The current study examined the presence of anxiety in children with suicide ideation. From a sample of 100 inpatients, children who displayed suicide ideation \( (n = 27) \) were selected and divided into two groups, high and low anxiety. Findings indicated that children with suicide ideation and anxiety were less happy and satisfied, experienced more negative life events, and were more distractible and intense than children with suicide ideation only. Additionally, according to their self-reports, parents of children with high anxiety reported more obsessive-compulsive and anxiety symptoms as well as greater hostility than parents of children with low anxiety. The authors have identified a subgroup of children with suicide ideation who are highly anxious and can be termed as experiencing “anxious suicidality.”

Suicidal behaviors in children, such as ideation or attempts, have attracted wide attention in the clinical literature. Researchers have investigated the link between childhood or adolescent suicidal behaviors and depressive symptomatology (e.g., Bettes & Walker, 1986; Friedrich, Reams, & Jacobs, 1982; Kovacs, Goldston, & Gatsonis, 1993; Levy & Deykin, 1989; Shaffer, 1988), hopelessness (e.g., Asarnow, Carlson, & Guthrie, 1987; Kashani, Reid, & Rosenberg, 1989; Topol & Reznikoff, 1982), substance abuse (Kandel, Raveis, & Davies, 1991; Levy & Deykin, 1989), and even musical preference (Martin, Clarke, & Pearce, 1993). While these studies have helped to lay a strong foundation for the further examination of childhood suicidality, other potentially crucial constructs have not yet been examined in relation to childhood suicidal behaviors. One such construct is anxiety.

Although anxiety has received little attention in relation to childhood suicide, among adults suicide risk has been found to be correlated significantly and positively with measures of trait and state anxiety (Apter et al., 1990; Apter, Plutchik, & van Praag, 1993) and a diagnosis of social phobia (Schneier, Johnson, Hornig, Liebowitz, & Weissman, 1992). Panic disorder, in particular, appears to be related to suicidality in adults, and the presence of panic attacks is associated with an increased risk for suicidal behavior or completed suicide (Fawcett, 1988; Fawcett et al., 1990; Weissman, Klerman, Markowitz, & Ouellette, 1989). However, some investigators are disinclined to acknowledge that anxiety and suicide ideation may be linked closely. For example, Noyes (1991) attested that “in contrast to depressed patients, those with anxiety disorders infrequently express thoughts of ending their lives” (p. 1).

Despite the increasing evidence that anxiety and suicidal behaviors are related in adults and the fact that suicidality in
childhood closely parallels that in adults (Bettes & Walker, 1986), the relationship between anxiety and suicidal behaviors has only recently been examined in child and adolescent populations. Mattison (1988), for example, posited that this relationship merited attention when he asserted that a “young patient with an anxious perfectionistic personality should be carefully monitored for suicidal symptoms” (p. 11).

The first empirical data, to our knowledge, supporting a relationship between childhood anxiety and suicidality was provided by McKenry, Tishler, and Kelley (1982). The authors had mothers of adolescents who were taken to a pediatric emergency unit report on their youngsters' anxiety. The findings displayed that adolescents who had been hospitalized due to a suicide attempt were rated as more anxious than a control group of nonsuicidal adolescents. Other authors present similar findings regarding the presence of anxiety in youngsters who are suicidal (e.g., Andrews & Lewinsohn, 1992; Bettes & Walker, 1986; Ohring et al., 1996).

Lewinsohn, Rohde, and Seeley (1993), in an examination of a sample of adolescents, reported that a history of suicide attempts was not significantly associated with the presence of anxiety and concluded that suicidal behavior is largely a presentation of severe depression. In contrast, Kashani, Goddard, and Reid (1989) found that suicidal children were more likely to experience anxiety than were nonsuicidal children. Depression was still the single best predictor of suicidal ideation in their sample, and approximately 64% of the suicidal children were diagnosed with major depressive disorder (MDD). However, the authors pointed out that, among the suicidal children without MDD, 60% were diagnosed with another psychiatric disorder, suggesting that other psychiatric disorders, such as anxiety, may also be associated with suicide ideation (Kashani, Goddard, & Reid, 1989).

