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Assessing Suicidality in Adults: Integrating Childhood Trauma as a Major Risk Factor

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Can knowing whether an adult client was abused as a child assist psychologists when assessing suicidality? Reviewing the files of 200 outpatients revealed, in keeping with previous studies, that child abuse was related not only to previous psychiatric admissions and younger age at first treatment and first admission, but also to past and present suicidality. Current suicidality was predicted better by child sexual abuse (experienced on average 20 years previously) than by a current diagnosis of depression. Evidence that abuse histories are not routinely taken, and recommendations for why, and how, taking abuse histories should be integrated into suicide assessment and treatment, are presented.

When confronted with the often anxiety-provoking task of assessing suicidality, psychologists are, for good reason, usually advised to focus on the current situation. With the obvious exception of previous suicide attempts, past events can appear to be of secondary importance. When asked to identify reasons for sometimes not taking an abuse history, psychologists and psychiatrists alike most commonly cited "more immediate needs and concerns to deal with" (Young, Read, Barker-Collo, & Harrison, 2001, p. 409). There is no more immediate concern than the possibility of suicide. This article, however, presents data suggesting that failure to be aware of an abuse history may greatly effect the accuracy of suicide assessments with adult clients.

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Child Abuse and Psychopathology in Adulthood

Inpatients and outpatients, male and female, report child sexual and physical abuse at significantly higher rates than the general population (Goodman, Rosenberg, Mueser, & Drake, 1997; Jacobson & Richardson, 1987; Lipschitz et al., 1996; Read, 1997; Wurr & Partridge, 1996). Compared with nonabused patients, abused patients develop symptoms and enter the psychiatric system earlier, have more frequent and longer hospitalizations, and are more likely to receive psychotropic medication (Briere, Woo, McRae, Foltz, & Sitzman, 1997; Goff, Brotman, Kindlon, Waites, & Amico, 1991; Pettigrew & Burcham, 1997; Read, 1998; Sansonnet-Hayden, Haley, Marriage, & Fine, 1987).

Numerous studies (including many controlling for mediating variables such as parental substance abuse or psychopathology) have demonstrated relationships between childhood abuse and adult disorders, many of which are highly correlated with suicidality, including the following: depression, anxiety disorders, dissociative disorders, substance abuse, eating disorders, personality disorders, and posttraumatic stress disorder (Banyard, 1999; Fleming, Mullen, Sibthorpe, & Bammer, 1999; Kendler et al., 2000; Mullen, Martin, Anderson, Romans, & Herbison, 1993), as well as schizophrenia (Briere et al., 1997; Read, 1997; Read & Argyle,

1999; Ross, Anderson, & Clark, 1994; Sansonnet-Hayden et al., 1987).

Child Abuse and Suicidality

Suicidality in adults has been found to be related to child abuse even after controlling for potentially mediating variables measuring childhood disadvantage and family dysfunction (Fergusson, Horwood, & Lynskey, 1996; Molnar, Shade, Kral, Booth, & Watters, 1998; Mullen et al., 1993; van der Kolk, Perry, & Herman, 1991). A review of studies of the relationship between child abuse and suicidality in adolescence and adulthood conducted between 1988 and 1998 (Santa Mina & Gallop, 1998) reported that all 21 studies found a significant relationship between child abuse and either suicide attempts or suicidal ideation (or both).

In an additional study of adult women presenting to a psychiatric emergency room, Briere et al. (1997) found that after controlling for "demographic variables, most of which also predict victimization and/or psychiatric outcome variables" (p. 99), childhood sexual abuse (CSA) was significantly related to both suicide attempts ($p = .001$) and suicidal ideation ($p = .026$). Childhood physical abuse (CPA) was also related to both suicide attempts ($p = .043$) and suicidal ideation ($p = .002$).

A recent study of adolescent psychiatric inpatients (Lipschitz et al., 1999) found that CSA was related both to previous suicide attempts ($p = .01$) and to suicidal ideation in the past week ($p = .003$). Although both suicidal attempters and those with high current suicidal ideation were also significantly more likely to have experienced CPA, the only two forms of abuse that remained significant after multiple regression analyses were CSA and emotional neglect. This is consistent with other studies that have found that CSA is even more strongly related than CPA to suicidality (Brown & Anderson, 1991; Kaplan, Asnis, Lipschitz, & Chorney, 1995; van der Kolk et al., 1991), although other studies have found little or no difference in the strengths of the relationships (Molnar et al., 1998; Read, 1998).

