Child Sexual Abuse (CSA)[1] and suicidality[2]

Suicide amongst young people is a major area of preventable deaths and a matter of great international concern (WHO, 2014). The multifaceted nature of suicide has given rise to an expansive field of enquiry that has sought to explore a multitude of risk factors associated with suicide. Amongst these various studies we find that Child Sexual Abuse (CSA) has been linked to suicide, parasuicide[3] and non-suicidal self-injury (NSSI)[4]. In this chapter the link between Childhood Sexual Abuse (CSA) and suicidality is discussed.

Suicidology: understanding and preventing suicide

The study of suicide, suicidology, is an expansive field of inquiry which has attracted interest from a diverse range of disciplines. Much of the research in the field of suicidology has followed in the Durkheimian tradition and is characterised by epidemiological approaches to understanding the phenomena of suicide (Hjelmeland & Knizek, 2011). National suicide prevention strategies have often sought to distil this body of research into workable approaches that can make practical use of the available knowledge (Mann, 2005). Yet despite the considerable scope of the research field, it should be noted that predictive models have been plagued by the complexity of the phenomena and often result in an overwhelming number of false positives (Schneidman, 2004).

Many of the studies have often failed to capture the uniqueness of individual cases potentially failing to illustrate the emotional impact of a completed suicide (Hjelmeland & Knizek, 2010). The work of Atkinson (1978) and Douglas (1967) serve as highly notable exceptions. The loss of any loved one is often a difficult experience, for those who have been bereaved by suicide, the mourning process is often described as being markedly different to other forms of loss (Jordan, 2001). Questions of 'why did they do it?' and 'why didn't I prevent it?' are often ever present in the minds of the mourners. The impact of a suicide extends far beyond the immediate tragic loss of the individual completing the act. In the case of CSA and suicidality, it seems likely that suicide is potentially the ultimate adverse outcome.

The relationship between CSA and suicidality

Childhood abuse, whether manifest as neglect, antipathy from parents, physical abuse or sexual abuse, has been consistently linked to suicidality (Miller, *et al.,* 2013; Ystgaard, *et al.,* 2004). Early life trauma has a profound adverse impact on psychological and physiological wellbeing in both the short-term and over the life course (Norman, *et al.,* 2012; Molnar, *et*

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[1] CSA has been used in this term as an umbrella term to incorporate the multitude of different forms of sexual abuse that include a wide range of sexually exploitative behaviours (Hallet, 2013).

[2] Suicidality is used here as an overarching term for a range of terms including, but not limited to, completed suicides, suicidal ideation, attempted suicides, parasuicides, and suicidal thoughts/feelings.

[3] This is used to refer to a self-injurious act that has all the characteristics of a suicide but does not result in death (Kerkhof, 2000).

[4] The relationship between self-harming or self-injurious behaviours is complex and highly contested (Klonsky, 2013). NSSI here is used in recognition of the conservable amount of North American literature on this topic.

al., 2001). Nemeroff (2016) and Glaser (2000), for example, have discussed the impact of early life trauma on brain development, while Labonte and Turecki (2010) explored the epigenetics of suicide with reference to the biological effects of early environmental adversity. In the case of CSA, Sunnqvist *et al.,* (2008) in their study of former psychiatric inpatients observed that victims of CSA have elevated of hyrdoxphenyglycole, cortisol and noradrenaline/adrenaline indicating considerable biological stress making them more susceptible to suicidality. Put simply, those had been subject to CSA had physiological characteristics that place them at increased risk of suicidality across the life course.

Exploring the effects of specific types of childhood abuse, is often complicated by the high proportion of individuals who experience co-occurring forms of abuse (Dong, *et al.,* 2004). As Oates (2004) notes, in many instances we should view the relationship between sexual abuse and suicide as cumulative. Victims of CSA often suffer with not only the distress of sexual abuse but compounding factors such as 'family dysfunction and other adverse life events' (Oates 2004:488). Further to this, the emotional distress that result from CSA often manifests in a range of mental disorders, such as depression and post-traumatic stress disorders, which are themselves independently associated with elevated suicidal behaviours (Spataro, 2004; Rihmer, 2011). Similarly, young people who are victims of CSA are more likely to engage in higher levels of substance misuse which is heavily associated with increased suicidality (Putnam, 2003; Appleby, 1999; Pridemore and Spivak, 2003). Historically, this has led some studies, such as Fergusson *et al*., (1996) and Silverman *et al.,* (1996), to suggest that the association between CSA and suicidality can be greatly understood through confounding factors (Gould *et al.*, 2003). Yet we should be careful to assume that known confounding factors are necessarily always relevant in the relationship between CSA and suicidality.

