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ORIGINAL ARTICLE

# Associations Between Relational Aggression, Depression, and Suicidal Ideation in a Child Psychiatric Inpatient Sample

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**Abstract** The current study examined relations between relational aggression, depressive symptoms, and suicidal ideation in a child clinical population. Participants included 276 children ($M_{age} = 9.55$ years; 69% Male) who were admitted to a child psychiatric inpatient facility. Findings suggested that relational aggression was associated with depressive symptoms, which in turn was associated with suicidal ideation. The test of indirect effects suggested that depressive symptoms fully accounted for the link between relational aggression and suicidal ideation. Moreover, these relations were found when also controlling for the variance associated with overt aggression, history of abuse, and social problems. Current findings appear to suggest that relational aggression is linked to depressive symptoms, which is linked to suicidal ideation within a clinical population, and as such there may be clinical utility in assessing relational aggression.

**Keywords** Relational aggression · Suicide · Depression

## Introduction

There is growing evidence [1] suggesting the importance of distinguishing between relational (i.e., behavior intended to threaten or actually damage peer relationships) and overt (i.e., physical and verbal acts intended to injure or harm an individual) forms of aggression despite their high statistical overlap. However, to date, the majority of this research has

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focused on community samples, with little to no research examining relational aggression within a clinical population. Evaluating whether relational aggression is uniquely associated with internalizing symptoms within a clinical population could provide insight into whether or not there is true clinical utility in assessing this form of aggression. Furthermore, although, previous research [2] has established a link between relational aggression and internalizing symptoms, including depressive symptoms, no research has examined the association between relational aggression and suicidal ideation, and understanding this association could aid in suicide prevention. Moreover, prior research [3] suggests that depressive symptoms account for the link between individual and social factors and suicidal ideation. Thus, if a link between relational aggression and suicidal ideation is found, it would also be useful to determine if depressive symptoms account for this association. Accordingly, the current study examined associations between relational aggression, depressive symptoms, and suicidal ideation in a child psychiatric inpatient sample while also considering the variance associated with overt aggression in addition to other risk factors of depression (i.e., age, gender, history of abuse, and social problems) [3].

## Relational Aggression

Child aggression has been repeatedly found to be associated with internalizing and externalizing behavioral outcomes [4]. Historically, however, the majority of studies have focused primarily on physical and verbal forms of aggression, often referred to as overt forms of aggression. Within the last two decades, relational aggression, or behaviors intended to harm others through threatened or actual damage to social relationships [5, 6], has received increasing attention in the literature. Relational aggression includes a wide variety of behaviors, including a child spreading rumors about another child, purposefully ignoring another child, or threatening to exclude a child from the peer group. Although, some research [5, 7] suggests that relational aggression is more prevalent among females when compared to males, relational aggression is associated with psychosocial adjustment difficulties for both males and females [8]. That is, relational aggression is associated with peer rejection, high levels of internalizing symptoms, externalizing behavior, and poor peer acceptance and peer isolation [1, 5, 8].

## Relational Aggression, Depressive Symptoms, and Suicidal Ideation

Specific to internalizing symptoms, relational aggression has been found to be associated with depressive symptoms, low self-esteem, and loneliness [1, 5, 9–11]. For example, in a community sample of third through sixth grade children, relationally aggressive children reported higher levels of depression than those who were not classified as relationally aggressive. Additionally, relationally aggressive girls were significantly lonelier than relationally aggressive boys and their nonaggressive peers [5]. Increases in relationally aggressive behavior over the course of 1 year have also been shown to be associated with increases in internalizing symptoms for children [9]. More importantly, relational aggression was found to be uniquely associated with internalizing difficulties (i.e., withdrawn, anxious, depressive symptoms) when controlling for the variance associated with overt aggression in a community sample of youth [2].

