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A Differentiation between Suicidal and Non-Suicidal Schizophrenic Patients

Gerald H. Smith
Western Michigan University

A DIFFERENTIATION BETWEEN SUICIDAL AND NON-SUICIDAL SCHIZOPHRENIC PATIENTS

by

Gerald H. Smith

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TABLE OF CONTENTS

CHAPTER I

INTRODUCTION

The problem

The purpose of this study is to differentiate between suicidal and non-suicidal schizophrenic patients by using two psychological rating scales: The Test of Objects, and the Self-Rating Depression Scale.

Review of the Literature

Shneidman and Farberow (1957) have investigated suicide extensively. They have found that the suicidal patient is usually a former mental patient. Suicide is usually committed within ninety days after his discharge. An important factor is that in the majority of the cases patients threatened suicide before actually carrying out an attempt. Another finding of their investigations revealed that the desire to die appeared more frequently among the elderly. The investigators have also found that there is a release of pent-up emotions, which leads to a state of feeling better after a suicide attempt has been made. However, this state of contentment usually only lasts for a short duration.

Farberow and Shneidman (1961) have also pointed out that when patients are treated with a severe form of punishment, there is a significant decrease in over-all attempts at suicide.

Schizophrenia is the most common diagnostic impression of suicidal patients. Farberow and Shneidman found significant differences between suicidal and non-suicidal schizophrenic patients. The former were found to be persons under severe stress. Better than seventy per cent had a history of at least one suicidal attempt. Those individuals who were classified as non-suicidal displayed the following characteristics: pasivity, acceptance, and indifference toward the environment. One very salient feature was the lack of ability to handle stress constructively or to ignore it.

It is believed by these authors that most schizophrenics who have a history of suicidal attempts are not effectively treated in the hospital, save for medication. As a result, the patients' problems are left untreated and his symptomology is suppressed. Also of significance is the fact that the hospital environment is usually highly controlled; hence, a patient is not permitted to test reality. The patient appears to be improving, but actually little is being done, and there is only a slight change for the better.

Dorpat and Ripley (1960) suggest that suicide was usually contemplated and quite often made known to others before the actual attempt. They found that suicide occurred twice as often in men as opposed to women. At least 33 per cent had not only made a prior attempt, but also had written a suicide note. More than 27 per cent had lost a family member within the year prior to the suicide. There were 51 per cent afflicted with a serious medical illness. Those who were at middle age were usually found to be alcoholic, while the elderly were quite often psychotically depressed. It was also revealed that clinical symptoms of depression were found in each of the 114 suicides of this study.

McPartland and Hornstra (1964) indicate that suicide attempts have enabled patients to respond more rapidly to treatment. The reason being that the communication between the patient and therapist is more meaningful after suicide attempts.

Gittleson (1966) believes that obsessions play a part in suicidal attempts. The rate of actual attempts was found to be lower for the depressives with obsessions persisting throughout the depression, than for those with obsessions not occurring at the time of depression.

Lesse (1967) suggests that keeping a suicidal patient active can be a supportive therapeutic technique; as of now, there is no one measure that is significantly

more effective in preventing recurrent suicidal attempts. It should be emphasized that in addition to understanding the dynamics of suicide, each individual patient must, in turn, be completely understood.

It has been stated by Skinner (1953) that the act of suicide is an attempt to remove an individual from a situation deemed unacceptable. The potential suicide combines previously learned responses with a mechanism never before utilized. The predisposing factor of depression would seem to indicate that as a child grows, continued states of depression can shape his behavior to the point where he may make an attempt on his own life.

Two factors which could also play a significant role in shaping suicidal behavior are broken homes and social isolation. Jacobs and Teicher (1967) conducted a study which compared 50 adolescents who attempted to kill themselves with 32 who made no such attempt. The findings revealed that there was a much greater likelihood of broken homes and loss of a love object in the lives of those who were suicidal as against those who were not. These results were attributed to a process by which the adolescent becomes isolated from significant others. Eventually all meaningful social relationships dissolve and, in turn, there is an attempt at self-destruction.

Lester (1967) found a significant change in some suicidal individuals; this is their concern about death.

It has been pointed out that suicidal patients feared death less than those who did not possess this destructive impulse. They were also much more aware of and concerned with the manipulative aspects surrounding death.

There are many factors involved in suicide. At the present time we can tentatively say that two processes are involved. First, the individual is shaped into committing suicide and second, there is usually an extreme mood of depression. It is possible for a manic person to attempt suicide; however, in this case the tone of emotion would suggest manipulation and/or delusions of grandeur.