The literature suggests that, although not all youngsters with suicide ideation experience anxiety and vice versa, the presence of suicide ideation and comorbid anxiety represents an important phenomenon that warrants further examination. Thus, we will examine the clinical picture of suicidal children who are also anxious. To accomplish this goal, the current paper will go beyond other studies that have examined whether or not suicidal children have higher anxiety levels than nonsuicidal children. Instead, children with suicide ideation and anxiety will be compared to children with suicide ideation only. In this manner, the presence of anxiety that is comorbid with suicidal thoughts in children can be examined. Specifically, it is expected that the children with anxiety and suicidal ideation will be more depressed, experience more hopelessness, encounter more negative and fewer positive life events, display poorer self-concept, and have parents with more psychopathology than suicidal children without anxiety.

METHOD

Participants

One hundred consecutive child admissions to an inpatient unit in a university-affiliated community mental health center in a mid-sized city served as participants. From this sample, 27 children (ages 8–11 years old) who exhibited suicide ideation were selected for further study. Suicide ideation was determined to be present if a child had a score greater than zero on items 3 or 4 on the Scale for Suicide Ideation (Beck, Kovacs, & Weissman, 1979), which respectively indicate passive or active suicidal desire. These 27 children consisted of 23 males and 4 females, which is a representative inpatient male–female ratio. The racial makeup of the sample, characteristic of the area in which the study was conducted, was comprised of 24 Caucasians and 3 African Americans. Utilizing a 5-point scale of parental annual income (1 = $30,000 and above; 2 = $25,000–$29,999; 3 = $15,000–24,999; 4 = $9,000–$14,999; 5 = below $9,000), the
median reported socioeconomic status (SES) was 4, with SES levels 5 \( (n = 10) \), 4 \( (n = 7) \) and 3 \( (n = 8) \) accounting for the entire sample. SES data were unavailable for two participants.

**Instruments**

The Scale for Suicide Ideation (SSI; Beck et al., 1979), developed as an adult measure to quantify and assess the degree of suicide ideation, is a clinician-rating scale presented in a semi-structured interview format. Following the interview, the clinician completes 19 items that encompass three dimensions of suicide ideation: active suicidal desire, specific plans for suicide, and passive suicidal desire (Beck et al., 1979). Each item is rated on a 3-point scale and a total score (range 0–30) can be computed, with higher scores indicating more elevated suicide ideation. The SSI has recently been validated for use with inpatient children by Allan and colleagues (1997) and found to possess adequate reliability and validity.

The Children’s Manifest Anxiety Scale–Revised (RCMAS; Reynolds & Paget, 1981, 1983; Reynolds & Richmond, 1978), a 37-item true–false scale, was used to assess each participant’s level of anxiety. The RCMAS has been found to be reliable (Reynolds & Paget, 1983) and valid (Reynolds & Richmond, 1978) for children and adolescents, with a high interitem correlation \( (\alpha = .85; \text{Reynolds & Richmond, 1978}) \). Total scores can be derived, with higher scores corresponding to the presence of greater anxiety. The national normative mean total score on the RCMAS for 10-year-olds (i.e., the mean age for the present study) is 14.79 \( (SD = 6.60; \text{Reynolds & Paget, 1983}) \).