Suicide Assessment

There have been many valuable attempts to summarize the suicide literature so as to guide professionals when assessing level of risk. Some provide helpful checklists or acronyms. For instance, the SAD PERSONS Scale (Patterson, Dohn, Bird, & Patterson, 1983) covered most of the risk factors identified by subsequent reviewers when listing Sex, Age, Depression (especially hopelessness), Previous attempts, Ethanol (alcohol and drug abuse), Rational thinking loss, Social support lacking, Organized plan, and Sickness. A more recent list added ethnicity, hospital discharge/apparent improvement, and recent losses (including unemployment), as well as expanding the diagnostic risk factors beyond depression to schizophrenia and panic disorder (Sommers-Flanagan & Sommers-Flanagan, 1995).

Despite the literature demonstrating its powerful relationship with adult suicidality, it appears that child abuse is, with some recent rare exceptions (e.g., Hudson & Ward, 2000; Joiner, Walker, Rudd, & Jobes, 1999) rarely mentioned in suicide assessment guidelines. Recent recommendations for estimating and managing suicidal emergencies (Kleespies, Deleppo, Gallagher, & Niles, 1999), for instance, focus predominantly on "diagnosis-specific risk factors," documenting the relationship of suicidality to major depression, substance abuse, schizophrenia, posttraumatic stress disorder (combat related), and borderline or antisocial personality disorders. Although it is acknowledged that child abuse "may play an important role in the development of suicidal behavior in adolescents" (Kleespies et al., 1999, p. 458), none of the studies reviewed by Santa Mina and Gallop (1998) that document the relationship between child abuse and suicidality in adults are cited, creating the impression that abuse history is not important in suicide assessments with adults.

Joiner et al. (1999) prioritized two primary domains for suicide assessment: current suicidal symptoms (especially a "resolved plans and preparation factor") and previous suicide attempts (especially multiple). In contrast to Kleespies et al. (1999), symptomatology and diagnoses were included as one of five secondary domains that "provide a context in which to interpret these two important sources of clinical data" (Joiner et al., 1999, p. 449). Child abuse is clearly identified by these reviewers in two of these five secondary domains: "precipitant stressors"—focusing on recent events and therefore of concern when assessing suicidality in children or adolescents—and, significantly, "other predispositions"—in which the relationship between "particularly traumatic life events (e.g., sexual and physical abuse) and suicide attempt" (Joiner et al., 1999, p. 450) is properly acknowledged, without implication that this is of relevance only to adolescents.

In their equation for combining the seven domains, the presence of any one risk factor (e.g., a history of child abuse) is sufficient to elevate a client with "moderate-to-severe symptoms of the resolved plans and preparation factor" from moderate suicide risk to severe suicide risk. Therefore, unlike many previous suicide assessment models, the taking of an abuse history is seen as integral for such an assessment.

Nevertheless, the possibility that many psychologists see negative life events as relatively unimportant when conducting suicide assessments is substantiated by a recent survey of 256 U.S. psychologists (Peruzzi & Bongar, 1999). Of 48 risk factors ranked from 1 (*unimportant*) to 9 (*critical*) when assessing suicidality in a depressed client, the four factors scoring above 8 were the following: medical seriousness of previous attempts, history of attempts, acute suicidal ideation, and severe hopelessness. Acute life stresses was rated 6.41 (*moderate importance*). The fact that the pool of items, drawn from previous reviews of the literature, had no reference to abuse or violence—past, recent, or ongoing—is further testimony to the possibility that researchers and clinicians alike may benefit from paying greater attention to the value of being aware of clients' abuse histories when conducting suicide assessments.

