



Research paper

Non-violent and violent forms of childhood abuse in the prediction of suicide attempts: Direct or indirect effects through psychiatric disorders?

Natalie J. Sachs-Ericsson^{a,*}, Ian H. Stanley^a, Julia L. Sheffler^a, Edward Selby^b, Thomas E. Joiner^a

^a Department of Psychology, Florida State University, United States

^b Department of Psychology, Rutgers University, United States

ARTICLE INFO

Keywords:

Adverse childhood experiences
Abuse
Psychiatric disorders
Suicide attempt

ABSTRACT

Background: Childhood abuse is linked to suicide. Potential pathways include the increased risk for the development of psychiatric disorders and the contribution of abuse to suicide capability. The current study compared the effects of childhood non-violent and violent abuse in the prediction of suicide attempts, and examined the potential mediated effects of psychiatric disorders.

Methods: Data from the National Comorbidity Surveys were obtained. At baseline, assessments of childhood non-violent abuse (e.g., parental verbal abuse) and violent abuse (e.g., parental physical abuse, relative rape) were obtained. We also assessed for other adverse childhood experiences, baseline suicidal behaviors, and psychiatric disorders. At the ten-year follow-up, we assessed for psychiatric disorders and suicide attempts that had occurred over time.

Results: Both non-violent and violent abuse predicted attempts, though participants experiencing violent abuse had significantly higher rates. Bootstrapped mediation analyses determined that the influence of non-violent abuse on suicide attempts was indirect, and exerted its influence through the psychiatric disorders that occurred during the ten-year follow-up.

Limitations: The study relied on retrospective reports of childhood abuse. Further, we could not clearly determine the temporal order of the psychiatric disorders and suicide attempts occurring over follow-up.

Conclusion: Different mechanisms may underlie the pathway between violent and non-violent abuse and suicide attempts. Verbal abuse may lead to negative cognitive styles and psychiatric disorders associated with suicidality; violent abuse may contribute to the capacity for suicide. Interventions may need to be specifically tailored to meet the distinct needs of individuals who have experienced past childhood abuse.

1. Introduction

Suicide is a leading cause of death worldwide (World Health Organization [WHO], 2014). Adverse childhood experiences (ACE), and in particular childhood verbal/emotional abuse, physical abuse, and sexual abuse have been identified as having both a direct and indirect influence on the development of suicidal behaviors (Short and Nemeroff, 2014). Several pathways linking childhood abuse to suicidal behaviors have been proposed, including biological, psychological, and behavioral mechanisms (see Sachs-Ericsson et al. (2016)). The actual mechanisms underlying the associations are likely quite complex and may differ for violent (e.g., physical abuse and rape) and non-violent abuse (verbal/emotional abuse) (Gibb et al., 2001a, 2001b; Joiner et al., 2007; Sachs-Ericsson et al., 2006). Further, childhood abuse perpetrated by a family member, compared to a non-family member, is

associated with the greater risk for suicide attempts (Brezo et al., 2008). Better understanding of the mechanisms linking child abuse to suicidal behaviors may help to clarify etiological factors and contribute to both prevention and treatment efforts.

Violent childhood abuse is strongly associated with suicidal behaviors. For example, exposure to violent childhood abuse (e.g., physical, sexual abuse, and domestic violence) accounted for a substantial proportion of variance in predicting suicide attempts among women (50%) and men (33%) (Affi et al., 2008). Several studies have documented a strong association between sexual abuse and suicide risk (see Short and Nemeroff (2014)). In a meta-analysis, Devries et al. (2014) found childhood sexual abuse to be associated with suicide attempts even when a range of different confounders were controlled. Norman et al. (2012) found violent forms of abuse to have a stronger association with suicide attempts compared to non-violent abuse.

* Corresponding author.

E-mail address: sachs@psy.fsu.edu (N.J. Sachs-Ericsson).

Joiner et al. (2007) proposed a theoretical explanation as to why violent forms of childhood abuse have a stronger association with suicidal behaviors, compared to non-violent abuse. Specifically, they contend that the extent to which the abuse is experienced as violent or painful contributes to habituation and tolerance of pain. The interpersonal theory of suicide (Joiner, 2005; Van Orden et al., 2010) asserts that an individual will not die by suicide unless s/he has both the desire to die by suicide (through thwarted belongingness and feelings of burdensomeness), and the ability or capacity to do so (i.e., capability for suicide). Thus, the desire for suicide is not sufficient for a lethal attempt to occur—an individual must also have the capability for suicide. Through the process of repeatedly experiencing painful events, such as abuse, one accumulates such capacity. In a test of this theory, Joiner and colleagues (Joiner et al., 2007) found violent forms of childhood abuse (physical and rape) to have a stronger association with suicide attempts than non-violent abuse (e.g., verbal abuse, molestation).

