Childhood physical and sexual abuse and lifetime number of suicide attempts: A persistent and theoretically important relationship

Thomas E. Joiner Jr.*, Natalie J. Sachs-Ericsson, LaRicka R. Wingate, Jessica S. Brown, Michael D. Anestis, Edward A. Selby

Department of Psychology, Florida State University, Tallahassee, FL 32306-1270, USA

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Abstract

Background: Research to date has indicated that childhood abuse is associated with suicide, though little research has examined the unique contribution of specific types of abuse to suicidal behavior. We predict that childhood physical and violent sexual abuse will have a greater effect on suicide attempts than molestation and verbal abuse.

Methods: The National Comorbidity Survey data were used to test these predictions while controlling for a number of psychiatric and psychosocial variables.

Results: As expected, childhood physical and violent sexual abuse showed similar effects on lifetime suicide attempts, which were stronger than the effects of molestation and verbal abuse.

Limitations: This was a cross-sectional, retrospective study, so true causality cannot be shown. Some measurement limitations exist. Additionally, effect sizes were small but still significant.

Conclusions: While all forms of childhood abuse are troubling and create risk for future psychopathology and suicidality, the present study indicates that childhood physical and violent sexual abuse should be seen as greater risk factors for future suicide attempts than molestation and verbal abuse.

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Introduction

Abuse during childhood can result in a number of difficulties later in life, including increased risk for death by suicide. Previous research has demonstrated that a connection between childhood abuse and suicide exists (Glowinski et al., 2001; Roy, 2003, etc.), but few studies have examined the effects of different forms of childhood abuse in relation to later suicide attempts. Although, any form of abuse has the potential to have deleterious effects on an individual, it would seem that more severe forms of childhood abuse would infer...
greater risk for suicide upon those victims due to psychological and environmental consequences surrounding such severe abuse relative to less severe forms of abuse.

Past work has examined the link between childhood physical abuse and suicidal behavior, and most but not all affirm the connection. For example, when examining families of 67 adolescent victims of suicide in comparison to 67 demographically matched community controls. Brent et al. (1994) found that the suicide victims had higher rates of childhood physical abuse than the controls. Glowinski et al. (2001) interviewed over 3000 female adolescent twins, and found that childhood physical abuse was one of the factors most associated with a suicide attempt history. Roy (2003) studied 280 people with alcohol use disorders, and found that childhood physical abuse was associated with lifetime suicide attempts. McHolm, MacMillan, and Jamieson (2003) reported similar results in depressed women, as did Anderson, Tiro, Price, Bender, and Kaslow (2002) in low-income African-American women. Kaplan, Pelcovitz, Salzinger, Mandel, and Weiner (1997) did not find a difference in suicide histories between 99 abused and 99 non-abused white, middle class, suburban adolescents, though victims of intrafamilial sexual abuse were excluded from participating in the study.

Considerably less work has evaluated the unique contribution of a particular form of abuse, controlling for other forms, to suicidality. Among adults with alcohol use disorders, Roy (2003) reported that different forms of abuse each related to lifetime suicide attempts, with similar effect sizes, but the forms of abuse were not controlled for each other. Anderson et al. (2002) reported a similar pattern among low-income African-American women. By contrast, Soloff, Lynch, and Kelly (2002) studied women with borderline personality disorder, and found that childhood sexual abuse but not physical abuse was related to adult suicide attempts. Brown, Cohen, Johnson, and Smailes (1999) reported that various forms of childhood abuse were linked to later suicidal behavior among community participants, but that childhood sexual abuse showed the strongest independent link.