Relational aggression appears to be stable over time and is associated with numerous and pervasive negative outcomes [2]. Furthermore, there is research to suggest that while depression is the strong predictor of suicidal behavior in children and adolescents [12], aggression may also contribute to the development of suicidal ideation and behavior

[13–17]. Given that childhood rates of suicidal ideation have been found to be as high as 20% [18] and suicide rates continue to increase among youth [19, 20], it is of the utmost importance to develop an understanding of the development of suicidal ideation and behavior to aid in the development of targeted interventions aimed at decreasing the incidence of these behaviors. However, there is a relative paucity of research specifically examining subtypes of aggression and their specific relation to suicidality. More specifically, studies published to date have either neglected to consider different subtypes of aggression or they have focused solely on physical or reactive/proactive forms of aggression [14–17] and have failed to examine the risk associated with other forms of aggression such as relational aggression. Relational aggression is associated with peer/social difficulties and depressive symptoms [1, 5, 10, 21], both of which are known risk factors for suicidal ideation [3]. Thus, there is reason to believe that relational aggression may also be associated with suicidal ideation. Moreover, it may be that depressive symptoms mediate the association between relational aggression and suicidal ideation, as depressive symptoms have been found to mediate associations between poor parent and peer relations and suicidal ideation [3]. Research also suggests that depression is the most important risk factor for suicidal ideation and threats [12] and may also account for the link between other internalizing problems, such as loneliness and suicidal ideation [22]. Thus, depressive symptoms were posited to account for the association between relational aggression and suicidal ideation.

## Clinical Utility of Relational Aggression

Although, previous findings [2] suggest that relational aggression contributes unique variance to the psychological and behavioral adjustment of youths, the clinical utility in evaluating relational aggression has not yet been truly established. That is, whether or not relational aggression is related to adjustment difficulties in a clinical sample has not been determined. One study [23], however, did examine relational aggression within a detained population, and it was found that relational aggression uniquely contributed to the variance associated with callous-unemotional traits when also taking into account the variance associated with overt aggression. Accordingly, in order to further evaluate the utility of assessing for relational aggression, the current study examines relational aggression in a population of children at risk for both aggression and suicidal behaviors, those admitted to a psychiatric inpatient facility.

## Current Study

In sum, the current study examined associations between relational aggression, depressive symptoms, and suicidal ideation while also accounting for the variance associated with overt aggression and other known risk factors for depression and suicidal ideation, specifically history of abuse and social problems [3]. Although, previous research examining aggression has supported a link between aggression and suicidal behavior [15–17] there is a paucity of research examining which subtypes of aggression place a child at risk for suicidal thoughts and ideation. Given the heterogeneous nature of aggression, further information about these subtypes and their link to long-term and significant mental health consequences could provide both theoretical and clinical information about the nature of suicidal behaviors among young children. This study, therefore, extends previous research by examining associations between internalizing symptoms, suicidal ideation, and a specific subtype of aggression, relational aggression, which is known to share common risk

factors with suicidal behaviors. Thus, this is the first study to date to examine associations between relational aggression and suicidal ideation. Furthermore, previous research has focused primarily on community samples when examining potential relations between aggression and suicide. Therefore, we seek to extend the current literature by including a sample of children admitted for psychiatric inpatient treatment. This provides a further benefit by allowing for an oversampling of children experiencing both aggressive behavior and internalizing difficulties.

## Method

### Participants

Participants included 276 children (190 boys, 86 girls, $M_{age} = 9.55$ years, age range: 6–12 years) admitted consecutively across 36 months for acute child psychiatric inpatient service. The majority of the children ($n = 172$) were African American and the remaining ($n = 104$) were Caucasian. Participants were recruited from an inpatient psychiatric service to maximize the likelihood of examining children exhibiting suicidal behavior. Exclusion criteria included (a) a history of traumatic brain injury, a diagnosis of either psychosis or pervasive developmental disorder, or an acute medical condition, (b) children in the custody of the Department of Human Services and who lacked a reliable informant to provide information about the child's history, and (c) children <6 years of age. Of the 299 children admitted consecutively, 4 parents declined to participate and 8 met one of the exclusion criteria. An additional 11 children were excluded from analyses because of an inability to complete data leaving 276 participants. The children's mean achievement score for reading on the *Wechsler Individual Achievement Test, 2nd Edition (WIAT-II)* was 86.51 (SD = 17.42), which falls in the average range. Eighty-eight percent of the children were enrolled in Medicaid; 12% had private health insurance, and most of the families (80%) reported annual incomes below $20,001. The sample's demographic characteristics are representative of the population served by the hospital.

