

Recent Suicidality in the General Population: Multivariate Association With Childhood Maltreatment and Adult Victimization

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Abstract

Three hundred and eighty-seven participants from the general population completed the Suicidality scale of the Detailed Assessment of Posttraumatic Stress (DAPS) and the Traumatic Events Survey (TES). Within the prior month, 14% of adults reported some degree of suicidal ideation and 2% reported an active or passive suicide attempt. Multinomial logistic analysis indicated that, as compared with nonsuicidal participants, age, childhood physical abuse, childhood sexual abuse, and childhood emotional abuse were associated with recent suicide attempts, whereas recent suicidal ideation without attempts was predicted solely by emotional abuse. In contrast, adult sexual or physical assaults were not associated with recent suicidality in any form.

Keywords

child abuse, sexual abuse, physical abuse, sexual assault

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Childhood maltreatment has been found to have a range of negative psychological effects, including anxiety, depression, low self-esteem, guilt, substance abuse, dysfunctional behaviors, and interpersonal difficulties (see reviews by Beitchman et al., 1992; Browne & Finkelhor, 1986; Meyers, 2010; Norman et al., 2012). Of these, perhaps one of the most troubling is the development of suicidal thoughts and behaviors. In a number of studies, childhood sexual, physical, and/or emotional abuse has been associated with later suicidal ideation, threats, or attempts (see reviews by Brodsky & Stanley, 2012; Evans, Hawton, & Rodham, 2005; Mironova et al., 2011; Rogers, 2003). These studies suggest that survivors of childhood maltreatment are several times more likely to be suicidal compared with their counterparts without such a history (e.g., Brown, Cohen, Johnson, & Smailes, 1999; Dube et al., 2001).

There is less agreement regarding the type of childhood victimization most related to suicidality. For example, Brown et al. (1999) reported that childhood sexual abuse was the largest independent risk factor for suicide attempts, and Read and colleagues found that childhood sexual abuse may be a more powerful predictor of current suicidality than depression (Read, Agar, Barker-Collo, Davies, & Moskowitz, 2001), even though depression has been described as the most common indicator and greatest predictor of suicide (Peruzzi and Bongar, 1999). On the other hand, Nilsen and Conner (2003) observed no relationship between childhood sexual abuse and suicidal ideation. Finally, Dube et al. (2001) concluded that the factor most strongly related to suicidality is childhood emotional abuse, followed by sexual and physical abuse, whereas Wiederman, Sansone, and Sansone (1997) found that both sexual and physical abuse histories were predictive of suicide attempts, whereas emotional abuse was not.

Some of this disagreement may be due to differences between studies in what variables are examined and what samples are used. Some have considered suicidal ideation alone (e.g., Bryant & Range, 1995), others suicide attempts (e.g., Langhinrichsen-Rohling, Monson, Meyer, Caster, & Sanders, 1998), and some a mix of ideation and behavior (e.g., Nelson et al., 2002). In a few cases, all major forms of childhood maltreatment have been considered in a multivariate fashion (e.g., Briere & Runtz, 1988), whereas, more commonly, a single form of childhood maltreatment (e.g., childhood sexual abuse) has been studied in isolation (e.g., Nilsen & Conner, 2003). In addition, many studies of child maltreatment and suicidality have been conducted in samples of university students (e.g., Yama, Tovey, Fogas, & Morris, 1995), some have examined clinical groups (e.g., Read et al., 2001), and only a few have used general population samples (e.g., Briere & Elliott, 2003). Finally, some studies have been limited to a single gender (e.g., Bryant & Range,

1995; Easton, Renner, & O'Leary, 2013), even though both men and women engage in suicidal behavior and their responses might be expected to differ.