Controlling for the effects of forms of abuse on each other in predicting outcomes is important for at least two reasons. First, and more generally, it allows specificity regarding which form is most linked to outcomes. Forms of abuse often occur together as well as with other negative childhood events. For example, Felitti and colleagues (1998) found that when respondents experienced one childhood adversity, the probability of having experienced another was approximately 80%. Kessler (2002) argued that researchers often look at one childhood adversity, such as sexual abuse, and assume subsequent problems are related to that adversity, ignoring the possibility that sexual abuse often occurs within a cluster of other childhood difficulties that may themselves account for the subsequent problems. Similarly, Mullen, Martin, Anderson, Romans, and Herbison (1993) argued that childhood abuse may be just one of several elements that occur within a context of family problems, and these other elements may account for the relationship between abuse and negative life outcomes. Family characteristics associated with childhood abuse include parental psychopathology, family conflict, low social economic status, parental loss or absence, and parental divorce (Felitti et al., 1998; Fleming et al., 1997; Kenny & McEachern, 2000; Molnar et al., 2001; Romans et al., 1995; Sidebotham & Golding, 2001; Zuravin & Fontanella, 1999). In order to understand the implications of various forms of abuse for suicide, it is important to try to distinguish their influence from other co-occurring adversities.

A related and particularly relevant reason to control for the effects of forms of abuse on each other in predicting outcomes is that it allows tests of important facets of theories that make differential predictions about forms of abuse and their associations to outcomes. According to Joiner’s (2005) theory of suicidal behavior, few people want to die by suicide, but also, and perhaps more importantly, few people can. The central idea of Joiner’s theory is that serious suicidal behavior requires each of three interpersonal-psychological precursors: (1) the acquired capability, through habituation to pain and fear, to enact lethal self-injury; (2) the sense that one is a burden on loved ones; and (3) the sense that one does not belong to or is not connected with a valued group or relationship. This theory is compatible with and adds to other prominent models of suicidality (e.g., Baumeister, 1990; Beck, 1996; Linehan, 1993). Difficult life events such as childhood abuse, especially when severe, may have the potential to be extremely painful and fear-inducing. According to Joiner’s model, then, more severe and painful forms of childhood abuse should be greater risk factors for suicide than less painful forms of abuse.

The acquired capability to enact lethal self-injury portion of Joiner’s model posits that those who, through various painful experiences, have habituated to pain and fear are the only ones capable of completing
suicide—anyone else is unable to do so, even if they desire death. According to this theory, repeated exposure to pain and provocation may cause habituation to the “taboo” and prohibited quality of suicidal behavior, thus diminishing the fear and pain associated with self-harm. A number of studies support the relationship between repeated exposure to injury/pain and suicidality (e.g., Dhossche, Snell, & Larder, 2000; Menninger, 1936; Phillips, McElroy, Keck, & Pope, 1993; Rosenthal, Rinzler, Wallsh, & Klausner, 1972; Veale, Boocock, Gournay, & Dryden, 1996). In this framework, repeated painful experiences may result in the ability to enact future lethal self-injury; childhood physical and violent sexual abuse may constitute pathways by which this occurs.

Childhood physical abuse and certain forms of childhood sexual abuse may be more closely linked to acquisition of lethality than other forms of abuse (i.e., neglect, verbal abuse), because they are, on average, more physically painful than the other forms of abuse. Regarding childhood sexual abuse, there is evidence that more painful forms (e.g., severe forced abuse) are more associated with suicidality than less painful forms (Mullen et al., 1993; Stepakoff, 1998). According to Joiner’s model, habituation to pain and fear combines with desire for death to result in serious suicidal behavior, and that desire for death stems from feeling a burden on loved ones and others, and feeling disconnected and alienated from others.

To the degree that any form of abuse facilitates either lethality (through habituation to pain and provocation) or desire for death (through increased feelings of burdensomeness or disconnection), Joiner’s (2005) model would view it as a risk for later suicidal behavior. However, we predict the strongest effects of all for childhood physical and violent sexual abuse, not only because they are physically painful, but also because they imply burdensomeness and disconnection. They therefore potentially increase risk through every mechanism specified in the model. Although habituation, burdensomeness, and disconnection are not directly measured within this sample, we nonetheless anticipate a direct relationship between the exposure to a particularly physically painful experience—physical abuse and/or violent sexual abuse—and number of suicide attempts. Regarding molestation and verbal abuse, we predict weaker effects. Fergusson (1996, 2000) measured both violent and non-violent childhood sexual abuse and found both forms to be related to later suicidal behavior; however, he did not distinguish between forms of abuse that contributed directly to failed suicide attempts versus those that preceded a successful completion. Joiner’s (2005) model contends that, while the non-violent forms of sexual abuse likely contribute to future suicidal behavior by causing or intensifying perceived burdensomeness and/or thwarted belongingness, their failure to expose the victim to physical pain makes them contributory, but insufficient causes of completed suicide. The victims of non-violent sexual abuse are thus at a higher risk for a non-lethal suicide attempt rather than for completed suicide. After this first attempt or any other exposure to physically painful or provocative experiences, however, they will become more habituated to physical pain and their risk for death by suicide will increase dramatically. In light of prior findings, we thus expect to find that, even when controlling for a host of established risk factors for suicidal behavior, violent childhood physical and sexual abuse will serve as significantly stronger predictors for the number of lifetime suicide attempts than will molestation and verbal abuse.