Seventy-two percent of the children received a primary diagnosis of a disruptive behavior disorder (attention deficit/hyperactivity disorder, oppositional defiant disorder, or conduct disorder), 20% received a primary diagnosis of an anxiety or affective disorder, and the remaining 8% were treated for other concerns (e.g., Tourette's Syndrome, Somatization Disorder). Eighty percent of the participants were or had received outpatient psychiatric services for emotional/behavioral problems prior to their admission. Over half (62%) of the children were on medication at the time of admission, with stimulants being the most common drug; and 20% had a documented history of abuse.

### Measures

#### *Aggression*

Relational and overt aggression were assessed using the Little et al. [24] measure. This child self-reported measure is comprised of 36-items designed to assess forms as well as functions of aggression. The 6-items that constitute the pure relational aggression subscale (e.g., "*I'm the kind of person who tells others I won't be their friend anymore*") and the 6-items that constituted the pure overt aggression subscale (e.g., "*I'm the kind of person who often fights with others*") were used in the current study. Children responded using a

five-point scale ranging from "*never*" to "*almost always*." The items for each subscale were internal and criterion-related validity of this measure has been established [24]. Internal consistency coefficients have been found to be adequate [24] (Cronbach's $\alpha = .62–.84$) and ranged from .67 to .79 in the current sample, suggesting acceptable reliability.

*Depressive Symptoms*

The children completed the *Children's Depression Inventory* (CDI) [25], a 27-item self-report measure in which children select 1 of 3 possible alternatives describing increasing levels of depressive symptoms. The participants selected the item that best described how they had been feeling during the previous 2 weeks. Items are then summed. The CDI is a well-validated measure as evidenced by its ability to discriminate between depressed and nondepressed youth [26, 27]. High correlations have also been observed between the CDI and other measures of depressive symptoms suggesting good construct validity [28, 29]. The reliability of the measure has been demonstrated with internal consistency estimates ranging from .70 to .86. Alpha coefficient was equally high with the present sample ($\alpha = .85$). Test–retest reliability from 1 week to 6 months has been found to be acceptable ($r = .54–.87$) [25]. One item on the CDI that assessed for suicidal ideation was excluded from the CDI sum score for analyses because of its overlap with suicidal ideation.

*Suicidal Ideation*

The children's suicidal ideation was assessed using the *Risk for Suicide Questionnaire (RSQ)*, a 14-item yes–no self-report questionnaire designed to screen hospitalized children and adolescents for potentially self-destructive behavior [30]. The authors of the measure designed the RSQ "to identify the smallest number of items that could accurately identify suicidal youth to ensure that the screening tool is practical to administer" and "to develop a screening instrument with high sensitivity, given the relative importance of detecting children and adolescents at high risk and the potentially devastating consequences of not doing so" [30]. The RSQ includes many of the same items from suicide measures that are commonly used in research and clinical capacities [31, 32]. Previous research [30] suggests that the RSQ shows good concurrent validity with other measures of suicidal behavior and the authors demonstrated sensitivity for the measure ranging from .84 to .98, from .37 to .65 for specificity, from .56 to .67 for positive predictive value, from .84 to .97 for negative predictive value, and from .86 to .87 for *c* statistic. Sample items include: "*In the past week, have you been having thoughts about hurting yourself*?" *and* "*In the past, have you been having thoughts about killing yourself*?"