Methodological issues aside, there are several theories offered in the literature to explain the general child maltreatment–suicide relationship. The most common is that child abuse can lead to disturbed parent–child attachment, stigmatization, and negative self-inferences, with associated negative cognitive-emotional states such as low self-esteem, anger, guilt, shame, self-blame, and unworthiness (Bryan, McNaughton-Cassill, Osman, & Hernandez, 2013; Easton et al., 2013; Feiring, 2005; Finzi-Dottan & Karu, 2006; Puzia, Kraines, Liu, & Kleiman, 2014). Also implicated are abuse-related cognitions involving helplessness and hopelessness, which are, in turn, associated with depression, desire for escape from psychological pain, and suicidal behavior (Baumeister, 1990; Beck, Brown, Berchick, Stewart, & Steer, 1990; Schniedman, 1998). Some authors point to abuse-related interpersonal difficulties, such as lack of trust, fear of intimacy, isolation, and sensitivity to rejection, that may motivate suicide threats and behaviors as a way, in part, to deal with relational conflicts or abandonment/rejection fears (Briere & Runtz, 2002; Stepp et al., 2008). Others hypothesize that suicidality can serve as a way to avoid or reduce abuse-related dysphoria and posttraumatic stress (e.g., Baumeister, 1990; Briere, Hodges, & Godbout, 2010; Wilcox, Storr, & Breslau, 2009). Finally, it has been suggested that childhood physical and sexual abuse may, in addition to producing distress, lead to a reduction in individuals' fear of self-harm, thus making it more likely that they will exhibit suicidal behavior (Easton et al., 2013; Joiner, 2005).

From a related perspective, some writers have suggested that the attachment disturbance, cognitive distortions, relational problems, affect dysregulation, and rejection sensitivity associated with some instances of suicidality reflect the more general relationship between borderline personality disorder and suicidal behavior (American Psychiatric Association, 2001; Gunderson & Ridolfi, 2001), especially given that borderline personality disorder is also linked to childhood abuse and neglect (e.g., Helgeland & Torgersen, 2003; Zanarini et al., 1997). It remains unclear, however, whether borderline disturbance itself causes suicidality, or, rather, that the problems and symptoms described above represent the underlying etiology of self-destructive behaviors, to some extent irrespective of whether a diagnosis of borderline personality disorder can be made (Briere & Scott, 2014).

Formal suicide-focused theories support the potential role of child abuse as a central etiologic factor. For example, both the Suicidal Mode Theory (SMT; Rudd, 2006) and the Interpersonal-Psychological Theory of Suicide (IPT; Joiner, 2005; Van Orden et al., 2010) propose that interpersonal trauma may produce emotions and cognitions that leave survivors with a

persisting vulnerability for suicidal ideation and behaviors. Empirical studies support these theories, suggesting, for example, that childhood maltreatment can result in low self-esteem, self-blame, and a lack of fear of self-harm that, in turn, motivate suicidal behaviors (e.g., Bryan et al., 2013; Easton et al., 2013).

Victimization in adulthood also has been related to suicidality in several studies (e.g., Afifi, Boman, Fleisher, & Sareen, 2009; Bryan et al., 2013; Read et al., 2001). This association makes sense, because adult traumas are more proximal to adult-onset suicidality, and events such as rape and intimate partner violence are highly aversive and might be expected to result in suicidal thoughts or behaviors (Devries et al., 2013; Kilpatrick & Seymour, 1992). On the other hand, some research suggests that childhood maltreatment may be more closely associated with suicidality than interpersonal violence in adulthood (e.g., Brodsky & Biggs, 2012; Nilsen & Conner, 2003), and that adult revictimization (adult trauma associated with prior childhood trauma) does not systematically moderate the significant link between child abuse and suicidality (Nilsen & Conner, 2003). Unfortunately, studies remain sparse in this area and the role of child versus adult victimization to predict suicidality remains to be fully assessed.

To address these potential gaps and inconsistencies in the literature, the current study used multinomial logistic regression analysis (MLRA) to assess the simultaneous multivariate relationship between demographics, the major forms of childhood maltreatment (physical, psychological, and sexual abuse), and adult victimization (sexual and physical assault) on both suicidal ideation and attempts, and to do so in a sufficiently large probability sample of the general population.

Method

The current study was performed on archival data from the Detailed Assessment of Posttraumatic Stress (DAPS; Briere, 2001) standardization study. Following approval by the institutional review board of the University of Central Florida, a national sampling service generated a random, stratified sample of adults based on geographical location of registered owners of automobiles and/or individuals with listed telephones. Participants were contacted by telephone, and those agreeing to participate were mailed a questionnaire containing demographic questions and, among other measures, the DAPS. A random subsample of participants in the standardization study also received the Traumatic Events Survey (TES; Elliott, 1992), to assess the predictive validity of DAPS scales. Participants received US\$5.00 upon mailing back the questionnaire.

