcoran P, Fekete S, *et al*. Deliberate self-harm within an international community sample of young people: comparative findings from the Child & Adolescent Self-harm in Europe (CASE) study. J Child Psychol Psychiatry. 2008;49(6):667-77. doi: 10.1111/j.1469-7610.2008.01879.x
13. Guerreiro DF, Neves EL, Navarro R, Mendes R, Prioste A, Ribeiro D, *et al*. Clinical features of adolescents with deliberate self-harm: a case control study in Lisbon, Portugal. Neuropsychiatr Dis Treat. 2009;5:611-7. doi: 10.2147/NDT.S7488
14. Brunner R, Parzer P, Haffner J, Steen R, Roos J, Klett M, *et al*. Prevalence and psychological correlates of occasional and repetitive deliberate self-harm in adolescents. Arch Pediatr Adolesc Med. 2007;161(7):641-9. doi: 10.1001/archpedi.161.7.641
15. Brown J, Cohen P, Johnson JG, Smailes EM. Childhood abuse and neglect: specificity of effects on adolescent and young adult depression and suicidality. J Am Acad Child Adolesc Psychiatry. 1999;38(12):1490-6. https://doi.org/10.1097/00004583-199912000-00009
16. Carter G, Reith DM, Whyte IM, McPherson M. Repeated self-poisoning: increasing severity of self-harm as a predictor of subsequent suicide. Br J Psychiatry. 2005;186:253-7. doi: 10.1192/bjp.186.3.253
17. Gibb SL, Beautrais AL, Fergusson DM. Mortality and further suicidal behavior after index suicide attempt: a 10-year study. Aust N Z J Psychiatry. 2005;39:95-100. doi: 10.1111/j.1440-1614.2005.01514.x
18. Brent D. Do physicians take self-injury seriously enough? Am J Psychiatry. 2011;168:452-54, 495-501.
19. Ackard DM, Neumark-Sztainer D, Story M, Perry C. Parent-child connectedness and behavioral and emotional health among adolescents. Am J Prev Med. 2006;30:59-66. doi: 10.1016/j.amepre.2005.09.013
20. Sičić M, Mužinić L. Faktori rizika kod pojave samoozljeđivanja djece i mladih. Ljetopis socijalnog rada. 2008;15:49-68. (in Croatian)
21. Frančišković T, Tovilović Z, Šuković G, *et al*. Health care and community-based interventions for war traumatized people in Croatia: community-based study of service use and mental health. Croat Med J. 2008;49:483-90.
22. Dautović M. Priručnik za skalu autodestruktivnosti SAD. Jastrebarsko: Naklada Slap, 2000. (in Croatian)
23. Petz B. Osnovne statističke metode za nematematičare. Jastrebarsko: Naklada Slap, 2002. (in Croatian)
24. Preacher KJ, Hayes AF. Asymptotic and resampling strategies for assessing and comparing indirect effects in multiple mediator models. Behav Res Methods. 2008;(40):879-91. doi: 10.3758/BRM.40.3.879
25. McMahon EM, Reulbach U, Corcoran P, Keeley HS, Perry IJ, Arensman E. Factors associated with deliberate self-harm among Irish adolescents. Psychol Med. 2010;8:1-9. doi: 10.1017/S0033291709992145
26. Fergusson DM, Woodward LJ, Horwood LJ. Risk factors and life processes associated with the onset of suicidal behaviour during adolescence and early adulthood. Psychol Med. 2000; 30:23-39. SIEC No: 20000277
27. Kerfoot M. Suicide and deliberate self-harm in children and adolescents. Child Soc. 1996;10(3):236-41.

