Recollections of Parental Rejection, Self-Criticism and Depression in Suicidality

Rui C. Campos, Avi Besser, and Sidney J. Blatt

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Q5: Au: Sobel, 1982 not in References.
Q6: Au: Please update Campos in press if new information is now available.
Q7: Au: Provide the department affiliation.
Q10: Au: Russek 1997 only cited once in text. Please clarify which is cited.

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Recollections of Parental Rejection, Self-Criticism and Depression in Suicidality

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The present study examines whether self-criticism and depressive symptoms mediate the relationship between recollections of parental rejection and suicidality. A community sample of 200 Portuguese adults completed, in counterbalanced order, a socio-demographic questionnaire, the short form of the Inventory for Assessing Memories of Parental Rearing Behaviour (EMBU), the Depressive Experiences Questionnaire (DEQ), the Center for Epidemiologic Studies Depression Scale (CES-D), and reports of any suicide intention and/or ideation and suicide attempts. Structural Equation Modeling (SEM) indicated that recollections of parental rejection are significantly associated with depressive symptoms and suicidality. Recollections of parental rejection are indirectly associated with depressive symptoms and suicidality through self-criticism. The association between self-criticism and suicidality is mediated by depressive symptoms. In addition to a significant direct association between recollections of parental rejection and suicidality, the final model indicated that recollections of parental rejection are significantly associated with self-criticism. That same self-criticism is significantly associated with depressive symptoms which, in turn, are significantly associated with suicidality. Individuals with recollections of parental rejection are at greater risk for suicide ideation and behavior, possibly because such experiences predispose them to intense self-criticism which is a risk factor for depression associated with suicidal ideation and behavior.

Keywords depression, parental rejection, self-critical perfectionism, suicidality

INTRODUCTION

Suicide is a major mental health problem across the life span, but especially in adolescents and older adults. In Portugal, in 2009, 1025 persons died by suicide (WHO, 2012). The national official rate of suicide is 10.3 deaths per 100,000 people and suicide is the leading cause of unnatural death (National Institute of Statistics, 2011). There are several theoretical models for suicide and suicide behavior that include sociocultural and psychological perspectives (e.g., Goldney & Schioldann, 2004), demonstrating the potential interaction among several risk factors (e.g., Beautrais, Collings, Ehrhardt et al., 2005). Early developmental vulnerabilities, like insecure attachment and malevolent object representations, as well as personality traits,
psychopathology—especially depression—life events, and contextual and social factors may interact as predisposing factors for suicide behavior (see review in Campos, Besser, & Blatt, 2012).

Substantial clinical (e.g., Blatt, 1974, 1995) and empirical (e.g., Beck, 1983; Blatt, Quinlan, Chevron et al., 1982; Fazaa & Page, 2003) evidence indicates that a personality dimension, Self-Critical Perfectionism, has a major role in suicide ideation and behavior (e.g., Campos, Besser, & Blatt, 2012; Yamaguchi, Koboayashi, Tachikawa et al., 2000). Furthermore, several theoretical and empirical studies have linked early, disrupted parental practices, insecure attachment (e.g., Titelman, Nilson, Estari et al., 2004; Titelman, Nilson, Svensson et al., 2011), and depression (e.g., Youssef, Plancherel, Laget et al., 2004) with suicidality. Clinical symptoms and psychopathology may result from disrupted working models or cognitive-affective schema of self and significant others deriving from early disrupted parental relationships. In general, empirical studies assessing adults' perceptions of early caretaking relationships confirm the relevance of these disrupted early relationships for pathological functioning (Blatt & Homann, 1992; Parker, 1983, 1994; Russek & Schwartz, 1997).

