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Predicting Suicidal Behaviors in Patients With Bipolar Disorder Based on Stressful Life Events, Emotion Regulation, and Coping Strategies

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1. Round 1

1.1. Reviewer 1

Reviewer:

The methods paragraph describes the study as “a correlational design using regression analysis,” but the manuscript repeatedly uses predictive and explanatory language that may imply temporal or causal inference. Because all variables were measured at a single time point, the design is cross-sectional and cannot establish whether stressful life events, emotion-regulation strategies, or coping styles precede suicidal behavior. The authors should describe the design consistently as a cross-sectional correlational study and replace causal expressions such as “contribute to,” “lead to,” or “reduce suicide risk” with associational wording unless those statements are clearly framed as interpretations based on previous longitudinal or experimental evidence.

The sampling procedure in the methods section requires greater precision. The paragraph states that participants were recruited “following announcements through social media and in-person recruitment at Iran Psychiatric Hospital and Rasoul Akram Hospital,” but it is unclear whether all participants were current inpatients, outpatients, former patients, or community members responding to online announcements. The authors should report the number recruited from each hospital and through each recruitment route, the clinical setting of assessment, and whether participants were hospitalized or receiving outpatient

treatment. These distinctions are important because suicide risk, symptom severity, medication status, and cognitive capacity may differ substantially across treatment settings.

The participant-selection paragraph reports that patients had bipolar disorder "confirmed by a psychiatrist and documented in the patient's medical record," but it does not specify whether diagnoses were established according to DSM-5, DSM-5-TR, or ICD criteria. The manuscript should identify the diagnostic system, clarify whether bipolar I disorder, bipolar II disorder, cyclothymic disorder, or other bipolar-spectrum conditions were included, and describe whether a structured diagnostic interview was used. Given the heterogeneity of bipolar disorders and their differential associations with suicide risk, diagnostic subtype should be reported and, where possible, controlled statistically or examined descriptively.

The inclusion and exclusion criteria are internally inconsistent. The methods paragraph lists "not having an acute physical illness such as cancer, multiple sclerosis, or diabetes" as an inclusion criterion and "having an acute medical disorder or serious physical illness" as an exclusion criterion. Diabetes and multiple sclerosis are not necessarily acute illnesses, and excluding all patients with these conditions may substantially limit external validity. The authors should explain the clinical rationale for excluding specific physical conditions, define what constituted a "serious" medical illness, and clarify whether stable chronic diseases were exclusionary. Exclusion criteria should be based on their potential to compromise informed consent, questionnaire completion, or interpretation of the psychological variables.

The manuscript excludes participants with substance abuse but does not define the assessment method, diagnostic threshold, or timeframe used. In the participant paragraph, the phrase "having no history of substance abuse" could indicate lifetime exclusion, current substance-use disorder, or recent problematic use. This distinction is critical because substance use is a major correlate of suicidal behavior in bipolar disorder. The authors should report whether substance use was determined through medical records, clinical interviews, or self-report; whether alcohol, prescription medication misuse, and illicit substances were considered; and whether the exclusion concerned current or lifetime disorders. A broad lifetime exclusion could produce a clinically unrepresentative sample.

The ethical procedures require substantially more detail because the outcome variable concerns suicide risk. The methods paragraph states that informed consent was obtained and confidentiality was maintained, but it does not describe how the researchers responded when a participant endorsed current suicidal ideation, intent, planning, or a high SBQ-R score. The authors should report whether a psychiatrist or clinical psychologist was immediately available, whether participants above the clinical cutoff received a structured risk assessment, whether emergency referral procedures were established, and whether treating clinicians were notified when necessary. Confidentiality cannot be absolute in cases of imminent risk, and the consent process should have explained the limits of confidentiality.

The statistical-analysis paragraph contains an inconsistency regarding the software version. The abstract reports that analyses were performed using "SPSS version 25," whereas the methods section reports "SPSS version 27." The authors should identify the correct version and use it consistently throughout the manuscript. More importantly, the statistical section should specify the regression entry method, coding of variables, treatment of missing values, significance threshold, confidence intervals, and whether regression coefficients were evaluated using two-tailed tests. Merely stating that regression analysis was used does not provide enough information for methodological replication.