A Study Demonstrating the Need to Know About Abuse When Assessing Suicide Risk

The files of 200 clients, 114 women and 86 men, consecutively treated at a New Zealand Community Mental Health Centre (CMHC) were reviewed. Their mean age was 36.6 years ($SD = 12.32$), ranging from 18 to 69. One hundred and forty-four were of European descent, 21 were Maori, 12 were Pacific Islanders, 19 were classified as "Other," and in four cases ethnicity was not recorded. Their most common diagnoses were depression (85), schizophrenia (28), substance abuse (20), bipolar disorder (15),

personality disorder (10), and anxiety disorder (9). The mean length of CMHC treatment was 150.6 days (SD = 67.77).

Disclosure of CSA (n = 40) or CPA (n = 34) included disclosures made and recorded during the current treatment and those made previously but recorded in the file. The cutoff for childhood abuse was 16 years of age inclusive. In the statistical analyses, the abuse categories were not mutually exclusive. Participants were grouped on the basis of presence versus absence of CSA and presence versus absence of CPA. Thus, some participants in the *not-CSA group* reported CPA and vice versa (see Tables 1 and 2). Similarly, those subjected to both forms of abuse—the *CSA and CPA group*—were analyzed in comparison to those experiencing either one or neither of CSA or CPA.

Previous suicide attempts were noted (n = 62). Current suicide risk was categorized as high (n = 65) if (a) there had been a very recent suicide attempt (the reason for referral to the CMHC), (b) the client was stated to be currently suicidal either on the "hazard sheet" or in the initial assessment notes, or (c) both. Four clients who were not acutely suicidal at assessment but who became so during treatment at the CMHC were also categorized as being at current high suicide risk, producing a total of 69.

Previous Suicide Attempts

Table 1 shows that clients who reported at least one form of child abuse (CSA or CPA) were more likely to have attempted suicide, $\chi^2(1, N = 200) = 13.45$, $p < .001$, than those who reported neither form of abuse. Participants who reported CSA were more likely to have attempted suicide, $\chi^2(1, N = 200)$ 11.70, $p < .001$, than those who did not report CSA. Participants reporting CPA were more likely to have attempted suicide, $\chi^2(1, N = 200) = 6.16$, $p < .05$) than those not reporting CPA. Those reporting both forms of abuse (CSA and CPA) were more likely to have attempted suicide than those reporting only one form of abuse or neither, $\chi^2(1, N = 200) = 5.91$, $p < .05$.

Table 1
Relationships Between Types of Abuse and Suicidality

Type of abuse	N or n	Previous suicide attempts	Current high suicide risk
Total sample	200	62 (31)	69 (35)
CSA or CPA	60	32 (53)***	28 (47)**
Nonabused	140	37 (26)	34 (24)
CSA	40	23 (58)***	20 (50)**
Not CSA	160	46 (29)	42 (26)
CPA	34	18 (53)*	16 (47)*
Not CPA	166	51 (31)	46 (28)
CSA and CPA	14	9 (64)*	8 (57)*
One or neither type of abuse	186	60 (32)	54 (29)

Note. Numbers in parentheses represent percentage of the total sample or subgroup. CSA = childhood sexual abuse; CPA = childhood physical abuse. * $p < .05$. ** $p < .01$. *** $p < .001$, χ^2 coefficients.

Table 2
Relationships Between Types of Abuse and Previous Treatment and Admissions

Type of abuse	N or n	Any previous admission (N = 200)	Age at first treatment (n = 170)[a]	Age at first admission (n = 77)[b]
Total sample	200	84 (42)	28.6	27.5
CSA or CPA	60	33 (55)*	24.2***	24.7*
Nonabused	140	51 (36)	30.6	29.5
CSA	40	23 (58)*	21.5***	23.9*
Not CSA	160	61 (38)	30.5	28.9
CPA	34	20 (59)*	26.3	25.7
Not CPA	166	64 (39)	29.1	28.1
CSA and CPA	14	10 (71)*	21.7*	25.0
One or neither type of abuse	186	74 (40)	29.1	27.8

Note. Numbers in parentheses represent percentage of total sample or subgroup. CSA = childhood sexual abuse; CPA = childhood physical abuse.
[a] Data were unavailable for remaining 30 participants.
[b] Data were unavailable for 7 of the 84 participants who had been admitted.
* $p < .05$. *** $p < .001$, χ^2 coefficients for previous admissions, two-tailed t tests for ages.

