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Original Research Article

PREVALENCE OF PSYCHIATRIC DISORDERS IN PEOPLE WHO ATTEMPTED SUICIDE: A CROSS-SECTIONAL STUDY IN A TERTIARY CARE CENTRE, SOUTH INDIA

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ABSTRACT

Background: Suicide attempts are a major public health concern, and psychiatric disorders may contribute to suicidal behaviour. This study assessed the prevalence of psychiatric disorders and described the sociodemographic and clinical characteristics of people who attempted suicide. **Materials and Methods:** This hospital-based cross-sectional study included 260 people who attempted suicide and presented to a tertiary care centre in South India. Data were collected through face-to-face interviews, supplemented by information from relatives and hospital records when necessary. Sociodemographic characteristics, substance use, medical and family history, and details of the suicide attempt were recorded using a semi-structured proforma. Psychiatric diagnoses were made by psychiatrist based on ICD 10 criteria during Psychiatric evaluation. Categorical variables were expressed as frequencies and percentages, and psychiatric disorder prevalence was reported with 95% confidence intervals. **Results:** Among 260 participants, 96 (36.9%; 95% CI: 31.3–42.9) had a psychiatric disorder. Mental and behavioural disorders due to alcohol were the most common diagnosis, affecting 59 participants (61.5% of those with psychiatric disorders; 22.7% of the total sample), followed by adjustment disorder in 14 (5.4%), emotionally unstable personality disorder in 10 (3.8%), and mood disorders in 9 (3.5%). Most participants were aged 18–30 years (64.3%), female (55.8%), and from rural areas (78.8%), students 64 (24.6%). Substance use was reported in 30.4%, while 16.5% had consumed alcohol within three hours before the attempt. Interpersonal conflict or emotional problems were the most frequently reported reasons (63.8%). **Conclusion:** Psychiatric disorders were identified in over one-third of participants, with alcohol use disorders predominating. The findings highlight the importance of psychiatric assessment, substance-use screening, and timely psychosocial support for people presenting after a suicide attempt.

INTRODUCTION

Suicide is a major public health problem worldwide. The Global Burden of Disease 2021 study estimated that around 746,000 people died by suicide in that year, while India's suicide rate was approximately 13 per 100,000 people.[1] For every suicide death, many more people attempt suicide and survive. The Lancet Commission on self-harm estimates that at least 14 million self-harm episodes occur each year, although the actual number may be higher. The burden is greatest in low- and middle-income countries (LMICs).[2] Young people in these countries are particularly affected.[3,4]

Suicide attempts rarely have a single cause. They often result from a combination of mental illness, stressful life events, social disadvantage, and easy access to a method of self-harm.[3] Psychiatric disorders are among the most widely studied factors. A meta-regression found that major depression, bipolar disorder, and schizophrenia were associated with approximately six to eight times higher suicide risk, with relative risks of 7.64, 6.05, and 5.98, respectively.[5] A meta-analysis of psychological autopsy studies also found that psychiatric morbidity

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was associated with nearly 17 times higher odds of suicide (OR 16.71).[6] Substance use, particularly alcohol use, is another recognised factor associated with suicidal behaviour.[7]

However, the role of psychiatric illness varies across settings. In South-East Asia, psychological autopsy studies reported psychiatric disorders in 37% to 88% of suicide deaths, and stressful life events were identified as risk factors in every case-control study.[8] In South Asia, many suicide attempts are also associated with the easy availability of toxic agricultural pesticides. For example, in Nepal, more than 24% of the 5,754 suicide deaths recorded in 2018–19 was due to poisoning, mainly involving pesticides.[9] In such settings, some attempts may occur as impulsive responses to a crisis, even among people without a diagnosed psychiatric disorder.

Hospital-based evidence from South India remains limited. One study at a tertiary care centre examined psychiatric patients with a history of childhood trauma and found that 18.5% had made at least one previous suicide attempt.[10] However, few studies have described the proportion of people presenting to hospitals after a suicide attempt who have a psychiatric disorder and the types of disorders most commonly identified. This information is important for planning psychiatric assessment, follow-up, and suicide prevention. Therefore, this study aimed to estimate the prevalence of psychiatric disorders among people who attempted suicide and describe their sociodemographic and clinical characteristics at a tertiary care centre in South India.

Aim & Objectives

- To estimate the prevalence of psychiatric disorders among people who attempted suicide.
- To describe the sociodemographic and clinical characteristics of people who attempted suicide.

MATERIALS AND METHODS

This hospital-based cross-sectional study was conducted in the Department of Psychiatry, Government Medical College and Hospital, Virudhunagar, Tamil Nadu, India, from March 2025 to August 2025. Ethical approval was obtained from the Institutional Research Ethics Committee, Government Medical College, Virudhunagar (IEC/NEW/77/02/25), on 25 February 2025.

People who presented to the casualty department after a suicide attempt and were referred for psychiatric evaluation were screened for eligibility. A suicide attempt was defined as a self-inflicted, potentially self-injurious act with at least some intent to die.[11]

Self-harm is when somebody injures or harms themselves to cope with or express extreme emotional distress and internal turmoil. They do not generally intend to kill themselves, but the results can be fatal.[11]

Inclusion and Exclusion Criteria

Participants aged 18 years or older who presented to the hospital following a suicide attempt, were medically stable and able to participate in the interview, and provided written informed consent were included in the study. Patients who were unconscious or medically unstable, those who refused to provide informed consent, non-suicidal self-injuries and those with incomplete data were excluded from the study.