Method

The current study draws on the National Comorbidity Survey (NCS), which is a nationwide epidemiological study designed to assess the prevalence and psychosocial correlates of DSM-III-R psychiatric disorders (for more information on the NCS see Kessler et al., 1997). The present study will examine those with complete data on all study variables (N for this study = 5838).

Sampling and weighting

The participants were selected through a multistage area probability sample based on household, within a stratified sample of counties within the United States. Response rate was 82.6%. More detail on the sampling and weighting can be found in Kessler (1994) and Kessler et al. (1994).
Participants

Participants were interviewed in their home and informed consent was obtained from each participant. There was an equal distribution of men (N = 2938) and women (N = 2939) within the sample. The average age of the participants was 33.2 years (SD = 10.70). Ethnicity was as follows: 75.6% Caucasian, 11.6% African-American, 9.4% Hispanic, and 3.4% categorized as “Other.”

Measures

Lifetime number of suicide attempts

NCS participants were asked whether they had ever attempted suicide, and if so, how many times. Those who stated they had never attempted suicide were coded “0”; all others were coded with their lifetime number of attempts.

Childhood experiences of abuse

Participants were provided with a list of negative events which included a question about childhood physical abuse. Participants who reported that they had been physically abused as a child were coded “1” and those who reported that they had not been physically abused as a child were coded “0”.

The list of traumatic events included questions about being raped (i.e., “someone had sexual intercourse with you when you did not want to by threatening you or using some degree of force”). If the participant responded positively to the question, the participant was then asked the age at which the event first occurred. Those participants who indicated that the rape occurred before age 15, were coded “1”, and all other participants were coded, “0”.

Participants also were asked specifically about molestation (i.e., “someone touched or felt your genitals when you did not want them to”). If the participant responded positively the participant was then asked the age at which the event first occurred. Those participants who indicated that they had been molested before the age of 15 were coded “1” and all other participants were coded “0”.

In a subsequent section of the NCS survey participants were asked several questions about their early family life including questions related to experiences of childhood verbal abuse. Participants were handed a list of specific behaviors related to verbal abuse, and asked how often any of the things on the list happened to them when they were growing up. The list included insults, swearing, and doing or saying something spiteful. Participants responded about the frequency of these experiences using a 4-point Likert-type scale anchored by 1 “Often” and 4 “Never”. Participants who indicated that they “often” experienced verbal abuse by a parent or stepparent, were coded “1”, and all other participants were coded “0”.

It should be noted that the assessments of physical abuse, sexual abuse, molestation, and verbal abuse vary in terms of their depth, specificity, and quality. Physical abuse was assessed with one question, as were sexual abuse and molestation, whereas verbal abuse was assessed by several different items. The measures on sexual abuse and molestation were quite specific, whereas the measure on physical abuse was more general.

It should also be noted that each of the four abuse variables was skewed, as would be expected. A total of 1.6% of the sample reported sexual abuse; 4.2% reported physical abuse; 5.9% reported molestation; and 8.4% reported verbal abuse. Here again, the indices of physical abuse and sexual abuse were the least advantaged in terms of distributional properties; therefore, skew would not be a convincing explanation for any supportive findings for physical abuse and sexual abuse. Intercorrelations between the four abuse measures ranged from 0.10 to 0.26 (p’s < 0.01); multicollinearity is thus unlikely to affect analyses.

