

Original Research Article

PREVALENCE OF SUICIDAL TENDENCIES IN INDIVIDUALS WITH COMMON MENTAL DISORDERS AND SEVERE MENTAL ILLNESS

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ABSTRACT

Background: Suicide is a major global health issue, strongly linked to psychiatric disorders. Both common mental disorders (CMD) and severe mental illness (SMI) significantly increase suicide risk. Early detection of high-risk individuals is critical for prevention. **Aim:** To assess and compare the prevalence of suicidal ideation and attempts among individuals with CMD and SMI, and identify associated sociodemographic and clinical factors.

Materials and Methods: A cross-sectional study was conducted on 80 adults with CMD (n = 40) or SMI (n = 40). Depression and anxiety severity were assessed using the Hamilton Depression Rating Scale and Hamilton Anxiety Rating Scale. Obsessive-compulsive symptoms were measured using the Yale-Brown Obsessive Compulsive Scale. General psychiatric symptoms were evaluated with the Brief Psychiatric Rating Scale. Suicidal ideation and intent were assessed using Beck's Suicidal Ideation Scale and Suicide Intent Scale. Data were analysed using SPSS; p < 0.05 was considered significant.

Results: Suicidal ideation was present in 38.6% of patients with CMD and 36.1% of patients with SMI. Suicide attempts were more frequent in the CMD (18.2%) than in the SMI (5.6%) group, although this difference was not significant. Major depressive disorder was most commonly associated with both ideation (60%) and suicide attempts (30%). Females exhibited higher suicidal ideation (55.6%), whereas males had more attempts (66.7%). Suicidal behaviour was more common among younger individuals and those from lower-middle socioeconomic backgrounds.

Conclusion: Suicidal ideation and attempts were common and comparable in CMD and SMI. Risk factors such as age, gender, and family history underline the importance of routine suicide risk screening in psychiatric care.

Keywords: Suicide, Suicidal Ideation, Suicide Attempt, Common Mental Disorders, Severe Mental Illness, Depression, Risk Factors.

INTRODUCTION

Suicide, from the Latin suicidium, means "to kill oneself" and refers to the voluntary act of bringing about one's death. It is a multifactorial and complex phenomenon driven by biological, psychological, social, and cultural determinants. Internationally, suicide is a significant public health issue with extensive social implications for communities, families, and individuals.^[1] As per the recent data

from 2021, the World Health Organisation (WHO) states that 1 in every 100 deaths is by suicide. Suicide accounts for about 1.1% of all deaths reported worldwide. More recent figures emphasise that approximately >720000 individuals die by suicide annually. Suicide is the third leading cause of death among 15–29-year-old individuals.^[2] The National Crime Records Bureau (NCRB) recorded an all-India suicide rate of 12.4 per 100,000 population in 2022, showing a slight

increase from 12.0 in 2021, with males comprising 72.5% of suicide deaths, while females comprised 27.5%. 50.4% of total suicides in India were reported in Maharashtra, Tamil Nadu, Madhya Pradesh, West Bengal, and Karnataka.^[3] A nationally representative survey carried out in 2012 found that suicide rates were much higher in South India compared to other parts of the country.^[4] This unchanged streak further highlights the regional differences in suicide burden in the nation. Suicidal risk is most predominant in patients with certain features like male gender, young age, social isolation, good premorbid functioning, and presence of depressive symptoms.^[5]

Many demographic, psychosocial, and clinical variables are implicated in the risk of suicide. Of these, mental illness is invariably ranked as one of the greatest risk factors.^[6] Research has indicated that as many as 90% of suicide victims have an underlying psychiatric condition, be it a common mental disorder or severe mental illness (SMI).^[7] The WHO defines Common mental disorders (CMD) as consisting of major depressive disorder (MDD), dysthymia, generalised anxiety disorder, panic disorder, phobias, social anxiety disorder, obsessive-compulsive disorder (OCD), post-traumatic stress disorder, and stress-related disorders. SMI comprises schizophrenia and psychotic disorders, bipolar affective disorder and severe depression.^[7]

