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Interpersonal Violence Victimization and Suicidal Ideation:

An Examination in Criminal Offenders

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Abstract

Background—Offenders are at elevated risk for interpersonal violence victimization (IVV), which is a risk factor for suicide-related outcomes in some populations, suggesting the importance of examining risk associated with IVV in offenders.

Aims—The present study examined the association between IVV and suicidal ideation (SI) among criminal offenders in a pretrial jail diversion program in the United States.

Methods—266 offenders were screened for ten common Axis I psychiatric disorders along with current SI and past-year IVV.

Results—Past-year IVV was significantly associated with current SI, and the association remained significant after adjusting for symptoms of ten Axis I psychiatric disorders, respectively and simultaneously. Gender did not moderate the IVV-SI association.

Conclusions—The findings support a connection between IVV and SI in criminal offenders.

Keywords

suicide; suicidal ideation; violence; victimization; offenders

Suicide rates are elevated among criminal offenders (Daniel, 2006; DuRand, Burtka, Federman, Haycox, & Smith, 1995; Konrad et al., 2007). The data support criminal/legal events conferring increased risk for both suicide (Cooper, Appleby, & Amos, 2002) and suicide attempts (Yen et al., 2005). A prospective study of patients with personality disorders showed that a legal event increased risk of suicide attempts in the month following the onset of the event (Yen et al., 2005). A report from Great Britain showed that one-third of suicides in prison occurred within a week of incarceration (Shaw, Baker, Hunt, Moloney, & Appleby, 2004). These findings highlight the need for suicide screening and prevention efforts in forensic settings.

The screening and monitoring of individuals with suicidal ideation (SI) in forensic settings is an important focus of overall prevention efforts. Supporting these efforts, a recent meta-analytic review revealed that the strongest predictor of suicide in prisoners was recent SI, conferring an approximately 15-fold risk (Fazel, Cartwright, Norman-Nott, & Hawton, 2008). Thus, determining factors associated with SI in forensic populations is important. One potential factor associated with SI in this population may be interpersonal violence victimization (IVV). The potential link between IVV and SI among offenders is of interest because interpersonal conflict is a potent risk factor for suicide in other populations (Beautrais, 2001; Foster, Gillespie, McClelland, & Patterson, 1999). Moreover, among offenders such conflict is especially likely to erupt into violence (Haggard-Grann, Hallqvist, Langstrom, & Moller, 2006), and offenders are at elevated risk for violence victimization (Blaauw, Arensman, Kraaij, Winkel, & Bout, 2002).

There are meager data available regarding the association between IVV and SI among offenders. Much of research on the association of IVV and SI in adulthood is derived from studies on intimate partner violence (Heru, Stuart, Rainey, Eyre, & Recupero, 2006; Pico-Alfonso et al., 2006; Rhodes et al., 2009). Prior research focused on the link between intimate partner violence victimization and psychiatric disorders such as depression, posttraumatic stress disorder (PTSD), and alcohol/drug abuse (Ellsberg, Jansen, Heise, Watts, & Garcia-Moreno, 2008; Leiner, Compton, Houry, & Kaslow, 2008), or the link between SI and psychiatric disorders including mood disorders, anxiety disorders, and substance disorders (Kamath, Reddy, & Kandavel, 2007; Kessler, Borges, & Walters, 1999). Yet, it is unknown whether the association of IVV and SI is accounted for by the relationship of psychiatric symptoms and SI.

Furthermore, interpersonal violence victimization may be experienced differently by men and women because women are at higher risk for PTSD following assaultive violence than after other types of traumatic events (Breslau & Anthony, 2007). However, there is only minimal information on gender as a moderator of the association between IVV and SI, although a large birth cohort study in New Zealand reported no gender difference in the association between domestic violence victimization and SI (Fergusson, Horwood, & Ridder, 2005).

The present study examines the associations between past-year IVV and current SI, defined as ideation occurring within the past 2 weeks. We hypothesized that past-year IVV would be associated with current SI. Further, the study examined whether the associations remained significant after adjustment for known sociodemographic correlates of risk in forensic populations (Fazel et al., 2008) and a range of Axis I psychiatric symptoms (Kamath et al., 2007; Kessler et al., 1999). We also tested gender as a moderator of the relationship between IVV and SI.