*History of Abuse*

A dichotomized variable representing whether or not the participants had a documented history of abuse was developed. As a part of the assessment process, parents/guardians were asked questions regarding the child's history of physical or sexual abuse or neglect during a semi-structured clinical interview. Those whose parents/guardians endorsed a history of abuse received a score of *2* while those without a history of abuse received a score of *1*. This was determined by a series of questions completed during the semi-structured clinical interview. First, parents were asked if their child had ever experienced

physical, emotional, or sexual abuse or neglect. If the parents answered yes, follow up questions were asked as necessary to determine the nature and timing of the abuse. However, regardless of their response to the first questions, parents were also asked if the child or the family had ever been involved with or had a case open with the Department of Human Services (DHS) for suspected abuse. If the parent responded with "yes," then further inquiry about the nature of the case and suspicion of abuse was completed. Finally, if DHS had been involved with the family, the parent was asked if the suspicion of abuse was confirmed by DHS. If the parent answered yes to their child having been the victim of abuse or that DHS was able to confirm a case of abuse involving the child then the child was considered to be a survivor of abuse and were given a score of "2" for this variable. Additionally, if there was evidence of abuse discovered after the child was admitted to the unit (e.g., bruises or scratches, child reports of sexual abuse), DHS was informed and if a determination of abuse was made by DHS at that time, the child was also given a score of "2" for this item.

### *Social Problems*

Social problems were assessed using the Child Behavior Checklist–Parent Report [33]. Parents respond on a 0–2 scale (*0* = Not True, *1* = Sometimes True, *2* = Very True) how well an item describes their child's behavior over the past 6 months. The Social Problems scale includes items such as "*Clings to adults or too dependent*," "*Complaints of loneliness*," "*Feels others are out to get him/her*," and "*Gets teased a lot*." Stability estimates over a one-week period were good ($r = .90$) and the stability appears to be maintained over longer periods as well ($r = .69$–$.73$ over a 12–24 months period) [33]. The Social Problems scale has also demonstrated good internal consistency ($\alpha = .82$) and significant correlations with both internalizing and externalizing behavioral problems (e.g., $r = .29$–$.48$) [33, 34]. Internal consistency in the current sample was modest ($\alpha = .61$).

## Procedure

After obtaining Institutional Review Board approval, caregivers of children admitted consecutively to a child psychiatric inpatient unit were invited to participate. The caregivers were asked if the clinical data collected at the time of admission as a routine part of their child's assessment during the admission process could be used for the present study. The caregivers were informed that their decision to allow their child's clinical data to be used as a part of the study would in no way affect their child's treatment (e.g., type of medical/psychological assessments received, behavioral management techniques used on the unit or decisions to use or withhold medications) and their care (e.g., access to physicians/medical consults, opportunities to earn rewards as part of the behavioral management program) was not contingent upon their participation. After being informed about the study, caregivers provided written consent for their child's information to be included in the study.

Caregivers completed a semi-structured interview regarding their child's psychological history as well as completed several questionnaires regarding their child's behavior. The children completed self-report measures with the assistance of either a master's level psychologist trained in the administration of standardized measures to children or a doctoral level clinical child psychologist within 48 h of their admission to the unit. The children provided verbal assent before the assessment began. The data was coded with a number to ensure the confidentiality of their records.

### Data Analysis

In order to examine bivariate associations, and to establish a link between relational aggression and suicidal ideation before evaluating a potential indirect effect pathway that included depressive symptoms, correlations were examined. A path model was then estimated using Mplus [35] statistical software in order to examine unique associations between the aggression subtype, depressive symptoms, and suicidal ideation. History of abuse and social problems were also included as covariates in the path model, as both history of abuse and social problems have been identified as risk factors for depressive symptoms as well as suicidal ideation/behavior [3, 36, 37]. Because there was some missing data (less than 10%), Full Information Maximum Likelihood Estimation (FIMLE) was used. FIMLE has been found to be less biased and more efficient than other strategies used to accommodate missing data [38]. The estimated model was fully saturated (i.e., a model that has zero degrees of freedom). We evaluated this fully saturated model because it includes all the direct effects and provides a more conservative test of the proposed mediated pathway. A fully saturated model will always result in a perfect fit to the data. Therefore, fit indices of the model are not reported.[1]

The bias corrected bootstrap method was used evaluate whether depressive symptoms accounted for the link between relational aggression and suicidal ideation. The bias corrected bootstrap method has been found to be a more accurate test of indirect effects than other strategies, such as Sobel's method [39]. Five hundred bootstrap samples and the 95% bias-corrected confidence intervals (CIs) were used to test the significance of indirect effects.