Prediction of Suicide

At the present time, there does not appear to be any one technique that can reliably measure a potential suicide. There are several indicators, however, which offer considerable promise.

After analyzing one case extensively, Beck (1945) pointed out that when a person of high intellectual capacity displays certain patterns on the Rorschach, there are strong indications of suicidal tendencies.

Card four on the Rorschach is considered by Lindner (1946) as a suicide card. Any response(s) which

signifies decay, bitterness, or blackness with depression is indicative of suicidal tendencies.

One of the most extensive patterns of suicide is that presented by Hertz (1949). Five or more of ten specific patterns found in any one individual's Rorschach are considered to be suggestive of a suicidal potential.

Bachrach (1951) states that a patient who suffers from depression is more apt to attempt suicide during an improved state. He believes that the Rorschach technique can enable a diagnostician in assessing predisposing factors. This, however, would largely depend on the competence and skills of the diagnostician in administering and interpreting the Rorschach.

Drake and Rusnak (1966) failed to differentiate suicidal schizophrenic patients from non-suicidal schizophrenic patients. Rorschach protocols of 14 of each of the above were analyzed for specific responses to D6 on Card VII. The results revealed no significant differences between the two groups in frequency of response to this area of the card; thus they failed to predict suicidal ideation.

Using the Rorschach, TAT, and MMPI, a study by Broida (1954) offered the following results. Out of 20 suicidal mental patients, three gave responses indicative of suicidal potential. Only Card IV was utilized

in this analysis. Of the control group of 20, there were no such responses. Card 3 BM of the TAT made no distinction between the two groups. The depressive scale on the MMPI, though, did significantly distinguish between the two groups.

The Potential Suicide Personality Inventory was administered by Devries (1966) to a group of suicidal patients, as well as to a group of non-suicidal patients. The former was further divided into three sub-groups: threatened, attempted, and both threatened and attempted. It was found that the combined as well as the three suicidal sub-groups can be distinguished from the non-suicidal group. None of the suicidal groups, though, could be differentiated from one another.

In a study conducted by Starer (1960) 25 schizophrenic patients with a suicidal history and 24 schizophrenic patients without such history were asked to copy 15 designs, which consisted of a circle with the number of each design in the center. A rectangular-like figure was placed on top and rotated to produce different figures. The findings showed that there were differences between the two groups in psychomotor disorganization and behavioral disorganization. The suicidal group displayed more of these characterizations than the non-suicidal group.

Dean (1967) utilized a 17 patient matched pair experimental design. The sources of data were an admission form, behavioral adjustment scale, social history form, mental status summary, opinions about mental illness scale, and a disposition summary. The sucidial patient was described as follows:

1. One who views achievement as the measure of an individual's value.
2. A person who does not accept personal failure.
3. A person who is despondent and depressed.

These findings were then utilized in constructing a suicide potential scale, which gave evidence of being useful in the detection of patients with suicidal tendencies.

In a study by Cohen, Motto, and Seiden (1966) 14 of 22 demographic factors distinguished between high risk suicidal individuals from low risk suicidals. These factors are of value in not only predicting suicide in patients, but also in preventing certain types of environments from shaping individuals into becoming suicidal candidates. First, however, it is necessary to use several psychological tests in addition to a complete case history in order to establish that a patient is suicidal.

Hypotheses

1. Suicidal patients will choose significantly fewer objects as being important, than non-suicidal patients, since the former feel they have less to live for.

2. Suicidal patients will choose significantly more depressive situations as being indicative of their own life style, than non-suicidal patients.

Definitions

A suicidal patient was defined as an individual who had made at least one attempt to take his own life; an attempt that could have resulted in death without immediate intervention.

The non-suicidal patient was defined as one who had no history of attempted suicide.

In this study, schizophrenia is a psychiatric diagnosis as defined by the American Psychiatric Association. The diagnosis of each patient was made by the staff at the institution where this research was conducted.

CHAPTER II

METHOD

Sample

Forty schizophrenic patients were chosen from Northville State Hospital, Northville, Michigan. In the suicidal group there were ten females and ten males. The same ratio was employed in the non-suicidal group. It was decided that no patient with any history of organicity would take part in this investigation. Of those patients who were involved, none were receiving any immediate medication or any type of therapy that could have had a direct bearing on the results of this study. The two groups were comparable in terms of age and education (See Tables I and II). The diagnosis for each patient was paranoid schizophrenia.

