Original Research Article

Assessing suicide risk in young males with mild depression

Simar Sachdeva[1] , Sanjay Gupta[2]

1. 3rd year postgraduate resident, Centre of Excellence, Department of Psychiatry, All India Institute of Medical Sciences, Banaras Hindu University
2. Dean, Professor and ex-HOD, Centre of Excellence, Department of Psychiatry, All India Institute of Medical Sciences, Banaras Hindu University

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Corresponding author: Dr Simar Sachdeva
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ABSTRACT

Background: Mild depression is associated with an increased risk of suicidal ideation. This study compared the effectiveness of pharmacotherapy alone and pharmacotherapy combined with dimension-based psychotherapy in reducing depressive symptoms and suicide risk.

Methods: In this prospective, randomized, hospital-based study, 26 young adult males (18–35 years) with mild depression (HAM-D 10–14) and suicidal ideation were randomized to receive pharmacotherapy alone (n = 13) or pharmacotherapy plus dimension-based psychotherapy (n = 13). Depressive severity and suicidal ideation were assessed using the Hamilton Depression Rating Scale (HAM-D) and Beck Scale for Suicide Ideation (BSI) over eight follow-up visits.

Results: Both groups showed significant reductions in HAM-D and BSI scores during follow-up ($p < 0.001$). However, the combined therapy group demonstrated significantly greater improvement in depressive symptoms from the second follow-up and suicidal ideation from the sixth follow-up onward.

Conclusion: Pharmacotherapy combined with dimension-based psychotherapy was more effective than pharmacotherapy alone in reducing depressive symptoms and suicidal ideation, supporting the integration of structured psychotherapy into the management of mild depression.

Keywords: Mild depression; Suicidal ideation; Suicide risk; Dimension-based psychotherapy; Pharmacotherapy; Hamilton Depression Rating Scale (HAM-D).

Introduction

Depression is one of the most prevalent mental disorders worldwide and a leading cause of disability, reduced quality of life, and premature mortality. Young adulthood is a particularly vulnerable period for the onset of depression because of the numerous psychological, social, educational, and occupational transitions experienced during this stage of life [1]. Although mild depression is often perceived as less disabling than moderate or severe depression, it may still be associated with significant emotional distress, impaired functioning, and an increased risk of suicidal ideation[2]. Therefore, suicide risk assessment should not be restricted to patients with severe depression but should also include those presenting with mild depressive symptoms [3].Suicide is a major global public health problem. According to the World Health Organization, more than 720,000 people die by suicide each year, and suicide is the third leading cause of death among individuals aged 15–29 years. Nearly three-quarters of global suicides occur in low- and middle-income countries, emphasizing the need for effective prevention strategies, particularly among vulnerable populations [4].Young males represent one of the highest-risk groups for suicide. Although depression is more frequently diagnosed in females, males consistently have higher suicide mortality rates. This disparity has been attributed to delayed help-seeking behavior, social stigma surrounding mental illness, emotional suppression, impulsivity, substance use, and the use of more lethal methods of suicide. Consequently, depression in young men is often underrecognized and undertreated, increasing the likelihood of progression to suicidal behavior [5,6].Traditionally, suicide risk has been associated with moderate-to-severe depression. However, growing evidence indicates that individuals with

mild depression may also experience suicidal ideation and engage in suicidal behaviors [6]. Persistent hopelessness, low self-esteem, social isolation, stressful life events, and inadequate social support can substantially increase suicide risk despite relatively mild depressive symptoms. Because these individuals often maintain functional independence and may not seek specialized psychiatric care, their suicide risk is frequently overlooked during routine clinical assessment [7,8].Suicidal behaviour is multifactorial and results from the interaction of psychiatric, psychological, biological, and environmental factors [9]. Previous self-harm, family history of suicide, substance use disorders, interpersonal conflicts, academic or occupational stress, and poor social support are well-recognized contributors to suicide risk. Comprehensive suicide risk assessment should therefore extend beyond evaluating depression severity and include these psychosocial determinants [10].Despite increasing awareness of suicide prevention, studies specifically evaluating suicide risk among young males with mild depression remain limited, particularly in low- and middle-income countries. Identifying suicide risk at an early stage may facilitate timely intervention and improve mental health outcomes. Therefore, the present study was undertaken to assess suicide risk among young males with mild depression and to identify the demographic, clinical, and psychosocial factors associated with increased suicide risk.

