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Interpersonal Violence, Alcohol Use, and Acquired Capability for Suicide

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Abstract

Acquired capability for suicide (ACS), defined as pain tolerance and fearlessness about death, is theorized as necessary to enact suicide. This study examined the associations of interpersonal violence and alcohol use with ACS in 502 college students. General fearlessness/pain tolerance was positively associated with male gender and alcohol use. Fearlessness about death was positively associated with male gender and general physical violence perpetration. However, these risk factors did not explain variance in ACS beyond male gender and history of suicide attempts/nonsuicidal self-injury. These findings add to the understanding of ACS correlates.

Keywords

college students; interpersonal violence; alcohol; acquired capability; suicide

Suicide is the third leading cause of death for persons ages 10 to 24 years old (Centers for Disease Control and Prevention [CDC], 2013). Risk factors for suicide, particularly interpersonal violence and alcohol use, are alarmingly prevalent in this population (Bagge & Sher, 2008; Wolford-Clevenger & P. Smith, 2014). However, understanding of the mechanisms through which these factors promote suicide risk in young adults is limited. Research that organizes these risk factors into a parsimonious understanding of the mechanisms underlying suicide is imperative to prevent this cause of death in such a vulnerable population.

The interpersonal theory of suicide (Joiner, 2005; Van Orden et al., 2010) may serve as a framework to understand these risk factors for suicide among young adults. The theory attempts to explain why only a minority of individuals who contemplate suicide go on to die by suicide (Joiner, 2005; Van Orden et al., 2010). Specifically, the theory posits that suicidal desire, caused by thwarted interpersonal needs, is necessary but not sufficient for suicide to occur. Individuals who engage in lethal suicidal behavior must acquire the capability to do so. Such capability is acquired via habituation to the pain and fear involved in death through chronic exposure to fear-inducing and physically painful events, respectively (Joiner, 2005;

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P. Smith & Cukrowicz, 2010; Van Orden et al., 2010). Events theorized to increase acquired capability for suicide (ACS) may be directly related to suicide (e.g., aborted attempts, nonsuicidal self-injury) or indirectly related to suicide (e.g., violence, risk-taking behaviors) (P. Smith & Cukrowicz, 2010). Essentially, events that induce physical pain and/or fear about death are postulated to promote ACS.

Research partially supports the interpersonal theory's two-factor model of ACS: pain tolerance and fearlessness about death. An exploratory factor analysis of the sole self-report measure of ACS, the Acquired Capability for Suicide Scale (ACSS), demonstrated a four-factor model, with one method factor and three interpretable factors: general fearlessness/pain tolerance, fearlessness about death, and spectator enjoyment of violence (P. Smith, Wolford-Clevenger, Mandracchia, & Jahn, 2013). General fearlessness/pain tolerance and fearlessness about death appear most consistent with acquired capability, whereas the spectator enjoyment of violence factor is more consistent with events or behaviors that are theorized to increase ACS. However, additional factor analytic work across multiple independent samples has resulted in a one-factor solution: fearlessness about death (Ribiero et al., 2014). Although the theory proposes ACS as consisting of fearlessness about death and pain tolerance, the development of this construct remains in its early stages.

Further, as measured by the original ACSS and objective pain tolerance measures, ACS has been supported in its predicted associations with physically painful and fear-inducing events. Such events include combat exposure, over-exercise associated with disordered eating, euthanasia exposure in veterinarians, painful and provocative events experienced by prisoners, nonsuicidal self-injury (NSSI), and even exposure to violent video games (Bryan & Cukrowicz, 2011; A. Smith et al., 2013; P. Smith et al., 2013; St Germain, & Hooley, 2013; Teismann, Förtsch, Baumgart, Het, & Michalak, 2014; Van Orden, Witte, Gordon, Bender, & Joiner, 2008; Witte, Correia, & Angarano, 2013). Additionally, suicide attempters have higher levels of ACS than suicide ideators and nonsuicidal individuals (P. Smith, Cukrowicz, Poindexter, Hobson, & Cohen, 2010). Several studies across various samples have generally supported the theory's hypotheses. However, behaviors particularly prevalent among young adults, such as interpersonal violence and alcohol abuse, have yet to be directly examined in relation to ACS. A better understanding of the events that may relate to ACS is needed to refine this tenet of the theory.