Sex[5] is commonly identified as being an important factor in understanding suicide with males being almost universally more likely to complete the act of suicide and females exhibiting higher rates of parasuicide (Arensmand, *et al.,* 2011). However, the relationship between sex, CSA and suicide is contested. While CSA appears to elevate suicidality in both sexes, it is not clear if one sex is at greater risk than the other. Chandy and colleagues (1996), for example, noted that females were at marginally higher risk than males, however, other studies have found the magnitude of increased propensity to attempted suicides amongst victims of CSA was the same for men and women (Dube *et al.,* 2005).

The complex web of interlocking issues makes understanding the relationship between CSA and suicide complex, however, by controlling for different types of early childhood trauma and other confounding factors we are able to more readily gain an insight into this complex topic (Kessler, 2002). For example, Devries *et al.,* (2014) in their meta-analysis, controlled for a series of confounders and were able to validate that CSA is associated with suicide attempts.

In identifying studies for their meta-analysis Devries and colleagues noted that the temporality of the association between CSA and suicide is not well established (2014:e1331). Two factors were identified as being particularly problematic; first, many studies fail to record the timings of CSA and suicidal behaviours. Second, high rates of suicidal behaviour and dating violence are both noted to occur in adolescence meaning that the temporal association is

[5] Here sex refers to a biological sex.

either not captured or is hard to validate (Rhodes, *et al.,* 2014). Further to the two points identified by Devries *et al.,* it can also be highly complex to definitively explore the impact of sexual abuse on suicide over the life course. In many instances it may not necessarily be known to the relevant authorities if a person has been a victim of CSA. Even where CSA is known to have happened, the complexity of linking data that might be decades apart might serve to obscure the relationship between CSA over the life course. Despite these complexities, there is evidence to suggest that victims of CSA are at elevated risk of making multiple suicide attempts (Colquhon, 2009). Similarly, Ystgaard *et al.,* (2004), in their study of a group of suicide attempters, observed a considerable link between CSA and repeated suicide attempts. In short, matching CSA and suicide over the life course is complex, however, the evidence available indicates that victims of CSA are more likely to make repeated suicide attempts.

The importance of temporality has been further discussed by Lopez-Castroman *et al*., (2013) who have noted that the age of CSA inception, the duration and the severity of CSA all differentially impacted on suicidal behaviours. Early onset of CSA and longer durations of abuse were both associated with lifetime suicide attempts. Those subject to severe sexual abuse, characterised by vaginal or anal penetration, were more likely to experience suicidal ideation and make attempts on their life than those subject to less severe CSA. Their study reminds us that suicide is more than completing the act, behaviours, feelings, thoughts and attempted suicides all need to be considered. Further to this, CSA is also a highly diverse concept with the form/severity, inception, duration and impact differentially manifesting in suicidal behaviours.

Few studies have attempted to explore the context in which CSA occurs with suicide. Those studies that do exist, such as Shaw *et al*., (2000) study of peer CSA and Wolfe *et al.,* (2006) study of institutionalised CSA have often lacked sufficient rigor to evidence any discernible differences. What is clear is that all CSA negatively impacts on the individuals wellbeing and increases susceptibility to suicidality.

Implications for Practice, Policy and Research

Despite the identified association between CSA and suicidality it appears that there is relatively little clarity about what strategies are effective. CSA is independently a risk for suicidality, however, practitioners and policy makers need to be alert to how associated behaviours, such as substance misuse and mental disorders, that can result from CSA can further increase their susceptibility. In short, presenting behaviours might have their manifestations in CSA meaning that any treatment should recognise the complex intertwined nature of different concepts (Oates, 2004). Those subject to early, severe and prolonged CSA are, unsurprisingly, more likely to be at greater risk of suicidality suggesting that where possible the focus should be on early intervention and prevention. Support should be holistic and focus on the unique needs of individual.

More robust longitudinal studies are needed to better validate and further refine our understanding of the relationship between CSA and suicidality. Studies need to be able to address the diversity of factors surrounding both CSA and suicide to allow a more refined understanding to be developed.

Critical reflection

In summary, both CSA and suicidality represent a spectrum of behaviours making the relationship between the two complex to understand. However, there is strong evidence to suggest that CSA is a risk factor for suicidality independent from other associated risks. The form, severity, inception and duration of CSA all appear to be significant in affecting suicidal behaviour. In addition to this, the multitude of adverse behaviours that can result from being a victim of CSA, such as increased likelihood of developing a mental disorder or using substances, can also serve to increase the risk of suicidality. Understanding the personal histories of victims of CSA and being alert to behaviours associated with elevated risk of suicidality will help us to better safeguard against completed suicides.

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