The Children’s Depression Rating Scale (CDRS; Poznanski, Cook, & Carroll, 1979; Poznanski, Cook, Carroll, & Corzo, 1983; Poznanski et al., 1984) is a 15-item, clinician-rating form that assesses children’s degree of depressive symptomatology. To measure level of hopelessness, the Hopelessness Scale for Children (Kazdin, French, Unis, Esveldt-Dawson, & Sherick, 1983; Kazdin, Rodgers, & Colbus, 1986), a 17-item true–false measure, was utilized. Self-concept was examined via the Piers–Harris Children’s Self Concept Scale (Piers, 1969). The level, severity, and impact of life events experienced by each child was assessed via the Life Events Checklist (LEC; Johnson & McCutcheon, 1980). Personality factors were measured with the Personality Inventory for Children (PIC; Lachar, 1984), and the Dimensions of Temperament Survey (DOTS; Lerner, Palermo, Spiro, & Nesselroade, 1982) was used to examine temperament patterns among the children. Finally, the Symptom Checklist-90–Revised (SCL-90R; Derogatis, 1983) was used to assess parental self-reported psychopathology. Each of these scales has good documented reliability and validity when used with children or their parents.

**Procedure**

The set of questionnaires was administered by a doctoral student in clinical psychology to each participant. Specifically, each child completed the self-report measures (i.e., RCMAS, Hopelessness Scale, Piers–Harris, LEC, and DOT) with the aid of the research assistant. Following a semistructured interview with the child, the research assistant completed that CDRS for each child. Each child’s parent, generally the mother, or guardian completed the SCL-90-R based on his or her own symptoms. The parent or guardian also completed the DOT and PIC reporting on the child’s behavior and personality. Finally, the SSI was completed after an interview with the child by a nursing staff member who was already familiar with the child and his or her behavior. Children with a score greater than zero on the SSI (indicating the presence of suicide ideation) were divided into two groups using a median split: Group 1 \( (n = 13) \) with high anxiety (RCMAS score > 15) and Group 2 \( (n = 14) \) with low anxiety (RCMAS score ≤ 15). Notably, the mean RCMAS for Group 1 (see Table 1) was nearly a full standard
TABLE 1
Questionnaire Total Scores for Group 1 (HIANX + HISI) and Group 2 (LOANX + HISI)

<table>
<thead>
<tr>
<th>Questionnaire</th>
<th>Mean HIANX + HISI Score (SD)</th>
<th>Mean LOANX + HISI Score (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSI</td>
<td>6.46 (2.8)</td>
<td>5.00 (3.5)</td>
</tr>
<tr>
<td>RCMAS</td>
<td>20.62 (3.6)</td>
<td>7.69 (5.8)*</td>
</tr>
<tr>
<td>CDRS</td>
<td>43.77 (10.3)</td>
<td>41.14 (16.6)</td>
</tr>
<tr>
<td>Hopelessness</td>
<td>8.69 (4.4)</td>
<td>5.86 (3.1)</td>
</tr>
<tr>
<td>Piers-Harris</td>
<td>38.46 (16.6)</td>
<td>56.93 (17.4)*</td>
</tr>
<tr>
<td>LEC (Negative)</td>
<td>6.85 (2.8)</td>
<td>4.21 (3.7)*</td>
</tr>
<tr>
<td>(Positive)</td>
<td>2.92 (2.7)</td>
<td>3.14 (2.9)</td>
</tr>
<tr>
<td>SCL-90-R (Global)</td>
<td>0.94 (0.7)</td>
<td>0.50 (0.4)</td>
</tr>
</tbody>
</table>

Note. HIANX = high anxiety; HISI = high suicide ideation; LOANX = low anxiety. SSI = Scale for Suicide Ideation; RCMAS = Children’s Manifest Anxiety Scale–Revised; CDRS = Children’s Depression Rating Scale; Hopelessness = Hopelessness Scale for Children; Pier-Harris = Piers-Harris Children’s Self Concept Scale; LEC = Life Events Checklist; SCL-90-R = Symptom Checklist-90–Revised.
*significant at \( p < .05 \) after a Bonferroni correction.

deviation above the national normative mean.