The present study examines the role of recollections of parental rejection in suicidality and the mediating role of self-criticism and depression in the relationship between those factors (i.e., reports of any suicide intention and/or ideation or suicide attempts). Understanding the risk factors for suicidal behaviors, including ideation, intention, and attempts, can provide the basis for early intervention. It is estimated that the rate of attempted suicide is at least 20 times greater than that of completed suicides (see, e.g., Fotti, Katz, Affifi et al., 2006) and this figure may even be underestimated because many attempts remain unknown and undocumented. Early disrupted parental practices and insecure attachment have been linked with risk of suicide both in adolescents and adults. Barksdale, Walrath, Compton et al., (2009) studied the relationship between disrupted parental relationships and suicidal behavior and concluded that caregivers of suicidal individuals differ from parents of non-suicidal youth in their degree of subjective internalized strain (e.g., worry, guilt) and objective strain (e.g., constraints on activities). Titelman, Nilsson, Svensson et al. (2011) compared suicide attempters with a control group on the Percept-genetic Object-Relation Test and concluded that a lack of a constructive attachment relationship distinguished these groups. Heo (2008) found that individuals who experienced trauma are more likely to report disrupted object relations, which, in turn, lead to greater mental anguish and suicidal ideation. Goldney (1985), using the parental bonding instrument (PBI; Parker, Tupling, & Brown, 1979), compared 43 women who had attempted suicide with 43 age-matched controls and found that the women who attempted suicide reported significantly lower parental care and higher parental overprotection.

Depression has also been a powerful predictor of suicidal behavior (Lamis, Malone, Langhinrichsen-Rohling et al., 2010). Caregivers perceived as punitive, depriving, and negligent constitute a precursor for depression in adults (Blatt, 1974, 1995). Depressed individuals report more negative experiences with their parents (e.g., Blatt, Wein, Chevron et al., 1979; Burbach & Borduin, 1986; Dahn, 2000; Karoly & Ruehlman, 1983); they recall their mothers and fathers as uncaring, rejecting, and punitive (Blatt, 2004). Recently, Campos, Besser, and Blatt (2010) found that the relationship between perceptions of quality of maternal caring and depressive symptoms is mediated by a predisposition to self-critical perfectionism. Campos (2010), like Quinlan, Blatt,
Chevron et al. (1992), found that depression was associated with negative and punitive concepts of both the father and mother as measured by semantic differential.

Self-critical perfectionism (i.e., overly critical evaluation of one’s own behavior, an inability to derive satisfaction from successful performance, and chronic concerns about others’ criticism and performance; Dunkley, Blankstein, Masheb et al., 2006, see also Blatt, 1995) also predicts depression and suicide ideation and behavior (Campos, Besser, & Blatt, 2012). Blatt (2004, 2008) has located the personality dimension of self-critical perfectionism within a broad conceptualization of personality development and psychopathology (see also Luyten, Corveleyn, & Blatt, 2005).

Self-critical perfectionism has been associated with suicide (e.g., Blatt, 1995) in both clinical and empirical research (Beck, 1983; Blatt, Quinlan, Chevron et al., 1982; Fazaa & Page, 2003). Recent findings indicate that self-criticism factor, as measured with the DEQ, predicts suicidal risk (Campos, Besser, & Blatt, 2012; Morrison & O’Connor, 2007; O’Connor, 2007). Fazaa and Page (2003) found that self-critical undergraduate students who attempted to kill themselves showed greater intent to die and greater lethality than did suicidal dependent undergraduates. O’Connor and Noyce (2008) found that brooding rumination in adults mediated the relationship between self-criticism and suicide ideation.

Considerable empirical and clinical research attests to the relevance of self-critical perfectionism to depression in both clinical and community samples (e.g., Besser, Luyten, & Blatt, 2011; Besser & Priel, 2003a, 2003b, 2005a, 2005b, 2010, 2011; Besser, Vliegen, Luyten et al., 2008; Blatt, 2008; Campos, Besser, & Blatt, 2010; Corveleyn, Luyten, & Blatt, 2005; Mongrain & Zuroff, 1995). Empirical evidence has also linked depression with suicidality (e.g. Lamis, Malone, Langhinrichsen-Rohling et al., 2010; Overholser, Freheit, & DiFilippo, 1997; Youssef, Plancherel, Laget et al., 2004).