Participants’ psychiatric diagnoses

The Composite International Diagnostic Interview (CIDI, World Health Organization, 1990), a semi-structured interview, was used to assess the participant’s lifetime DSM-III-R psychiatric diagnoses. The reliability and validity of the CIDI have been established (Wittchen, 1994).
Family of origin variables

Several variables were identified as potential correlates of childhood abuse. Participants were asked to indicate if, before the age of 15, they had experienced the divorce of their parents (1 = yes; 0 = no) or the death of either parent (1 = either parent died; 0 = neither parent died). Moreover, family conflict was assessed on a scale from 1 (a lot) to 4 (none). Participants were also asked to compare their family’s income to the average family in their community at the time they were growing up, on a scale from 5 (better off) to 1 (a lot worse off).

Family history of psychiatric symptoms

Participants were asked about psychiatric symptoms of each of their parents, within each of the following domains: suicide attempts, depression, mania, anxiety, substance use, and antisocial personality disorder. The items for each domain were based on Family History Research Diagnostic Criteria (Andreasen et al., 1977).

Rather than exclude from the analyses those participants who had no knowledge of their mother’s psychiatric symptoms (n = 364) or father’s psychiatric symptoms (n = 894), we created two additional dichotomous variables: “Knowledge of Mother’s symptoms” and “Knowledge of Father’s symptoms”. Participants who could not recall a parent’s symptoms were coded “0”, those who could recall were coded “1”.

Data-analytic strategy

We were interested in the association between forms of childhood abuse and lifetime number of suicide attempts, when respondents’ age and gender, psychiatric history, family psychiatric history, and family of origin variables were controlled. The four forms of childhood abuse (i.e., physical, sexual, molestation, verbal) and all of the covariates were simultaneously entered into a regression equation predicting lifetime number of suicide attempts. This approach allows evaluation of the specific association between a given form of abuse and lifetime suicide attempts, controlling for a host of key covariates as well as for other forms of abuse.

Results

Table 1 shows the results of the regression equation predicting lifetime number of suicide attempts, with respondents’ age and gender, psychiatric history, family psychiatric history, and family of origin variables as predictors. Before addressing results relevant to our main predictions, we first note other findings of interest. Both age and gender were associated with lifetime suicide attempts, such that younger people and women reported more attempts. Most disorders were uniquely associated with lifetime suicide attempts. There were relatively few effects for the family variables; exceptions were father’s anxiety (more anxiety related to fewer attempts), father’s antisocial personality disorder (more antisocial behavior related to more attempts), and father’s suicide attempts (more paternal attempts related to more attempts for participants).

In total, 272 individuals responded that they had made at least one suicide attempt. The range in number of suicide attempts for those who indicated that they had, in fact, made at least one attempts was 1 to 10 (mean = 1.57; SD = 1.102). A total of 190 individuals reported a total of one suicide attempts, while 38 reported two attempts, 24 reported three attempts, 13 reported four attempts, five reported five attempts, and one reported ten attempts.

The effects for childhood physical abuse (partial correlation = 0.074, t = 5.98, p < 0.05) and sexual abuse (partial correlation = 0.065, t = 5.40, p < 0.05) were relatively pronounced, similar to one another, and exceeded effects for molestation (partial correlation = 0.033, t = 2.88, p < 0.05) and for verbal abuse (partial correlation = 0.017, t = 1.68, p = ns). Treating these correlations as independent (though they are not), and applying the z-test for the difference between independent correlations (see Cohen & Cohen, 1983, pp. 53–54), these correlations appear to significantly differ from one another (z’s > 8.64, p < 0.05).

1This test was developed for use with independent, zero-order correlations; because we used partial correlations, these comparisons should be viewed as reasonable estimates (see Cohen & Cohen, 1983, p. 53).

2In an additional analysis, rape after age 15 was added as a covariate in an effort to explore whether the differential effects of various forms of childhood abuse remained significant when controlling for the effects of abuse later in life. The independent variables retained...
Few studies have evaluated the unique contribution of a particular form of abuse, controlling for other forms, to suicidality. In this study, we did so through the differential analysis of violent versus non-violent abuse. Table 1 presents the predictors of respondent suicide attempts. 