RESULTS

Initial analyses (Wilcoxon 2-sample tests and chi-squares) were conducted to determine potential differences on demographic information between Group 1, who exhibited high anxiety and high suicide ideation (HIANX + HISI) and Group 2, who exhibited low anxiety and high suicide ideation (LOANX + HISI). Results demonstrated that the two groups did not differ significantly in terms of age, gender, racial composition, or SES. Group 1 was comprised of 10 males and 3 females (12 Caucasians and 1 African American) with a mean age of 9.92 (SD = 1.38) and SES of 4.08 (SD = 0.79). Group 2 was comprised of 13 males and 1 female (12 Caucasians and 2 African Americans) with a mean age of 10.50 (SD = 1.29) and SES of 4.08 (SD = 0.95).

Independent \( t \)-tests were then conducted to examine differences between Group 1 and Group 2 on the questionnaire total score data (see Table 1) and Piers–Harris and SCL-90-R subscale scores (see Tables 2 and 3). Bonferroni corrections were used to adjust for the large number of \( t \)-tests conducted and control for Type I error. Notably, Group 1 and Group 2 did not differ on levels of suicide ideation, depression, or hopelessness. However, as expected, significant between group differences were found on the RCMAS. Thus, anxiety, which was selected a priori as the construct of interest in relation to suicide ideation, is the major differentiator between the two groups.

Differences between Group 1 and Group 2 were found on the Piers–Harris with Group 1 reporting lower or poorer self-concept. On the Piers–Harris subscales (see Table 2), a significant difference between the two groups was found on subscale 6, Happiness/Satisfaction, which includes items regarding a child’s overall level of happiness with him- or herself and life (e.g., “I am a happy person,” “I wish I were different”). On the LEC, children in Group 1 reported more negative life events than Group 2, but did not differ from the less anxious group on positive life events.

On the PIC, children in Group 1 were rated as exhibiting poorer social skills (\( M = 22.33; SD = 4.8 \)) and higher social incompetence (\( M = 18.67; SD = 5.1 \)) than Group 2 (social skills: \( M = 16.85; SD = 5.9 \); social incompetence: \( M = 12.85; SD = 5.9 \)). For the self-report DOT, the children in Group 1 reported higher intensity of reaction (\( M = 5.15; SD = 2.0 \)) than Group 2 (\( M = 2.64; SD = 1.4 \)). For the DOT parent reports on their children, Group 1 scored higher on the distractibility subscale (\( M = 4.92; SD = 2.0 \)) than Group 2 (\( M = 3.14; SD = 1.4 \)).
TABLE 2
Piers-Harris Children’s Self Concept Scale Subscale Scores for Group 1 (HIANX + HISI) and Group 2 (LOANX + HISI)

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Mean HIANX + HISI Score (SD)</th>
<th>Mean LOANX + HISI Score (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavior</td>
<td>8.38 (4.8)</td>
<td>13.36 (3.9)</td>
</tr>
<tr>
<td>Intellect</td>
<td>10.46 (4.7)</td>
<td>13.21 (4.7)</td>
</tr>
<tr>
<td>Physical appearance</td>
<td>6.85 (3.7)</td>
<td>7.86 (3.8)</td>
</tr>
<tr>
<td>Anxiety</td>
<td>4.69 (3.3)</td>
<td>8.14 (3.4)</td>
</tr>
<tr>
<td>Popularity</td>
<td>5.38 (3.2)</td>
<td>7.57 (3.3)</td>
</tr>
<tr>
<td>Happiness satisfaction</td>
<td>4.31 (1.9)</td>
<td>7.14 (2.1)*</td>
</tr>
</tbody>
</table>

Note. HIANX = high anxiety; HISI = high suicide ideation; LOANX = low anxiety.
*significant at \( p < .05 \) after a Bonferroni correction.

The individual subscales of the SCL-90-R were also examined in detail due to a definite, but nonsignificant, trend on the global severity score. Results displayed that parents in Group 1 scored higher than parents in Group 2 on the obsessive-compulsive, anxiety, and hostility subscales (see Table 3).