Researchers have also documented an association between childhood non-violent verbal abuse and suicide attempts (Norman et al., 2012). Gibb et al. (2001a, 2001b) and Sachs-Ericsson et al. (2016) proposed that childhood verbal abuse may confer risk for suicidal behaviors indirectly through the development of maladaptive cognitive styles and negative self-schemas. When childhood abuse is verbal—rather than sexual or physical—the child is more likely to develop negative inferential styles (Gibb et al., 2003a) because negative self-schemas are directly supplied by the abuser (e.g., “you are worthless”). Such maladaptive cognitive processes are strongly linked to the development of depression and anxiety disorders (Gibb et al., 2004b, 2003b, 2001a, 2001b). Studies have demonstrated a link between childhood verbal abuse, the development of negative self-schemas, and an increase in psychiatric disorders (Alloy et al., 2006; Crossfield et al., 2002). Further studies have demonstrated that negative cognitive styles mediate the association between verbal abuse and suicidal ideation (Gibb et al., 2001b).

2. Abuse, psychiatric disorders, and suicidality

One established pathway between childhood abuse and suicidal behavior is through psychiatric disorders. Childhood abuse experiences—both violent and non-violent—are powerful risk factors for the development of mental health problems. Affi et al. (2008) found that the estimated attributable fractions for psychiatric disorders related to having experienced any violent form of childhood abuse (sexual, physical abuse, domestic violence) ranged from 22% to 32% among women and 20% to 24% among men. In a meta-analysis, Norman et al. (2012) found verbally abused individuals to have a three-fold higher risk of developing depression or anxiety than non-abused individuals. In turn, these psychiatric disorders are strongly associated with an increased risk of suicidal behaviors (Bertolote et al., 2004; Nock et al., 2010).

Researchers have examined the mediating role of psychiatric disorders in the abuse-suicide attempt association. Dube et al. (2001) found that illicit drug use, depressed affect, and alcoholism partially mediated the relationship between ACEs (e.g., verbal, physical, and sexual abuse; parental substance abuse, mental illness, incarceration; domestic violence, parental loss) and suicide attempts. In a prospective school-based sample, researchers found that disruptiveness and anxiousness partially accounted for the ACEs-suicide attempt association (Wanner et al., 2012). In a large prospective study of children from Africa, researchers found exposure to ACEs (e.g., parental illness/death, verbal abuse, physical abuse, sexual abuse and community violence) predicted later suicidality (suicide attempts, planning, and ideation); further, suicide risk was mediated by mental health and substance disorders (Cluver et al., 2015).

3. The current study

Data for the current study were obtained from the two waves of the National Comorbidity Surveys (NCS-1 [baseline] and NCS-2 [10-year follow-up]). Controlling for several baseline risk factors, we examined the effects of retrospective reports of childhood violent abuse (parental physical abuse or rape by a family member) and non-violent childhood abuse (parental verbal abuse) in the prediction of suicide attempts over a ten-year period. Whereas we anticipated both violent and non-violent abuse to predict suicide attempts, we expected the association to be stronger for violent abuse. Further, we expected the association between non-violent verbal abuse and suicide attempts to be indirect and mediated by psychiatric disorders. Whereas there have been a few studies comparing the impact of violent and non-violent childhood abuse on suicidal behaviors, this is one of the few longitudinal studies examining differential mechanisms linking abuse subtypes (i.e., violent versus non-violent) to suicide attempts. Moreover, the present study is incremental in its use of the interpersonal theory of suicide (Joiner, 2005) to explain *why* the relationship between abuse subtypes and suicidal behaviors differ.

4. Method

4.1. Internal Review Board (IRB)

Approval for the secondary data analyses of the NCS data sets was obtained from the University's IRB of the first author's University's affiliation.

5. Participants

5.1. NCS-1

The baseline NCS-1 is a nationwide epidemiological study of over 8000 respondents (Kessler, 1994). A representative sub-sample of participants (N=5877; aged 15–59, mean=33.2, SD=10.7) were interviewed with the entire psychosocial survey which was designed to assess the prevalence of DSM III-R (American Psychiatric Association [APA], 1987) psychiatric disorders.

5.2. NCS-2

NCS-2 is a 10-year follow-up that included 62% of the original NCS-1 respondents (Kessler, 2013). Of the 5463 respondents successfully traced, 166 were deceased and 5001 were re-interviewed, for a conditional response rate of 87.6%. Pertinent to the current study, and as reported by Borges et al. (2008), there was no difference between NCS-2 respondents and non-respondents in their reports of suicide-related variables at the baseline assessment ($\chi^2/2=7.08$, $p=.313$).

6. NCS-1 Baseline

6.1. Procedures

Interviews were conducted by highly trained and closely supervised interviewers. To improve accuracy, there was a life review section at the beginning of the interview. Participants were provided with instructions designed to improve recall (Kessler et al., 2000) and validity of the self-reported abuse items (Sachs-Ericsson et al., 2005).

6.2. Demographics

Participants completed a demographic questionnaire to assess age, sex, race, and education.

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