Selection of Tests

The Test of Objects (See Appendix A) was developed from a pilot study done by Esler (1964). Using the Normal Test of Means this instrument was able to differentiate at the .01 level between schizophrenic patients with a suicidal history and schizophrenic patients without a suicidal history. At the present

TABLE I

DATA ON AGE AND EDUCATION

OF MALE PATIENTS

Suicidal	Non-Suicidal
Age	Age
Median: 32 years	Median: 30 1/2 years
Range: 25-55 years	Range: 26-49 years
Education	Education
Median: 13 1/2 years	Median: 12 1/2 years
Range: 12-16 years	Range: 12-16 years

TABLE II

DATA ON AGE AND EDUCATION

OF FEMALE PATIENTS

Age	Age
Median: 32 years	Median: 28 1/2 years
Range: 26-54 years	Range: 27-45 years
Education	Education
Median: 12 1/2 years	Median: 12 1/2 years
Range: 12-16 years	Range: 12-16 years

time, however, this test could not reliably predict who would or would not attempt suicide in the future.

The Self-Rating Depression Scale (See Appendix D) was devised by Zung (1965). The primary purpose behind the development of this scale was for use in psychiatric research. Nevertheless, it has been of value in the practice of medicine where most depressions are first encountered. The frequently referred to hidden depression can be detected by this scale. It has been found that this test significantly correlates with other depression rating scales, which take more time to administer and score.

One change was made in utilizing this instrument in the present research. Instead of scoring each protocol and measuring the degree of depression, the Self Rating Depression Scale was utilized in the same way as the Test of Objects (See Appendix B). That is, the purpose was to analyze how depression was related to the suicidal act, and not to predict whether or not a schizophrenic patient was a suicidal risk.

Procedure

The Test of Objects and the Self Rating Depression Scale were administered independently to 40 schizophrenic patients. The Test of Objects was presented first with the instructions that the subject was to

make a check mark next to the object indicating its degree of importance. After completion of this task, the patient was then given the Self Rating Depression Scale. He was asked to indicate how each of these conditions affected him by placing a check mark in the column which indicated the degree of this condition.

There were eight non-suicidal patients who refused to take part in the investigation. Eventually, suitable replacements were found.

Analysis of Data

In testing the first hypothesis, the number of objects chosen by the suicidal group as important was compared with the number selected as important by the non-suicidal group. The statistical test used was the Mann-Whitney U test with .05 as the level of significance.

The second hypothesis was tested by comparing the number of conditions selected by suicidal patients as being depressive with the number of depressive conditions chosen by the non-suicidal group. The statistical technique used was also the Mann-Whitney U test with .05 as the level of significance.

CHAPTER III

RESULTS

Differences between suicidal and non-suicidal schizophrenic patients were analyzed by the Mann-Whitney U test.

The first hypothesis advanced in this study was found to be significant at the .05 level. Thus, suicidal patients chose significantly fewer objects as being important than non-suicidal patients.

The second hypothesis was also found to be significant at the .05 level. Hence, suicidal patients chose significantly more depressive situations as being indicative of their own life style than non-suicidal patients (See Table 3).

TABLE III

MANN-WHITNEY U TEST OF DIFFERENCES BETWEEN SUICIDAL AND NON-SUICIDAL SCHIZOPHRENICS ON THE TEST OF OBJECTS AND DEPRESSION SCALE

	Non-Suicidal		Suicidal		U	P
	N	R_1	N	R_2		
Test of Objects	20	489	20	291	121	.05
Depression Scale	20	344	20	437	133	.05

CHAPTER IV

DISCUSSION AND CONCLUSION

A statistical comparison between suicidal and non-suicidal schizophrenic patients revealed that as a group the former selected fewer items from the Test of Objects as being important in their lives. One explanation for this finding is that the suicidal patient has been molded into this state of indifference. Throughout his lifetime the deprivation of meaningful objects has given him less motivation to live when faced with major adjustment problems. In essence, there is not much to live for; therefore, the desire to conquer his problems is not worth the effort.

It should be noted that this investigation showed fourteen suicidal patients to have indicated that the majority of the items on the Test of Objects were important to them. It should also be emphasized that there was one non-suicidal schizophrenic patient who indicated that the majority of these objects were unimportant. Equally important is the fact that this study refers only to schizophrenic patients who possess the self-destructive impulse. It should not be inferred from these findings that other types of suicidal patients

have the same etiological factors in their history.