Interpersonal violence is prevalent among young adults (Black et al., 2011). In particular, intimate partner violence (IPV), defined as physical, psychological, and sexual aggression perpetrated against an intimate partner (Saltzman, Fanslow, McMahon, & Shelley, 2002), is a type of interpersonal violence that occurs at high rates among both young adult men and women (Black et al., 2011; Langhinrichsen-Rohling, Misra, Selwyn, & Rohling, 2012). Specifically, the prevalence rates of IPV in dating relationships range from 20–37% for physical violence, 60–90% for psychological aggression, and 2–18% for sexual abuse (Shorey, Cornelius, & Bell, 2008). Acts of IPV perpetration and victimization are arguably physically painful and fear-inducing. For example, IPV victims sustain severe physical injuries and develop or acquire chronic, painful conditions including disabilities, gastrointestinal disorders, and sexually transmitted diseases (Coker et al., 2002). Further, permissive attitudes toward violence are associated with IPV perpetration (Eckhardt &

Crane, 2014), which may predispose individuals toward acquiring pain tolerance and fearlessness about death. Support, although largely indirect, exists for these hypotheses. Both IPV victimization and perpetration have been found to be associated with increased risk for suicide attempt in various samples (e.g., clinical, help-seeking, psychological autopsy, and community samples) (Golding, 1999; Heru, Stuart, Rainey, Eyre, & Recupero, 2006). However, no published studies have examined the relationship between these risk factors and ACS.

Aggression against non-intimates, another aspect of interpersonal violence, has received limited attention in relation to ACS, despite its association with suicide attempts (Swogger, Van Orden, & Conner, 2014). Physical violence perpetrated against non-intimates and traits related to violence (e.g., psychopathy) are associated with risk for suicide attempts, conferring indirect support for the likelihood that physical violence promotes ACS (P. Smith, Selwyn, Wolford-Clevenger, & Mandracchia, 2014; Swogger, You, Cashman-Brown, & Conner, 2011). In military veteran samples, exposure to combat involving high levels of violence, injury, and death is associated with ACS, suggesting that witnessing or enacting physical violence increases one's pain tolerance and fearlessness about death (Bryan & Cukrowicz, 2011). Additionally, an experiment demonstrated that playing violent video games (i.e., first-person shooter) relative to nonviolent video games (i.e., racing) increased pain tolerance, suggesting that exposure to physical violence promotes ACS (Teismann et al., 2014). However, additional tests of the association of general physical violence perpetration with physical pain tolerance and fearlessness about death are needed to understand whether physical aggression is relevant to the development of ACS.

Alcohol use is also a robust correlate of suicide attempts particularly prevalent among young adults that has not been examined in relation to ACS (Bagge & Sher, 2008; Boenisch et al., 2010; Klimkiewicz et al., 2012). For example, binge-drinking rates range from 35–40% among young adults (Windle, 2003), and those classified as binge drinkers are more likely to report histories of suicide attempts relative to their peers (Schaffer, Jeglic, & Stanley, 2008). Epidemiological research suggests that this relationship is not solely due to comorbid psychological disorders, demonstrating independent associations of alcohol use and alcohol use disorders with suicide attempts (Borges, Walters, & Kessler, 2000). Research also hints that ACS may be the mechanism through which alcohol use promotes risk for suicide. For instance, acute alcohol intoxication is common to suicides by violent methods (e.g., by gun, Kaplan et al., 2013), and among individuals who died by suicide, those with alcohol use disorders have been documented as more aggressive than those without such disorders (Chachamovich et al., 2012). These findings present compelling reason to investigate the relationship between alcohol use and ACS.