Blatt and Homann (1992), reviewing research on the characteristics of parents of self-critical individuals, found a link between this personality vulnerability and attachment insecurity, a fact which impaired concepts of self and significant others, thereby creating a vulnerability to depression. Insecurely attached individuals have difficulty with separation and constantly seek reassurance and support in anticipation of rejection, resulting in low self-esteem and increased need for interpersonal contact. Insecure attachment styles may also play a role in the self-punitive, distrustful style of relating that characterizes self-criticism (Besser & Priel, 2005b). Thus, a negative view of self characterizes both fearful and preoccupied insecure attachment. Avoidant insecure attachment is often linked to negative evaluation of self and setting unrealistic standards. Preoccupied insecure attachment also involves a negative sense of self in relation to others, including feeling unloved and unlovable (also see Blatt, 2004). Thus, a negative sense of self appears to result from disrupted early attachment relationships with primary caregivers (parents).

Blatt, Wein, Chevron et al. (1979) found that self-criticism on the DEQ correlated significantly with negative concepts of the father and mother on a semantic differential. Campos, Besser, and Blatt (2010) found that a lack of maternal care and overprotection related to self-criticism and McCraine and Bass (1984) reported that self-critical individuals tend to recall their parents as being cold. Thus, consistent evidence indicates that the quality of parental caring has a significant role in the development of a self-critical vulnerability to depression, which is consistent with the findings of an association of insecure attachment with self-critical vul-
nerability to depression (Besser & Priel, 2005a). For example, Quinlan, Blatt, Chevron et al. (1992) found that descriptions of both parents as less benevolent and more punitive correlated with the self-criticism factor of the DEQ. Thus, research consistently suggests that perceived dysfunctional early relationships with caregivers is associated with self-criticism (Blatt, Wein, Chevron et al., 1979; Campos, Besser, & Blatt, 2010) as well as with depression (see review in Campos, Besser, & Blatt, 2010) and suicidal behavior. Previous research has also suggested that self-criticism and depression are powerful predictors of suicidality and that experiences of distress mediate the association between self-criticism and suicidality (see Campos, Besser, & Blatt, 2012).

Thus, two assumptions underlie the hypotheses of the current study: (a) that dysfunctional early relationships with caregivers are associated with the development of a self-critical vulnerability to depression, and (b) that self-criticism and depression are associated with suicidality. Thus, we hypothesized that early rejecting relationships with parents would be associated with self-critical vulnerability underlying the predisposition to depression and suicidality. Figure 1 illustrates the conceptual model underlying the current study.

METHOD

Participants and Procedure

A convenience sample of 200 adults, 104 males and 96 females, ranging in age from 19 to 63 years ($M=35.83$, $SD=11.62$) and living in several Portuguese districts, participated in this study. Their education ranged from 6 to 19 years of schooling ($M=11.69$, $SD=3.17$). A minority (10%) was unemployed and approximately 46% were married or were living with a romantic partner, while 54% were neither. Participants responded to a request for volunteers to take part in a study concerning personality and mood. Of the 237 individuals initially contacted, 25 declined to participate due to time constraints. Protocols of 12 of the 212 individuals initially interviewed were eliminated due to missing socio-demographic information or an elevated number of missing responses, thus yielding a final sample of 200 participants who were contacted by trained research assistants and volunteered to participate after signing an informed-consent form. All protocols were collected in individual sessions by trained research assistants and instructions were presented in writing. Participants were neither paid nor compensated. The questionnaires were presented in a counterbalanced format.

Measures

Sociodemographic Questionnaire. Before completing the four questionnaires assessing parental rejection, depressive symptoms, self-criticism, and suicidality, participants contributed socio-demographic data. This questionnaire was designed to collect information about gender, age, education, marital status, employment, and district of
residence. Participants were also asked how many times they had visited a doctor in the past year, if they suffered from a chronic illness, if they had ever visited a psychologist or psychiatrist, and if they had ever been diagnosed with a psychiatric disorder. Frequency data, means, and standard deviations for the socio-demographic variables appear in Table 1. Two of the 4 items of the Suicidal Behavior Questionnaire Revised (SBQ-R; Osman, Bagge, Gutierrez et al., 2001) were used: “Have you ever thought about or attempted to kill yourself?” and “Have you ever told someone that you were going to commit suicide, or that you might do it?” to assess ideation, attempts and intention.