Method

Participants

Participants were 266 adult offenders mandated to a pretrial jail diversion program after being charged with a crime in Upstate New York (USA). Nineteen subjects with death

ideation (e.g., endorsing a wish to die) but not reporting SI were excluded from the analysis given the uncertainty of assigning these individuals to a non-SI group, leaving a total sample of 247. The mean age of the participants was 33.7 years ($SD = 11.0$), with a range of 18 to 62. Most of the sample was male ($N = 183$; 74.8%); 137 (55.5%) reported having less than 12 years of education. The composition of self-reported race/ethnicity included 128 (51.8%) non-Hispanic Black, 70 (28.3%) non-Hispanic White, 29 (11.7%) Hispanic, 3 (1.2%) Native American, and 17 (6.9%) other race/ethnicity. More than half of the participants had never been-married (58.7%), 21.5% reported either being married or living with a partner. Nearly all ($N = 233$; 94.7%) participants reported a history of at least one nonviolent charge, with 153 (62.3%) reporting one or more violent charges. The mean number of lifetime violent charges was 2.2 ($SD = 3.5$) and nonviolent charges was 13.5 ($SD = 15.3$).

Procedure

Individuals who were over 18 years, could speak and read English, and were within their first 2 weeks in the supervision program were recruited following a brief announcement about the study. Among individuals offered the opportunity to participate, 73.8% agreed to participate in the study. Informed consent and demographic information were obtained during brief individual sessions. Following these meetings, participants completed group-administered, self-report measures and were compensated with a \$20 giftcard.

Measures

Suicidal Ideation (SI)—Three yes/no questions from the Psychiatric Diagnostic Screening Questionnaire (PDSQ; Zimmerman, 2002; Zimmerman & Mattia, 2001) inquire about SI during the past 2 weeks: (1) “Did you have thoughts of suicide, even though you would not really do it?”; (2) “Did you seriously consider taking your life?”; (3) “Did you think about a specific way to take your life?” The presence of SI was determined by a “yes” response to any of these three items. The PDSQ also includes three items assessing death ideation (e.g., “Did you think you’d be better off dead?”) that were used to exclude subjects with death ideation but not SI from analysis (as described previously).

Interpersonal Violence Victimization (IVV)—Two yes/no items were used to indicate the presence of violence victimization in “close relationships” during the past year: (1) “Have you been pushed, grabbed, shoved, or slapped?” or (2) “Have you been kicked, bit, strangled, or hit with a fist?” The creation of these items was informed by the revised Conflict Tactics Scales (Straus, Hamby, Boney-McCoy, & Sugarman, 1996), an instrument which contains questions about these minor (pushed, etc.) and severe (kicked, etc.) violence victimization experiences. In the current analysis, the presence of IVV was determined by a positive response to either of these questions.

Axis I Psychiatric Symptoms—Symptoms of DSM-IV Axis I disorders were measured using subscales of the Psychiatric Diagnostic Screening Questionnaire (PDSQ; Zimmerman, 2002; Zimmerman & Mattia, 2001). The PDSQ is a self-report diagnostic screening measure consisting of 125 items that are answered yes or no. The PDSQ assesses symptoms of 13 common psychiatric disorders: major depressive disorder, panic disorder, agoraphobia, generalized anxiety disorder, social anxiety disorder, PTSD, obsessive-compulsive disorder,

alcohol abuse/dependence, drug abuse/dependence, psychosis, bulimia/binge-eating disorder, somatoform disorder, and hypochondriasis. For each disorder, the items either refer to the past 2 weeks (e.g., major depressive disorder) or the past 6 months (e.g., alcohol abuse/dependence). The PDSQ has been extensively tested with psychiatric outpatients, and each of the scales shows good-to-excellent reliability (internal consistency, test-retest) and validity (comparisons with semistructured diagnostic interviews), except the psychosis scale (Zimmerman & Chelminski, 2006; Zimmerman & Mattia, 2001; Zimmerman & Sheeran, 2003).

The PDSQ generates continuous scores on each scale, and cutoff scores are available so that the measure can be used as a screening instrument for psychiatric disorders. However, there is evidence that common behavioral disorders represent extremes of continuous dimensions (Plomin, Owen, & McGuffin, 1994). For this reason we created a continuous variable for each disorder by summing the total items endorsed, following Lesser et al.'s (2005) approach. Internal consistency for the subscales used in the current study was adequate ($\alpha = .81$ to $.92$), with the exception of the psychosis scale ($\alpha = .69$). Due to limited evidence supporting the role of bulimia/binge-eating disorder, somatoform disorder, and hypochondriasis in suicidal thoughts or behavior, these three psychiatric disorders were excluded from the data analysis while each of the remaining ten scales were included.

