

Original Research Article

Clinical Characteristics and Psychosocial Correlates of Suicide Attempts: A Retrospective Cross-sectional Study from a Tertiary Care Centre

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ABSTRACT

Background: Suicide is a major public health problem and a leading cause of preventable mortality worldwide. Suicide attempts are substantially more common than completed suicides and represent the strongest predictor of future suicide. Understanding the socio-demographic, clinical, and psychosocial characteristics of individuals who attempt suicide is essential for identifying high-risk populations and developing effective prevention strategies, particularly in low- and middle-income countries such as India.

Aim: To evaluate the socio-demographic profile, clinical characteristics, psychiatric diagnoses, methods of suicide attempt, and psychosocial correlates among adults presenting with suicide attempts to a tertiary care teaching hospital.

Methods: A hospital-based retrospective cross-sectional study was conducted at a tertiary care teaching hospital in Chennai, South India. Medical records of adults (≥ 18 years) presenting with suicide attempts between January and December 2023 were reviewed. Of 84 eligible records screened, 56 fulfilled the inclusion criteria. Data regarding socio-demographic characteristics, methods of suicide attempt, psychiatric diagnoses, psychosocial precipitants, substance use, family history, previous suicide attempts, and hospitalization details were collected using a semi-structured data extraction proforma. Statistical analysis was performed using SPSS version 25.0. Categorical variables were expressed as frequencies and percentages, and associations were analysed using the Chi-square test, with $p < 0.05$ considered statistically significant.

Results: Among the 56 participants, 66.1% were females, and 58.9% belonged to the 18-30-year age group. Self-poisoning was the predominant method of suicide attempt (62.5%), with rodenticide poisoning (23.2%) being the most common subtype, followed by drug overdose (33.9%). Marital conflict (25.0%) and interpersonal conflict (23.2%) were the leading psychosocial precipitants. Depression was the most frequent psychiatric diagnosis (41.1%), followed by adjustment disorder (21.4%). Previous suicide attempts were documented in 32.1% of participants and were significantly associated with the interval between successive attempts ($p < 0.001$). Most participants attempted suicide while alone (67.9%), and alcohol was the most commonly reported substance among those with substance use (26.8%).

Conclusion: Suicide attempts in this cohort predominantly involved young adults and women and were strongly associated with depression, interpersonal stressors, and self-poisoning. Previous suicide attempts significantly increased the likelihood of recurrence, highlighting the importance of long-term follow-up. Strengthening early identification of psychiatric disorders, comprehensive psychosocial assessment, family-based interventions, responsible prescribing practices, and

restriction of access to highly lethal means may substantially reduce the burden of suicidal behaviour and improve suicide prevention in similar healthcare settings.

Keywords: Suicide attempt, Suicidal behaviour, Deliberate self-harm, Depression, Poisoning, Psychosocial factors, Retrospective cross-sectional study, India.

INTRODUCTION

Suicide is a major global public health concern and remains one of the leading causes of preventable mortality worldwide. According to the World Health Organization (WHO), more than 700,000 people die by suicide each year, with suicide ranking as the third leading cause of death among individuals aged 15–29 years. For every completed suicide, an estimated 20 or more individuals attempt suicide, making non-fatal suicidal behaviour a substantial contributor to global morbidity and healthcare burden. Suicide not only causes premature mortality but also results in profound psychological, social, and economic consequences for families, communities, and healthcare systems.^{1,2}

Suicidal behaviour is a multifactorial phenomenon arising from the complex interaction of biological, psychological, psychiatric, social, cultural, and environmental determinants.³⁻⁷ Psychiatric disorders, particularly depressive disorders, bipolar affective disorder, schizophrenia, personality disorders, and substance use disorders, are among the strongest risk factors for suicidal behaviour. Previous suicide attempts, feelings of hopelessness, impulsivity, chronic physical illnesses, adverse childhood experiences, and exposure to stressful life events further increase the likelihood of suicide attempts.³⁻⁶ Depression remains the psychiatric disorder most consistently associated with suicidal ideation and suicidal behaviour and accounts for a substantial proportion of suicide deaths worldwide.^{6,8}

In addition to psychiatric illnesses, psychosocial stressors play a pivotal role in precipitating suicidal behaviour, particularly in low- and middle-income countries. Marital discord, interpersonal conflicts, relationship difficulties, unemployment, financial hardship, academic stress, domestic violence, social isolation, and chronic medical illnesses frequently act as immediate triggers for suicide attempts.⁹ These stressors often coexist with untreated mental illness, thereby increasing vulnerability to impulsive self-harm.