Researchers have theorized that alcohol use may increase ACS proximally through its acute numbing and disinhibiting effects or distally through the painful and fearsome events resulting from its chronic use (P. Smith & Cukrowicz, 2010). For instance, alcohol may be consumed in order to gain “courage,” that is, to dampen perceptions of the pain and fear about death involved in suicide (P. Smith & Cukrowicz 2010). Although not mutually exclusive, an alternative process by which alcohol consumption may lead to ACS is through the increases in painful and fear-inducing events likely to occur during intoxication. For

example, alcohol intoxication is associated with increased interpersonal violence victimization and perpetration (Shorey, Stuart, & Cornelius, 2011; Stuart et al., 2013), injury (Cherpitel, 1993), and risky sexual behaviors (Scott-Sheldon, Carey, & Carey, 2010). Therefore, individuals may habituate to the pain and fear involved in suicide through proximal or distal effects of increased alcohol consumption (Joiner, 2005; Van Orden et al., 2010). However, a test of the basic association between alcohol use and ACS is needed to probe whether these effects may exist.

A parsimonious organization of suicide risk factors is necessary to understand the mechanisms underlying suicide in young adults. The present purpose was to test the interpersonal theory's predictions about the associations of suicide risk factors, interpersonal violence and alcohol use, with ACS. Specifically, we aimed to test the postulated associations of general physical violence perpetration, IPV perpetration and victimization, and levels of alcohol use, with the ACS factors derived from P. Smith and colleagues' (2013) factor analysis. First, given that interpersonal violence victimization and perpetration involve high levels of pain and fear, we hypothesized that general physical violence perpetration and IPV perpetration and victimization would positively correlate with each facet of ACS. Second, given evidence for alcohol's potential proximal and distal effects on ACS, we hypothesized that alcohol use would positively associate with the ACS factors. Finally, we aimed to test whether general physical violence perpetration, IPV victimization and perpetration, and alcohol use contribute unique variance to ACS beyond gender and history of suicide attempts and threats, two of the strongest risk factors for suicide.

Method

Participants

A convenience sample of undergraduate students ($N = 502$) at a southeastern university volunteered to participate in the current study in exchange for research credit in an introductory to psychology course. The inclusion criteria were that participants must have been in a dating relationship for at least a month in the past year and be 18 years of age or older. The sample was $M = 18.80$ years old ($SD = 1.93$). Most were women (65.7%), White/Caucasian (81.2%), heterosexual (95.6%), not cohabitating with their partner (94.4%), and freshmen (76.1%). Reported family income was: less than \$50,000 (23.4%), \$50,000–\$100,000 (32.3%), \$100,000–\$150,000 (20.6%), \$150,000–\$200,000 (12.4%), and greater than \$200,000 (11.2%). The average relationship length was 14.37 months ($SD = 14.55$).

Procedure

The university Institutional Review Board approved the study procedures. Students chose to participate in the study via an online recruitment site shared by other researchers. Participants anonymously completed a number of questionnaires online which included the measures for the current study, in addition to measures pertaining to other research on violence. Students received partial course credit for participating. Given the sensitive nature of the items related to violence, participants viewed a mental health resources page following completion of the study that included contact information for the first author.

However, research has demonstrated that inquiring about suicidal behavior does not increase one's risk for suicide (P. Smith, Poindexter, & Cukrowicz, 2010).

Measures

A demographic questionnaire collected information regarding age, gender, racial/ethnic identity, academic status, family income, relationship length, and cohabitation status. History of suicide attempts/NSSI was assessed using item four of the borderline personality disorder subscale of the Personality Diagnostic Questionnaire-4 (PDQ4; Hyler et al., 1988). This item asked participants to indicate whether or not they have ever attempted to harm or to kill themselves on a "yes" or "no" scale.