Current Suicide Risk

Table 1 shows that current suicide risk was related to all four child abuse categories, with CSA maintaining a more significant relationship to current suicidality, $\chi^2(1, N = 200) = 8.44$, $p < .01$, than CPA, $\chi^2(1, N = 200) = 4.94$, $p < .05$. The relationship between being abused (CSA or CPA) and current suicidality, $\chi^2(1, N = 200) = 9.84$, $p < .01$, was somewhat weaker than its relationship to previous suicide attempts $\chi^2(1, N = 200) = 13.45$, $p < .001$.

To compare the abilities of child abuse and a current diagnosis of depression to predict current suicidality, a hierarchical linear regression was performed. In the first analysis, current risk of suicide was the dependant variable, and CSA and CPA were predictors. Overall, prediction of current suicidality from these predictors was significant: $R^2 = .055$, $F(2, 197) = 5.68$, $p < .005$. A history of CSA contributed significantly to prediction of suicidality ($p = .013$), but CPA did not ($p = .110$).

In the second analysis, being diagnosed as depressed was added into the equation to ascertain the extent to which current depression added to the prediction of current suicidality. The increase in prediction (to $R^2 = .064$) was not significant ($p = .157$). Only CSA contributed significantly to prediction of current suicidality ($p = .010$).

However, child abuse is also a predictor of abuse in adulthood (Darves-Bornoz, Lemperiere, Degiovanni, & Gaillard, 1995). In the current study, for instance, clients who reported CSA were 3.5 times more likely to have been sexually assaulted as adults (18% vs. 5%) than those who did not report CSA, $\chi^2(1, N = 200) = 7.21$, $p < .01$. Furthermore, abuse in adulthood is related to suicidality (Kaplan et al., 1995). Therefore, it was necessary to

determine whether more recent traumatic events could improve prediction of current suicidality. Consequently, adult sexual assaults (ASA) and adult physical assaults (APA) were added to the regression equation. The increase in prediction (to $R^2 = .071$) was not significant ($p = .51$). Of the five variables in the final equation (CSA, CPA, depression, ASA, and APA), the only one significantly contributing to the prediction of current suicidality was CSA ($p = .018$).

Previous Treatment and Admissions

Table 2 shows that members of all four abuse categories were significantly more likely ($p < .05$) to have had previous psychiatric admissions than nonmembers of each category. Fifty-five percent of those experiencing at least one form of child abuse (CSA or CPA), compared with 36% of nonabused clients, had been admitted, $\chi^2(1, N = 200) = 5.95$, $p < .05$. Reporting both physical and sexual abuse (CSA and CPA) was related to a higher probability of having been admitted (71%) than just one or neither form of abuse (40%), $\chi^2(1, N = 200) = 5.35$, $p < .05$.

Participants reporting either CSA or CPA were, on average, significantly younger ($M = 24.2$ years, $SD = 9.65$) than nonabused participants ($M = 30.6$ years, $SD = 11.75$) at time of first treatment, $F(1, 121) = 6.19$, $p < .001$. Participants reporting CSA were significantly younger ($M = 21.5$ years, $SD = 8.58$) at time of first treatment than those with no identified CSA ($M = 30.5$ years, $SD = 11.48$), $F(1, 69) = 8.60$, $p < .001$. Participants reporting CSA or CPA were significantly younger at first admission to hospital than those with no history of abuse, $F(1, 75) = 4.57$, $p < .05$. This relationship was significant for CSA, $F(1, 54) = 3.96$, $p < .05$, but not for CPA.

Methodological Limitations

As in most studies linking child abuse to adult sequelae years later, it was not possible to verify the reported abuse. Whether abuse histories are underestimated or overestimated by mental health staff is an ongoing debate (Good, 2000; Read & Argyle, 2000). Dill, Chu, Grob, and Eisen (1991) found that abuse disclosures by psychiatric patients were reliable and that "patients tend to underreport abuse histories rather than overreport them" (p. 168). Darves-Bornoz et al. (1995, p. 82) found that "The problem of incorrect allegations of sexual assaults was no different for schizophrenics than the general population." Herman and Schatzow (1987) found that 74% of adult patients' abuse disclosures were validated through other sources. In the current study, there was some form of corroborating evidence for 30 of the 40 CSA cases (75%), most commonly in the form of receiving counseling specifically for sexual abuse. (In New Zealand, sexual abuse counseling is provided by government-subsidized counselors, but only after the government has ruled that sexual abuse counseling is necessary.)