## Results

### Descriptive Statistics

Means, standard deviations, and correlations of study variables are reported in Table 1. Children's mean scores for depression ($T$ score = 53.65, SD = 12.03) fell within the non-clinical range. Child reports of both relational and overt aggression were positively correlated with both depressive symptoms and suicidal ideation. Additionally, depressive symptoms were correlated with suicidal ideation. Surprisingly, history of abuse and social problems were not related to depressive symptoms; but both history of abuse and social problems were marginally statistically significantly related to suicidal ideation.

### Path Analysis

A path model was then estimated in order examine unique associations between relational and overt aggression and depression and suicidal ideation. Furthermore, this model examined whether depressive symptoms accounted for the link between the aggression subtypes and suicidal ideation. As seen in Fig. 1, child reports of both relational and overt

[1] In order to evaluate the overall model fit, a path model that excluded the path from social problems to depressive symptoms was estimated, which provided 1 degree of freedom and allowed for model fit statistics to be evaluated. A $CFI > .95$, $RMSEA < .06$, and $SRMR < .08$ indicates a good fit to the data [54–56]. This modified model provided a good fit to the data, $\chi^2(1) = 1.29$, $CFI = .99$, $RMSEA = .04$, $SRMR = .01$. Thus, the fully saturated model appears to adequately capture the nature of the data.

**Table 1** Correlations, means and standard deviations

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
|---|---|---|---|---|---|---|---|---|
| 1. Gender | – | | | | | | | |
| 2. Age | .09 | – | | | | | | |
| 3. History of abuse | .11† | .01 | – | | | | | |
| 4. Social problems | −.06 | −.02 | .09 | – | | | | |
| 5. Overt aggression | −.13* | −.02 | .05 | .00 | – | | | |
| 6. Relational aggression | −.01 | −.07 | .06 | .09 | .68* | – | | |
| 7. Depressive symptoms | .00 | .04 | −.01 | .08 | .43* | .43* | – | |
| 8. Suicidal ideation | −.05 | .19* | .11† | .12† | .23* | .20* | .49* | – |
| Mean | – | 9.55 | 1.31 | 9.96 | 11.79 | 11.55 | 13.78 | 3.32 |
| SD | – | 1.85 | .46 | 4.41 | 5.17 | 4.65 | 8.43 | 2.27 |

† $P < .08$; *$P < .05$; gender (*male* 1, *female* 2); history of abuse (*no* 1, *yes* 2)