The Conflict Tactics Scales-Revised (CTS2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996; Straus, Hamby, & Warren, 2003) is 78 items that assess the frequency of physical assault, psychological aggression, sexual coercion, negotiation, and injuries over that past 12 months on a 7-point Likert scale: 0 (*not in the past year or never*) to 6 (*more than 20 times*). Half of the items inquire about perpetrating these behaviors, and the other half being victimized. Among court-mandated men and college students the CTS2 was a valid and reliable measure of partner violence (Straus et al., 1996; Vega & O'Leary, 2007). In an international sample, it had good internal consistency (Straus, 2003); however in the current sample, a majority of the subscales' internal consistency coefficients were unacceptable ($\alpha = .44 - .69$). In order to improve the reliability of our measurement of IPV victimization and perpetration, we combined the physical assault, psychological aggression, sexual coercion, and injury subscales into two subscales, which improved the reliability significantly (victimization $\alpha = .80$; perpetration $\alpha = .80$).

General Violence Conflict Tactics Scale (GVCTS; Stuart, Moore, Kahler, & Ramsey, 2003a, Stuart, Moore, Ramsey, & Kahler, 2003b), a modified version of the CTS2 physical assault subscale, was used to assess general physical violence. The GVCTS lists each of the 13 acts of physical violence from the CTS physical assault subscale and inquires how often participants perpetrated these acts as an adult (since 18 years of age or over the past year) against adult relatives, friends, co-workers, employers, acquaintances, strangers, police officers, gangs or group members, ex-intimates, or "others." The total score for the scale consists of the sum of these acts. The internal consistency of the measure in the current study was good ($\alpha = .90$).

Alcohol Use Disorders Identification Test (AUDIT; Saunders, Aasland, Babor, & Grant, 1993) is a 10-item screening instrument that was used to assess participants' degree of alcohol consumption in the past year. The sum of the AUDIT can be used to assess alcohol use (Babor, Higgins-Biddle, Saunders, & Monteiro, 2001). The AUDIT has demonstrated good internal consistency, test-retest reliability as well as concurrent, discriminant, and construct validity when completed by college students (Babor et al., 2001; Kokotailo et al., 2004; Saunders et al., 1993). The internal consistency of the scale in the current study was good ($\alpha = .80$).

The Acquired Capability for Suicide Scale (ACSS; Van Orden, Witte, Gordon, Bender, & Joiner, 2008) is 20 items that assess general fearlessness/pain tolerance and fearlessness

about death on a 5-point Likert scale: 0 (*not at all like me*) to 5 (*very much like me*). The general fearlessness/pain tolerance and fearlessness about death subscales were computed using the sum of the factor items from P. Smith et al.'s (2013) factor analysis. The general fearlessness/pain tolerance subscale consisted of four items (e.g., "I can tolerate a lot more pain than most people."). The fearlessness about death subscale consisted of five items (e.g., "The fact that I am going to die does not affect me."). We did not use the spectator enjoyment of violence factor, as it appears more apt to represent a correlate of ACS rather than a part of the construct. Although our measurement of pain tolerance is somewhat crude given it includes items regarding general fearlessness, we opted to use the two factors (general fearlessness/pain tolerance and fearlessness about death) resulting from P. Smith and colleagues' (2013) scales rather than Ribiero et al.'s (2014) Fearlessness about Death scale as to not exclude the pain tolerance element of ACS. The internal consistencies of these subscales were acceptable in a sample of prison inmates (P. Smith et al., 2013) and were acceptable in the current sample (general fearlessness/pain tolerance: $\alpha = .68$, fearlessness about death: $\alpha = .72$)

Results

Table 1 presents means, and standard deviations, and correlations of study variables. A high percentage of participants reported scores greater than 0 on the IPV perpetration (75.3%) and victimization (71.8%) scales, which included physical assault, psychological aggression, sexual coercion, and injuries. A tenth (9.7%) of the sample reported perpetrating in some level of general physical violence. Finally, 13% reported ever attempting to harm or kill themselves.