Data Analysis

Descriptive statistics, stratified by SI, were examined using χ^2 tests or independent samples *t*-tests. A hierarchical logistic regression analysis was conducted to examine whether gender moderates the relationship between IVV and SI. Next, a series of logistic regression models were used to compare the SI group with the no SI group on IVV: (1) an unadjusted model (IVV as the only predictor for SI); (2) an adjusted model for demographic variables only; (3) a series of ten models adjusted for each PDSQ scale one at a time along with the demographic variables; and (4) an adjusted model for demographic variables and all 10 PDSQ scales simultaneously. Odds ratios (ORs) and 95% confidence intervals (CIs) of IVV on SI were computed based on the method of maximum likelihood (Hosmer & Lemeshow, 2000).

Results

Preliminary Analysis

Of the total sample, 14.7% ($N = 39$) reported current SI. Table 1 shows descriptive statistics of demographic variables and PDSQ scales by SI. With the exception of symptoms of obsessive-compulsive disorder and agoraphobia, symptoms of all psychiatric disorders were significantly more prevalent among individuals with SI than those without SI. None of demographic variables significantly differed by the presence of SI. Among participants, 61.9% reported IVV during the past year.

Gender Differences

A hierarchical logistic regression analysis with SI as the criterion variable was conducted in order to examine whether gender moderates the relationship between IVV and SI. The

gender by IVV interaction term did not approach significance ($\beta = 0.33, p = .78, R^2 < .01$), indicating that the association of IVV and SI did not differ according to gender.

Interpersonal Violence Victimization and Suicidal Ideation

OR's and 95% CI's of past-year IVV on SI are presented in Table 2. The unadjusted model shows that IVV was significantly associated with SI (OR = 3.29, 95% CI = 1.39, 7.79), and the association remained significant after adjusting for age, gender, race, and marital status (OR = 3.60, 95% CI = 1.49, 8.72). The associations between IVV and SI were re-examined after adjusting for each PDSQ scale and remained statistically significant in each instance. For example, after adjusting for the effect of depressive symptoms and demographics on SI, IVV significantly increased the odds of having SI. Finally, offenders with a history of violent victimization were more likely to report SI even after adjusting for all 10 PDSQ scales and demographics (OR = 4.60, 95% CI = 1.35, 15.63).

Discussion

The present study supports an association between IVV and SI above and beyond risk associated with a range of common psychiatric symptoms among pretrial offenders. This is the first study of which we are aware to document this association in an offender population. These results are consistent with studies in a variety of other populations, including women experiencing domestic violence (Leiner et al., 2008), urban male patients seeking emergency care (Rhodes et al., 2009), psychiatric inpatients (Heru et al., 2006), and community residing adults (Simon, Anderson, Thompson, Crosby, & Sacks, 2002).

The findings show that, after accounting for the variance explained by ten Axis I psychiatric symptoms on SI, pretrial offenders who have experienced being a victim of interpersonal violence in the past year are more likely to experience SI compared to those who have not. Although the 95% confidence intervals of odds ratios were wide, none crossed zero. This supports the robust association of IVV and SI in this population with individual variations in the degree of the association. What accounts for the association between IVV and SI is unclear. One possibility is that IVV causes SI more or less directly. More complex causal scenarios include that IVV and related victimization experiences produce feelings of loss, humiliation, or shame (Kim, Talbot, & Cicchetti, 2009), loneliness or related experiences such as social isolation (El-Bassel, Gilbert, Rajah, Foleno, & Frye, 2001), and/or lead to the break-up of valued relationships (Zlotnick, Johnson, & Kohn, 2006), all of which can promote suicidal thoughts and behavior (Joiner, 2005). Importantly, current results suggest that the association between IVV and SI is not attributable to DSM-IV Axis I psychopathology. However, mediation by other unmeasured variables associated with suicidal thoughts and behavior cannot be ruled out. For example IVV could be a marker for relationship distress that explains its link with SI.

The results do not suggest a gender difference in the association between IVV and SI among offenders. Despite women's higher risk of PTSD following physical violence (Breslau & Anthony, 2007), present results support the importance of assessing suicide risk among victims of IVV in forensic settings regardless of gender and other mental health symptoms. Current findings are consistent with Fergusson et al.'s study (2005) in which there was no

differential risk of SI upon psychological or physical violence victimization in intimate partner relationships on men and women among community young adults.