The prevalence rates for abuse in this study, although comparable to others based on chart review (Read & Fraser, 1998; Wurr & Partridge, 1996), are likely to be an underestimation. The proportion of child abuse identified in client files ranges from 0% to 30% of the child abuse discovered by researchers when surveying the same samples (Briere & Zaidi, 1989; Rose, Peabody, & Stratigeas, 1991; Wurr & Partridge). Thus, the positive relationship found between abuse and suicidality may be an underestimate of the strength of that relationship because the nonabused subgroup included clients who had been abused but whose abuse was not identified.

The degree of generalizability from this sample to users of public outpatient services beyond New Zealand is uncertain. Socioeconomic status (SES), for instance, was not ascertained. Nevertheless, in New Zealand, as elsewhere, lower SES groups would have been overrepresented because more affluent individuals have greater access to private services. The sample appears to be reasonably representative in terms of gender, age, and diagnostic categories.

Implications for Practice

Need for Abuse Histories to Be a Part of Routine Assessment Procedures

Previous studies (cited earlier) have, like the current study, found child abuse to be related to previous hospitalizations, younger age at first treatment or hospitalization, and suicidality. Thus, this study supports the existence of the relationship between having been abused as a child and a range of measures of severity of disturbance in adulthood. The current findings would appear to add weight, therefore, to the recommendation of many researchers and clinicians that the taking of abuse histories should be a routine part of assessment processes so as to ensure accurate formulation and appropriate treatment planning (Goodman et al., 1997; Jacobson & Richardson, 1987; Read & Fraser, 1998; Sansonnet-Hayden et al., 1987; Young et al., 2001). Evidence that this still may not be the case comes from the United States (Lipschitz et al., 1996; Rose et al., 1991), the United Kingdom (Lab, Feigenbaum, & de Silva, 2000; Wurr & Partridge, 1996), and New Zealand (Agar, 1998; Read & Fraser, 1998). Some clinicians seem particularly unlikely to ask two groups with particularly high suicide rates: men (Lab et al., 2000; Read & Fraser, 1998) and clients diagnosed as schizophrenic (Read & Fraser, 1998; Young et al., 2001).

Abuse Histories and Suicide Assessment

This study supports the relationship between child abuse and suicidality in adulthood. It also supports previous findings that although CPA is related to suicidality, CSA is even more strongly related. It is important to note that this relationship between CSA and current suicidality remained significant even in a regression analysis including sexual and physical abuse in adulthood. Thus, the relationship between CSA and suicidality in adulthood cannot be explained by the facts that APA and ASA are also related to suicidality and that APA and ASA are more common in those who have been abused as children. This finding that trauma may have an even greater psychological impact on children than on adults can be explained in terms of the plasticity of the brain in the early years of life and the consequent enduring disturbance to a range of neurological and biochemical functions caused by early trauma (Perry & Pollard, 1998). Alternatively, it can be understood in terms of early negative life events forming enduring cognitive styles such as external locus of control and hopelessness or attributions such as self-blame for the abuse itself (Barker-Collo, Melnyk, & McDonald-Miszczak, 2000).

However, what is particularly remarkable about the current study, and most informative to psychologists faced with suicidal clients, is the finding that CSA was more predictive of current suicidality than a current diagnosis of depression. Given that the abuse occurred on average more than 20 years ago (average age was 36.6 years and the cut-off age for CSA was 16), but the diagnoses of depression occurred at the same time as the suicide assessments, this finding seems even more noteworthy.

The relationship between depression and suicidality is almost tautological. Depression has been described as "the most common indicator and greatest predictor of suicide" (Peruzzi & Bongar, 1999, p. 576). Yet, statistically speaking it seems to be even more important to know whether clients have suffered CSA than whether they are depressed. How should psychologists incorporate this rather curious finding into their practice?