These findings support the notion that, among children with suicide ideation, a subtype of suicide ideation that we have termed “anxious suicidality” exists. Additional analyses were conducted to add further “convergent validity” to our delineation of the “anxious suicidal” group as a distinct subgroup of children experiencing suicide ideation.

Convergent Validity

First, we wanted to ensure that the differences between our two suicide ideation groups were not due to the effects of anxiety alone. That is, analyses were conducted to determine whether our findings were specific to anxiety and nonspecific to suicide ideation. The entire sample of 87 children (100 minus 13 children with mental retardation or a psychotic spectrum disorder) were divided, via a tertile split of RCMAS total scores, to form high anxiety \((n = 32;\) RCMAS \(M = 19.25)\) and low anxiety \((n = 29;\) RCMAS \(M = 3.07)\) groups. These groups were then compared on the questionnaire data. Significant findings included several PIC scales (e.g., psycho-

TABLE 3
Symptom Checklist-90-Revised (SCL-90-R) Subscale Scores for Group 1 (HIANX + HISI) and Group 2 (LOANX + HISI)

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Mean HIANX + HISI Score (SD)</th>
<th>Mean LOANX + HISI Score (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Somatization</td>
<td>0.84 (0.7)</td>
<td>0.46 (0.6)</td>
</tr>
<tr>
<td>Obsessive-compulsive</td>
<td>1.14 (1.0)</td>
<td>0.47 (0.5)*</td>
</tr>
<tr>
<td>Interpersonal sensitivity</td>
<td>1.12 (0.9)</td>
<td>0.61 (0.5)</td>
</tr>
<tr>
<td>Depression</td>
<td>1.36 (0.9)</td>
<td>0.82 (0.7)</td>
</tr>
<tr>
<td>Anxiety</td>
<td>1.10 (0.9)</td>
<td>0.47 (0.5)*</td>
</tr>
<tr>
<td>Hostility</td>
<td>0.71 (0.5)</td>
<td>0.32 (0.3)*</td>
</tr>
<tr>
<td>Phobic anxiety</td>
<td>0.40 (0.6)</td>
<td>0.13 (0.2)</td>
</tr>
<tr>
<td>Paranoid ideation</td>
<td>0.87 (0.7)</td>
<td>0.52 (0.6)</td>
</tr>
<tr>
<td>Psychoticism</td>
<td>0.48 (0.6)</td>
<td>0.31 (0.4)</td>
</tr>
</tbody>
</table>

Note. HIANX = high anxiety; HISI = high suicide ideation; LOANX = low anxiety.
*significant at \( p < .05 \) after a Bonferroni correction.
sis, withdrawal) and the Hopelessness Scale total score. Overall, however, the pattern of differences was not the same as that found between our groups with suicide ideation. Notably, the groups did not differ on any of the SCL-90-R subscales. Thus, the findings for the “anxious suicidality” group are not attributable to the simple presence or absence of anxiety.

Second, because the possible comorbidity of anxiety and depression was of concern, particularly given the documented importance of depression in relation to suicide ideation, we computed the correlation between the RCMAS and CDRS total scores for the entire sample of 27 children with suicide ideation, which was nonsignificant ($r = .10; p = .63$). Thus, not only do the two suicide ideation groups not differ on mean levels of depression (see Table 1), but levels of anxiety and depression were not related in a meaningful manner.

Third, the two suicide ideation subgroups both scored high in terms of depression (see Table 1). CDRS total scores for the two suicide ideation groups were $> 40$ (range for high anxious = 25–58; range for low anxious = 19–62) and thus indicative of clinical depression as defined by Poznanski and colleagues (1984). Although our two suicide ideation groups did not differ in terms of depression or hopelessness, the relationship between suicide ideation and depression is so well established that separate consideration of this issue seemed necessary.