The method of suicide attempt is largely influenced by the accessibility and availability of lethal means. In many developing countries, including India, self-poisoning using pesticides

and rodenticides remains one of the most common methods because of their widespread availability, particularly in rural and semi-urban communities. Means restriction through legislative control, safe storage of pesticides, and responsible prescribing of potentially toxic medications has been shown to reduce suicide mortality significantly.¹⁰⁻¹²

India contributes substantially to the global burden of suicide, accounting for nearly one-fourth of all suicide deaths worldwide. According to the National Crime Records Bureau (NCRB), more than 170,000 suicide deaths were reported in India in 2023, with southern states, including Tamil Nadu, consistently reporting suicide rates higher than the national average.¹³ Young adults constitute the most affected age group, reflecting the influence of educational, occupational, interpersonal, and socioeconomic stressors during this critical stage of life.¹⁴ Previous studies from India have also demonstrated that women, individuals with depressive disorders, and those experiencing marital or interpersonal conflicts constitute a considerable proportion of patients presenting with suicide attempts.¹⁵⁻¹⁸

A previous suicide attempt is recognized as the strongest predictor of future suicidal behaviour and completed suicide. Longitudinal studies have demonstrated that individuals presenting with deliberate self-harm remain at substantially increased risk of repeated suicide attempts and suicide over subsequent years, emphasizing the importance of comprehensive psychiatric evaluation and structured follow-up after every suicide attempt.^{4,5,19}

Although several studies have examined the epidemiology of suicide attempts in India, considerable regional variation exists in socio-demographic characteristics, methods of self-harm, psychiatric comorbidities, and psychosocial precipitants. Institution-based studies from different geographical regions therefore remain essential for identifying locally relevant risk factors and informing targeted suicide prevention strategies. Hospital-based retrospective analyses also provide valuable insight into the clinical profile of suicide attempters presenting to emergency and psychiatric services, thereby facilitating early identification of high-risk individuals, optimizing psychiatric intervention, and strengthening

community-based suicide prevention programmes.^{20,21}

Therefore, the present study was undertaken to evaluate the socio-demographic characteristics, methods of suicide attempt, psychiatric diagnoses, psychosocial precipitants, and clinical correlates among adults presenting with suicide attempts to a tertiary care teaching hospital in South India. The findings are expected to contribute to the existing evidence base and assist in developing targeted preventive interventions for individuals at high risk of recurrent suicidal behaviour.

AIMS & OBJECTIVES

Aim

To evaluate the socio-demographic profile, clinical characteristics, psychiatric diagnoses, methods of suicide attempt, and psychosocial correlates among adults presenting with suicide attempts to a tertiary care teaching hospital.

Objectives

1. To describe the socio-demographic characteristics of adults presenting with suicide attempts.
2. To assess the methods of suicide attempt, psychiatric diagnoses, substance use, and other clinical characteristics.
3. To identify the psychosocial factors associated with suicide attempts.
4. To examine the association between previous suicide attempts and the time interval between repeated attempts.

MATERIALS AND METHODS

Study Design and Setting

This retrospective cross-sectional study was conducted at Sri Muthukumaran Medical College Hospital and Research Institute, Chennai, India. The study involved a detailed review of medical records maintained in the Medical Records Department.

Study Population

The study included all adult patients who were managed following a suicide attempt between 1 January 2023 and 31 December 2023 in the Departments of Psychiatry, General Medicine (both inpatient and outpatient services), and the Emergency Department.

During the study period, 84 patients with documented suicide attempts were identified. After applying the predefined eligibility criteria, 56 patients were included in the final analysis.

Inclusion Criteria

Patients were included if they:

- Were aged 18 years or older;
- Received treatment in the Psychiatry, General Medicine, or Emergency Department following a suicide attempt;
- Had objective clinical evidence confirming a suicide attempt; and
- Had complete medical records containing the required study variables.

Exclusion Criteria

Patients were excluded if they:

- Were younger than 18 years of age;
- Lacked objective evidence of a suicide attempt; or
- Had incomplete or missing clinical records.