The current findings suggest that the absence of depression is not a satisfactory reason for not conducting a suicide assessment. It seems that for survivors of child abuse it is quite possible to be a high suicide risk without showing any diagnosable signs of depression. A psychosocial history with a full abuse history, therefore, places the psychologist in a good position from which to decide whether or not to conduct a suicide assessment. (The risk factor acronym SAD PERSONS can become SAD PERSONAS, with the added A representing abuse.)

Psychologists should acknowledge that child abuse is indeed a powerfully predictive factor for suicide in adulthood. This awareness needs to incorporate all forms of child abuse. Two studies have assessed the effects of childhood neglect on adult (van der Kolk et al., 1991) and adolescent (Lipschitz et al., 1999) suicidality and found it to be at least as predictive as CSA. "This implies that although childhood trauma contributes heavily to the initiation of self-destructive behavior, lack of secure attachments maintains it" (van der Kolk et al., 1991, p. 1669).

Awareness of the literature and the current findings should also be used when deciding whether to involve the family in suicide assessments. Recent suicide guidelines recommend the involvement of family members, without mentioning the need to check whether these individuals have abused the client (Joiner et al., 1999; Kleespies et al., 1999). Not all child abuse takes place within families, but knowing the client's abuse history enables the psychologist (in consultation with the client) to assess whether and, if so, how to involve family members.

Without having taken an abuse history, psychologists trying to estimate suicide risk in adults may seriously compromise their assessment. Young et al. (2001) found that the presence of more pressing concerns, such as suicide, is the most common reason for not taking abuse histories. It may well be that it is indeed too distressing, and unnecessary, to start asking about abuse at the point in time when it has just been established that the client is thinking quite often about suicide and has a plan as to how to kill him or herself. Ideally, therefore, a psychosocial history, including abuse, should be taken before asking about suicide ideation and plans.

Treating Suicidal Clients: Building the Therapeutic Relationship and Instilling Hope

Guidelines for managing suicidal emergencies (Kleespies et al., 1999) and for outpatient treatment of suicidality (Rudd, Joiner, Jobes, & King, 1999) both emphasize the centrality of the therapeutic relationship. Kleespies et al. (1999) also stressed that

> interventions depend on the etiology of the suicidal symptoms. . . . A treatment plan with achievable goals is developed to guide the process of recovery. Such a plan can in turn provide the patient with a sense of hope as improvement occurs. (p. 461)

Developing a shared understanding of the cause of feeling suicidal and discussing ways to address those causes may be, for some clients, a prerequisite for a therapeutic relationship. Lothian's (1998) survey of users of mental health services found that 67% had been abused but that only 20% had been asked about abuse during their assessment. Those who had been abused were particularly likely to be dissatisfied with their treatment. Although 69% of the abused clients believed that there was a connection between having been abused and their current mental health problems, only 17% thought their clinicians shared this belief, and 60% didn't know what their clinician thought about this. Perhaps, then, it is important to ask, "Why do you think you are feeling so bad that you want to kill yourself?" Whether the answer is about trauma, loss, or other explanations, the feeling for the client that the psychologist is interested in where it all began can build the therapeutic relationship while creating hope that the causes are understandable and treatable.

Attention might need to be paid, in suicidal clients who have been abused, to cognitions and attributions, with a particular focus on self-blame. It may not be necessary to wait until a client is feeling less suicidal before challenging the commonly held belief among adults who were abused as children that they were somehow responsible. It may sometimes contribute as much to keeping someone alive as the establishing and monitoring of safety plans.

Conclusion

The current findings, and previous studies, demonstrate that knowledge of abuse histories of adult clients will enhance the accuracy of suicide assessments. Taking an abuse history when severe suicidal risk has just been identified may be neither necessary nor advisable. Nevertheless, child abuse should certainly be included as a risk factor when determining whether or not to conduct a suicide assessment and should, wherever possible, be included in any equation used to estimate level of risk.

Knowing that a client was abused as a child may sometimes also enhance the effectiveness of the longer term treatment of suicidal clients through (a) the improved therapeutic relationship that can result from a shared understanding of the cause of feeling suicidal and (b) the instillation of hope that those issues can be addressed.

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