The full standardization sample (consisting of all those completing the DAPS, with or without the TES; $N = 836$) was stratified to approximate the age, gender, race, and geographical area of individuals living in the United States. Because the test publisher ended data collection as soon as the data required to fill relevant cells of the stratification matrix were complete, the actual response rate is unknown; the recruitment of participants was terminated before all eligible participants were able to respond. Of this sample, a random subsample of 387 adult participants completed both the TES and DAPS and were the subject of the present study.

Participants

The mean age of participants in this subsample was 49.3 years ($SD = 15.4$ years, range = 18-91 years). A total of 57.6% ($n = 223$) of participants were male and 42.4% ($n = 164$) were female. Racial breakdown was 83.3% ($n = 324$) Caucasian American, 4.9% ($n = 19$) Black/African American, 3.3% ($n = 13$) Asian American, 3.3% ($n = 13$) Hispanic American, 2.6% ($n = 10$) Native American, and 1.5% ($n = 6$) "Other." Exposure to interpersonal violence was relatively common. Across gender, 17.1% ($n = 66$) participants reported childhood sexual abuse, 31.3% ($n = 121$) reported childhood physical abuse, 27.6% ($n = 107$) reported at least one adult physical assault, and 5.7% ($n = 22$) reported at least one adult sexual assault (see definitions of these victimization types below).

Measures

The DAPS is a 104-item, normed and standardized test of trauma and its psychological effects, rated over the prior month. The various components of the DAPS, including its Suicidality scale, have been shown to be reliable and valid in a variety of studies (see psychometric reviews by Plake, Impara, & Spies, 2003; Weathers, Keane, & Foa, 2009).

The TES is a measure of exposure to potentially traumatic events, and has been used in a number of published studies of trauma impacts (e.g., Briere & Elliott, 2003; Briere & Rickards, 2007; Croyle & Waltz, 2007; Elliott, 1997), where it has been shown to have predictive validity. Of the 30 interpersonal and environmental traumas examined by the TES, 20 address adult events and 10 refer to childhood events. Because the TES is usually employed to determine specific, dichotomously defined trauma exposure (e.g., presence or absence of childhood physical or sexual abuse, or adult exposure to a natural disaster), there is only one scale (Emotional Abuse) for which internal consistency can be assessed, which is described below.

Victimization variables. Childhood and adult physical and sexual victimization histories were determined on the basis of participants' responses to TES items. They were categorized as having experienced *childhood physical abuse* (0 = no, 1 = yes) if they positively endorsed one or both of the following items: "Before the age of 18, did your parents or caretaker ever do the following": (a) "hit you with a fist, kick you, or throw you down on the floor, into a wall, or down stairs," and (b) "do something to you on purpose that left marks, bruised, burned, or caused you to bleed, lose teeth, or have broken bones." They were rated as having experienced *childhood sexual abuse* (0 = no, 1 = yes) if they endorsed either or both of the following items: (a) "Before the age of 18, did anyone 5 or more years older than you ever kiss or touch you in a sexual way or have you touch them in a sexual way," and (b) "Before the age of 18, did anyone less than 5 years older than you use physical force to kiss or touch you in a sexual way, or force you to touch them in a sexual way?" *Childhood emotional abuse* was assessed with the 40-item Emotional Abuse scale of the TES, which asks about maternal and paternal behaviors in the "most difficult year" before age 18, including parents having "yelled at you," "rejected you," and "humiliated you in front of others," each rated on a continuous Likert-type scale ranging from 0 to 3. The total score is the sum of maternal and paternal subscales, and varies from 0 to 120, where higher score represents more experiences of childhood emotional abuse. This scale has been shown to be internally consistent and to have predictive validity (e.g., Briere & Rickards, 2007; Croyle & Waltz, 2007).

