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Review Paper

Role of Coping Self-efficacy in Depression and Suicide-related Behaviours: A Review of Literature

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ABSTRACT

Suicidal deaths have drastically increased, with teenagers and young adults being the most affected. Although depression is most commonly associated with suicide, researchers are beginning to acknowledge suicide-related behaviours as comorbid with mental health disorders instead of it being just a symptom of disorders. Bandura's theory of self-efficacy proposes that one's belief in their own coping abilities, also known as coping self-efficacy, influences the decision of whether one wants to engage in coping behaviours or not and how much effort to invest in the coping behaviour. Thus, individuals with low coping self-efficacy may engage in ineffective and passive strategies such as avoidance which does not resolve the problem, resulting in recurrent stress. Persistent stress results in feelings of defeat and entrapment, which if combined with low coping self-efficacy and inefficient coping, results in a tunnel vision where suicide-related behaviours seem like the only solution. Coping self-efficacy comprises of three dimensions, namely, stopping unwanted thoughts and emotions, problem-solving and getting support from friends and family, each influencing coping strategies differently and affecting mental health and well-being. This literature review presents findings and theories on depression, suicide-related behaviours, dimensions of coping self-efficacy and its influence on coping behaviours and mental health.

Keywords: *Suicide, Depression, Coping self-efficacy, Thought suppression, Emotion-focused coping, Problem-solving, Support*

Suicide is a leading cause of death worldwide accounting for more deaths than malaria, HIV/AIDS, breast cancer, or war and homicide (*Suicide Worldwide in 2019: Global Health Estimates*, 2021). According to a WHO (2021) report, in 2019, over 700,000 deaths by suicide were recorded, out of which India alone recorded over 170,000 suicidal deaths. Among 15-29 year olds, suicide is the fourth leading cause of death; with almost 30-40% of these individuals suffering from clinical depression (World Health Organisation, 2019). While these statistics record only reported deaths by suicide, there are almost no records of unreported suicidal deaths, miscoded suicide deaths, suicide survivors, self-harm and suicidal ideations.

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Suicide, defined as "death caused by self-directed injurious behaviour", (*Suicide,* 2021) is one of the few global public health concerns that can be prevented (Hogan & Grumet, 2016; *Suicide*, 2021).

In India, prior to 2017, suicide was considered a punishable offence under Section 309. But with the introduction of the Mental Healthcare Act, 2017, suicide was decriminalized and any individual attempting suicide is assumed to suffer from severe stress and appropriate care and treatment is to be provided (*Suicide Law In India,* 2021).

Identifying individuals at suicide risk and providing appropriate support is one of the most effective prevention strategies against future suicidal attempts. With such staggering increase in deaths by suicide, research to understand psychological processes underlying suicidal-related behaviours is vital to develop and implement effective intervention and prevention strategies.

Depression and suicide-related behaviours

Suicide-related behaviours are commonly associated with depression (Conejero et al., 2018; Horwitz et al., 2018; Paschall & Bersamin, 2018). The Diagnostic and Statistical Manual of Mental Disorders – 5 (DSM-5) lists recurrent thoughts of death and suicidal-related behaviours as a diagnostic criterion for Major Depressive Disorder along with symptoms such as loss of interest and pleasure, significant weight loss or gain, insomnia or hypersomnia, psychomotor retardation or agitation, fatigue, feeling worthless or excessive guilt, and decreased ability to concentrate or indecisiveness (DSM-5, 2013). However, researchers have started recognizing suicide-related behaviours as a separate mental health concern being co-morbid with disorders rather than as a symptom of a disorder (Nock et al., 2009; Oquendo & Baca-Garcia, 2014).

In a review on all recorded suicidal attempts in India, about 39.73% of individuals had a diagnosis of depression (Vijayakumar, 2010). Certain physical illnesses such as cancer recorded almost 9.2% patients suffering from severe suicidal ideations of which only 3.8% patients had a diagnosis of depression (Latha & Bhat, 2005). As only a small percentage of individuals suffering from suicidal ideations were diagnosed with depression, it raises questions about whether all individuals at suicide risk suffer from depression and whether all individuals suffering from depression are at suicide-risk. Although clinical depression is not the only predictor of suicide-related behaviours, individuals suffering from depression are at a higher risk of suicide (Wetherall et al., 2019).