There are many factors involved in the suicidal act. Not only must there be a wish to die, disenchantment with the social environment, but also a rather severe state of dysphoria. A statistical comparison between these two groups substantiated that suicidal patients selected more conditions of depression as pertaining to themselves than the non-suicidal patients. It does not necessarily mean that all depressive schizophrenics will attempt to end their lives. It is implied, though, that very often depression serves as a prerequisite of the suicidal act. Equally important is the fact that if the depression is severe enough it could possibly induce a non-schizophrenic to end his life as well. In this study there were eight suicidals who checked the majority of the non-depressive conditions. As for the non-suicidal group, three patients checked the majority of the depression items.

Predicting whether or not an individual is a potential suicidal candidate largely rests on the psychological techniques used and the competence of the diagnostician. More than one psychological index should be employed and the validity and reliability should be high enough to have faith in the technique.

It is also important in diagnostics to refer to the patient's history and present life style. Although both tests were able to differentiate between suicidal and non-suicidal patients, neither technique has been substantiated for individual prediction. Both tests do, however, warrant further investigation.

The etiological factors of suicide are many; that is why it is vital to examine the entire individual. That does not mean that we cannot develop a symptomology of suicide; quite the contrary, as already mentioned it is fairly certain that depression is a prerequisite of self-destructive impulses. Feelings of worthlessness is still another, and we could go so far as to imply that few objects are of any great importance when one wants to die.

So too must one be ever so careful in labeling a patient suicidal; for the psychological impact of falsely being diagnosed as such could, in turn, cause great harm. Even if there has been a history of suicide attempts, it does not necessarily mean that the wish to die will actually be carried out. Only at the lowest ebb of one's life does self-imposed death become the final solution as an adjustment process.

Durkheim (1951) states that the emotional patterns of those who are suicidal are formulated during the early stages of infancy and childhood

through family interaction. Socialization in the family creates frustration for all; hence, the taking of one's own life is a potential escape for everyone. It is necessary to determine how later social precipitants of suicide correlate with early emotional patterning. The prevention and treatment of suicide can only come with a better understanding of interpersonal relationships.

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APPENDIX A

TEST OF OBJECTS

DIRECTIONS

Please check the following items as to how important they are to you.

ITEM	VERY IMPORTANT	IMPORTANT	VERY UNIMPORTANT	UNIMPORTANT
1. Soft drinks				
2. Television				
3. Doughnuts				
4. Peaches				
5. Spareribs				
6. Pie				
7. Chocolate cake				
8. Self				
9. Summer cottage				
10. Water				
11. Time				
12. Swimming				
13. Laughter				
14. Hobby				
15. Being active				
16. Christmas				
17. July fourth				
18. Warm summer evenings				
19. Entertainment				
20. Hamburgers				
21. Ice cream				

ITEM	VERY IMPORTANT	IMPORTANT	VERY UNIMPORTANT	UNIMPORTANT
22. Fish				
23. Dancing				
24. Traveling				
25. Playing				
26. Long life				
27. Milk				
28. Potatoes				
29. Nature				
30. Hot dogs				

APPENDIX B

SELF RATING DEPRESSION SCALE:

CONDITIONS THAT ARE REPRESENTATIVE

OF DEPRESSION

DIRECTIONS

Please check the following items as to how they apply to you.

	A Little of the Time	Some of the Time	Good Part of the Time	Most of the Time
1. I feel down-hearted and blue				
2. Morning is when I feel the best				
3. I have crying spells or feel like it				
4. I have trouble sleeping at night				
5. I eat as much as I used to				
6. I still enoy sex				
7. I notice that I am losing weight				
8. I have trouble with constipation				
9. My heart beats faster than usual				
10. I get tired for no reason				

	A Little of the Time	Some of the Time	Good Part of the Time	Most of the Time
11. My mind is as clear as it used to be				
12. I find it easy to do the things I used to				
13. I am restless and can't keep still				
14. I feel hopeful about the future				
15. I am more irritable than usual				
16. I find it easy to make decisions				
17. I feel that I am useful and needed				
18. My life is pretty full				
19. I feel that others would be better off if I were dead				
20. I still enjoy the things I used to do				

SELF-RATING DEPRESSION SCALE

	A Little of the Time	Some of the Time	Good Part of the Time	Most of the Time
1. I feel down-hearted and blue			X	X
2. Morning is when I feel the best	X	X		
3. I have crying spells or feel like it			X	X
4. I have trouble sleeping at night			X	X
5. I eat as much as I used to	X	X		
6. I still enjoy sex	X	X		
7. I notice that I am losing weight			X	X
8. I have trouble with constipation			X	X
9. My heart beats faster than usual			X	X
10. I get tired for no reason			X	X