MDD, a CMD, is a strong predictor of suicidal behaviour. Research puts the figure at approximately 50% of those who commit suicide meeting diagnostic criteria for MDD.⁸ Some other psychiatric illnesses that are typically linked with a higher risk of suicide include bipolar disorder, schizophrenia, anxiety disorders, and substance use disorders.^[9] Among individuals with SMI, the lifetime risk of suicide is estimated to be approximately 4.9%.¹⁰ The presence of psychosis contributes to >10% of suicides, and schizophrenia is associated with a tenfold increased risk of death by suicide.^[8]

Given the strong link between psychiatric disorders and suicidal behaviour, timely identification and assessment of suicidal ideation and intent are essential for effective suicide prevention strategies. Suicidal ideation is defined as thinking about, considering, or planning suicide, and suicidal intent can be defined as the degree to which the person wants to implement their ideation and end their life.^[11] A study found that 95% of individuals who attempted suicide had previously exhibited suicidal ideation, suggesting the predictive value of suicidal ideation and intent.^[12]

This study examined the prevalence of suicidal ideation and intent among individuals with CMD and SMI and compared the sociodemographic and clinical correlates of suicidality between these two groups. By identifying the specific mental health conditions associated with elevated suicide risk, this study aims to contribute to early identification and

targeted intervention strategies that can mitigate suicide among high-risk psychiatric populations.

Objectives

This study aimed to explore the relationship between suicidal behaviour and sociodemographic factors among individuals diagnosed with CMD and SMI and to compare the prevalence of suicidal ideation and intent between these two groups.

MATERIALS AND METHODS

This cross-sectional study was conducted on 80 adult psychiatric patients (40 with CMD and 40 with SMI) attending the outpatient department of Psychiatry at a tertiary care hospital.

Inclusion Criteria

Patients were eligible for inclusion if they were aged between 18 and 60 years, clinically stable, capable of providing informed consent, and diagnosed with any mental health condition among CMD, SMI.

Exclusion Criteria

Patients were excluded if they were younger than 18 or older than 60 years of age, uncooperative during interviews, or had a dual psychiatric diagnosis or personality disorder.

Methods

A systematic sampling strategy was used to obtain representative samples of eligible psychiatric patients. Patients were assessed using a semi-structured proforma designed for data collection for this study, including age, gender, education, occupation, illness duration, psychosocial stressors, family history, and physical comorbidities. The Modified Kuppaswamy Scale was used to assess socioeconomic status.

The Hamilton Depression Rating Scale (HAM-D) was used to assess the severity of depression. It contains 17 to 21 items rated on 0–2 or 0–4 scales, with scores of 0–7 considered normal, 8–17 mild, 18–24 moderate, and ≥ 25 severe depression. The scale focuses on somatic symptoms and shows high inter-rater reliability (0.87–0.95). The Hamilton Anxiety Rating Scale (HAM-A) was used to measure anxiety severity, consisting of 14 items, each rated on a scale of 0–4 (0= not present, 4= severe).

The severity of OCD was assessed using the Yale-Brown Obsessive Compulsive Scale (Y-BOCS), which is a 10-item semi-structured scale with five items each for obsessions and compulsions rated 0–4 (0= none, 4= extreme). The Brief Psychiatric Rating Scale (BPRS) is used to evaluate major psychiatric symptoms and consists of 18 items rated 1–7 (1 = not present, 7= most severe) based on clinician observation and patient report.

The Beck's Suicidal Ideation Scale (BSIS), a 21-item self-report tool, was used to assess suicidal thoughts and behaviours. Each item contains three statements graded in severity from 0 to 2. The first part (items 1-5) evaluates an individual's attitudes toward living and dying and includes items such as

wishes and reasons for living or dying and active and passive suicide attempts. The second part (items 6 -19) evaluates previous suicidal ideations and anticipated reactions to those thoughts. The third part (remaining items) evaluates previous suicide attempts and suicidal intent during the last attempt. To assess the severity and intent of suicide attempts, Beck's Suicide Intent Scale (SIS), a 15-item scale, was used. Items are scored 0–2 and evaluate both the method and the motivation.

Statistical Analysis

Data were analysed using IBM SPSS Statistics version 25. Descriptive statistics were used to summarise demographic, clinical, and psychosocial variables. Continuous variables are expressed as means and standard deviations, and categorical variables are presented as frequencies and percentages. The Chi-square test was used to compare categorical variables between the CMD and SMI groups, including family history, psychosocial stressors, and suicidal behaviour. Statistical significance was set at $p < 0.05$.