Specifically, the suicide ideation group ($n = 27$) was divided into clinically depressed ($n = 14; \text{CDRS} \geq 40$) and nondepressed ($n = 13; \text{CDRS} < 40$) groups. These groups were compared on the questionnaire data with differences emerging for some PIC subscales (e.g., depression, social incompetence) and one SCL-90 subscale, Somatization. Therefore, when the suicide ideation groups were divided in the conventional manner (i.e., via scores for depression), results emerged that were drastically different than the findings between the high and low anxious suicide ideation groups. Only approximately half of the children with suicide ideation were clinically depressed according to their CDRS scores. Overall, the evidence supports our assertion that we have identified a subgroup of suicide ideation in which anxiety, despite the presence of depression or hopelessness, is a critical component.

**DISCUSSION**

The extant literature regarding childhood suicide has focused predominantly on depression and hopelessness. Some authors (e.g., Sokol & Pfeffer, 1992) have even contended that children’s reduced proclivity to experience depression may help protect them from suicide. Previous research examining the relationship between anxiety and suicidality in youngsters has primarily explored correlations between measures of anxiety and suicide ideation or compared children with an anxiety disorder to a control group without anxiety disorders on a measure of suicide ideation.

The current study went beyond prior research by examining whether the addition of anxiety to the clinical picture of suicide ideation would be associated with differences in other constructs. We found that, indeed, children high in suicide ideation and anxiety diverged in meaningful ways from children with high suicide ideation and low anxiety. Notably, our two groups did not differ significantly on levels of depressive symptomatology or hopelessness. In terms of temperament, however, children with comorbid anxiety and suicide ideation were described as more active and displaying more intense reactions than the control group with low anxiety. These descriptions are consistent with the symptoms of generalized anxiety disorder, such as conspicuous feelings of restlessness and exaggerated startle response (DSM-IV; American Psychiatric Association, 1994) and give further credence to the assertion that anxiety is the pivotal differentiating factor between these two groups.

Clearly, not all children with suicide ideation are anxious. However, a major subgroup of children with suicide ideation
may exhibit serious "anxious suicidality." This subgroup of children with "anxious suicidality" has never before been delineated and explored in the literature. These children differ from their cohorts with suicide ideation who do not exhibit anxiety in a number of fundamental ways.

Even though the two groups did not differ on level of depression, the group with "anxious suicidality" reported that they were less satisfied and happy than their cohorts with suicide ideation and low anxiety. It appears that adding anxiety to the clinical picture of suicide ideation creates a particularly distressing child psychopathological state. Not surprisingly, they also reported experiencing more perceived negative life events than nonanxious suicidal children. Thus, these children are likely either experiencing tremendous stress due to negative circumstances in their lives or they have a propensity to negatively perceive routine events.

One particularly interesting finding was the parents' self-reports on the SCL-90-R, which indicated that the parents of children with anxiety and suicide ideation present with major psychopathology. Specifically, they reported being anxious, obsessive-compulsive, and hostile. The hostility component, which is comprised of characteristics such as aggressiveness, irritability, rage, and resentment (Dero- 
gatis, 1983), is of interest because it may have severe negative repercussions on the parent–child relationship as well as, conceivably, thwarting a warm and supportive home environment. These findings cannot definitively state whether the parents directed their hostile, anxious, or obsessive-compulsive behavior toward their children; however, this is likely because a person's problems tend to spill over into his or her home life.

Poor family relations and nonsupportive environments that may result from parental psychopathology are related to a variety of childhood psychiatric disorders, such as depression (Burbach & Borduin, 1986; Kashani, Allan, Dahlmeier, Rezvani, & Reid, 1995). Some authors (e.g., Asarnow et al., 1987; King, Segal, Nay-
lor, & Evans, 1993; Taylor & Stansfeld, 1984) have asserted that children with suicidal ideation may experience problematic parent–child relationships. For example, Kosky, Silburn, and Zubrick (1986) assert that "discordant, hostile family interactions predisposed [children in their sample] to suicidal thoughts" (p. 527). It seems logical that a child in an atmosphere rife with anxiety and hostility, who lacks a cohesive or supportive family, may experience considerable anxiety and perhaps develop feelings of worthlessness and desire to die (Kosky, Silburn, & Zubrick, 1990).