		A Little of the Time	Some of the Time	Good Part of the Time	Most of the Time
11.	My mind is as clear as it used to be	X	X		
12.	I find it easy to do the things I used to	X	X		
13.	I am restless and can't keep still			X	X
14.	I feel hopeful about the future	X	X		
15.	I am more irritable than usual			X	X
16.	I find it easy to make decisions	X	X		
17.	I feel that I am useful and needed	X	X		
18.	My life is pretty full	X	X		
19.	I feel that others would be better off if I were dead			X	X
20.	I still enjoy the things I used to do	X	X		

MARKED SPACES INDICATE CONDITIONS THAT ARE REPRESENTATIVE OF DEPRESSION.

APPENDIX C

MALE SUICIDALS:

NUMBER OF ATTEMPTS
HOW RECENT BEFORE BEING TESTED

TOTAL/MEAN ATTEMPTS
TOTAL/MEAN TIME BEFORE BEING TESTED

FEMALE SUICIDALS:

NUMBER OF ATTEMPTS
HOW RECENT BEFORE BEING TESTED

TOTAL/MEAN ATTEMPTS
TOTAL/MEAN TIME BEFORE BEING TESTED

MALE SUICIDALS

Code	Number of Attempts	How Recent Before Being Tested
1	2	2 weeks
2	4	2 months
3	1	1 week
4	5	6 months
5	2	2 months
6	1	3 months
7	1	2 weeks
8	2	2 months
9	3	3 1/2 months
10	1	2 weeks
Total	22	81 weeks
Mean	2.2	8.1 weeks

FEMALE SUICIDALS

Code	Number of Attempts	How Recent Before Being Tested
1	4	2 weeks
2	3	6 months
3	1	1 week
4	3	3 months
5	2	1 month
6	2	2 weeks
7	6	4 months
8	2	2 weeks
9	4	1 week
10	3	6 weeks
Total	30	70 weeks
Mean	3	7 weeks

APPENDIX D

DATA RECORDS FOR:

MALE SUICIDALS
FEMALE SUICIDALS

TOTAL SUICIDALS

MALE NON-SUICIDALS
FEMALE NON-SUICIDALS

TOTAL NON-SUICIDALS

SUICIDAL*

MALE	TEST OF OBJECTS		SELF-RATING DEPRESSION SCALE	
Code	Important	Unimportant	Depressive Condition	Non-Depressive Condition
1	9	21	12	8
2	22	8	10	10
3	3	27	11	9
4	23	7	10	10
5	23	7	6	14
6	21	9	13	7
7	10	20	1	19
8	18	12	6	14
9	18	12	13	7
10	19	11	6	14

*Figures in both columns for the Test of Objects include the sum of both "Important" columns; the same holds true for the "Unimportant" columns. The Self-Rating Depression Scale was scored in the same manner.

SUICIDAL (continued)

FEMALE	TEST OF OBJECTS		SELF-RATING DEPRESSION SCALE	
Code	Important	Unimportant	Depressive Condition	Non-Depressive Condition
11	16	14	4	16
12	11	19	14	6
13	14	16	10	10
14	18	12	17	3
15	15	15	15	5
16	18	12	7	13
17	21	9	10	10
18	18	12	9	11
19	19	11	5	15
20	20	10	16	4
Total:	336	264	195	205
Mean:	16.8	13.2	9.75	10.25

NON-SUICIDAL*

MALE	TEST OF OBJECTS		SELF-RATING DEPRESSION SCALE	
Code	Important	Unimportant	Depressive Condition	Non-Depressive Condition
21	23	7	9	11
22	19	11	7	13
23	29	1	10	10
24	30	0	11	9
25	28	2	10	10
26	30	0	9	11
27	16	14	10	10
28	18	12	4	16
29	23	7	11	9
30	16	14	2	18

*Figures in both columns for the Test of Objects include the sum of both "Important" columns; the same holds true for the "Unimportant" columns. The Self-Rating Depression Scale was scored in the same manner.

NON-SUICIDAL (continued)

FEMALE	TEST OF OBJECTS		SELF-RATING DEPRESSIVE SCALE	
Code	Important	Unimportant	Depressive Condition	Non-Depressive Condition
31	14	16	11	9
32	16	14	3	17
33	30	0	8	12
34	22	8	5	15
35	20	10	10	10
36	23	7	6	14
37	28	2	1	19
38	26	4	8	12
39	22	8	5	15
40	30	0	8	12
TOTAL:	463	137	148	252
Mean:	23.15	6.85	7.4	12.5