Study instruments

A self-designed semi-structured Questionnaire was used to collect

- Sociodemographic characteristics (age, sex, marital status, occupation, educational status, and residence);
- Physical and psychiatric comorbidities;
- Method of suicide attempt;
- Precipitating factors and stated reasons for the attempt;
- Substance use associated with the attempt;
- Family history of suicide attempts
- Previous history of suicide attempts;
- Whether the attempt occurred alone or in the presence of others;
- Presence of suicidal ideation or suicide note;
- Day and time of the suicide attempt;
- Time interval between previous and current suicide attempts (where applicable);
- Duration of subsequent inpatient hospitalization as an indirect indicator of the severity of the suicide attempt.

Data collection and Statistical Analysis

Data were extracted retrospectively from hospital case records using a self-designed semi-structured data extraction proforma. Data were entered into Microsoft Excel and analyzed using Statistical Package for the Social Sciences (SPSS) version 25.0

Categorical variables were summarized as frequencies and percentages, while continuous variables were expressed as mean $\pm$ standard deviation (SD) or median with interquartile range (IQR) depending on the

distribution of the data. Associations between categorical variables were assessed using the Chi-square test or Fisher's exact test, wherever appropriate. A two-tailed p-value <0.05 was considered statistically significant.

RESULTS

A total of 84 medical records of patients presenting with suicide attempts between January 2023 and December 2023 were screened. After applying the eligibility criteria, 56 patients were included in the final analysis.

Socio-demographic Characteristics

Among the 56 participants, 37 (66.1%) were females and 19 (33.9%) were males, indicating a female predominance. The majority of participants (58.9%) belonged to the 18–30 years age group. Most participants had completed higher secondary education (44.6%) or were graduates (42.9%). More than half (55.4%) were unemployed. The majority were married (60.7%), belonged to the lower middle socioeconomic class (57.1%), resided in semi-urban areas (62.5%), and were Hindus (75.0%) (Table 1).

Method of Suicide Attempt

Poisoning was the predominant method of suicide attempt, accounting for 35 (62.5%)

cases. Among poisoning methods, rodenticide poisoning (23.2%) was the most common, followed by phenol poisoning (16.1%), insecticide poisoning (12.5%), and other poisons (8.9%). Drug overdose accounted for 19 (33.9%) cases, while hanging and knife injuries were relatively uncommon (Table 2)

Reasons for Suicide Attempt

Marital conflict (25.0%) was the most frequently reported precipitating factor, followed by interpersonal conflict (23.2%) and relationship issues (17.8%). Financial difficulties accounted for 8.9% of attempts, while occupational problems and physical illness were less common (Table 3).

Psychiatric Diagnoses

Depressive disorders were the most common psychiatric diagnosis (41.1%), followed by adjustment disorders (21.4%) and acute stress disorder (12.5%). No diagnosable psychiatric illness was identified in 17.9% of participants (Table 4).

Previous Suicide Attempts

A previous history of suicide attempts was documented in 18 (32.1%) participants, whereas 38 (67.9%) had no prior history of self-harm. (Table 5).

Variable	Category	n	%
Gender	Male	19	33.9
	Female	37	66.1
Age (years)	18–30	33	58.9
	31–40	14	25.0
	41–50	5	8.9
	51–60	2	3.6
	≥61	2	3.6
Education	Illiterate	4	7.1
	Primary school	3	5.4
	Higher secondary	25	44.6
	Graduate	24	42.9
Occupation	Unemployed	31	55.4
	Unskilled	1	1.8
	Semi-skilled	17	30.4
	Skilled	7	12.5
Religion	Hindu	42	75.0
	Christian	10	17.9
	Muslim	4	7.1
Residence	Rural	4	7.1
	Semi-rural	1	1.8
	Semi-urban	35	62.5
	Urban	16	28.6
Socioeconomic status	Lower middle	32	57.1
	Upper lower	21	37.5

	Lower	3	5.4
Marital status	Married	34	60.7
	Unmarried	20	35.7
	Widowed	1	1.8
	Separated	1	1.8
Table 1. Socio-demographic characteristics of study participants (N = 56)			

Method	n	%
Poisoning		
• Rodenticide	13	23.2
• Phenol	9	16.1
• Insecticide	7	12.5
• Salicylate	1	1.8
• Other poisons	5	8.9
Drug overdose		
• Own prescribed sedatives	3	5.4
• Over-the-counter drugs	4	7.1
• Other own prescribed drugs	11	19.6
• Relative's prescribed drugs	1	1.8
Hanging	3	5.4
Knife injury	1	1.8
Table 2. Method of suicide attempt among study participants (N = 56)		