Children with "anxious suicidality" may perceive that they cannot discuss their problems with adult caregivers due to their demanding and hostile nature. Additionally, the parents reported that the children have poor social skills and high social incompetence, characterized by a lack of friends, poor peer relationships, and the absence of leadership abilities. These factors may negatively influence the children’s abilities to develop and maintain friendships. Thus, they may also have few people outside of the home with whom to discuss problems. This potential lack of social support inside and outside the home may represent one reason for the children's suicide ideation. Clearly, a child's ability to maintain good peer relations and engage in positive activities with other children may be closely related to a child's tendency to experience suicide ideation (Sokol & Pfeffer, 1992).

In summary, childhood suicide ideation appears to be a multidetermined process: A number of catalysts, either alone or in combination, can contribute to its formation. Depression and hopelessness seem to be the most well documented conditions that stimulate suicide ideation, but literature is slowly appearing indicating that other states, such as anxiety, may play a pivotal role in the development and/or maintenance of suicide ideation. This study examined a group of children with suicide ideation and found that comorbid anxiety is associated with other problems, particularly the presence of parental psy-
chopathology and a higher level of overall unhappiness.

Limitations

The sample size, although relatively large for a clinical examination of suicide ideation, is small and limits the ability to conduct multivariate statistics. The sample is limited to inpatient children, so our findings may not generalize to other populations. Also, statements concerning causality in the relationship between childhood anxiety and suicidal ideation cannot be made. Additionally, we did not have the children describe their perceptions of their families. Thus, the parents’ self-report of hostility does not guarantee that this hostility is directed toward the child. Further, the stress of having a child who is suicidal and currently hospitalized may be part of the reason why the parents are displaying anxiety, hostility, and obsessive-compulsive behavior. However, it seems likely that, regardless of etiology, the parent’s current psychological state could have a negative impact on the child.

Clinical Implications

The data indicate that any assessment for anxiety disorders in children should also be accompanied by suicide assessment (Ohring et al., 1996) and vice versa. The possibility of significant suicide ideation in children with anxiety symptoms or disorders is striking and clinically significant. In terms of treatment, interventions targeting a child’s degree of anxious symptomatology may help ease the child’s suicidal ideation (Ohring et al., 1996). However, our data indicate that clinicians may need to take further steps when attempting to assuage the suicidal thoughts of children with “anxious suicidality.” Namely, working with the family may help create a less hostile and more supportive environment (Kosky et al., 1986). Family therapy may reduce conflict and strengthen familial communication (Sokol & Pfeffer, 1992) in order to provide a supportive environment for the child. Given the social skills deficits apparent in children with “anxious suicidality,” social skills training (c.f., LeCroy, 1994) may also be an important treatment component and may facilitate the procurement of support from peers. Specifically, teaching children to match social behaviors exhibited by popular children (e.g., smiling, good voice intonation) may bolster their social skills and lead to subsequent improvements in peer relations (Weist, Borden, Finney, & Ollendick, 1991).

Future Research

Possible relationships between anxiety and suicide ideation in children should be examined in adolescents. Children are generally under greater parental influence, and the presence of a hostile parent may have a more prominent effect on a child than on an adolescent, who may have a social support system apart from the family. We did not assess the children’s perceptions of their parents (e.g., the Family Environment Scale; Moos & Moos, 1981), which may help future researchers determine whether these parental factors played a causal role in the development of the children’s suicidal/anxious status. Additionally, the examination of children with anxiety disorders, versus high scores on an anxiety scale, may help further elucidate the relationship between childhood anxiety and suicide ideation.

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