Table 2 reports skewness, kurtosis, tolerance, and variance inflation factor values, but these indices alone do not demonstrate that all assumptions of multiple linear regression were met. The sentence "the participants' data were normally distributed" is also imprecise because regression assumes approximate normality of residuals rather than necessarily normal distributions of all predictors. The authors should report diagnostics for linearity, homoscedasticity, independence of errors, influential observations, and residual normality. The Durbin–Watson statistic, standardized residual plots, Cook's distance, leverage values, and a plot of standardized predicted values against residuals would provide a more complete assessment. The authors should also clarify whether the suicidal-behavior outcome was sufficiently continuous and normally distributed for linear regression, given that SBQ-R scores are often skewed and bounded.

Response: Revised and uploaded the manuscript.

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1.2. Reviewer 2

Reviewer:

The manuscript does not report a priori sample-size or statistical-power analysis. The methods state that 200 participants were initially recruited and 193 were analyzed, but no rationale is provided for this target. Because the simultaneous regression model includes 10 predictors, the authors should report how the required sample size was calculated, including the expected effect size, significance level, desired statistical power, and number of predictors. A post hoc statement that the sample exceeded a general rule of thumb is insufficient. A formal power calculation would strengthen confidence that nonsignificant coefficients, such as those for social support and positive reappraisal, were not attributable to inadequate power.

The handling of excluded cases requires clarification. The results paragraph states that seven participants were excluded "because of incomplete questionnaires or outlying data," whereas the methods state only that seven were excluded because of incomplete questionnaire completion. The authors should report separately how many cases were excluded for missing data and how many were excluded as outliers. They should also specify the criteria used to identify outliers, such as standardized residuals, leverage values, Cook's distance, or Mahalanobis distance. Excluding multivariate outliers after inspecting outcome patterns may influence regression estimates and should therefore be documented transparently.

The description of the Life Stress Scale contains several bibliographic and scoring inconsistencies. The manuscript states that the scale was developed by Paykel in 1998, while the abstract refers to a "Stressful Life Events Questionnaire (1985)," and the psychometric evidence is attributed to Turner and Wheaton. The authors should verify the exact instrument used, its original title, developer, publication year, item structure, response format, and scoring method. The description currently combines a five-point severity rating with a dichotomous yes/no scoring system, without explaining how these responses are integrated into the total score. This ambiguity prevents replication and raises uncertainty about the meaning of the stressful-life-events score used in the regression analysis.

The description of the Ways of Coping Questionnaire should be checked against the version actually administered. The paragraph lists eight dimensions but uses labels that do not fully correspond to the standard Lazarus and Folkman subscales. For example, "accepting responsibility" appears in the descriptive paragraph but is absent from Table 2 and Table 4, while "self-control" and "confrontive coping" are represented differently across sections. The authors should provide the exact subscale names, the number of items per subscale, whether a Persian adaptation was used, and how each subscale was scored. The same terminology must be used consistently in the instrument description, tables, results, and discussion.

The manuscript should report the reliability of each measure and subscale in the present sample rather than relying only on coefficients from previous studies. The instrument paragraphs provide historical Cronbach's alpha values for the Emotion Regulation Questionnaire, Suicidal Behaviors Questionnaire–Revised, Life Stress Scale, and Ways of Coping Questionnaire, but no internal-consistency estimates are presented for the 193 participants. Because reliability can vary by population, language, diagnostic status, and clinical setting, the authors should calculate and report Cronbach's alpha or preferably McDonald's omega for each relevant scale and subscale. Reliability estimates are particularly important for coping subscales, which may contain relatively few items and may have modest internal consistency.

Response: Revised and uploaded the manuscript.

2. Revised

Editor's decision after revisions: Accepted.
Editor in Chief's decision: Accepted.

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