**TABLE 1. Socio-Demographic Variables**

<table>
<thead>
<tr>
<th>Variables</th>
<th>N</th>
<th>%</th>
<th>Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>35.83 (11.62)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>11.69 (3.17)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>104</td>
<td>52%</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>96</td>
<td>48%</td>
<td></td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married or living together</td>
<td>92</td>
<td>46%</td>
<td></td>
</tr>
<tr>
<td>Not married</td>
<td>108</td>
<td>54%</td>
<td></td>
</tr>
<tr>
<td>District</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Évora</td>
<td>83</td>
<td>41.5%</td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td>117</td>
<td>58.5%</td>
<td></td>
</tr>
<tr>
<td>Being employed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>180</td>
<td>90%</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>20</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>Number of times went to the doctor last year</td>
<td>2.53 (2.44)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Having a chronic disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>38</td>
<td>19%</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>162</td>
<td>81%</td>
<td></td>
</tr>
<tr>
<td>Ever gone to a psychologist or a psychiatrist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>56</td>
<td>28%</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>144</td>
<td>72%</td>
<td></td>
</tr>
<tr>
<td>Psychiatric disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>4</td>
<td>2%</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>195</td>
<td>98%</td>
<td></td>
</tr>
</tbody>
</table>

`1According to Blatt, D’Afflitti, and Quinlan (1976) each of the standardized scores of the 66 items should be multiplied by the factor weight coefficient obtained with the standardized sample for the loadings on Self-Criticism, Dependency, and Efficacy. In this unit-weight scoring system, all 66 items contribute to the final score of each factor, proportionally to their factor weight coefficients.
The validity of the self-criticism factor of the DEQ has been demonstrated in a range of different cultures (see summary in Blatt, 2008). The Portuguese version of the DEQ has adequate psychometric properties (Campos, 2000, 2009)—the internal consistency and the factor structure were very similar to those initially obtained by Blatt, D’Afflitti, and Quinlan (1976). In the present study, the Cronbach’s alpha for the self-criticism factor was .80.

Center for the Epidemiological Studies of Depression Scale. This 20-item inventory (CES–D; Radloff, 1977) assesses the symptoms of depression. Scores range from 0 to 60, with higher scores indicating more severe depression. The CES–D is well suited for adults from the general population who are asked to indicate the frequency with which they have experienced each of 20 symptoms of depression over the past week on a 4-point scale (0 to 3). The CES–D has acceptable levels of internal consistency, reliability and validity (e.g., Eaton, Muntaner, Smith et al., 2004). The CES-D was adapted for a Portuguese population by Gonçalves and Fagulha (2003, 2004) and has good psychometric characteristics. The Cronbach’s α values varied between .87 and .92 in different samples. In the present sample, the α reliability coefficient for the CES–D was .90.

RESULTS

Data Analysis

We examined the normality of the distributions of the variables using the Kolmogorov-Smirnov test (K-S test), the Lilliefors test, and the Shapiro-Wilk test. The results indicated that the distributions of these measures were relatively normal (p values >.53). We also examined whether there was multicollinearity between the recollections of parental rejection scales, the self-criticism factor, the depressive symptoms scale, and the suicidality variables. Eigenvalues of the scaled and uncentered cross-products matrix, condition indices, and variance decomposition proportions, along with variance inflation factors (VIF) and tolerances from multicollinearity analyses indicated the absence of any multicollinearity. Our analyses focused on the role of the personality characteristic self-criticism and depressive symptoms in mediating the association between parental rejection and suicidality.

Structural equation modeling (SEM; Hoyle & Smith, 1994) was used in three stages to assess measurement errors in the dependent and independent variables. In the first stage, we examined the direct associations between parental rejection and suicidality and between the former and depressive symptoms. In the second stage, we examined whether self-criticism mediated the association between parental rejection and suicidality, and in the third step we examined whether depressive symptoms mediated the associations between parental rejection and/or self-criticism and suicidality, following the criteria for mediation proposed by Baron and Kenny (1986). All analyses were conducted with AMOS (version 18; Arbuckle, 2009) using the maximum-likelihood method in which we specified two latent factors: suicidality, which was defined by two indicators (intention and ideation or attempt), and parental rejection, which was defined by two indicators (mother rejection and father rejection).