Individuals suffering from depression experience feelings of defeat and entrapment (Carvalho et al., 2013). A 'feeling of defeat' results from a reduction in one's perceived ability to attain a social place (Carvalho et al., 2013) which forms "harsh self-criticism" (Gilbert, 2007). People with depression may have a "global inferiority view of the self," a sense of failed struggle and a loss of social standing (Carvalho et al., 2013). In other words, such feelings of defeat contribute to symptoms of depression.

Along with defeat, entrapment is also strongly associated with depression (Kendler et al., 2003; Sturman & Mongrain 2008; Taylor et al., 2011; Carvalho et al., 2013). Internal entrapment specifically, which is described as feeling trapped by painful feelings, thoughts and memories (Gilbert & Allan, 1998), has a higher correlation with individuals with depression compared to individuals without depression (Carvalho et al., 2013).

According to Theory of Depression by Aaron Beck, childhood experiences develop dysfunctional beliefs and negative views of the world, the future and self, which increases risk of depression (Beck, 1967; Reilly et al., 2012). When such negative beliefs and schemas are formed, individuals view reality in a perspective consistent with these beliefs and schemas. A negative view of self includes beliefs such as “I am unlovable”; “I am inadequate”, “I am useless” and “When I ask someone for help, I will be rejected” (Southam-Gerow et al., 2011; Hwang, 2016; Doering et al., 2018). Such depreciating thoughts and beliefs are known to influence one’s effort invested in coping strategies (Bandura, 1997; Parto & Besharat, 2011; Karademas & Kalantzi- Azizi, 2004; Takaki, Nishi, Shimogama et al., 2003; Bonner, 2015), which subsequently influences its effectiveness in times of distress.

These cognitive factors are not limited to depression but are also observed in suicide-related behaviours as explained by the Interpersonal Theory of Suicide and Integrated Motivational Volitional Model of Suicidal Behaviour.

Suicide-related behaviours and models

Until a few decades ago, suicidal behaviour was used interchangeably with suicidal ideation, self-harm, attempted suicide and death by suicide (Klonsky, May, & Saffer, 2016). However, in the last decade, a distinction between suicidal ideation and suicidal behaviour has been strongly established. While, suicidal ideation refers to wishing, thinking about or planning suicide (McAuliffe, 2002; Harmer, 2021), suicidal behaviour includes any self-injurious action or behaviour with or without the intent to die (Klonsky et al., 2016). Moreover, the attributes of suicidal intent are a series of deliberate actions with the purpose of taking one’s own life (Leenaars, 2004). Suicidal ideation precedes suicidal intent (McAuliffe, 2002). Thus, findings of suicidal intent assume presence of suicidal ideation as well.

The Interpersonal Psychological Theory of Suicide explains suicidal behaviour in terms of transition from suicidal ideation to suicidal attempt (Joiner, 2005). According to this theory, a desire for suicide is developed when there is perceived burdensomeness and thwarted belongingness. Perceived burdensomeness refers to the perception that one’s existence is a burden to their friends, family and other social groups; and thwarted belongingness refers to the experience of feeling isolated, alienated and not belonging to any group. These two psychological states along with capability for suicide play a crucial role in suicidal ideation and behaviour.

However, one important limitation of this model is that it is reductionist by focusing only on thwarted belongingness and perceived burdensomeness as contributors to suicidal-related behaviours. A range of other factors such as adverse life events and individual differences that are known to influence suicidal-related behaviours are not explained.

The Integrated Motivational Volitional (IMV) model of suicidal behaviour, attempts to fill this gap by encompassing certain factors affecting the development of suicidal ideation (O’Connor, 2011). The IMV model is a three-part framework divided into pre-motivational, motivational and volitional phases. The pre-motivational phase comprises background factors including personality characteristics such as socially prescribed perfectionism and triggering events that increase risk of suicidal ideation and behaviour. The motivational phase focuses on factors such as feelings of defeat and entrapment leading to development of suicidal ideation and intent. Transition from feelings of defeat to feelings of entrapment is moderated by threat-to-self moderators (TSM) such as social problem-solving, coping, memory biases and ruminative processes. Additionally, transition from feelings of entrapment to suicidal

ideation and intent is moderated by motivational moderators such as thwarted belongingness, burdensomeness, future thoughts, goals, norms, resilience, social support and attitudes. Furthermore, the volitional phase explains the progression from suicidal ideation and intent to suicidal behaviour which is moderated by volitional moderators such as access to means, planning, exposure to suicide, impulsivity, physical pain sensitivity, fearlessness about death, imagery and past behaviour (O'Connor & Kirtley, 2018).