Reason	n	%
Marital conflict	14	25.0
Interpersonal conflict	13	23.2
Relationship issues	10	17.8
Financial debt	5	8.9
Occupational issues	2	3.6
Physical illness	1	1.8
Others	11	19.7
Table 3. Reasons for suicide attempt (N = 56)		

Diagnosis	n	%
Depression	23	41.1
Adjustment disorder	12	21.4
Acute stress disorder	7	12.5
No psychiatric diagnosis	10	17.9
Bipolar affective disorder	1	1.8
Anxiety disorder	1	1.8
Psychosis	1	1.8
Conversion disorder	1	1.8
Table 4. Psychiatric diagnosis among study participants (N = 56)		

Previous suicide attempt	n	%
Yes	18	32.1
No	38	67.9
Table 5: previous history of suicidal attempt (n = 56)		

Duration of Hospital Stay

The duration of hospitalization ranged from 0 to 6 days. Most participants required admission for 3 days (32.1%), followed by 2 days (30.4%) and 4 days (17.9%), indicating that the majority

of attempts required short-term inpatient management (Table 6).

Duration	n	%
Same-day discharge	4	7.1
1 day	3	5.4
2 days	17	30.4
3 days	18	32.1
4 days	10	17.9
5 days	2	3.6
6 days	2	3.6

Table 6: Duration of Hospital stay (n = 56)

Day of Hospital Admission

Hospital admissions following suicide attempts occurred throughout the week, with the highest proportion recorded on Thursday (28.6%),

followed by Sunday (19.6%) and Tuesday (16.1%). The lowest number of admissions occurred on Monday (7.1%) (Table 7).

Days	n	%
Monday	4	7.1
Tuesday	9	16.1
Wednesday	8	14.3
Thursday	16	28.6
Friday	8	14.3
Sunday	11	19.6
Total	56	100.0

Table 7: Distribution of Participants According to Day of Hospital Admission (N = 56)

Circumstances of Suicide Attempt

Most participants attempted suicide alone (67.9%), while 32.1% attempted suicide in the presence of others. Only 1 (1.8%) participant left a suicide note, whereas 55 (98.2%) did not. (Table 8).

Substance use

Most participants (71.4%) reported no substance use. Among those with substance use, alcohol was the most commonly reported substance (26.8%), followed by tobacco (10.7%), cannabis (7.1%), and cocaine (1.8%). (Table 9).

Attempt	n	%
Attempted alone	38	67.9
Attempted in the presence of others	18	32.1
Total	56	100.0

Table 8: Circumstances of Suicide Attempts Among Study Participants (N = 56)

Substance use	n	%
Nil	40	71.42
Alcohol	15	26.78
Tobacco	6	10.7
Cannabis	4	7.14
Cocaine	1	1.78

Table 9: Distribution of Substance Use Among Study Participants (N = 56)

Family History of Suicide Attempts

A family history of suicide attempts was absent in 67.9% of participants. Among those with a

positive family history, 17.9% had an affected first-degree relative and 14.3% had an affected second-degree relative. (Table 10).

		n	%
Family History of Suicidal Attempt	Nil	38	67.9
	First degree	10	17.9
	Second degree	8	14.3

Table 10: Family history of suicidal attempt (n = 56)

Timing of Suicide Attempts

The highest proportion of suicide attempts occurred during the morning (33.9%), followed

by the evening (26.8%), night (25.0%), and afternoon (14.3%). (Table 11).

Timing	n	%
Morning	19	33.9
Afternoon	8	14.3
Evening	15	26.8
Night	14	25.0
Total	56	100.0

Table 11: Distribution of Suicide Attempts According to Time of Occurrence (N = 56)

Presence of a Suicidal note:

A suicide note was documented in only one participant (1.8%), while 55 participants

(98.2%) did not leave a suicide note, indicating that suicide notes were uncommon in the study population. (Table 12).

Suicidal note	n	%
Yes	1	1.8
No	55	98.2
Total	56	100.0

Table 12: Presence of a Suicide Note Among Study Participants (N = 56)

Association between Previous Suicide Attempts and Time Interval Between Attempts

A statistically significant association was observed between previous history of suicide attempts and the time interval between attempts (Chi-square test, $p < 0.001$). Among

the 18 participants with a previous history of suicide attempts, 8 had repeated attempts within months, 6 within one year, 3 after more than one year, and 1 had no interval between attempts. None of the participants without a previous history had repeat attempts during the observed intervals.