Several fit indices were used. We first used the χ² test to evaluate how the proposed model fit the data as compared to the saturated model (the baseline model that represents perfect model fit). A non-significant χ² has traditionally been used as a criterion for not rejecting a SEM...
model. A nonsignificant $\chi^2$ indicates that the matrix of the parameters estimated based on the proposed model is not significantly different from the matrix based on the empirical data. However, this is a very strict and sensitive criterion that is influenced by the number of variables and the number of participants (e.g., Landry, Smith, Swank et al., 2000). For this reason, we also used additional fit indices: the $\chi^2/df$ ratio, the root mean square error of approximation (RMSEA and two-sided 90% confidence intervals), the comparative fit index (CFI), and the non-normed fit index (NNFI). A model in which the $\chi^2/df$ value was $\leq$3, the CFI and NNFI values were greater than .90, and the RMSEA index was between .00 and .06 with confidence intervals between .00 and .08 (Hu & Bentler, 1999) was considered acceptable. These moderately stringent acceptance criteria clearly reject inadequate or poorly specified models while accepting those that meet real-world criteria for reasonable fit and representation of the data (Kelloway, 1998). Descriptive statistics for the demographic variables are presented in Table 1. Zero-order correlations and the means and their standard deviations for the variables included in the final SEM models appear in Table 2.

**Preliminary Analyses.** A preliminary analysis explored any possible associations between socio-demographic variables (gender, age, education, employment status, marital status, number of visits to a physician in the past year, chronic illness, having ever visited a psychologist or psychiatrist, and having received a psychiatric diagnosis) and the study variables (depressive symptoms and suicidality). A series of correlations indicated significant associations between marital status and depressive symptoms ($r = -.19, p < .01$), and between number of visits to a physician in the past year and depressive symptoms ($r = .17, p < .05$). Moreover, gender was significantly associated with high levels of suicide ideation or attempt ($r = .14, p < .05$), and having ever visited a psychologist or psychiatrist was significantly associated with high levels of suicide ideation or attempt ($r = .19, p < .01$) and with high levels of suicide intention ($r = .25, p < .0001$). No significant associations were found between the study variables and any of the following socio-demographic variables: age, education, employment status, chronic illness, and having received a psychiatric diagnosis. Accordingly, subsequent analyses controlled for marital status, number of visits to a physician in the past year, and having received a psychiatric diagnosis.

<table>
<thead>
<tr>
<th>Variables</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>M</th>
<th>SD</th>
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<tr>
<td><strong>Personality Characteristic</strong></td>
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</tr>
<tr>
<td>1. Self-Criticism</td>
<td>—</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>—.55</td>
<td>1.05</td>
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<td><strong>Depressive Symptoms</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>2. CES-D</td>
<td>.56***</td>
<td>—</td>
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<td></td>
<td></td>
<td></td>
<td>12.36</td>
<td>8.28</td>
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<tr>
<td><strong>Parental Rejection</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Mother Rejection</td>
<td>.26***</td>
<td>.32***</td>
<td>—</td>
<td></td>
<td></td>
<td></td>
<td>12.87</td>
<td>4.12</td>
</tr>
<tr>
<td>4. Father Rejection</td>
<td>.39***</td>
<td>.28***</td>
<td>.44***</td>
<td>—</td>
<td></td>
<td></td>
<td>10.53</td>
<td>3.12</td>
</tr>
<tr>
<td><strong>Suicidality</strong></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Ideation and attempt</td>
<td>.38***</td>
<td>.39***</td>
<td>.27***</td>
<td>.37***</td>
<td>—</td>
<td></td>
<td>1.44</td>
<td>.73</td>
</tr>
<tr>
<td>6. Intention</td>
<td>.21**</td>
<td>.27***</td>
<td>.29***</td>
<td>.29***</td>
<td>.44***</td>
<td>—</td>
<td>1.21</td>
<td>.47</td>
</tr>
</tbody>
</table>

*Note. N = 200. **p < .01, two-tailed. ***p < .001, two-tailed.*
to a physician in the past year, gender, and having ever visited a psychologist or psychiatrist.

Direct Association Models

Parental Rejection and Suicidality. The SEM model used to test direct associations of Parental Rejection and Suicidality fit the observed data very well: \( \chi^2 (1) = 1.066, p > .302, \frac{\chi^2}{df} = 1.066, \text{NNFI} = .992, \text{CFI} = .999, \text{RMSEA} = .018 \). As indicated in Figure 2A, the association between Parental Rejection and Suicidality was significant (\( \beta = .68, t = 4.618, p < .0001 \)). This model significantly explained 47% of the variance in Suicidality.

