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Original article

More than words: The association of childhood emotional abuse and suicidal behavior

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A B S T R A C T

Background: All types of abuse and neglect have been associated with suicide attempts. However, the association between the level of each type of childhood trauma and suicidal behavior severity (including the progression from ideation to attempts), adjusting for their co-occurrence, is not yet clear.
Methods: We used a cross-sectional web-based survey collected from the Brazilian Internet Study on Temperament and Psychopathology (BRAINSTEP) to investigate the isolated effects of each type of childhood trauma on suicidal behavior severity. The sample consisted of 71,429 self-selected volunteers assessed with the Childhood Trauma Questionnaire (CTQ) and the following key question: "Have you ever thought about or attempted to kill yourself?" (Suicidal Behavior Questionnaire, SBQ-17).
Results: After adjusting for demographic variables, and childhood trauma subtypes, severe emotional abuse (EA) was associated with suicidal ideation and attempts, mainly for serious suicide attempts (OR, 22.71; 95% CI, 2.32–222.05). We found associations of smaller magnitude for severe emotional neglect (EN) with serious suicide attempts, and for severe physical neglect (PN) and sexual abuse (SA) with attempts without really meaning to die. No meaningful trend for physical abuse (PA) was found. Using as reference group ideators, EA was associated with serious suicide attempts, with a peak at the 95th percentile (OR, 4.39; 95% CI, 2.04–9.41). We found associations of smaller magnitude for PN and SA, and no meaningful trend for EN and PA.
Conclusions: Suicidal behavior was strongly associated with emotional abuse in childhood, even when compared with ideators, suggesting that it is a relevant factor for the progression from ideation to attempts.

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1. Introduction

Suicide accounted for 1.4% of all deaths worldwide in 2012, making it the second leading cause of death among young adults globally [1]. For each suicide death, there are about 10 to 40 suicide attempts [2,3], which is a strong risk factor for further attempts [4–6]. Suicidal ideation and plans are important precursors of suicide and had a globally lifetime prevalence of 9.2% and 3.1%, respectively [7]. Therefore, others types of suicidal behavior are also a major cause of public health concern [8].

Most people who consider suicide do not go on to make a suicide attempt [9]. Anyway, one of the strongest predictors of incident suicide attempts was previous suicidal ideation. Regarding the course of suicidal ideation, Have et al. found that, among those with baseline suicidal ideation, 31.3% still endorsed these thoughts and 7.4% reported having made a suicide attempt 2 years later [10]. Most often cited risk factors for suicide – including depression, hopelessness, most mental disorders, and impulsivity – predict suicidal ideation but do not distinguish those who have made suicide attempts from those who have experienced ideation without attempts [9]. Three theories of suicide propose that the main factors causing suicide ideation are different from those who cause the progression to attempts [11]. Some factors have been identified as key points: acquired capability for suicide [12]; impulsivity, planning, access to means, imitation, volitional moderators [13]; dispositional (genetic), acquired (habituation), and practical contributors (knowledge of and access to lethal means) for increased capacity for suicide [14].

Research, focused only on suicide deaths, has two serious methodological problems: the need for large longitudinal studies due to low frequency of the outcome and the limited information in psychological autopsy studies [11,15]. Thus, the study of suicidal behavior is important alternative to understand and prevent this severe outcome [12].

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Childhood maltreatment (CM) is a serious public health problem worldwide [16,17], affecting up to 33% of the population [18]. The main forms of CM (emotional, physical and sexual) are important risk factors for various disorders (e.g., depression, drug abuse, chronic pain), with high impact on the global burden of disease [17,19]. For instance, adverse childhood experiences contribute up to 67% of the risk for lifetime suicide attempts [20].

Two systematic reviews about types of CM and long-term health consequences have shown that all types of abuse and neglect were associated with suicide attempts [17,19]. However, most studies have not comprehensively adjusted for key confounders, including the co-occurrence of more than one type of maltreatment [17,19,21], since physical abuse, emotional abuse and emotional negligence frequently occur together [22]. Also, maltreatment has been typically considered a dichotomous measure, i.e., classifying subjects as maltreated or not [16,17,23]. As a result, it is not yet clear how the different levels and types of childhood trauma are associated to suicidal behavior.

Using a large web-based sample in which many well-known risk factors for suicidal behavior were replicated [5], we evaluated how each type of childhood maltreatment was associated with suicidal behavior severity (ideation, plan, attempt), adjusting for their co-occurrence. Moreover, in line with the ideation-to-action framework [9], we also compared attempters to ideators to analyze the association of each type of CM to the progression from suicide ideation to plans and attempts. We hypothesized that the emotional abuse would be more associated with suicidal behavior severity than the physical forms of maltreatment (abuse and neglect) based on our previous results on the association of child maltreatment with personality traits [24].