Ethical considerations

This study was approved by the Institutional Ethics Committee of the tertiary care hospital. Written informed consent was obtained from all participants after explaining the study's nature and purpose.

RESULTS

The majority of patients were between 30 and 39 years of age (38.8%), followed by those aged 40–49 years (26.3%). Females constituted 51.3% of the study patients, while males accounted for 48.8%. Most patients were Hindu (78.8%), and the majority were married (61.3%). Regarding education, 38.8% had primary-level education, and 31.3% had completed a diploma or higher studies. The most common occupations were homemaking (33.8%), skilled work (16.3%), and unemployment (11.3%). Socioeconomically, the largest group belonged to the lower-middle class (56.3%), with smaller proportions in the upper-lower (23.8%), lower (10.0%), and upper-middle (10.0%) classes (Table 1).

Table 1: Demographic data of the study

		Number of patients	Percentage
Age	18-29	19	23.8%
	30-39	31	38.8%
	40-49	21	26.3%
	> 50	9	11.3%
Sex	Female	41	51.3%
	Male	39	48.8%
Religion	Christian	8	10%
	Hindu	63	78.8%
	Muslim	9	11.3%
Marital status	Married	49	61.3%
	Separated	2	2.5%
	Single	24	30%
	Widower	5	6.3%
Education	Diploma & above	25	31.3%
	Higher Secondary	12	15%
	Primary	31	38.8%
	Secondary	12	15%
Occupation	Clerical	8	10%
	Farmer	3	3.8%
	Homemaker	27	33.8%
	Professional	3	3.8%
	Semi-professional	2	2.5%
	Semi-skilled	7	8.8%
	Shop owner	2	2.5%
	Skilled	13	16.3%
	Student	1	1.3%
	Unemployed	9	11.3%
	Unskilled	5	6.3%
S.E status	Lower	8	10%
	Lower middle	45	56.3%
	Upper lower	19	23.8%
	Upper middle	8	10.0%

On the HAM-D, 51.2% of patients exhibited depressive symptoms, with moderate depression (16.3%) being the most common, followed by severe (13.8%), very severe (8.8%), and mild (7.5%) depression, respectively. Nearly half (48.8%) of the patients did not have depressive symptoms. On the HAM-A, 51.2% showed varying levels of anxiety, with moderate-to-severe anxiety observed

in 23.8%, mild-to-moderate in 15%, and very severe in 8.8%. The remaining 48.8% of patients did not have anxiety symptoms.

On the YBOCS, obsessive-compulsive symptoms were present in 12.5% of patients, moderate in 6.3%, severe in 3.8%, and mild in 2.5%. The majority (87.5%) had no such symptoms.

Regarding family history, 50% had a history of alcohol use, 43.8% had psychiatric illness, and 23.8% reported a suicide in the family. Nearly one-third (28.8%) reported no family history. Among psychosocial stressors, 37.5% had social or environmental stressors, 25% had financial issues,

and 3.8% reported occupational stress. No identifiable stressors were reported by 33.8%. Suicidal ideation was present in 37.5% of patients, and 12.5% had a history of suicide attempts. The remaining 62.5% and 87.5% had no suicidal ideation or attempts, respectively (Table 2).

Table 2: Distribution of depression, anxiety, obsessive-compulsive symptoms, family history, psychosocial stressors, and suicidality

		Number of patients	Percentage
HAM-D	Normal	4	5.0%
	Mild depression	6	7.5%
	Moderate depression	13	16.3%
	Severe depression	11	13.8%
	Very severe	7	8.8%
HAM-A	Nil	39	48.8%
	Mild severity	3	3.8%
	Mild to moderate severity	12	15.0%
	Moderate to severe	19	23.8%
	Very severe	39	48.8%
YBOCS	Nil	7	8.8%
	Mild	2	2.5%
	Moderate	5	6.3%
	Severe	3	3.8%
Family history	Nil	70	87.5%
	Alcohol use	40	50.0%
	Psychiatric illness	35	43.8%
	Suicidal death	19	23.8%
Psychosocial stressor	Nil	23	28.8%
	Financial	20	25.0%
	Occupational	3	3.8%
	Social/Environmental	30	37.5%
Suicidal ideation	Nil	27	33.8%
	Present	30	37.5%
Suicide attempt	Nil	50	62.5%
	Yes	10	12.5%
	Nil	70	87.5%

The prevalence of alcohol use in the family history was comparable between the CMD (26.3%) and SMI (25%) groups ($p = 0.236$). Similar findings were observed for a family history of psychiatric illness (CMD: 21.3% vs. SMI: 22.5%) and suicide (CMD: 17.5% vs. SMI: 22.5%). However, a negative family history was reported more often in patients with CMD (20%) than in those with SMI (8.8%).