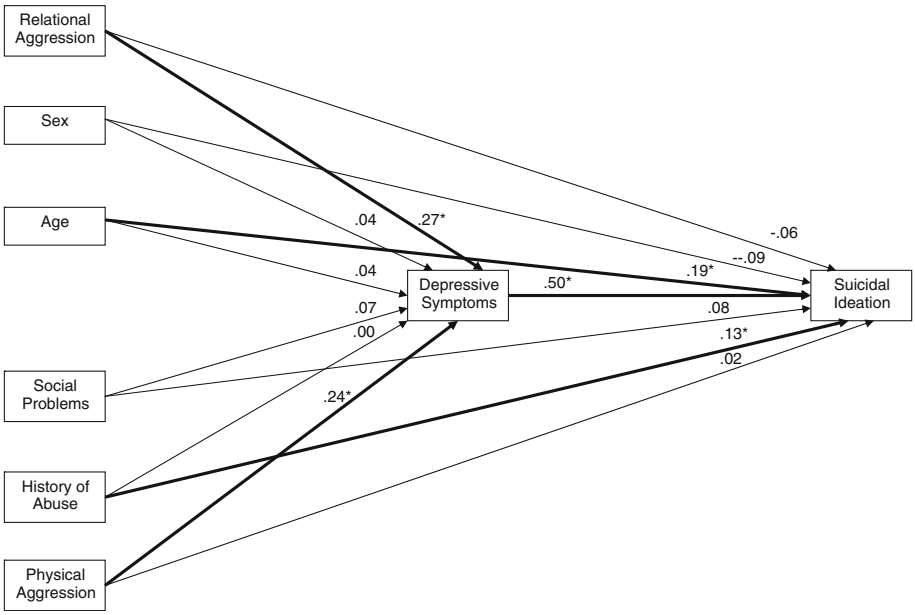


**Fig. 1** Standardized parameter estimates reported. *Thicker lines* and *asterisks* indicate $P < .05$. Covariances between exogenous variables not included in figure for clarity purposes

aggression were significantly uniquely associated with depressive symptoms when also considering the variance associated with history of abuse, social problems, sex, and age. Neither subtype of aggression was directly associated with suicidal ideation when also accounting for the variance associated with depressive symptoms, history of abuse, social problems, sex, and age. Rather depressive symptoms mediated the relation between relational aggression and suicidal ideation, such that the link between relational aggression and suicidal ideation was fully accounted for by depressive symptoms ($\beta = .14$, $P = .004$, 95% CI = .04–.23). Similarly, depressive symptoms mediated the link between overt aggression and suicidal ideation ($\beta = .12$, $P = .01$, 95% CI = .03–.22).

## Discussion

The current study examined associations between relational aggression, depressive symptoms, and suicidal ideation while also accounting for the variance associated with overt aggression, history of abuse, and social problems in a child psychiatric inpatient sample. Findings extend previous research by examining associations in a clinical population and by being one of the first studies to specifically examine associations between relational aggression and suicidal ideation. Results suggested that relational aggression was associated with depressive symptoms, and the link between relational aggression and suicidal ideation was fully accounted for by depressive symptoms.

Consistent with previous research [5] in community samples of children, both correlation and regression analyses suggested that relational aggression was associated with depressive symptoms in the clinical inpatient sample. This relation was found when also controlling for the variance associated with overt aggression, as well as history of abuse and social problems. That is, even when accounting for the statistical overlap in both forms of aggression, relational aggression is uniquely associated with depressive symptoms. Current findings appear to suggest that relational aggression is linked to depressive symptoms within a clinical population, and as such there may be clinical utility in assessing relational aggression.

Moreover, the current study demonstrated that depressive symptoms fully accounted for the link between relational aggression and suicidal ideation. Current findings are consistent with previous research indicating that depressive symptoms mediate the link between social relationships and suicidal ideation [3]. Findings indicate that there may be utility in targeting the association between relational aggression and depressive symptoms in order to prevent subsequent suicidal ideation associated with relational aggression. However, future research needs to be conducted before firm conclusions are drawn.

Note that it is important to interpret findings in light of the limitations associated with the current study. First, the current study was cross-sectional and correlational in nature, and as such causation has not been evaluated. That is, the direction of the relation between relational aggression and depression is not established by these results. Additionally, the aggression subscales were only modestly internally consistent. The sample was also predominantly male and the majority of families were African-American and of low socioeconomic status, which may limit the generalizability of current findings. Although, gender and race/ethnicity are not necessarily considered risk factors for suicidal behaviors, they tend to contribute to variations in suicide rates. For example, although, African-Americans have traditionally been thought to have lower rates of suicide than Caucasians, this gap has narrowed over the past few years [40]. Furthermore, rates of suicide also tend to be higher among adults who come from a lower SES [41]. Previous research suggests that other factors such as stressful life events, psychiatric disturbance or poor parent–child relationships account for a significant proportion of the variance in suicidal ideation and attempts among African-American youths and this may also be true for individuals from a lower SES [42–45]. Furthermore, it is well documented that males are more likely to commit suicide but females are more likely to report suicide attempts and ideation [46, 47]. However, the extent to which risk factors for suicide are moderated by gender is not necessarily clear. For example, while depression has been found to predict suicidal behaviors in both males and females, one large-scale study found that the relation was stronger for males [48]. Others have found that aggression in combination with depressive symptoms may in fact place girls at greater risk for suicidal behaviors and ideation than boys [14, 49]. Therefore, the inclusion of a predominantly male sample in the current study