MATERIALS AND METHODS

This prospective, randomized, hospital-based comparative interventional study was conducted in the Department of Psychiatry, Institute of Medical Sciences, Banaras Hindu University (IMS-BHU), Varanasi, Uttar Pradesh, India, from April 2024 to March 2025.The study was carried out over a period of one year, including patient recruitment, intervention, follow-up, and data analysis.

Study Participants

Young adult male patients aged 18–35 years attending the Psychiatry Outpatient Department and diagnosed with mild depressive disorder according to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) were screened for eligibility. Participants with suicidal ideation, with or without a suicide attempt within the previous six months, were enrolled after providing written informed consent.

Inclusion Criteria

- Male patients aged 18–35 years.
- Diagnosis of mild depressive disorder according to DSM-5-TR criteria.
- Hamilton Depression Rating Scale (HAM-D-17) score of 10–13.
- Presence of suicidal ideation, with or without a suicide attempt during the previous six months.
- Willingness to provide written informed consent.
- Exclusion Criteria
- Moderate or severe depressive disorder.
- Bipolar disorder, schizophrenia, or other psychotic disorders.
- Severe substance use disorder requiring specialized treatment.
- Intellectual disability or significant cognitive impairment.
- Serious neurological or medical illness affecting psychiatric assessment.
- Patients requiring emergency psychiatric hospitalization because of imminent suicide risk.

Sample Size and Sampling Technique

Eligible participants were recruited using purposive sampling. Following baseline assessment, participants were randomized in a 1:1 ratio into two treatment groups using a computer-generated randomization sequence.

Study Procedure

At baseline, demographic and clinical information, including age, occupation, education, family type, residence, psychiatric history, substance use, and psychosocial stressors, were recorded using a structured case record form. Depression severity was assessed using the 17-item Hamilton Depression Rating Scale (HAM-D-17), while suicidal ideation was evaluated using the Beck Scale for Suicide Ideation (BSI). A structured suicide risk assessment checklist was also administered before initiating treatment.

Intervention

Group I: Pharmacotherapy

Participants received standard pharmacological treatment comprising escitalopram (5–10 mg/day) with clonazepam (0.5 mg) prescribed on an as-needed basis according to clinical judgment.

Group II: Pharmacotherapy Plus Structured Psychotherapy

In addition to standard pharmacotherapy, participants received individualized psychotherapy based on their psychosocial stress profile. The intervention included psychoeducation, relaxation and deep-breathing exercises, stress management techniques, cognitive restructuring, problem-solving therapy, and supportive counselling targeting identified stress domains.

Follow-up Assessment

Participants were evaluated at baseline and during eight scheduled follow-up visits. Depression severity and suicidal ideation were reassessed at each follow-up using HAM-D-17 and BSI, respectively.

Outcome Measures

Primary Outcome

- Change in HAM-D score from baseline to the final follow-up.
- Secondary Outcomes
- Change in BSI score from baseline to the final follow-up.
- Comparison of treatment response between the two study groups.
- Association of sociodemographic variables with changes in depression severity and suicidal ideation.

Statistical Analysis

Data were entered into Microsoft Excel and analyzed using IBM SPSS Statistics version 26.0 (IBM Corp., Armonk, NY, USA). Continuous variables were expressed as mean ± standard deviation (SD) or median with interquartile range (IQR), while categorical variables were presented as frequencies and percentages. Inter-group comparisons were performed using the independent-samples t-test and Chi-square test. Within-group comparisons were analyzed using the paired t-test. A two-tailed p value <0.05 was considered statistically significant.

Ethical Considerations

The study protocol was approved by the Institutional Ethics Committee, Institute of Medical Sciences, Banaras Hindu University, Varanasi. Written informed consent was obtained from all participants before enrolment. Confidentiality of participant information was maintained throughout the study, and participants identified as being at high suicide risk received immediate psychiatric evaluation and appropriate clinical management according to institutional protocols

Results:

A total of 25 young adult males with mild depression and suicidal ideation were enrolled in the study. Thirteen participants received pharmacotherapy alone, while twelve received pharmacotherapy combined with structured psychotherapy. The mean age of participants was comparable between the two groups (32.40 ± 7.97 years vs. 33.32 ± 7.80 years; p = 0.561), indicating successful baseline matching. No statistically significant differences were observed in baseline demographic characteristics between the study groups (Table 1). The distribution of age between the two treatment groups is illustrated in Figure 1.