Regarding psychosocial stressors, financial stress was reported in both the CMD (22.7%) and SMI (27.8%) groups, with no significant difference ($p =$

0.194). Occupational stress was reported exclusively in CMD (6.8%), whereas social/environmental stressors were more common in CMD (43.2%) than in SMI (30.6%). A lack of identifiable stressors was more frequent in SMI (41.7%) than in CMD (27.3%).

Current suicidal ideation was similar across groups (CMD: 38.6% vs. SMI: 36.1%, $p = 0.816$). However, current suicide attempts were more frequent in CMD (18.2%) than in SMI (5.6%), although this was not a significant difference ($p = 0.146$) (Table 3).

Table 3: Comparison of family history, psychosocial stressors, and suicidality between CMD and SMI

Variable	Category	CMD (n, %)	SMI (n, %)	P value
Family history	Alcohol use	21 (26.3%)	20 (25.0%)	0.236
	Psychiatric illness	17 (21.3%)	18 (22.5%)	
	Suicidal death	14 (17.5%)	18 (22.5%)	
	Nil	16 (20.0%)	7 (8.8%)	
Psychosocial stressor	Financial	10 (22.7%)	10 (27.8%)	0.194
	Occupational	3 (6.8%)	0 (0.0%)	
	Social/Environmental	19 (43.2%)	11 (30.6%)	
	Nil	12 (27.3%)	15 (41.7%)	
Current suicidal ideation	Present	17 (38.6%)	13 (36.1%)	0.816
	Nil	27 (61.4%)	23 (63.9%)	
Current suicide attempt	Yes	8 (18.2%)	2 (5.6%)	0.146
	Nil	36 (45.0%)	34 (94.4%)	

Among psychiatric diagnoses, bipolar affective disorder and schizophrenia were the most frequent,

each accounting for 18.8% of cases. The most common were depressive disorder (10.0%), OCD

(12.5%), and delusional disorder (7.5%). Suicidal ideation was most prevalent in patients with bipolar affective disorder (23.3%), followed by those with depressive disorder (16.7%), schizophrenia (16.7%) and depression with psychotic features (10%). The highest rate of suicide attempts was observed in

depressive disorder (30%), followed by depression with psychotic features (20%), schizophrenia, adjustment disorder, recurrent depressive disorder, and somatoform disorder (each 10%). No suicidal ideation or attempts were reported in patients with generalised anxiety disorder (Table 4).

Table 4: Distribution of psychiatric diagnoses and their association with suicidal ideation and suicide attempts

Diagnosis	Frequency (n, %)	Suicidal Ideation (n, %)	Suicide Attempt (n, %)
Adjustment disorder	5 (6.3%)	1 (3.3%)	1 (10%)
Bipolar affective disorder	15 (18.8%)	7 (23.3%)	1 (10%)
Delusional disorder	6 (7.5%)	1 (3.3%)	0
Depression with psychotic features	4 (5%)	3 (10%)	2 (20%)
Depressive disorder	8 (10%)	5 (16.7%)	3 (30%)
Generalised anxiety disorder	5 (6.3%)	0	0
Mixed anxiety & depressive disorder	5 (6.3%)	2 (6.7%)	0
Obsessive-compulsive disorder (OCD)	10 (12.5%)	3 (10.0%)	0
Recurrent depressive disorder	2 (2.5%)	1 (3.3%)	1 (10%)
Schizophrenia	15 (18.8%)	5 (16.7%)	1 (10%)
Somatoform disorder	5 (6.3%)	2 (6.7%)	1 (10%)