Time interval between attempts	Previous history present n (%)	Previous history absent n (%)	Total	p value
No previous interval / First attempt	1 (5.6)	38 (100.0)	39	
Within months	8 (44.4)	0	8	
Within one year	6 (33.3)	0	6	
More than one year	3 (16.7)	0	3	
Total	18 (100.0)	38 (100.0)	56	<0.001

Table 13: Association between previous history of suicidal attempt and time interval between attempts (n =56)

Chi-square test; statistically significant at $p < 0.05$.

DISCUSSION

The present retrospective cross-sectional study evaluated the socio-demographic characteristics, clinical profile, psychiatric diagnoses, methods of suicide attempt, and psychosocial correlates among adults presenting with suicide attempts to a tertiary care teaching hospital in South India. The findings indicate that suicide attempts predominantly occurred among young adults and women and were strongly associated with depressive disorders, interpersonal stressors, and self-poisoning, emphasizing the multifactorial nature of suicidal behaviour and

the need for comprehensive prevention strategies.

Females constituted two-thirds (66.1%) of the study population, indicating a predominance of suicide attempts among women. Similar findings have been reported in several Indian studies, where females accounted for a higher proportion of non-fatal suicide attempts despite higher completed suicide rates among men.¹⁵⁻¹⁸ This trend may be explained by greater exposure to psychosocial stressors such as marital discord, domestic violence, interpersonal conflicts, and gender-related

inequalities, which increase psychological vulnerability and healthcare utilization following suicide attempts.²²

Young adults aged 18–30 years represented the majority (58.9%) of participants, consistent with national and international studies demonstrating that suicidal behaviour is most prevalent during early adulthood.^{1,14,23} This period is characterized by educational, occupational, financial, and interpersonal challenges that may increase emotional distress and impulsive behaviour. Early identification of psychological distress and timely mental health interventions in this age group are therefore essential for suicide prevention.

Most participants were married (60.7%), unemployed (55.4%), belonged to the lower middle socioeconomic class (57.1%), and resided in semi-urban areas (62.5%). These findings are comparable with previous Indian studies reporting that marriage does not necessarily protect against suicidal behaviour and that unemployment and socioeconomic disadvantage contribute substantially to psychological distress.^{15,16,24,25} Financial insecurity, occupational instability, and reduced access to mental healthcare may collectively increase vulnerability to suicide attempts.

Self-poisoning was the predominant method of suicide attempt (62.5%), with rodenticide poisoning being the most common, followed by phenol and insecticide poisoning. These findings are consistent with reports from India and other low- and middle-income countries where pesticides remain readily accessible because of widespread agricultural use.^{10,19,26} Drug overdose was the second most common method (33.9%), with most medications obtained through participants' own prescriptions, suggesting that easy access to prescribed medications may facilitate impulsive self-harm. These observations support the implementation of means-restriction strategies, including regulation of hazardous pesticides, safe storage practices, responsible prescribing, and counselling regarding medication safety, which have been shown to reduce suicide mortality.¹⁰⁻¹²

Marital conflict (25.0%) and interpersonal conflict (23.2%) were the leading psychosocial precipitants of suicide attempts, highlighting the important contribution of family and relationship stressors. Similar findings have been reported in Indian and Nepalese studies, emphasizing that unresolved interpersonal difficulties frequently precipitate suicidal crises.^{9,17} These findings underscore the

importance of integrating family counselling, crisis intervention, and psychosocial support into suicide prevention programmes, particularly for individuals experiencing ongoing interpersonal stress.

Psychiatric disorders were highly prevalent in the present study, with depression accounting for 41.1% of all diagnoses, followed by adjustment disorder (21.4%) and acute stress disorder (12.5%). These findings are consistent with previous Indian and international studies demonstrating that depression is the psychiatric condition most strongly associated with suicidal behaviour.^{3,6,8,9,17,21} Depression contributes to suicidal behaviour through hopelessness, impaired problem-solving ability, cognitive distortions, and diminished impulse control. Consequently, routine screening for depression and early psychiatric intervention in emergency departments and primary care settings should form an essential component of suicide prevention. Nearly one-fifth of participants had no identifiable psychiatric diagnosis, suggesting that acute psychosocial crises and impulsive behaviour may independently precipitate suicide attempts in vulnerable individuals.

Approximately one-third (32.1%) of participants reported a previous suicide attempt, and a significant association was observed between previous attempts and the interval to recurrence ($p < 0.001$). Previous suicide attempts are widely recognized as the strongest predictor of future suicidal behaviour and completed suicide.^{4,5,27,28} These findings emphasize the need for comprehensive psychiatric evaluation, individualized safety planning, and structured long-term follow-up after every suicide attempt to reduce the risk of recurrence.