Baseline HAM-D scores were comparable between the pharmacotherapy and combined therapy groups (13.10 ± 1.34 vs. 13.00 ± 1.39; p = 0.715). Both groups demonstrated a statistically significant reduction in depressive symptoms from baseline throughout the follow-up period ($p < 0.001$ for all within-group comparisons).No significant difference was observed between the groups at the first follow-up. However, from the second follow-up onward, participants receiving pharmacotherapy plus psychotherapy exhibited significantly greater reductions in HAM-D scores compared with those receiving pharmacotherapy alone. This superiority of combined therapy remained statistically significant throughout subsequent follow-up visits ($p < 0.001$). By the eighth follow-up, the mean HAM-D score had decreased to 4.58 ± 0.97 in the pharmacotherapy group and 3.94 ± 0.75 in the combined therapy group (Table 2). The trend in HAM-D score reduction across all follow-up visits is depicted in Figure 2.Baseline Beck Scale for Suicide Ideation (BSI) scores were similar in both treatment groups (18.10 ± 1.37 vs. 17.66 ± 1.27; p = 0.100). Significant reductions in suicidal ideation were observed in both groups at every follow-up compared with baseline ($p < 0.001$ for all within-group comparisons).Between-group comparisons showed no statistically significant differences during the first five follow-up assessments. However, beginning with the sixth follow-up, the combined therapy group demonstrated significantly lower BSI scores than the pharmacotherapy group (p = 0.011), with the difference becoming highly significant at the seventh and eighth follow-ups ($p < 0.001$). At the final follow-up, mean BSI scores were 9.62 ± 2.93 and 6.77 ± 2.78 in the pharmacotherapy and combined therapy groups, respectively (Table 3). The longitudinal changes in suicidal ideation scores are presented in Figure 3.Improvement in depressive severity and suicidal ideation was observed across all sociodemographic categories (Table 4). Participants aged 18–25 years demonstrated a mean reduction of 10.4 points in HAM-D scores and 42 points in BSI scores, while those aged 26–35 years showed reductions of 10.2 and 40 points, respectively (both $p < 0.001$).Comparable improvements were observed irrespective of religion, residence, family type, occupation, and socioeconomic status. Students demonstrated slightly greater reductions in both depressive symptoms and suicidal ideation than employed participants. Similarly, participants from nuclear families showed marginally greater improvement than those from joint families. However, all subgroups demonstrated statistically significant improvement from baseline ($p < 0.001$).Analysis of changes between consecutive follow-up visits demonstrated a more rapid decline

in depressive severity among participants receiving combined therapy (Table 5). The largest reduction occurred during the baseline-to-first follow-up interval (−2.8 points), with gradual reductions thereafter. In contrast, the pharmacotherapy group exhibited a slower but steady decline in HAM-D scores across all follow-up intervals.Suicidal ideation also declined progressively in both treatment groups (Table 6). Although early reductions were comparable, participants receiving combined therapy demonstrated substantially greater reductions during later follow-up intervals, particularly from the fifth follow-up onward. The greatest decline occurred between the sixth and seventh follow-ups (−16 points) in the combined therapy group compared with a reduction of −7 points in the pharmacotherapy group, indicating sustained benefits of psychotherapy in reducing suicide risk.Across all outcome measures, reductions in depressive severity were accompanied by corresponding reductions in suicidal ideation. Combined pharmacotherapy and psychotherapy produced earlier and greater improvements than pharmacotherapy alone. Although depressive symptoms improved relatively early, reductions in suicidal ideation occurred more gradually, suggesting that improvement in mood precedes improvement in suicide risk. These findings highlight the importance of addressing psychosocial stressors through structured psychotherapy in addition to pharmacological treatment for young males with mild depression and suicidal ideation.