Participants were classified as having experienced *adult sexual assault* (0 = no, 1 = yes) if they responded positively to the item, "Since age 18, did you ever have sexual contact with someone (e.g., touching genitals, buttocks, breasts, or having intercourse) because you were threatened or physically forced." Finally, they were rated as having experienced *adult physical assault* (0 = no, 1 = yes) if they responded positively to the following TES item: "As an adult (since age 18) did anyone ever intentionally hit you with a hand, fist, or object causing marks, bruising, bleeding, burns, or broken bones, or otherwise cause you serious injury?"

Suicidality variables. Items of the DAPS Suicidality scale were used to evaluate suicidal ideation and/or behavior in the present study. As per the other scales of the DAPS, the Suicidality scale was normed and standardized on the general population, and has been shown to be internally consistent/reliable in general population, clinical, and university student samples (α s = .90, .95, and .92, respectively; Briere, 2001). As described in the DAPS manual, it is highly correlated with the Suicide scale of the Personality Assessment

Inventory (PAI; Morey, 1991; $r = .84$), but less correlated with measures less associated with suicidality.

Two variables were created based on the Suicidality scale: *suicidal ideation*, whether participants had endorsed any item involving suicidal thoughts in the last month (e.g., “Suicidal thoughts”), and *suicide attempt(s)*, whether participants had reported a passive suicide attempt (i.e., “Doing something dangerous because you hoped you might be killed [for example, driving much too fast or taking dangerous chances]”) or an active attempt (e.g., “Attempting suicide”). These two variables, dichotomously scored, were then used to create an additional *suicide level* variable: no suicidal ideation or attempts (0), suicidal ideation but no attempts (1), or at least one suicide attempt (2).

Analyses

Step-wise multinomial logistic regression analysis was used to predict level of suicidality on the basis of gender, age, the three childhood abuse variables, and the two adult victimization variables. As described in the “Measures” section, all victimization variables in the analyses were dichotomous, except childhood emotional abuse, which was a continuous variable. In MLRA, the dependent variable is coded into three or more nonoverlapping groups (in this case, no suicidality, suicide ideation only, or suicide attempt[s]), whereas the predictor variables may be nominal or continuous in nature (Hosmer & Lemeshow, 2000). It is superior to discriminant function analysis in the current instance because it makes no assumptions regarding predictor normality or homogeneity of variance, and thus allows analysis of dichotomous predictor variables such as gender or victimization history. When MLRA indicated a significant relationship between a predictor and suicide level, post hoc Tukey or Z tests (for continuous or nominal variables, respectively) were used to evaluate specific differences between the three groups.

Results

Within the last month, 14.2% ($n = 55$) of adults in this study reported some degree of suicidal ideation, but no suicide attempts, on the DAPS, and 2.3% ($n = 9$) reported an active or passive suicide attempt. MLRA revealed a significant overall relationship between level of suicidality (none, ideation only, or attempt[s]) and the demographic and victimization variables, $\chi^2(14) = 51.98, p < .001$.

As shown in Table 1, when demographics were entered into the logistic equation at Step 1, likelihood ratio tests indicated that age, but not gender,

Table 1. Predictors of Suicide Ideation and Passive/Active Suicide Attempts by Step-Wise MLRA.

Step	Variables Entered	Level of Suicidality			MLRA Likelihood Ratio	$\chi^2(2)$	<i>p</i>
		None (<i>n</i> = 323)	Ideation Only (<i>n</i> = 55)	Suicide attempt(s) (<i>n</i> = 9)			
1	Gender	59.8% female	47.3% female	44.4% female	1.32	<i>ns</i>	
	Age	<i>M</i> = 49.62 (<i>SD</i> = 15.14) ^a	<i>M</i> = 49.42 (<i>SD</i> = 16.20) ^a	<i>M</i> = 35.22 (<i>SD</i> = 12.55) ^b	6.31	.043	
2	Childhood emotional abuse	<i>M</i> = 14.40 ^a (<i>SD</i> = 16.29)	<i>M</i> = 23.35 ^b (<i>SD</i> = 20.02)	<i>M</i> = 29.34 ^b (<i>SD</i> = 20.33)	15.60	<.001	
	Childhood physical abuse	30.3% ^a	29.1% ^a	77.8% ^b	6.44	.040	
	Childhood sexual abuse	16.4% ^a	10.9% ^a	77.8% ^b	15.54	<.001	
	Adult physical assault	26.0%	30.9%	66.7%	1.37	<i>ns</i>	
	Adult sexual assault	5.5%	5.6%	11.1%	0.59	<i>ns</i>	