The following analyses were conducted using original and log-transformed variables to adjust for skewness and kurtosis in the general physical violence and IPV perpetration and victimization variables. When results between these analyses differed, we report the results from the analyses using log-transformed variables. To test the first and second hypotheses, we computed correlations. General fearlessness/pain tolerance exhibited weak correlations with alcohol use ($r = .10, p = .034$), such that increases in alcohol use were associated with increases in greater general fearlessness/pain tolerance. General fearlessness/pain tolerance was unrelated to IPV victimization, IPV perpetration, and general physical violence perpetration. Fearlessness about death was weakly correlated with perpetrating general physical violence ($r = .12, p = .008$), such that increases in violence perpetration were associated with increases in fearlessness about death. Fearlessness about death was unrelated to IPV victimization, IPV perpetration, and alcohol use.

Next, we conducted two hierarchical linear regressions to examine whether alcohol use and interpersonal violence perpetration and victimization contributed unique variance to the ACS factors, above and beyond well-established correlates of suicide: male gender and history of suicide attempts/NSSI. In each regression, gender and suicide attempts/NSSI history were entered as predictor variables in the first step.

In the second step, general physical violence perpetration, IPV perpetration, IPV victimization, and alcohol use were entered as predictors.

For the regression with general fearlessness/pain tolerance as the criterion, the overall model fit for the first and second steps were significant, both explaining 5% of the variance ($R^2 = .05$, $F_{(2,395)} = 10.25$, $p < .001$; $R^2 = .05$, $F_{(6,391)} = 3.67$, $p = .001$). Suicide/NSSI history ($\beta = .57$, $t = 2.13$, $p = .034$) and male gender ($\beta = .40$, $t = -4.22$, $p < .001$) were the sole variables associated with increases in general fearlessness/pain tolerance in both steps. The second step did not contribute significant variance to general fearlessness/pain tolerance beyond step 1. Further, these variables explained only a very small percentage of the variance in general fearlessness/pain tolerance.

For the regression with fearlessness about death as the criterion variable, the overall model fit for the first and second steps were significant, explaining 6% ($R^2 = .06$, $F_{(2,395)} = 13.01$, $p < .001$) and 8% ($R^2 = .08$, $F_{(4,391)} = 5.30$, $p < .001$) of the variance, respectively. In the first step, gender was associated with fearlessness about death ($\beta = -.25$, $t = 5.10$, $p < .001$), such that male gender was associated with increases in fearlessness about death. In the second step, gender ($\beta = -.27$, $t = 5.40$, $p < .001$) and alcohol use ($\beta = -.10$, $t = -2.03$, $p = .043$) were associated with fearlessness about death, such that being male and lower alcohol use were associated with increases in fearlessness about death. However, the second step did not contribute significant variance beyond step 1 ($p = .23$). Further, these variables explained only a very small percentage of the variance in fearlessness about death.

Discussion

The current study is among the first to explore the theorized associations of interpersonal violence and alcohol use with ACS in young adults. The few associations that emerged between suicide risk factors and ACS were weak and were accounted for by well-established risk factors for suicide: male gender and history of suicide attempts/NSSI. These findings converge with work highlighting male gender and history of suicidal behavior as key risk factors for the development of ACS but also provide tentative evidence against interpersonal violence and alcohol use as correlates of ACS.

General physical violence perpetration was bivariately, positively correlated with fearlessness about death, which supports prior research showing that physically aggressive experiences, such as combat exposure, are associated with increases in fearlessness about death (Bryan & Cukrowicz, 2011). However, physical violence perpetration was not associated with increases in general fearlessness/pain tolerance, which is inconsistent with experimental evidence that physical aggression committed through violent video games increases physical pain tolerance (Teismann et al., 2014). While this is one of the few tests of a correlation between physical violence perpetration and fearlessness about death, this association was not present in multivariate models. Furthermore, this study cannot determine whether engagement in physical violence increases fearlessness about death or fearlessness about death increases one's tendency to engage in violence. Further research is needed to test the temporality of the relationship between physical violence perpetration and fearlessness about death and to rule out potential third variables, such as male gender or sensation-seeking traits (Witte et al., 2012).