Predicting violence *perpetration* is a focus of assessments in forensic settings. Our data suggest that understanding violence *victimization* is also important among offenders. Specifically, our results suggest that victimization in interpersonal relationships is associated with increased risk for SI in this population, indicating the need to include IVV in suicide screening assessments in forensic settings. Additionally, our findings highlight the importance of administrative efforts to decrease interpersonal violence that occurs in correctional settings, which could potentially contribute to SI.

Limitations of the study should be noted. The cross-sectional research design does not allow for causal inferences. The analyses focused on SI, with unclear generalization to suicidal behavior. Past-year IVV was limited to a categorical assessment based on two questions. Psychiatric symptoms were assessed using a self-report screening measure and are not the equivalent of diagnostic data obtained through research interviews. The sample consisted of offenders in a jail diversion program, with unclear generalization to other groups of offenders.

Nevertheless, the present study provides novel data on the association of IVV and SI in an offender population, with the association remaining after adjustment for multiple symptoms of Axis I disorders. These results indicate that continued research on this topic is warranted. Studies using prospective designs, more detailed assessments of IVV, additional offender groups, and examinations of SI as well as suicidal behavior will be most informative.

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Table 1
Descriptive data and univariate comparisons of subjects with and without suicidal ideation (SI)

	SI (N = 39)		No SI (N = 208)		Test	p value
	N/M	%/SD	N/M	%/SD		
Demographic variables						
Age (M, SD)	34.5	10.5	33.5	11.2	t = -0.51	.608
Gender						
Men	28	15.3	155	84.7	$\chi^2 = 0.13$	.722
Women	11	17.2	53	82.8		
Race					$\chi^2 = 2.42$	.120
White	19	20.4	74	79.6		
Nonwhite	20	13.0	134	87.0		
Marital status					$\chi^2 = 0.07$	.788
Married/living with a partner	9	17.0	44	83.0		
Single/separated/divorced/widowed	30	15.5	164	84.5		
Education					$\chi^2 = 0.17$	.897
Education < 12 years	22	16.1	115	83.9		
Education 12 years	17	15.5	93	84.5		
PDSQ scales (M, SD)						
Depression ^a	9.3	3.0	4.6	3.5	t = 7.85	.000
Generalized anxiety disorder	6.5	3.0	3.8	3.6	t = 4.95	.000
PTSD	6.7	4.6	4.1	4.5	t = 3.36	.001
Obsessive compulsive disorder	1.9	2.2	1.3	1.9	t = 1.53	.128
Agoraphobia	2.5	2.8	1.6	2.6	t = 1.85	.065
Panic disorder	3.2	2.8	1.5	2.4	t = 3.42	.001
Social anxiety	5.2	4.7	2.9	3.8	t = 2.93	.005
Alcohol abuse/dependence	2.4	2.4	1.2	2.3	t = 3.02	.003
Drug abuse/dependence	4.0	2.4	2.6	2.5	t = 3.22	.001
Psychosis	1.5	1.4	0.6	1.1	t = 3.51	.001

Note.

^aThe suicide items were excluded from the PDSQ depression scale.

Table 2

Odds ratios (95% confidence intervals) for suicidal ideation (SI) associated with experiencing interpersonal violence victimization (IVV)

	Violence victimization OR (95% CI)	<i>p</i> value
Unadjusted	3.29 (1.39, 7.79)	.007
Adjusted for demographics ^a	3.60 (1.49, 8.72)	.005
Adjusted for demographics ^a and each of the following PDSQ scales ^b		
Depression ^c	3.24 (1.19, 8.84)	.022
Generalized anxiety disorder	3.35 (1.36, 8.30)	.009
PTSD	3.38 (1.29, 8.89)	.013
Obsessive compulsive disorder	3.45 (1.42, 8.38)	.006
Agoraphobia	3.27 (1.33, 8.01)	.010
Panic disorder	3.77 (1.46, 9.75)	.006
Social anxiety	4.01 (1.58, 10.49)	.004
Alcohol abuse/dependence	3.60 (1.40, 9.25)	.008
Drug abuse/dependence	3.69 (1.50, 9.10)	.005
Psychosis	2.91 (1.17, 7.22)	.022
Adjusted for demographics ^a and all 10 PDSQ scales ^b	4.60 (1.35, 15.63)	.015

Note.

^a Adjusted for age, gender, race, and marital status.

^b Continuous scores from the PDSQ scales were used.

^c Depressive symptoms excluding suicide items were used.