DISCUSSION

Suicidal behaviour is a significant public health concern, particularly among individuals with psychiatric disorders. This study specifically focused on patients diagnosed with CMD and SMI, excluding those with alcohol use disorders, following the revised study objectives. The primary aim was to explore and compare the prevalence of suicidal ideation and suicide attempts between the CMD and SMI groups. Suicidal behaviour was predominantly observed among younger individuals, consistent with findings by Patel et al., who reported that the peak incidence of suicidal behaviour occurs between the ages of 15 and 44 years.^[4]

In the present study, males constituted 48.8% of the sample, whereas females accounted for 51.3%. Suicidal ideation was more prevalent among females (55.6%), whereas suicide attempts were more frequent among men (66.7%). This gender pattern is consistent with the findings of Miranda et al., who reported higher odds of suicidal ideation in females (OR 4.39) and significantly greater odds of suicide attempts in males (OR 31.33), compared to females (OR 6.96).^[13]

As for the socioeconomic status in our study, lower-middle class was most prevalent (56.3%), followed by the upper-lower (23.8%), while the upper-middle and lower classes were equally distributed (10% each). These findings are consistent with the observations of Ju et al., who reported that the highest prevalence of the middle class (53.1%), followed by the low class (25.4%) and the high class (21.5%). In a large population-based study of 58,590 patients suffering from mental disorders.^[14]

Regarding marital status, mental disorders were more common in married people (61.3%) than among the single (30%). These findings are supported by Elkington et al., who reported that married persons are more prone (70%) to SMI relapse compared to unmarried persons (57%) in India occurred among married women, suggesting

that marriage may not necessarily serve as a protective factor against suicidality, especially in specific sociocultural contexts.^[15]

In our study, 36.1% of SMI patients had suicidal ideations, but only 5.6% had actually attempted. These observations align with the findings of Wang et al., who in their study on 486 patients reported that SMI patients had high prevalence of suicidal ideations (36.8%) compared to suicidal attempts (15%).^[16]

Among patients with CMD, 17 (38.6%) had suicidal ideation. Notably, 20% who had suicidal behaviours within this group were among the patients diagnosed with depressive disorder. This finding aligns closely with a study by Unni et al., who reported that 59.7% of suicidal ideators were diagnosed with depressive disorders.^[17]

In our study, the highest prevalence of suicidal ideation was noted as 23% among individuals with bipolar disorder, followed by 16.7% in depressive disorder. This finding aligns with the observations of Rihmer et al., who reported that a higher prevalence of bipolar disorder of about 24%, followed by depressive disorder of about 12%.^[18]

Suicidal ideation and intent were reported at comparable rates between the CMD and SMI groups, with no significant differences. This is consistent with findings by Shibre et al., who observed similar proportions of suicidal behaviour among patients with bipolar disorder (23.8%), a CMD, and MDD (26.3%), an SMI, with no significant difference between the groups.^[19] Similarly, Berardelli et al. reported that 17.6% and 21.4% of individuals with suicidal behaviours had CMD and SMI, respectively, further supporting the comparable risk across diagnostic categories.^[20]

Suicidal ideation and suicide attempts were observed in both the CMD and SMI groups, with comparable prevalence rates. Demographic factors such as younger age, female gender (for ideation), and male gender (for attempts) mirrored patterns reported in the national and international literature.

Socioeconomic disadvantage, marital status, and positive family history of psychiatric illness or suicide emerged as key correlates of suicidality. Suicide prevention strategies should include the early identification of high-risk individuals, psychosocial support, and targeted interventions tailored to vulnerable subgroups. Future research involving larger, multicentre cohorts is warranted to enhance our understanding of the pathways to suicidality and inform the development of effective, evidence-based preventive frameworks.

CONCLUSION

Suicidal behaviour among psychiatric patients is significantly influenced by demographic factors, socioeconomic status, illness severity and family history. Younger individuals, those from lower-middle and upper-lower socioeconomic strata, and patients with a family history of psychiatric illness or suicide exhibited higher vulnerability to suicidal ideation and attempts than others. Suicidal ideation and suicide attempts were observed in both the CMD and SMI groups, with no significant difference in prevalence.

These findings support the need for routine suicide risk assessment in all psychiatric evaluations, regardless of the patient's diagnosis. Strengthening community awareness, integrating mental health education, and improving access to mental health care are essential for reducing the burden of suicide among vulnerable populations.

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