These two models have had large contributions to our understanding of suicide-related behaviours, which are commonly observed with mental health disorders, in particular, depression.

The models, rates of suicide and depression comorbidity above, show that although depression increases risk of suicide, not all individuals with depression engage in suicide-related behaviours and not all individuals engaging in suicide-related behaviours have a diagnosis of depression only. Based on this, perhaps, it can be hypothesized that depression and suicide-related behaviours follow a parallel pathway of cognitive processing instead of an overlapping one. There may be certain mediating and moderating variables that are common or even distinguish individuals engaging in suicide-related behaviours from individuals who do not engage in suicide-related behaviours. Coping self-efficacy is one such variable, explained below.

Coping self-efficacy, coping and suicide-related behaviours

Adverse circumstances demand one to adopt coping strategies. Lazarus and Folkman (1984) define coping as behavioural and cognitive strategies used to manage demands of stressors. Effective coping strategies result in reduction of distress, whereas, ineffective coping strategies maintain or even increase distress. There are two potential explanations for ineffective coping. First, the demands of the stressor are more than one's capability; and second, low coping self-efficacy.

Coping self-efficacy refers to one's belief in their ability to cope with a stressor (Chesney et al, 2006). Coping self-efficacy (CSE) has been shown to improve one's wellbeing (Wissing, 2011) and health by improving regulation of thoughts, mood, behaviours, motivation, and a sense of control (Broadnax, 2016). Self-efficacy influences one's decision in whether or not they should attempt to cope with the stressor (Bandura, 1997; Parto & Besharat, 2011) and how much effort to put in the coping behaviour (Karademas & Kalantzi- Azizi, 2004; Takaki, Nishi, Shimogama et al., 2003; Bonner, 2015).

High CSE, on one hand, is associated with resourcefulness in finding solutions to environmental barriers and regulating emotional activity (Broadnax, 2016), which reduces psychological distress (Brummert Lennings & Bussey, 2017). This suggests that having high overall CSE positively influences effective coping strategies. On the other hand, one's lack of belief in their ability to carry out coping behaviours i.e., low CSE is associated with feelings of helplessness, a significant contributor to suicide-related behaviours (Lester, 2012; Asselmann et al., 2016; Mishara & Chagnon, 2016; Srivastava, 2018). Low CSE is associated with a low sense of control over internal and external factors, high stress, and high negative reactivity to stressful situations (Broadnax, 2016). Low CSE also determines one's levels of motivation, effort and persistence (Broadnax, 2016) against perceived adverse circumstances (Pisanti, 2012). Thus, it can be inferred that low CSE results in lack of motivation and insufficient efforts to cope with the stressor. This leads to ineffective coping, thereby maintaining distress, which in turn reinforces the belief that one is not capable to cope with

the stressor (Bandura, 1977; Bonner, 2015). A reduction in one's belief in their ability to cope again influences the willingness and effectiveness of coping strategies leading to further ineffective coping, thereby maintaining distress. This becomes a vicious cycle (Bonner, 2015).

A study by Thompson et al. (2002) notes, that those individual with a history of attempted suicide had low perceived self-efficacy compared to those who had no history of attempted suicide. An interesting point to note is that individuals, who had low perceived self-efficacy believed that they did not have the skills to obtain resources to cope with the stressor. In other words, demands of the stressor were perceived as more than one's capability. Hence, it can be assumed that if belief in one's ability to cope is low or even absent, their actual efforts to cope will not be sufficient, which can potentially develop symptoms of depression and increase suicide risk.

Although findings suggest overall CSE to have respective influence on coping behaviours, it may be beneficial to explore the sub-dimensions of CSE individually instead of overall CSE. Coping self-efficacy comprises of three sub-dimensions namely, stopping unwanted thoughts and emotions (emotion/thought-stopping), problem-solving, and getting social support (Chesney et al., 2006).

Thought suppression, coping, depression and suicide-related behaviours

While the coping behaviour of stopping unwanted thoughts and emotions i.e. thought suppression refers to the deliberate attempt to not think of something (Najmi et al., 2007), coping self-efficacy of stopping unwanted thought and emotions, refers to one's *belief* in their ability to alter their emotional response to an unsettling event or problem (eg, "Take your mind off negative thoughts") (Chesney et al., 2006).