### Table 1

<table>
<thead>
<tr>
<th>Order of entry of set</th>
<th>Respondent’s age and gender</th>
<th>Respondent’s psychiatric history</th>
<th>Family psychiatric history</th>
<th>Family of origin variables</th>
<th>Parental history of suicide attempts</th>
<th>Childhood experiences of abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>19.20*</td>
<td>57.54*</td>
<td>35.99*</td>
<td>31.03*</td>
<td>29.92*</td>
<td>29.61*</td>
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<td></td>
<td>Age</td>
<td>Alcohol dependence</td>
<td>Knowledge of father’s symptoms</td>
<td>Parents divorced before age 15</td>
<td>Paternal attempt</td>
<td>Verbal abuse</td>
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<td></td>
<td>Gender</td>
<td>Substance dependence</td>
<td>Knowledge of mother’s symptoms</td>
<td>Death of a parent</td>
<td>Maternal attempt</td>
<td>Rape before age 15</td>
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<td>5.15*</td>
<td>Major depression</td>
<td>Maternal depression</td>
<td>Parental conflict</td>
<td>Paternal depression</td>
<td>Molestation before age 15</td>
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<td>Dysthymia</td>
<td>Maternal anxiety</td>
<td>Income</td>
<td>Paternal anxiety</td>
<td>Physical abuse</td>
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<td>Bipolar disorder</td>
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<td>Maternal adult antisocial behavior</td>
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<td>Simple phobia</td>
<td>Paternal depression</td>
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<td>Panic disorder</td>
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<td>Agoraphobia without panic disorder</td>
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<td>Post-traumatic stress disorder</td>
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<td>Adult antisocial behavior</td>
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<td>Number of depressive episodes</td>
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*p < 0.05.

**Discussion**

Their significance and remained in the same order of magnitude, however, we believe that abuse after age 15 does not fit into the model we sought to examine in this study and have therefore chosen to report the results without considering this additional covariate.
childhood abuse to later instances of suicidal behavior. Results of the study showed that the association between childhood physical and sexual abuse to lifetime suicide attempts was persistent in the face of numerous covariates, each of which are considered strong suicide- and abuse-related variables. Furthermore, as predicted, childhood physical and violent sexual abuse related more closely to lifetime suicide attempts than did verbal abuse and molestation. We view these results as supportive of a key aspect of Joiner’s (2005) theory—that painful and provocative experiences confer increased risk for later suicidal behavior.

The covariates in this study, both demographic variables like age, gender, and family of origin, along with clinical variables like individual and family psychiatric histories as well as childhood abuse all are among the most well documented correlates of serious suicidal behavior. Covariance of these variables from the association between childhood abuse and the lifetime number of suicide attempts represents a rigorous test. When controlling for these covariates we found that the occurrence of serious suicidality, as well as a significant relationship between childhood abuse and number of suicide attempts remained.

Before discussing further implications of our results, it is important to consider several cautions and considerations regarding the work. First, our statistical procedures yielded relatively small effect sizes. However, we statistically controlled for other variables that could possibly account for the relationship between childhood abuse and number of suicide attempts. The reported effect sizes not only indicate the size of the relationship between childhood abuse and suicide attempts, but also speak to the size of the relationship between childhood abuse and suicide attempts above and beyond (or controlling for) the relationship between suicide attempts and the other variables. This is a stringent test, and for this reason, large effect sizes are not expected. Note, however, that the relationships found were in fact statistically significant.