Table 1. Comparison of Age and Sex Distribution Between Study Groups

Variable	**Pharmacotherapy (n = 50)**	**Pharmacotherapy + Psychotherapy (n = 50)**	**p-value**	**Statistical Test**
Age (years)				
Mean ± SD	**32.40 ± 7.97**	**33.32 ± 7.80**	0.561	Independent *t*-test
Median (IQR)	**33.0 (26.2–38.0)**	**32.5 (28.0–39.0)**		
Sex				
Female, n (%)	**37 (74.0%)**	**38 (76.0%)**	1.000	Chi-square test
Male, n (%)	**13 (26.0%)**	**12 (24.0%)**		

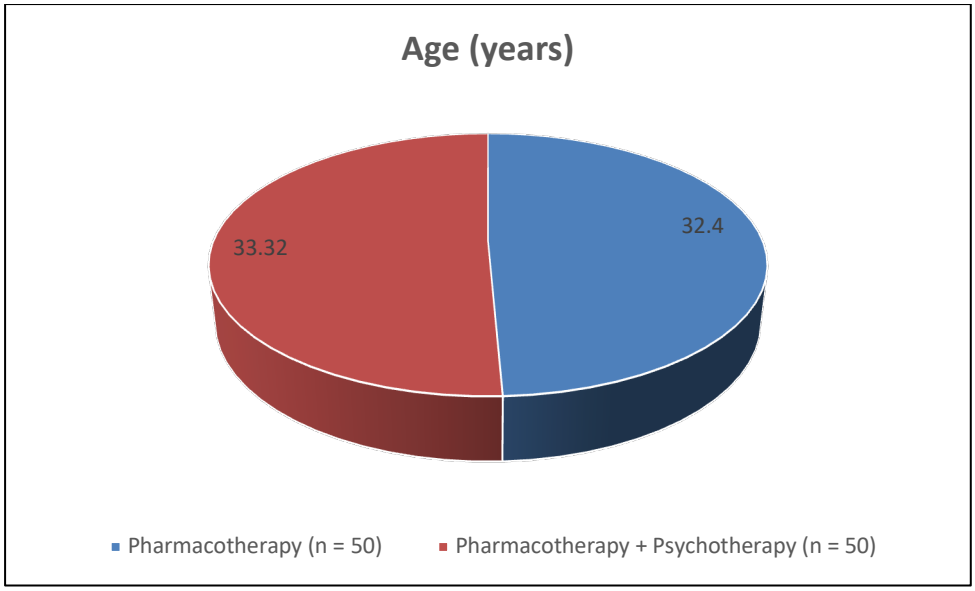

Figure 1 Comparison of Age Distribution Between Study Groups

Table 2. Comparison of HAM-D Scores Across Follow-ups

Time point	Pharmacotherapy (n = 13) Mean ± SD	Pharma + Psychotherapy (n = 12) Mean ± SD	Inter-group p-value	Intra-group p-value (Pharma vs BL)	Intra-group p-value (Pharma+Psy vs BL)	Statistical Test
HAMD_BL	13.10 ± 1.34	13.00 ± 1.39	0.715	—	—	Independent *t*-test
HAMD_FU1	12.70 ± 1.31	12.37 ± 1.29	0.217	**<0.001**	**<0.001**	Paired *t*-test
HAMD_FU2	11.28 ± 1.33	11.53 ± 1.27	**0.005**	**<0.001**	**<0.001**	
HAMD_FU3	10.82 ± 1.39	10.72 ± 1.20	**<0.001**	**<0.001**	**<0.001**	
HAMD_FU4	9.25 ± 1.34	8.86 ± 1.37	**<0.001**	**<0.001**	**<0.001**	

HAMD_FU 5	8.77 ± 1.16	6.24 ± 1.01	**<0.00 1**	**<0.001**	**<0.001**	
HAMD_FU 6	6.04 ± 1.09	5.82 ± 0.94	**<0.00 1**	**<0.001**	**<0.001**	
HAMD_FU 7	5.31 ± 1.03	4.41 ± 0.85	**<0.00 1**	**<0.001**	**<0.001**	
HAMD_FU 8	4.58 ± 0.97	3.94 ± 0.75	**<0.00 1**	**<0.001**	**<0.001**	