Coping self-efficacy of stopping unwanted thoughts and emotions has almost never been investigated individually. Thus, this section will focus only on thought-stopping and emotion-focused coping behaviours and its relation to depression and suicide-related behaviours.

The vast literature on thought-stopping and emotion-focused coping in relation to depression and suicide-related behaviours shows that while thought-stopping lowers risk of suicide-related behaviours (Cukrowicz et al., 2008; Parto & Besharat, 2011), emotion-focused coping increases psychological distress and even depression rather than reduction in psychological distress (Cukrowicz et al., 2008; Parto & Besharat, 2011).

The Ironic Process theory, also referred to as the 'white bear' problem (Wegner et al., 1987) is a classic theory on thought suppression. According to this theory, attempts at suppressing unwanted thoughts, makes it more likely for the thoughts to be brought to one's conscious awareness, possibly with an increased frequency and intensity. This is also thought to increase the intensity of the negative emotions associated with it (Pettit et al., 2009). This implies that any attempts at suppressing aversive thoughts, emotions and memories may increase the frequency and intensity of such thoughts, emotions and memories, thereby sustaining or even increasing distress.

This can be extended to Beck's cognitive theory of depression (Beck, 1967). Attempts at suppressing negative thoughts and emotions about the future, world and self may increase the intensity and frequency of these thoughts and emotions to the point of severe depression accompanied with feeling internally trapped resulting in a desperate urge to escape these aversive thoughts and emotions, where suicide-related behaviours are perceived as the only

solution. This is supported by findings suggesting that individuals engage in non-suicidal injury (NSSI) or self-harm to regulate distressing emotions or even distract oneself from distressing emotions (Taylor et al., 2018). Thus, practitioners should be mindful of developing interventions targeting stopping or regulating such unwanted thoughts instead of encouraging thought suppression.

Findings show a correlation between suppression of unwanted thoughts with suicide-related behaviours such as suicidal ideation, self-harm, and suicidal attempts (Najmi et al., 2007). Thought suppression mediates emotional reactivity and self-injurious thoughts and behaviours. In other words, high emotional reactivity to aversive thoughts and emotions triggers thought suppression eventually leading to self-injurious thoughts and behaviours. Any attempt at suppressing these thoughts exacerbates the intensity of unwanted thoughts and emotions. Thus, in a desperate need to cope with the heightened distressing thoughts and emotions, one engages in suicide-related behaviours. An important point to note is that this study did not indicate the effect of thought suppression on the frequency of suicide attempts. Thus, the role of thought suppression must be assumed carefully for other suicide-related behaviours.

Emotional coping is efforts to regulate emotions through processes such as rumination, blaming oneself, and venting of negative emotions (Cukrowicz et al., 2008). Individuals, particularly middle-aged individuals, suffering from mood disorders such as depression have a tendency to use emotion-focused coping (Folkman and Lazarus, 1986). This is supported by a meta-analysis indicating a high correlation between depression and emotion-focused coping (e.g., 'criticize or blame myself', 'take my frustrations out on the people closest to me') (Penley et al., 2002). Emotion-focused coping is associated not only with depression, but also suicide-related behaviours such as suicidal ideation, suicidal attempts and increased suicide risk in future, in clinical as well as non-clinical sample (D'Zurilla et al., 1998; Edwards & Holden, 2001; Cukrowicz et al., 2008).

Persistent failure to stop these unwanted thoughts and emotions affects one's belief in their ability to find solutions to stop unpleasant thoughts. In other words, persistent failures contribute to reduced CSE for stopping unwanted thoughts and emotions, thereby reducing the efficiency of thought-stopping and emotion-focused coping. This, in turn, can contribute to feeling trapped internally adding to severity of depression and increasing risk of suicide-related behaviours. According to Baumeister (1990), ''Suicide thus emerges as an escalation of the person's wish to escape from meaningful awareness of current life problems and their implications about the self'' (p. 91).

All these findings are consistent with the claim that thought-suppression as well as emotion-focused coping increase risk of suicide-related behaviours. Despite this, it is noteworthy to mention that all these studies relied on self-reports of adopted coping strategies. This raises questions on whether this reflects the actual coping behaviours adopted or beliefs of individuals about their thought-stopping and emotion-focused coping behaviours in distressing situations (Cukrowicz et al., 2008). It is important for individuals to identify their maladaptive coping strategies and seek professional help to modify such thoughts and behaviours. Furthermore, it will benefit practitioners and researchers to be mindful of this in their treatment plan, goals and research predictions.