Note. Percentages refer to proportion of participants endorsing each dichotomous variable. Significant differences in means tested with Tukey's method; significant differences in proportions were tested with Z tests. Mean values not sharing a common superscript are significantly different at $p < .05$. MLRA = multinomial logistic regression analysis.

predicted suicidality. At Step 2, degree of suicidality was associated with all three types of childhood maltreatment (emotional, physical, and sexual). Post hoc Tukey's tests of the significant MLRA effect indicated that recent suicide attempters were younger than those with no suicidality or with ideation alone (35.2 years vs. 49.6 and 49.4 years, respectively), and that both those with suicidal ideation only and those with suicide attempts had higher emotional abuse scores than those with no suicidality (23.4 and 29.3 vs. 14.4, respectively). Post hoc *Z* tests revealed that those who had made at least one recent suicide attempt had higher rates of childhood sexual and physical abuse relative to those with no suicidality or suicidal ideation alone (77.8% vs. 16.4% and 10.9%, respectively, for sexual abuse, and 77.8% vs. 30.3% and 29.1%, respectively, for physical abuse). In contrast, there were no effects of sexual or physical victimization in adulthood on suicidality.

Discussion

This study found that recent suicidal ideation and behavior were differentially associated with various forms of childhood, but not adult, interpersonal victimization. Within a month of the survey, 14% of participants had experienced suicidal ideation and 2% had engaged in a passive or active suicide attempt, both of which were related to childhood sexual, physical, and emotional abuse. Adult physical and sexual assault, however, were not predictors. Post hoc analyses further indicated that sexual and physical abuse predicted recent active/passive attempts, but not ideation alone, whereas emotional abuse predicted both ideation and attempts.

The childhood maltreatment findings reported here are generally supported by the existing literature, which, as noted earlier, links child abuse to later suicidality. By examining maltreatment variables simultaneously with MLRA, however, we were able to show that each form of childhood abuse had a specific, independent effect on suicidality, rather than reflecting the effects of a general "adverse childhood" factor. In this regard, physical, sexual, and emotional abuse all independently increase the likelihood of suicide attempts, whereas only emotional abuse is associated with suicidal ideation.

These results suggest that recent suicidal ideation without proximal suicide attempts represents a somewhat different phenomenon than recent suicide attempts, at least with respect to traumatic antecedents. Ideation without attempts may be less specifically trauma related than suicide attempts, whereas actual attempts may reflect, in part, greater lethal intention associated with experiences of sexual or physical aggression in childhood. Not only are physical acts of child abuse associated with later risk factors for suicide attempts, such as depression and substance abuse (Center for Substance

Abuse Treatment, 2008), they also involve a central component of the IPTS (Joiner, 2005): the acquired ability to engage in lethal self-injury. As Joiner noted, this ability can be developed “through repeated experience with . . . painful and fear-inducing behaviors,” including physical act of child abuse (Joiner, 2009). Psychological abuse, on the other hand, although clearly distress-producing, is not typically associated with physical pain or the same degree of fear.

Along with other researchers (e.g., Brown et al., 1999), we found that childhood sexual abuse was a substantial, independent predictor of suicidality. Not only may childhood sexual victimization habituate the survivor to the pain and fear associated with self-destructiveness, it also is associated with a wide and perhaps more severe range of negative psychological effects relative to other forms of childhood trauma (e.g., Arnow, 2004; Briere & Elliott, 2003), including depression, borderline personality traits, helplessness, hopelessness, substance abuse, involvement in nonsuicidal self-injury, relationship problems, and reduced impulse control (Beitchman et al., 1992; Browne & Finkelhor, 1986; Neumann, Houskamp, Pollock, & Briere, 1996). Many of these difficulties, in turn, have been shown to increase the likelihood of suicidality (Bongar & Sullivan, 2013; Evans et al., 2005).