28. Beautrais A. Risk factors for suicide and attempted suicide among young people. Aust N Z J Psychiatry. 2000;34:420-36. http://dx.doi.org/10.1007/s10578-008-0096-7
29. Tripković M, Frančišković T, Grgić N, Ercegović N, Graovac M, Zečević I. Family factors associated with self-harmness in adolescents in Croatia. Coll Antropol. 2013;37(4):1081-8.
30. Croatia Economic Vulnerability and Welfare Study. World Bank, Poverty Reduction and Economic Management Unit, Europe and Central Asia Region. Report No. 22079; 2000.
31. Šverko B, Galić Z, Maslić Seršić D, Galešić M. Unemployed people in search of a job: reconsidering the role of search behavior. J Vocat Behav. 2008;72(3):415-28.
32. McLaughlin J, Miller P, Warwick H. Deliberate self-harm in adolescents: hopelessness, depression, problems and problem-solving. J Adolesc. 1996;19:523-32. DOI: 10.1006/jado.1996.0051
33. Buchman-Schmitt J, Chiurliza B, Chu C, Michaels SM, Joiner E. Suicidality in adolescent populations: a review of the extent literature through the lens of the interpersonal theory of suicide. Int J Behav Consult Ther. 2014;9(3):494-502.
34. Vulić-Prtorić A. Depresivnost u djece i adolescenata. Jastrebarsko: Naklada Slap, 2003. (in Croatian)
35. Vulić-Prtorić A. Obiteljske interakcije i psihopatološki simptomi u djece i adolescenata. Suv Psihol. 2002;5(1):31-51. (in Croatian)
36. Erikson E. Childhood and Society. New York: Norton, 1963.
37. Klarić M, Frančišković T, Salčin Satriano A. Obitelj i psihotrauma. Medicina Fluminensis. 2010;46(3):309-17. (in Croatian)
38. Klarić M, Frančišković T, Klarić M, *et al*. Psychological problems in children of war veterans with posttraumatic stress disorder in Bosnia and Herzegovina: cross-sectional study. Croat Med J. 2008;49:491-8.
39. Gratz KL. Measurement of deliberate self-harm: preliminary data on the Deliberate Self-Harm Inventory. J Psychopathol Behav Assess. 2001;23:253-63. doi: 10.1023/A:1012779403943
40. Gutierrez PM, Osman A, Barrios FX, Kopper BA. Development and initial validation of the Self-Harm Behavior Questionnaire. J Pers Assess. 2001;77(3):475-90. doi: 10.1207/S15327752JPA7703_08

Sažetak

FINANCIJSKE OBITELJSKE PRILIKE, BRAČNI STATUS RODITELJA I SAMOOZLJEĐIVANJE KOD ADOLESCENATA U HRVATSKOJ

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Cilj ovoga istraživanja bio je utvrditi razinu samoozljeđivanja kod adolescenata u općoj populaciji (učenici srednjih škola u Zagrebu, Hrvatska), kao i utvrditi razlikuje li se razina samoozljeđivanja prema obiteljskim financijskim prilikama i bračnom statusu roditelja. Istraživanje je provedeno na 701 adolescentu (muški i ženski, u rasponu dobi od 14 do 19 godina). Za određivanje financijskih obiteljskih prilika primijenjen je posebno dizajniran upitnik koji uključuje obiteljske i demografske podatke. Za procjenu razine autoagresivnosti rabio se mjerni instrument Ljestvica auto-destruktivnosti. Rezultati su pokazali da 87,3% adolescenata pokazuje prosječnu razinu autoagresivnosti, dok je iznadprosječna i vrlo visoko iznadprosječna autoagresivnost prisutna u 12,7% adolescenata. Rezultati pokazuju da adolescenti u jednoroditeljskim obiteljima iskazuju značajno višu razinu samoozljeđivanja i to među adolescentima oba spola, dok lošije obiteljske financijske prilike (percepcija financijskog stresa) razlikuju istu razinu samoozljeđivanja. Praktična primjena ovoga istraživanja naglašava važnost socijalne potpore roditeljima adolescenata koji odrastaju u jednoroditeljskim i/ili obiteljima lošijih financijskih prilika.

Ključne riječi: *Adolescent; Adolescent, ponašanje; Agresivnost; Obitelj s jednim roditeljem; Društvena potpora; Hrvatska*