Parental Rejection and Depressive Symptoms. The SEM model used to test direct associations of Parental Rejection and depressive symptoms has zero degrees of freedom thus fit indexes could not be estimated. As indicated in Figure 2B, the association between Parental Rejection and depressive symptoms was significant (\( \beta = .45, p < .001 \) (two tailed)).

When we controlled for the effects of marital status, number of visits to a physician in the past year, gender, having ever visited a psychologist or psychiatrist, the significant associations, as presented in this figure, were not altered. These effects were removed to simplify the figure.

FIGURE 2. Direct association model of the relationship between parental rejection and A) Suicidality B) Depressive symptoms. Note. Rectangles indicate measured variables and large circles represent latent constructs. Small circles reflect residuals (e) or disturbances (d); bold numbers above or near endogenous variables represent the amount of variance explained (\( R^2 \)). Unidirectional arrows depict hypothesized directional or “causal” links. Standardized maximum likelihood parameters are used. Bold estimates are statistically significant. \( N = 200 \). ***p < .001 (two tailed).
Parental Rejection and Suicidality: The Mediating Role of Self-Criticism. A mediational SEM model, including parental rejection, self-criticism, and suicidality, fit the observed data very well: $\chi^2 (3) = 3.906, p > .272, \chi^2 / df = 1.302, \text{NNFI} = .978, CFI = .995, \text{RMSEA} = .039$. Figure 3 illustrates that parental rejection was in significant indirect association with suicidality through its association with self-criticism. High levels of parental rejection were significantly associated with high levels of self-criticism ($\beta = .49, t = 4.801, p < .0001$) that were significantly associated with high levels of suicidality ($\beta = .20, t = 2.80, p < .05$). The indirect associations between high levels of parental rejection and high levels of suicidality through high levels of self-criticism ($z = 2.45, p < .05$) were significant when subjected to the $z$ test (Sobel, 1982), significantly explaining 24% of the variance in self-criticism and 43% of the variance in suicidality.

![Diagram](image.png)

**FIGURE 3.** Indirect associations model of the relationships among parental rejection, self-criticism, and suicidality. Note. Rectangles indicate measured variables and large circles represent latent constructs. Small circles reflect residuals (e) or disturbances (d); bold numbers above or near endogenous variables represent the amount of variance explained ($R^2$). Unidirectional arrows depict hypothesized directional or “causal” links. Standardized maximum likelihood parameters are used. Bold estimates are statistically significant. The number in parentheses is the beta value before Self-Criticism scores (assumed mediators) were entered into the model. $N = 200, * p < .05; *** p < .001$ (two tailed). When we controlled for the effects of marital status, number of visits to a physician in the past year, gender, having ever visited a psychologist or psychiatrist, the significant associations, as presented in this figure, were not altered. These effects were removed to simplify the figure.
association with depressive symptoms, and how self-criticism had a significant mediating association with suicidality through its association with depressive symptoms. High levels of parental rejection were significantly associated with high levels of depressive symptoms ($\beta = .19$, $t = 1.982$, $p < .05$) and with high levels of self-criticism ($\beta = .50$, $t = 4.745$, $p < .0001$). High levels of self-criticism were significantly associated with high levels of depressive symptoms ($\beta = .46$, $t = 5.953$, $p < .0001$). Depressive symptoms were significantly associated with high levels of suicidality ($\beta = .24$, $t = 2.437$, $p < .05$). The indirect associations between high levels of parental rejection and high levels of suicidality through high levels of depressive symptoms ($\zeta = 1.622$, $p < 0.10$) were non-significant when subjected to the $\zeta$ test (Sobel, 1982). However, the indirect associations between high levels of parental rejection and high levels of depressive symptoms through high levels of self-criticism ($\zeta = 3.74$, $p < 0.001$) were significant when subjected to the $\zeta$ test (Sobel, 1982).