The finding that emotional abuse was predictive of both ideations alone and active/passive suicide attempts is less reported in the child abuse literature, perhaps in part because the effects of childhood psychological maltreatment is less investigated in general (Bryant & Range, 1995; Mullen, Martin, Anderson, Romans, & Herbison, 1996). Although the reasons for this relationship were not examined in the current study, emotional abuse has been especially linked to depression, low self-esteem, and hopelessness in a number of studies (e.g., Briere & Runtz, 1988; Gross & Keller, 1992), which may lead both to the rumination and self-castigation seen in suicidal ideation, as well as motivating self-destructiveness.

As opposed to the childhood maltreatment findings, adult experiences of physical or sexual assault were not related to suicidal ideation or active or passive attempts in this study. To some extent, this accords with the literature on the effects of childhood versus adult victimization, wherein the former is typically seen as even more psychologically injurious than the latter (e.g., Briere & Rickards, 2007; Ogle, Rubin, & Siegler, 2013). This may be especially true for chronically suicidal individuals, whose first suicidal thoughts or behaviors often occur relatively proximal to their childhood abuse (Briere & Runtz, 1986). This does not mean that suicide attempts never arise from adult trauma; clearly, extreme life events, such as disasters, loss of people or financial well-being, or especially horrendous adult traumas can produce suicidality (e.g., Afifi et al., 2009; Bryan et al., 2013). The current data do,

however, highlight the potential early etiology and chronicity of some suicidal thoughts or behaviors.

There are several aspects of the current study that bear consideration when interpreting its findings. First, because it involved a nonclinical, general population sample, this study may relate less directly to people whose suicidality occurs in the context of significant psychiatric comorbidities, as often is the case in clinical groups. Second, because passive suicide attempts do not involve behavior directly focused on ending life immediately (defined in Segen's [2012] Medical Dictionary as "The placing of oneself in a potentially fatal situation—e.g., crossing a busy street without looking—and not caring (actually hoping) that death occurs"), it might be argued that its inclusion in the present study unduly broadened the definition of suicide attempts. On the other hand, numerous clinicians and writers view passive suicidality as a serious phenomenon with potentially lethal outcomes (e.g., Simon & Hales, 2012; Van Orden et al., 2015). In the absence of empirical data bearing on this issue, we suggest that behavior at the level indexed in the current study ("Doing something dangerous because you hoped you might be killed") is a form of suicide attempt, albeit perhaps (but not necessarily) with a lower probability of lethal injury than a fully intentional suicide attempt. Additional research is clearly indicated in determining the relationship between active and passive attempts, including whether they are predicted by equivalent variables, including past victimization.

Finally, the present study was limited to the prediction of recent suicidality, that is, that which had occurred within 1 month of the survey. This is advantageous in the sense that the resultant findings are relevant to the immediate concerns of clinicians who are presented with a currently suicidal client. It contributes less to our understanding of lifetime risk of suicidal ideations or attempts, because any given participant in this study might have been involved in suicidal ideation or attempts in months prior to the last one, and not be identified as such in this study. In addition, this focus on immediate suicidality in the general population reduced the statistical power of our prediction of passive or active suicide attempts, because recent attempts in nonclinical samples appear to be relatively rare (2% in the current study). Yet, even with low power, statistically significant results were found for this variable, suggesting the strength of the relationship between childhood victimization and later suicidal behavior.

The clinical implications of these results are several. First, the relationship between child abuse and suicide attempts found in this study reinforces the need to evaluate suicidal individuals for prior abuse experiences, and to assess clinically presenting abuse survivors for suicidality (Briere & Scott, 2014). In the first instance, information that a given suicidal person has a

history of childhood maltreatment may encourage the clinician to consider one of several empirically based therapies currently available for adolescents and adults abused as children (e.g., Cloitre, Cohen, & Koenen, 2006; Lanktree et al., 2012; see a review by Courtois & Ford, 2012)—some of which take suicidality directly into account (e.g., Linehan, 1993). Such treatments may reduce suicidality above-and-beyond approaches that focus solely on cognitive distortions or depression. In a similar vein, clinicians treating abuse survivors should be aware of the link between childhood maltreatment and suicidality, both to address potential lethality that might otherwise be overlooked, and to encourage the therapist to utilize treatments that have been shown to be helpful in reducing life-threatening behavior (e.g., Bongar & Sullivan, 2013; Weinberg et al., 2010; Worchel & Gearing, 2010).

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