2. Methods

2.1. Data collection

The Brazilian Internet Study on Temperament and Psychopathology (BRAINSTEP) is a large web-survey aimed to study the relationship between several psychological, behavioral and psychopathological measures, and described in detail elsewhere [25]. The data for this study were collected from self-selected (a type of convenience sample) volunteers by the research platform on the Internet site www.temperamento.com.br, which was broadcast on national TV news programs and newspapers. This website is non-commercial and advertisement-free. We chose this approach because technology facilitates the reporting of behaviors that are sensitive and stigmatized [26], which is the case for suicidal behavior [8] and childhood trauma.

2.2. Sample

Volunteers answered the instruments anonymously on the Internet from January 15, 2011 to December 31, 2014. Subjects completed standardized questionnaires and scales, which included demographic data, lifetime suicidal behavior (Suicide Behavior Questionnaire-17; SDQ-17) [27,28], and the assessment of childhood abuse and negligence (Childhood Trauma Questionnaire; CTQ) [29].

To ensure and check for validity of the data, we used the following strategies: (1) at the end of the first page on demographics the question “Do you commit to answering the questions honestly?” to increase the validity of answers [30]; questions checking for attention within some of the instruments throughout the system (e.g., “Please mark the option ‘sometimes’ in this question”); (3) at the end of each phase, there was one direct question on level of sincerity and another on attention. Only those who committed to be honest in their answers stated being sincere and serious throughout the study and had correct answers in the attention validity items were included in the analyses. After validity checks (17.7% of the initial sample were excluded) and the exclusion of those < 18 (for ethical reasons) and > 50 years old (because of the influence of menopausal status on major depression on women [31], and of potential differences between Internet users and non-users), the final sample consisted of 71,429 volunteers.

All participants gave their electronic informed consent before completing the questionnaires. This form was elaborated to fulfil the requirements of the Brazil legislation (Resolution 196/1996) and the Code of Ethics of the World Medical Association (Declaration of Helsinki). Their participation was voluntary and they could cancel their participation at any moment without justification. The Institutional Review Board from PUCRS University approved the study protocol.

2.3. Measures

2.3.1. Suicidal behavior

Lifetime suicidal behavior was assessed by using the first item of the Suicidal Behavior Questionnaire (SBQ-17) [27,28], which evaluated suicidal behavior with the following key question: “Have you ever thought about or attempted to kill yourself?” There were seven possible answers: (1) “No”, (2) “It was just a passing thought.”, (3) “I briefly considered it, but not seriously.”, (4) “I thought about it and was somewhat serious.”, (5) “I had a plan for killing myself which I thought would work, and seriously considered it.”, (6) “I attempted to kill myself, but I do not think I really meant to die.” and (7) “I attempted to kill myself, and I think I really hoped to die”. We adapted these answers to five new categories of suicidal behavior severity: (1) “No ideation”, (2) and (3) to “Ideation”, (4) and (5) to “Serious ideation”, (6) to “Attempt” and (7) to “Serious attempt”.

2.3.2. Childhood maltreatment

Childhood maltreatment was assessed with the Portuguese version of the Childhood Trauma Questionnaire (CTQ) [29], which is the most widely used instrument to screen for abuse and neglect that occurred during childhood. [22,29,32]. This instrument is composed by a 25-item questionnaire (five questions for each trauma domain) for which participants were required to rate the frequency of traumatic events in a 5-point Likert-type. The CTQ assesses emotional abuse (EA), physical abuse (PA), sexual abuse (SA), emotional neglect (EN), and physical neglect (PN). Emotional abuse refers to verbal assaults on a child’s sense of worth or well-being, or any humiliating, demeaning, or threatening behaviour directed toward a child by an older person (e.g., People in my family called me things like “stupid”, “lazy”, or “ugly”). Physical abuse refers to bodily assaults on a child by an older person that pose a risk of, or result in, injury (e.g., “I got hit so hard by someone in my family that I had to see a doctor or go to the hospital”). Sexual abuse refers to sexual contact or conduct between a child and an older person, including explicit coercion (e.g., “Someone tried to touch me in a sexual way, or tried to make me touch them”). Emotional neglect refers to the failure of caretakers to provide basic psychological and emotional needs, such as love, encouragement, belonging and support (e.g., “There was someone in my family who helped me feel that I was important or special”). Physical neglect refers to failure to provide basic physical needs, including food, shelter, and safety (e.g., “I didn’t have enough to eat). Each type of trauma scale is presented in scale ranging from 5 to 25” [33].

The total trauma (TT) score was calculated by adding the scores of specific traumas, scoring from 25 to 125. The categorical severity

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