Moreover, the significant association between self-criticism and suicidality dropped and became non-significant ($\beta = .07$, $t = .689$, ns) when depressive symptoms were included in the model. The mediating association between high levels of self-criticism and high levels of suicidality ($\zeta = 2.28$, $p < .05$) was significant when subjected to the $\zeta$ test (Sobel, 1982), significantly explaining 25% of the variance in self-criticism, 33% of the variance in depressive symptoms, and 49% of the variance in suicidality.
It is noteworthy that these results of the direct and mediating models were unaltered when examined while controlling the shared variance associated with marital status, number of visits to a physician in the past year, gender, having ever visited a psychologist or psychiatrist, and parental rejection, as well as the associations between these variables and self-criticism, depressive symptoms, and suicidality. It is also noteworthy that these results of the direct and mediating models were unaltered when examined while controlling for the effects of Dependency and Efficacy. Parental Rejection had no significant effect on Dependency or on Efficacy and Dependency, and Efficacy had no significant effect on depression or suicidality. Finally, no significant moderation effects were found for Efficacy in the associations between parental rejection and depression or suicidality. In the interest of parsimony and to simplify the presentation of the models, these variables were trimmed from the final model.

Summary of Results

1. Parental rejection is significantly associated with suicidality and with depressive symptoms.
2. Parental rejection is indirectly associated with suicidality and depression through self-criticism.
3. The association between self-criticism and suicidality was mediated by depressive symptoms.

DISCUSSION

The present study examined whether self-criticism and depressive symptoms mediate the relationship between recollections of parental rejection and suicidality. Findings indicate that recollections of parental rejection are significantly associated with suicidality and with depressive symptoms, and that recollections of parental rejection are also indirectly associated with suicidality and depression through self-criticism. Moreover, the association between self-criticism and suicidality was mediated by depressive symptoms.

These findings build on those of Campos, Besser, and Blatt (2012) that found that distress (including depression) mediates the relationship between self-criticism and suicidality. The findings of the present study suggest a more comprehensive theoretical model for suicide risk—that self-criticism is the result of parental rejection and that self-critical individuals may be at risk for suicide through their vulnerability to depression. These results support the view that disrupted parent-child interactions constitute a distal vulnerability factor for suicide risk.

Theoretically, self-critical individuals are concerned about losing parental approval as a result of failing to meet the expectations that controlling, demanding, and intrusive parents have set for them (e.g., Blatt, 1995; Blatt & Homann, 1992). Parental rejection may, in fact, be a response to the child's inability to fulfill imposed parental standards and wishes. The results of the present study confirm the association between rejecting parent–child interactions and the development of self-critical personality traits and their predisposition toward depression. Thus, vulnerability to depression and suicidality appears to be associated with rejecting care-giving and the subsequent development of self-critical (introjective) personality characteristics (Blatt, 1974, 1995). Early disrupted child caring practices of both parents have been linked to introjective (self-critical) personality organization.

The present findings are consistent with the assumptions of both attachment and object–relations theories which emphasize the unique role of the parent–child relationship in psychological development. The parent–child relationship has extensive and lasting effects on emotional, social, and
psychological development (Quinlan, Blatt, Chevron et al., 1992). Representations of self and significant others in self-critical (introjective) depression, are usually “fragmented, isolated, static, and ambivalent, and there is a [weak] resolution of the contradiction between separate images and properties” (Blatt, 1974, p. 149).

Moreover, results of the present study are congruent with theoretical assumptions relating to the role of internal working models in the etiology of suicidality. The recollection of disruptive parental behavior was probably part of the basis for the psychoanalytic speculation (e.g., Combra de Matos, 2001) that the etiology of suicide is an unconscious parental wish that the child not exist, and an unconscious attempt to rid oneself of an ambivalently loved or inaccessible object (Freud, 1917/1963; Kernberg, 2004; Leichsenring, 2004; Titelman, 2006).

The present results also support previous research indicating that self-criticism is a vulnerability factor in depression and suicidality. Highly self-critical, perfectionistic individuals are vulnerable to intense depression, often accompanied by suicidal impulses (e.g., Blatt, 1995, 2008; Campos, Besser, & Blatt, 2012). Highly self-critical individuals often experience depression when confronted with stressful life events, particularly events that disrupt self-definition and/or a sense of personal achievement (e.g., Blatt & Zuroff, 1992)—a time when depressed individuals may be at risk for suicide (e.g., Beck, 1983; Blatt, 1974, 1995; Blatt, Quinlan, Chevron et al., 1982; Overholser, Freiheit, & DiFilippo, 1997).