Another consideration to note is that the study was cross-sectional and retrospective. Since so few people attempt, and even fewer die by suicide, it is a difficult topic to study prospectively. Additionally, childhood sexual abuse is difficult to study prospectively, as the study of children is usually consented for and reported by parents; if parents are abusing their children, they are less likely to participate in studies and less likely to report abuse. Because of the cross-sectional design of the study, we are unable to make clear causal inferences, as we cannot definitively establish a timeline with independent variables occurring before the measurement of suicidality. Given that data suggest that only a small percentage of children attempt suicide, and the large majority of suicides occur in adults (McIntosh, 2003), it may be logical to infer that, in a majority of the cases, the child abuse occurred before the suicide attempt. Another common concern with the use of retrospective data is the possibility that participants are unable to recall, or incorrectly recall, information. Additionally, Robins et al. (1985) found that victims of childhood trauma who managed to experience more positive overall outcomes tended to underreport childhood difficulties. If such were the case in this sample, it could potentially artificially inflate the differences between childhood abuse victims who did and did not attempt suicide later in their lives. In this study, however, events that were assessed were likely to be salient and severe (e.g., sexual abuse, physical abuse, and suicide attempt), which should minimize reporting biases. Added steps were taken, including preliminary studies, to insure the accurate collection of data but it is still possible that the data are limited because information was gathered retrospectively.

Finally, Joiner’s (2005) model emphasizes mechanisms like habituation and opponent processes. It is important to highlight that these mechanisms were not directly examined in our study, and we eagerly await future research that directly addresses these issues. In such research, it may be of interest to include measures relevant to habituation and opponent processes (e.g., fear of death) and to evaluate whether these measures mediate the association between past abuse and future suicidality. Additionally, analyses that include data on frequency of physical and violent sexual abuse would provide substantial additional insight into the matter.

A significant strength of our study is that the NCS questionnaire allowed the possibility to assess not only sexual abuse, but more specifically, to separately evaluate violent as well as less physically painful forms of abuse (i.e., molestation). Our results showed a distinction such that the more physically painful abuse was more closely related to number of later suicide attempts than was less painful abuse. Assessment approaches that combine types of sexual abuse may find weaker effects than the approaches that separately examine physically painful versus less painful sexual abuse. A suggestion for further study is the continued separate evaluation of different forms of sexual abuse. In line with the results of this study and Joiner’s (2005) theory of suicide, we would expect that results would consistently find a stronger relationship between the more
physically severe sexual abuse and number of lifetime suicide attempts, and a weaker relationship between less physically severe sexual abuse and number of lifetime suicide attempts.

An additional strength of our study is that we examined suicidality in terms of the number of actual occurrences of suicide attempts. Because relatively few people attempt suicide, and even fewer die by suicide, research on predictive variables is often difficult to conduct. In many instances, the construct of suicidality is measured by self-report forms assessing suicidal ideation. As has been demonstrated, those who have made multiple suicide attempts are at higher risk for eventual suicide than others. Our work specifically studied those people who have attempted suicide and are at higher risk. Future work may address those people who actually die by suicide. In line with results reported here, we would expect that individuals who suffered physical or violent sexual abuse as children would be amongst those most likely to fit within that category.

These results may also help to inform clinical work. For clinicians, it is essential to be able to evaluate risk for suicide in clients in order to select the appropriate course of action. Suicide risk assessment strategies have already pointed to the importance of placing individuals who have previously made multiple suicide attempts and have a history of abuse into a category of at least moderate risk (Joiner, Walker, Rudd, & Jobes, 1999). However, these results allow for a more fine-grained distinction. Multiple attempters who have suffered physical or violent sexual abuse should be placed into a higher risk category than those who have suffered verbal abuse or molestation. Therefore, it is important for clinicians to determine not only whether or not a client has suffered abuse, but also what type of abuse it was in order to evaluate risk for suicide.

A clear understanding of the role of physically painful childhood trauma in later suicide attempts would be invaluable to both researchers and clinicians, allowing them to gain further insight into the mechanisms behind what remains a tragic and relatively mysterious phenomenon. We found that the association between childhood physical and violent sexual abuse to number of lifetime suicide attempts was persistent even when numerous significant covariates were controlled for. Additionally, we found that the relation of childhood physical and violent sexual abuse to number of lifetime suicide attempts exceeded the relation between verbal abuse and molestation to number of lifetime suicide attempts. We look forward to future work that addresses this general framework relating childhood abuse to suicidal behavior, as well as the specific idea proposed in Joiner’s (2005) theory—that painful and provocative experiences confer increased risk for later suicidal behavior.

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References