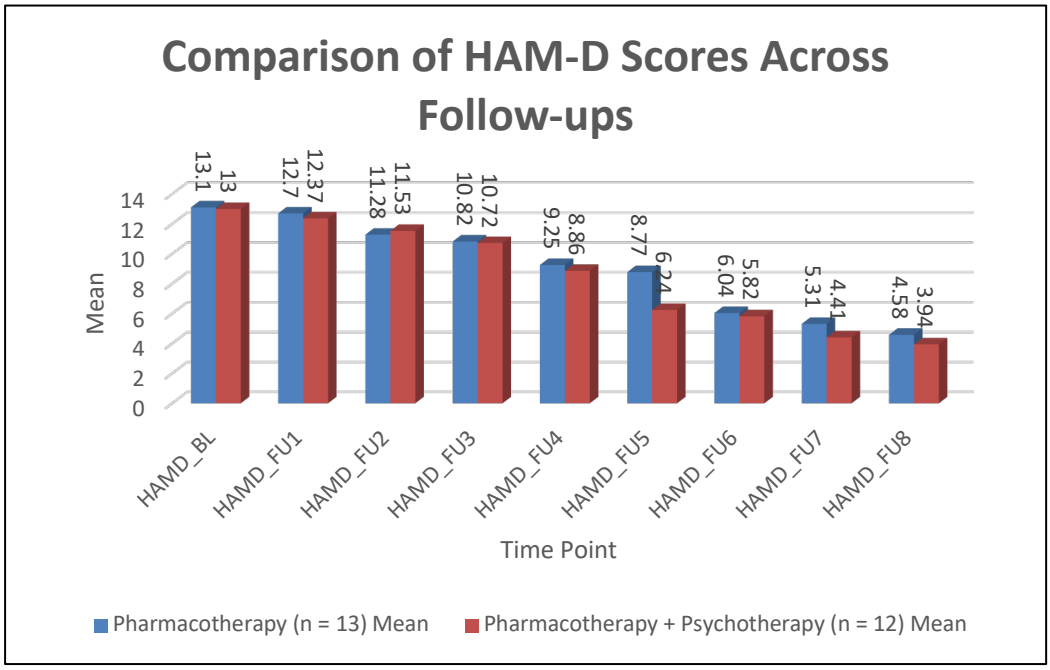

Figure 2. Comparison of HAM-D Scores Across Follow-ups

Table 3. Inter-group and Intra-group Comparison of BSI Scores Across Follow-ups

Time point	Pharmacotherapy (n = 13) Mean ± SD	Pharma + Psychotherapy (n = 12) Mean ± SD	Inter-group p-value	Intra-group p-value (Pharma vs BL)	Intra-group p-value (Pharma+Psy vs BL)	Statistical Test

BSI_BL	18.10 ± 1.37	17.66 ± 1.27	0.100	—	—	Independent *t*-test
BSI_FU1	16.62 ± 1.52	16.24 ± 1.45	0.205	**<0.001**	**<0.001**	Paired *t*-test
BSI_FU2	15.62 ± 1.52	15.24 ± 1.45	0.205	**<0.001**	**<0.001**	
BSI_FU3	15.18 ± 1.60	14.66 ± 1.49	0.096	**<0.001**	**<0.001**	
BSI_FU4	13.51 ± 2.29	12.75 ± 2.50	0.115	**<0.001**	**<0.001**	
BSI_FU5	12.14 ± 2.95	11.44 ± 2.77	0.226	**<0.001**	**<0.001**	
BSI_FU6	11.30 ± 2.92	9.82 ± 2.79	**0.011**	**<0.001**	**<0.001**	
BSI_FU7	10.44 ± 2.93	8.27 ± 2.84	**<0.001**	**<0.001**	**<0.001**	
BSI_FU8	9.62 ± 2.93	6.77 ± 2.78	**<0.001**	**<0.001**	**<0.001**	