Self-critical individuals are prone to experience anger, which they can direct toward others and/or themselves (Hewitt & Flett, 1991) and thus can be self-destructive and suicidal (e.g., Beck, 1983; Blatt, 1974, 1995, 2008; Blatt, Quinlan, Chevron et al., 1982; Fazaa & Page, 2003; Hewitt, Flett, & Weber, 1994; Hewitt, Newton, Flett et al., 1997). Fazaa and Page (2003) found that suicide attempts among self-critical (introjective) college students were often in response to intra-psychic stressors. They also found that the suicide attempts of self-critical (introjective) college students showed great intent to die. Further studies should extend our model by including measures of general and specific life stressors as well as measures of the level of anger.

Limitations of this Study

There are several limitations to this study. It is important to note that the relationships between recollections of parental rejection, the personality dimension of self-criticism, depressive symptoms, and suicidality were assessed in a non-clinical sample with self-report measures in a cross-sectional design. The results should be compared with findings from high-risk samples in a longitudinal design before any causal inferences can be made. However, given the increasing evidence of the value of Blatt’s theory regarding the centrality of self-critical perfectionism as a vulnerability factor to depression and suicidality, as well as the value of early disrupted parental practices in vulnerability to suicide risk, the findings of the present study emphasize the importance of formulating a wide-ranging, theoretically based mechanism thorough which early parental-child interactions may constitute a vulnerability factor for increased suicide risk. The present study puts forward a possible mechanism by which early parental practices may create a vulnerability to depression and suicidality, and the mediational role of depressive symptoms in the self-critical perfectionism personality predisposition to depression and suicide risk.

Conclusions and Clinical Implications

To the best of our knowledge this is the first study to present empirical support for the association between recollections of
parental rejection and depression, suicidality, and self-criticism and to further demonstrate that high levels of self-criticism are associated with depression, which is, in turn, associated with suicidality. Increased suicide risk is associated with a particular individual/personality factor, self-critical perfectionism, which, in turn, relates to depression. The present study also highlights the central role of recollections of early parental malpractices. Our findings demonstrate the need for public health initiatives designed to reduce the risk of suicidal behavior in young adults in the community by possibly addressing inner variables like personality and representations of parental practices, especially when the clinician identifies a depressive individual. Self-critical individuals and those with a history of early trauma and rejecting parents should be the focus of interventions by mental health professionals, especially when depressed, since they may be at risk for suicide. Psychotherapy should address their core personality traits of perfectionism, self-punishment, and the inability to profit from pleasurable life experiences. Psychotherapy should also address internalized malevolent object representations, which may actually be distal vulnerability factors for suicide.

Recent findings give some suggestion about how psychotherapy may reduce suicidal behavior. The mechanisms of the therapeutic process are extensions of the processes of normal psychological development, involving experiences of engagement and disengagement that contribute to the revisions and extensions of mental representations that enable patients to relinquish and revise repetitive maladaptive internalizations (Blatt, 2008). Both the content and the structural cognitive organization of these maladaptive schemas are revised in the treatment process. Research findings suggest that in therapy, these schemas become more differentiated, articulated, and integrated and move toward more mature and constructive representations of self and of others. Changes in these representations are expressed in changes in personality structure. Changes in self-criticism or introjective personality organization reduces depressive symptoms (Blatt, Zuroff, Hawley et al., 2010), consequently leaving individuals in less distress and thus less vulnerable to suicide. In general self-criticism is associated with the turning against self type of defense mechanism that may be associated with suicidality. Instead of expressing anger, the individual turns the anger against themselves (Campos, Besser, & Blatt, 2011). Thus reduction in negative representations of self (e.g., self-criticism) appears to be an important aspect of treatment for depression and suicidality.

There are also cross cultural implications of our results. Campos (2009) found that male and female Portuguese young adults scored significantly lower than American young adults on the DEQ self-criticism scale and also on a self-report measure of depression (Campos, in press), which suggests that American young adults are at greater risk for suicidality.

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