may have influenced the findings and thus, further research that specifically addresses the association between relational aggression and depression and suicidal ideation should be performed before drawing any definitive conclusions. Moreover, the current study relied on child-reports of relational aggression, depressive symptoms, and suicidal ideation. However, using child reports of relational aggression has the potential to reveal acts of relational aggression that are either covert or that occur outside of school or the home [50]. As a result, children may be able to report on relationally aggressive behavior of which other informants are not aware. Additionally, current findings [2] using child reports of relational aggression are similar to what is found when using parent reports of aggression, suggesting that children are accurate reporters of aggressive behavior. Furthermore, since children have been demonstrated to be reliable reporters of their own internalizing difficulties [51], and because child and parent reports of children's ideational symptoms of internalizing distress are typically low in agreement [52], child reports of internalizing symptoms may be preferred over teacher and parent reports. Caregiver reports of history of abuse and social problems were used, and caregivers may have been responded in a socially desirable manner. Future studies should incorporate the use of reports from multiple informants to further support the current findings. Finally, the average score of depressive symptoms fell in the non-clinical range. It may be that current findings are stronger in clinical samples in which children exhibit and report higher levels of depressive symptoms.

Despite these limitations, the current study advances the aggression literature by establishing a link between relational aggression and depressive symptoms and subsequent suicidal ideation, as well as by providing evidence of the clinical utility in assessing for relational examining within clinical populations. The association between relational aggression and internalizing distress [1, 5, 8, 10] illustrates the need for effective prevention interventions. Additionally, the link between suicidal ideation, relational aggression, and depressive symptoms in the present sample further indicate how interventions are critical to prevent long-term maladaptive outcomes for relational aggressors.

Although, adapting efficacious interventions for overt aggression may seem like a starting point for combating relational aggression, the nature of relational aggression may necessitate a novel approach. For example, since relationally aggressive acts, such as starting a rumor about a disliked classmate, are often planned and deliberately carried out, lessons intended to prevent overt aggression through reducing impulsivity may not be effective for youth who are relationally aggressive [53]. Since interventions for relational aggression would likely involve the major prosocial themes of antiviolence programs, Merrell, Buchanan, and Tran [8] suggest that incorporating lessons on relational aggression into already existing interventions which promote positive social behavior may be more effective than developing and implementing programs that exclusively address relational aggression. However, based on the current and previous findings, the impact of aggressive behaviors on internalizing symptomatology may need to be further enhanced in these programs. Regardless of how parents, teachers, and school systems ultimately decide to combat relational aggression, early intervention will be essential. Since relationally aggressive acts such as exclusion begin as early as preschool [53], it is necessary to teach youth to understand that relational aggression is as harmful as physical aggression and contributes to the development of both internalizing and externalizing symptomatology. Otherwise, if relational aggression is not addressed in early childhood, children will likely not recognize relational aggression as problematic, and relational aggression may become and continue to be a normative part of children's social behaviors, potentially contributing to depressive symptoms and suicidal ideation.

## Summary

In order to further evaluate the clinical utility of assessing for relational aggression, the current study examined associations between relational aggression, depressive symptoms, and suicidal ideation in a sample of 276 children ($M_{age} = 9.55$ years; 69% Male) admitted to a child psychiatric inpatient facility. More specifically, we examined whether relational aggression was associated with both depressive symptoms and subsequent suicidal ideation while also accounting for the variance associated with overt aggression in addition to other risk factors of depression (age, gender, history of abuse, and social problems). Findings appeared to indicate that relational aggression was associated with depressive symptoms, and the link between relational aggression and suicidal ideation was fully accounted for by depressive symptoms. These results suggest that relational aggression is associated with internalizing symptomatology in a child psychiatric inpatient sample and may support the utility in assessing for relational aggression in this population. Furthermore, findings may indicate that it is important to target the association between relational aggression and depressive symptoms in order to prevent subsequent suicidal ideation.

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