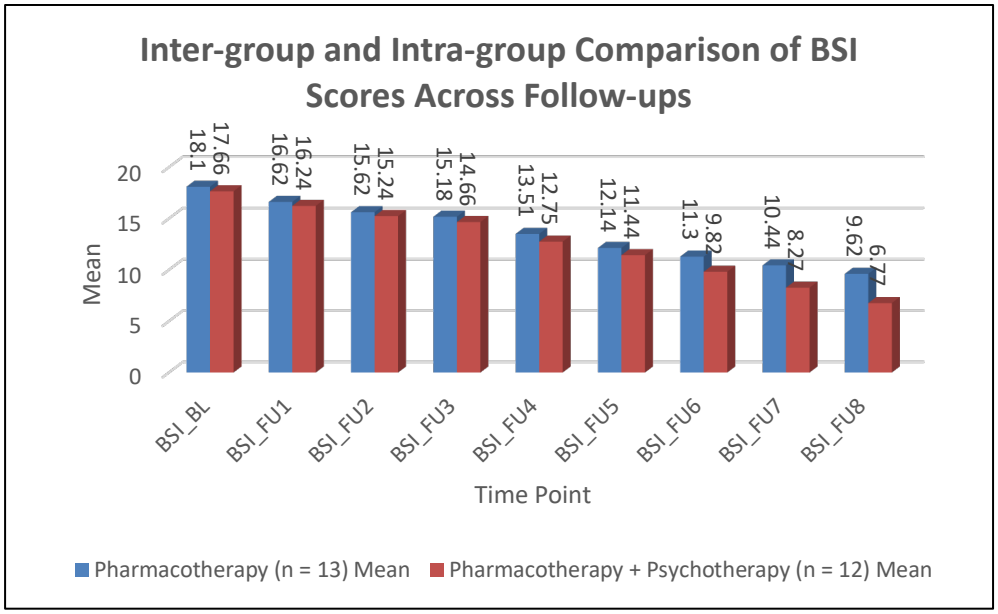

Figure 3. Inter-group and Intra-group Comparison of BSI Scores Across Follow-ups

Table 4. Sociodemographic Analysis Of Suicide Risk

Variable	Category	n	HAM-D BL (Mean±SD)	HAM-D FU7	ΔHAM-D	p value	BSI BL	BSI FU7	ΔBSI	p value
Age	18–25	28	12.2 ± 2.1	5.8	-10.4	<0.001	72	30	-42	<0.001
Age	26–35	22	11.0 ± 2.3	6.8	-10.2	<0.001	75	35	-40	<0.001
Religion	Hindu	35	13.5 ± 2.2	6.2	-10.3	<0.001	73	32	-41	<0.001
Religion	Muslim	15	12.8 ± 2.4	6.5	-10.3	<0.001	74	34	-40	<0.001
Residence	Urban	45	13.3 ± 2.1	5.9	-10.4	<0.001	72	30	-42	<0.001
Residence	Rural	5	12.1 ± 2.5	7.2	-9.9	<0.001	76	36	-40	<0.001
Family Type	Nuclear	32	11.2 ± 2.0	5.7	-10.5	<0.001	71	29	-42	<0.001
Family Type	Joint	18	12.3 ± 2.6	7.1	-10.2	<0.001	76	36	-40	<0.001
Occupation	Student	27	12.5 ± 2.3	5.6	-10.9	<0.001	73	28	-45	<0.001
Occupation	Employed	23	12.8 ± 2.2	6.9	-9.9	<0.001	74	35	-39	<0.001
Socioeconomic	Lower	20	11.5 ± 2.4	7.5	-10.0	<0.001	78	38	-40	<0.001

Status										
Socio economic Status	Middle	30	1.1 ± 2.1	5.8	-10.3	<0.001	72	30	-42	<0.001

Table 5. Progression of depressive severity over time

Interval	Pharmacotherapy Δ	Combined Therapy Δ
BL–FU1	-1.2	-2.8
FU1–FU2	-1.0	-2.5
FU2–FU3	-0.8	-2.0
FU3–FU4	-0.7	-1.6
FU4–FU5	-0.6	-1.2
FU5–FU6	-0.5	-0.9
FU6–FU7	-0.4	-0.7

Table 6. Progression of Suicidal risk over time:

Interval	Pharmacotherapy Δ	Combined Therapy Δ
BL–FU1	-3	-2
FU1–FU2	-2	-4
FU2–FU3	-5	-5
FU3–FU4	-6	-7
FU4–FU5	-7	-8
FU5–FU6	-7	-12
FU6–FU7	-7	-16

Discussion:

In the present study, the mean age was comparable between the pharmacotherapy group (32.40 ± 7.97 years) and the pharmacotherapy plus psychotherapy group (33.32 ± 7.80 years), with no statistically significant difference ($p = 0.561$). Females constituted the majority of participants in both groups (74.0% and 76.0%, respectively), and sex distribution was also comparable ($p = 1.000$). These findings indicate that both treatment groups were well matched at baseline. Similar findings were reported by Bai et al. (2022) [11], who observed that depression predominantly affected young and middle-aged adults and highlighted the increasing burden of depression in this economically productive age group.In the present study, both treatment groups demonstrated significant reductions in HAM-D scores throughout follow-up (all intra-group $p < 0.001$). Baseline HAM-D scores were comparable (13.10 ± 1.34 vs. 13.00 ± 1.39; $p = 0.715$). However, from the second follow-up

onward, patients receiving pharmacotherapy combined with dimension-based psychotherapy showed significantly greater improvement than those receiving pharmacotherapy alone. By the eighth follow-up, mean HAM-D scores had decreased to 4.58 ± 0.97 and 3.94 ± 0.75, respectively. Comparable findings were reported by Bahlmann et al. (2022) [12], who demonstrated that a structured psychotherapeutic relapse-prevention intervention significantly improved depressive symptoms and emotional coping following suicidal events. The authors concluded that psychotherapy provides additional clinical benefit when combined with pharmacological treatment.The present study demonstrated significant reductions in suicidal ideation in both treatment groups throughout follow-up (all $p < 0.001$). Although baseline BSI scores were comparable (18.10 ± 1.37 vs. 17.66 ± 1.27; $p = 0.100$), significantly greater reductions were observed in the combined therapy group from the sixth follow-up onwards. At the eighth follow-up, mean BSI scores declined to 9.62 ± 2.93 in the pharmacotherapy group and 6.77 ± 2.78 in the combined therapy group. Similar observations were reported by Bahlmann et al. (2022) [12], who found that psychotherapeutic interventions after suicidal crises reduced suicidal behaviour and improved long-term clinical outcomes. Likewise, Beck et al. (1990) [13] reported that reducing hopelessness through cognitive interventions was associated with a substantial reduction in future suicide risk.In the present study, significant improvement in both depressive symptoms and suicidal ideation was observed across all sociodemographic groups (all $p < 0.001$). Students exhibited the greatest improvement (ΔHAM-D = −10.9; ΔBSI = −45), while urban residents and participants from nuclear families also demonstrated relatively greater reductions. These findings are comparable with those reported by Aschan et al. (2013) [14], who found that lower socioeconomic status, stressful life events, and poor social support were significant determinants of suicidal behaviour. Similarly, Beautrais et al. (1998) [15] reported that unemployment and adverse socioeconomic conditions significantly increased the risk of serious suicide attempts, emphasizing the importance of psychosocial factors in suicide prevention.

The present study demonstrated progressive reductions in depressive severity throughout follow-up, with consistently greater interval improvement in the combined therapy group. Between baseline and the first follow-up, HAM-D scores declined by 2.8 points in the combined therapy group compared with 1.2 points in the pharmacotherapy group, and this advantage persisted throughout subsequent assessments. These findings support the cognitive model proposed by Beck (1967) [16], which suggests that modification of dysfunctional thinking patterns accelerates recovery from depression. Similarly, Blackburn (1991) [17] reported that cognitive psychotherapy enhances symptom improvement by addressing maladaptive beliefs, while Belmaker and Agam (2008) [18] emphasized that combined pharmacological and psychotherapeutic treatment provides superior outcomes compared with medication alone.Although depressive symptoms improved relatively early, reductions in suicidal ideation occurred more gradually. The combined therapy group demonstrated progressively greater reductions in BSI scores during later follow-up intervals, particularly after the fifth follow-up. These findings are consistent with Beck (1986) [19], who identified hopelessness as one of the strongest predictors of suicide and suggested that improvement in suicidal ideation generally follows cognitive restructuring rather than symptomatic improvement alone. Likewise, Baumeister (1990) [proposed that suicidal behaviour results from persistent psychological distress and escape from self, supporting the need for psychotherapeutic interventions that address underlying psychosocial stressors.

Conclusion

Both pharmacotherapy alone and pharmacotherapy combined with dimension-based psychotherapy significantly reduced depressive symptoms and suicidal ideation. However, the combined approach produced greater and more sustained improvements in HAM-D and BSI scores, supporting the integration of structured psychotherapy with pharmacotherapy for better clinical outcomes and suicide risk reduction.

Limitation of the Study

The study was conducted at a single tertiary care center with a relatively small sample size, which may limit the generalizability of the findings. Additionally, the relatively short follow-up period precluded assessment of the long-term sustainability of treatment effects and recurrence of suicidal ideation.

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