Problem-solving coping self-efficacy, depression and suicide-related behaviours

Problem-solving consists of applying four important problem-solving skills, namely, defining and formulating the problem, generating solutions, making decisions and lastly, implementing and verifying solutions (Klein et al., 2011). Problem-solving coping self-efficacy, on the other hand, refers to one's *belief* in their ability to overcome problems by using cognitive strategies that make the problem appear as less severe ("Break an upsetting problem down into smaller parts") (Chesney et al., 2006).

Several findings have established a correlation between perceived problem-solving skills and suicide-related behaviours (Linda et al., 2012; Chu et al., 2018; Zhang et al., 2021). Appraisals or belief about one's problem-solving abilities plays a role in overall performance (Taylor et al., 2010). Underlying negative appraisals or beliefs of problem-solving abilities contributes to feelings of entrapment (Taylor et al., 2010; Owen et al., 2018). This is concerning as feelings of entrapment has strong contributions to suicide-related behaviours (O'Connor, 2011; O'Connor & Kirtley, 2018; Li et al., 2018; Teismann & Brailovskaia, 2019).

One of the factors influencing formation of negative beliefs about problem-solving abilities is failed problem-solving in the past. Individuals with deficient problem-solving abilities view problems as threats instead of challenges, try to impulsively and hurriedly resolve the problem, experience frustration when faced with a problem or even adopt avoidant coping strategies such as inaction, being passive, overdependence on others and procrastination when facing a problem (Chu et al., 2018). Such approaches are ineffective to resolve stressors, thereby, resulting in failure to resolve problems, leading to forming negative feelings and beliefs about one's own problem-solving abilities.

Applying Bandura's theory of self-efficacy here, negative beliefs in one's own ability limits actual efforts invested in carrying out the behaviour (Bandura, 1977). This implies lowered resourcefulness in finding solutions to problems i.e. deficits in problem-solving abilities. This continuous cycle of negative beliefs and inefficient strategies has emotional consequences such as symptoms of depression. This is supported by D'Zurilla and colleagues' model of social problem-solving that suggests that failure to solve problems makes a person vulnerable to emotional difficulties. This persistent cycle of poor outcomes of problems results in negative emotional reactions (D'Zurilla & Goldfried, 1971; Anderson et al., 2009). Constant failure to resolve stressors, perhaps due to demands of stressor being more than one's capability, reinforces one's belief in their inability to solve problems, which is internally entrapping, and if accompanied by rumination, develops symptoms of depression and a desperate urge to escape the problem. Ruminating over one's inability to resolve the problems may result in distressing thoughts and emotions, which as mentioned above, has its own challenges. Such a progression of beliefs in one's abilities to actual effectiveness of problem-solving and feeling internally trapped, are strong predictors of suicide-related behaviours (O'Connor, 2011; O'Connor & Kirtley, 2018). Thus, deficits in problem-solving abilities combined with low problem-solving coping self-efficacy can be considered as early signs of suicide risk in the future (McAuliffe et al., 2006; McLaughlin et al., 1996; Pollock & Williams, 2004; Roskar et al., 2007; Speckens & Hawton, 2005; Chu et al. 2018). Despite such strong findings associating problem-solving appraisal and problem-solving with depression and suicide-related behaviours, it is important to highlight that most of these studies are correlational studies. Thus, the exact direction of this association cannot be assumed with certainty. Further research is required to establish the long-term direction of association of these variables.

Social support coping self-efficacy, depression and suicide-related behaviours
A significant problem-solving strategy to resolve distress is seeking social support (Bonner, 2015). Social support from friends, family, colleagues, and even strangers can function as protective factors against depression as well as suicide-related behaviours (Kleiman & Liu, 2013; Bell et al., 2017; Fredrick et al., 2018; Scardera et al., 2020). Social support is operationalised differently in different research. Some studies define social support structurally i.e. being a part of social groups, and other studies define social support in terms of functionality i.e. emotional support offered (Reblin & Uchino, 2008).