Alcohol use was positively associated with greater general fearlessness/pain tolerance, but not fearlessness about death, at the bivariate level. Of question is whether persons with greater general fearlessness/pain tolerance are prone to consume alcohol more, if consuming greater levels of alcohol increases fearlessness/pain tolerance, or if there is a third variable that accounts for these relationships (e.g., male gender, male gender role traits). Indeed, this is further supported by the lack of a unique association between alcohol use and ACS facets in the multivariate analyses. Interestingly, alcohol use was not associated with fearlessness about death. An explanation for this null finding is alcohol use may only have a proximal effect on decreasing fear about death, an effect that is directly testable with a longitudinal study. Future work should implement longitudinal designs to improve our understanding of the associations between hazardous drinking and ACS. However, the associations of alcohol use and interpersonal violence with the ACS facets were no longer significant when gender and suicide attempt/NSSI history were accounted for. The relationship between male gender and ACS converges with past research (Anestis, Bender, Selby, Ribeiro, & Joiner, 2011; Witte et al., 2012) as well as the notion that higher levels of ACS may explain the higher rate of death by suicide among men compared to women (CDC, 2013). Men may exhibit higher levels of fearlessness about death and pain tolerance than women due to greater masculine gender role traits such as sensation-seeking, stoicism, and restrictive emotionality (Anestis et al., 2011; Granato, Selwyn, & P. Smith, 2013; Witte et al., 2012). Such masculine gender role adherence may predispose men to engage in greater aggression (Moore & Stuart, 2004), which in turn may increase their ACS. For example, in the current study, general physical violence perpetration was associated with fearlessness about death, and alcohol use was associated with general fearlessness/pain tolerance with alcohol use at the bivariate level. However, these associations disappeared when male gender was accounted for in the multivariate model. This may be due to only violence perpetration and alcohol use over the past year being measured. Perhaps measures that better capture chronic alcohol use and general propensities toward violence rather than frequencies of aggressive acts could clarify these relationships. Future work should further examine reasons the associations among gender, physical violence perpetration, and fearlessness about death.

Limitations, Future Directions, and Clinical Implications

The current findings suggest interesting trends for further investigation; however, limitations of this study should be improved upon to advance the understanding of events associated with increases in the ACS. First, the cross-sectional design of the study did not allow for tests of temporality and causality. More sophisticated designs are needed to rule out potential third variables and confirm temporality of the variables. Second, the self-report methods of the study may be influenced by biases in recall or social desirability. Relatedly, the self-report measure used for ACS needs further validation. Behavioral indicators of ACS, such as pain algometers for pain tolerance would provide a stronger test of the theory's predictions. Additionally, to improve reliability of our measurement, we included various forms of IPV within the IPV victimization and perpetration scales. Future work should test the unique associations of each IPV type with ACS. Third, our measurement of history of suicidal behaviors was limited to one yes-no item that assessed whether participants ever tried to hurt or kill themselves. This precluded separation of suicide attempts from NSSI. However, for a preliminary test of the unique associations of suicide

risk factors with ACS, this item adequately represents behaviors that have demonstrated a robust association with ACS (P. Smith & Cukrowicz, 2010). Fourth, the multivariate models tested in the current study accounted for a small amount of the variance (< 10%) in the ACS factors. Continued efforts are needed to identify painful and provocative events that influence ACS. Finally, the current study used a convenience sample of undergraduates, which is only a subset of the young adult population who is vulnerable for suicide. Future work is needed using more diverse samples.