Although most participants did not report substance use, alcohol was the most commonly used substance among those with substance use (26.8%). Alcohol has consistently been identified as an important risk factor for suicidal behaviour because it impairs judgment, increases impulsivity, and exacerbates underlying psychiatric disorders.^{21,28} Routine screening for alcohol and substance use disorders should therefore be incorporated into suicide risk assessment in both emergency and psychiatric settings.

Most participants had no documented family history of suicidal behaviour, suggesting that acute psychosocial stressors and psychiatric illness may have contributed more prominently than familial predisposition in the present cohort. Nevertheless, suicidal behaviour is

widely recognized as the result of a complex interaction between genetic susceptibility and environmental influences, and family history remains an important risk factor that should be routinely evaluated during psychiatric assessment.^{7,29}

The majority of suicide attempts occurred while participants were alone (67.9%), and suicide notes were uncommon (1.8%), indicating that many attempts were undertaken in circumstances minimizing the possibility of interruption or rescue. The highest proportion of attempts occurred during the morning hours (33.9%), although evidence regarding temporal patterns of suicidal behaviour remains inconsistent.^{17,29,30} These findings reinforce the importance of careful suicide risk assessment even in the absence of explicit warning signs such as suicide notes.

Most participants required hospitalization for two to three days, reflecting the moderate clinical severity of the majority of suicide attempts. However, the duration of hospitalization should not be considered a surrogate measure of suicide risk, as medical stabilization alone does not address the underlying psychiatric illness or psychosocial determinants of suicidal behaviour. Comprehensive psychiatric assessment, psychosocial intervention, and appropriate discharge planning remain essential to reduce the risk of subsequent suicide attempts.^{20,31}

Overall, the findings of the present study reinforce that suicidal behaviour results from a complex interaction of psychiatric illness, psychosocial adversity, and environmental accessibility to lethal means.⁷ Young adults, women, individuals with depression, those experiencing interpersonal or marital conflicts, and those with a previous history of suicide attempts constitute particularly vulnerable groups. Strengthening early identification of mental disorders, improving access to psychiatric care, restricting access to highly lethal means, and implementing family- and community-based psychosocial interventions are likely to play a pivotal role in reducing the burden of suicide attempts and preventing recurrent suicidal behaviour.

STRENGTHS OF THE STUDY

The present study provides a comprehensive description of the socio-demographic, psychiatric, and psychosocial characteristics of adults presenting with suicide attempts in a tertiary care teaching hospital in South India. By including information regarding methods of

suicide attempt, psychiatric diagnoses, substance use, family history, precipitating psychosocial factors, and recurrence, the study offers a holistic understanding of the multifactorial determinants of suicidal behaviour. Furthermore, the inclusion of patients from Psychiatry, Emergency Medicine, and General Medicine improves the clinical relevance of the findings.

LIMITATIONS

Several limitations should be acknowledged. The retrospective design relied on the completeness and accuracy of medical records, which may have resulted in incomplete documentation of certain variables. The relatively small sample size and single-centre setting limit the generalizability of the findings. Furthermore, standardized psychiatric rating scales and structured diagnostic interviews were not available because of the retrospective nature of the study. Causal relationships cannot be established owing to the cross-sectional design.

CONCLUSION

The present study identified that suicide attempts in this tertiary care population were predominantly observed among young adults and women, with self-poisoning emerging as the most common method of self-harm. Depression was the leading psychiatric diagnosis, while marital and interpersonal conflicts were the principal psychosocial precipitants. A significant association between previous suicide attempts and recurrent suicidal behaviour further emphasizes the need for continued monitoring of this high-risk group. These findings underscore the importance of integrating mental health services into emergency and general medical settings to facilitate early psychiatric evaluation, comprehensive psychosocial assessment, and individualized risk management. Suicide prevention efforts should extend beyond clinical treatment to include strengthening family support systems, improving community awareness, ensuring continuity of mental healthcare, and restricting access to commonly used lethal means, particularly pesticides and toxic medications.

Although limited by its retrospective design and single-centre setting, this study provides valuable regional evidence on the clinical and psychosocial profile of suicide attempters in South India. Future multicentre prospective studies incorporating standardized

assessments and longitudinal follow-up are needed to further clarify risk factors for suicidal behaviour and to guide the development of effective, evidence-based suicide prevention strategies.

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