However, the actual presence of social support is not the same as one's perception of available social support. Perceived social support is the subjective interpretation of emotional support (eg. "expression of empathy"), instrumental support (eg. help with daily chores) and informational support (eg. financial advice) received from social relationships such as friends and family (Scardera et al., 2020). Social support coping self-efficacy, on the other hand, refers to one's *belief* in their ability to seek desired support from friends and family to help cope with problems (eg. "Get emotional support from friends and family") (Chesney et al., 2006).

Overall, social support buffers the impact of distressing life events on general mental health, depression as well as suicidal-related behaviours (Alsubaie et al., 2019; Taylor et al., 2010). Positive social support provides desirable benefits such as calling a helpline number or interrupting a suicidal attempt in times of crises (Kleiman & Riskind, 2013). Furthermore, social support is often accompanied by positive experiences that can distract one from suicidal thoughts, thereby interrupting any potential suicidal attempt in the future (Kleiman & Riskind, 2013). In other words, social support functions more as a protective factor against depression severity and suicide risk, instead of an indicator of suicide-related behaviour (Kleiman & Riskind, 2013).

However, as mentioned above, an actual presence of social support is different from one's perception of available support as well as *belief* in their ability to obtain desired support in times of crises. A study suggests that perception of high social support is a good starting point that increases awareness of available external resources (Panagioti et al., 2014). This improves coping and help-seeking behaviour, establishing the hope of "being rescued" in adverse situations (Hirsch & Barton, 2011). This reduces feeling of 'being alone', hopelessness, helplessness and feeling of entrapment, thereby protecting one from suicide risk.

Low social support coping self-efficacy i.e., doubting one's ability to seek support and connect with others in itself is an obstacle to form positive social relationships as it amplifies shyness, loneliness, poor self-esteem, and fears in social interaction, hence, contributing to symptoms of depression (Riaz Ahmad et al., 2014). Such beliefs and perceptions are associated with high suicidal ideation and behaviours as well (Miller, Esposito-Smythers, & Leichtweis, 2015). Individuals at suicidal risk engage in help negation i.e., avoiding help-seeking behaviours (Kleiman & Riskind, 2013; Deane, Wilson, & Ciarrochi, 2001), commonly observed in college students (Yakunina, Rogers, Waehler, & Werth, 2010). This may explain the high rates to suicidal death in teenagers and young adults.

Having a healthy level of social support CSE encourages one to seek help from friends, family or even professionals to cope with internal entrapping conflicts that usually accompanies depression and/or external situations (Hirsch & Barton, 2011). Establishing presence of desirable support may "lighten the load", and convey a feeling of being cared for (Hirsch &

Barton, 2011). According to Schneidman's cubic model of suicide, an unfulfilled emotional need of affiliation is one of the many important contributors to suicide-risk (Shneidman, 1987; You et al., 2011). This is consistent with Maslow's hierarchy of needs, which states a need to belong and feel connected to others as one of the psychological needs to be met to achieve a state of self-actualization (Maslow, 1943). According to the Interpersonal Theory of Suicide, failure to satisfy this need develops a "desire for death" (Joiner, 2005). Such an emotional experience is referred to as thwarted belongingness, which eventually contributes to depression as well as increases suicide-risk.

Therefore, it is safe to assume that high social support CSE encourages one to seek help to cope with pressing stressors. A perception of available social support protects one from feeling lonely, helpless, hopeless and trapped, which are strong contributors to suicide-risk (Riaz Ahmad et al., 2014). Thus, providing support via improving access to professionals such as counselors, psychologists and psychiatrists, as well as emphasizing the importance of available support from friends and family is a beneficial strategy to reducing depression severity and protection from suicide-risk (Hirsch & Barton, 2011).

CONCLUSION

All the findings, theories and models explained above, indicate a complex contribution of cognitive, emotional and social processes in depression and suicide-related behaviours. Every individual has a natural instinct to try to resolve sources of stress; however, the effectiveness of these coping strategies is varied. Based on the theories, models and findings of studies, efforts invested in these coping behaviours depends on a number of factors, one of which is the individuals own belief about his/her own ability to stop unwanted thoughts and emotions, find solutions to problems and getting the desired social support when required. Early identification of such signs indicating severe depression and potential suicide risk in the near future is an effective prevention strategy. Although modifying one's negative core belief is challenging, practitioners and future research may benefit by being able to identify low coping self-efficacy as an indicator of depression severity and long-term suicide risk and provide appropriate treatment plans and interventions.

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