The findings from this study have modest implications for clinical assessment of suicide risk. Given that ACS is posited to be an indicator of risk for acting on suicidal desire, male gender and alcohol use should be considered indicators for elevated pain tolerance and, thus, risk for suicide. Additionally, male gender and history of physical violence perpetration should be considered as indicators of fearlessness about death. While male gender emerged as the most salient correlate of ACS facets in the current sample, history of physical violence perpetration and alcohol use should also be considered potentially important indicators of suicide risk in women as well. However, future work testing the temporality and causality among these variables is critical before making strong claims regarding whether these events promote ACS and thus risk for suicide.

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Table 1

Means, Standard Deviations, and Correlations of Study Variables

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
|-------------------------------------------|------------------|---------|--------|--------|--------|--------|-------|---|
| 1. General Fearlessness/Pain Tolerance | - | - | - | - | - | - | - | - |
| 2. Fearlessness about Death | .40*** | - | - | - | - | - | - | - |
| 3. IPV Perpetration | .07 | .02 | - | - | - | - | - | - |
| 4. IPV Victimization | .08 | .03 | .90*** | - | - | - | - | - |
| 5. General Physical Violence Perpetration | .01 | .12** | .20*** | .15*** | - | - | - | - |
| 6. Alcohol Use | .10* | -.02 | .20*** | .20*** | .15*** | - | - | - |
| 7. Gender | -.19*** | -.23*** | .00 | -.05 | .11* | -.15** | - | - |
| 8. Suicide Attempt/NSSI History | .08 ^a | -.01 | .09* | .10* | -.05 | .05 | .12** | - |
| Mean | 11.53 | 13.00 | 11.83 | 11.98 | 10.43 | 4.76 | - | - |
| (SD) | 3.86 | 4.69 | 23.83 | 24.34 | 2.40 | 4.80 | - | - |

Note: NSSI = Nonsuicidal Self-Injury; SD = Standard Deviation; Gender is coded as 0 = Men and 1 = Women; Threat is coded as 0 = Absent and 1 = Present;

* p < .05,

** p < .01,

*** p < .001,

^a p = .09, (two-tailed).

Table 2

Hierarchical Regression Results

| Fearlessness about Death | | | | | |
|----------------------------------------|-------|---------|---------|----------------|----------------|
| Variable | B | β | t | R ² | R ² |
| Step 1 | | | | .06** | |
| Gender | -2.46 | -.25 | -5.10** | | |
| Suicide attempt/NSSI History | .29 | .02 | 0.41 | | |
| Step 2 | | | | .08** | .01 |
| Gender | -2.64 | -.27 | -5.40** | | |
| Suicide Attempt/NSSI history | .39 | .03 | 0.55 | | |
| IPV Perpetration | -.01 | -.06 | -0.43 | | |
| IPV Victimization | .01 | .04 | 0.32 | | |
| General Physical Violence Perpetration | .13 | .07 | 1.40 | | |
| Alcohol Use | -.10 | -.10 | -2.03* | | |

| General Fearlessness and Pain Tolerance | | | | | |
|-----------------------------------------|-------|---------|---------|----------------|----------------|
| Variable | B | β | t | R ² | R ² |
| Step 1 | | | | .05** | |
| Gender | -1.66 | -.21 | -4.22** | | |
| Suicide attempt/NSSI History | 1.2 | .11 | 2.13* | | |
| Step 2 | | | | .05*** | 0 |
| Gender | -1.61 | -.20 | -4.02** | | |
| Suicide Attempt/NSSI history | 1.22 | .11 | 2.11* | | |
| IPV Perpetration | -0.01 | -.04 | -0.32 | | |
| IPV Victimization | 0.01 | .03 | 0.24 | | |
| General Physical Violence Perpetration | -0.08 | -.06 | -1.05 | | |
| Alcohol Use | 0.03 | .03 | 0.67 | | |

Note:

* = $p < .05$,

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**
= $p < .01$,

NSSI = Nonsuicidal Self-Injury, IPV = Intimate Partner Violence