Sample size

The sample size was calculated based on the study by Chandrasekaran R et al,[12] A total of 260 consecutive people with suicidal attempt who met the eligibility criteria were included in the study. Participants were recruited from those presenting to the hospital following a suicide attempt during the study period.

The sample size was calculated using the formula $n = 4pq/d^2$, where n is the required sample size, p is the prevalence reported in a previous study (31%), q is 100 − p (69%), and d is the allowable error (6%). Substituting these values into the formula, the sample size was calculated as $n = (4 \times 31 \times 69)/(6 \times 6) = 8556/36 = 237.67$, which was rounded up to 238 participants. After adding 10% to account for non-response (24 participants), the final sample size was 262 participants.

Study instruments and data collection

A total of 260 consecutive patients admitted to the medical and psychiatry wards of Government Medical College Hospital, Virudhunagar, who fulfilled the inclusion and exclusion criteria, were recruited for the study. Written informed consent was obtained from participants willing to participate. Data were collected from the patients and their reliable attendants using a semi-structured proforma. Sociodemographic information included age, gender, residence, religion, education, occupation, marital status, family type, and family income. Clinical details included substance use patterns, alcohol consumption before the attempt, age at onset of substance use, medical and surgical history, previous suicide attempts, and family history.

Information regarding the current suicide attempt included the reported reason and method, whether a relative had been informed, help-seeking behaviour, and the time taken for rescue and arrival at the casualty department. Psychiatric disorders were diagnosed by a psychiatrist according to the International Classification of Diseases, 10th Revision (ICD-10) diagnostic criteria.

The Modified Kuppuswamy Socioeconomic Scale was used to assess the participants' socioeconomic status. Psychiatric diagnoses were made by the psychiatrist based on ICD 10 criteria during Psychiatric evaluation. Participants in whom no psychiatric disorder was identified were classified as having no diagnosed psychiatric disorder.

Statistical Analysis

Categorical variables were summarised as frequencies and percentages. Continuous variables were presented as mean and standard deviation or

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median and interquartile range, depending on their distribution. The prevalence of psychiatric disorders was reported with 95% confidence intervals.

RESULTS

Among 260 people who attempted suicide, 96 had a psychiatric disorder, while 164 had no psychiatric diagnosis. [Table 1]

Table 1: Prevalence of psychiatric disorders among people who attempted suicide

Psychiatric disorder	n (%)	95% CI (%)
Present	96(36.9%)	31.3–42.9
Absent (impulsive attempt, no psychiatric diagnosis)	164(63.1%)	57.1–68.7
Total	260	–

Mental and behavioural disorders due to alcohol were the most common psychiatric diagnoses, affecting 59 participants (61.5% of those with psychiatric disorders and 22.7% of the total sample). Adjustment disorder was reported in 14 participants, followed by emotionally unstable personality disorder in 10. Mood disorders were identified in 9 participants, including depressive disorders and bipolar affective disorder. Schizophrenia was diagnosed in 3 participants, while somatic symptom disorder was reported in 1 participant. [Table 2]

Table 2: Distribution of Psychiatric Diagnoses Among People Who Attempted Suicide

Diagnostic category	Diagnosis	n	% of those with a disorder (n = 96)	% of all attempters (N = 260)	95% CI of prevalence (%)
Alcohol use disorders	All alcohol use disorders	59	61.5	22.7	18.0–28.2
	Alcohol dependence syndrome	56	58.3	21.5	–
	Harmful use of alcohol	2	2.1	0.8	–
	Alcohol dependence syndrome with cannabis dependence	1	1	0.4	–
Adjustment disorder	—	14	14.6	5.4	3.2–8.8
Emotionally unstable personality disorder	—	10	10.4	3.8	2.1–6.9
Mood disorders	All mood disorders	9	9.4	3.5	1.8–6.4
	Depressive disorder	8	8.3	3.1	–
	Bipolar affective disorder	1	1	0.4	–
Schizophrenia	—	3	3.1	1.2	0.4–3.3
Somatic symptom disorder	—	1	1	0.4	0.1–2.1
Any psychiatric disorder	—	96	100	36.9	31.3–42.9

Of the 260 participants, 167 (64.3%) were aged 18–30 years and 145 (55.8%) were female. Most participants were from rural areas (205; 78.8%) and were Hindu (249; 95.8%). Middle-school education was reported by 75 (28.8%), while 86 (33.1%) were semi-skilled workers and students were 64 (24.6%). The largest socioeconomic groups were lower middle (108; 41.5%) and lower (95; 36.5%). A total of 135 participants (51.9%) were married, and 207 (79.6%) belonged to nuclear families. [Table 3]

Table 3: Sociodemographic Profile of People Who Attempted Suicide

Characteristic	Category	n (%)
Age group (years)	18–30	167 (64.3%)
	31–45	59 (22.7%)
	46–60	28 (10.8%)
	>60	6 (2.3%)
Gender	Male	115 (44.2%)
	Female	145 (55.8%)
Residence	Rural	205 (78.8%)
	Urban	55 (21.2%)
Religion	Hindu	249 (95.8%)
	Muslim	3 (1.2%)
	Christian	8 (3.1%)
Education	Postgraduate	6 (2.3%)
	Graduate	35 (13.5%)
	Higher secondary	34 (13.1%)
	High school	48 (18.5%)
	Middle school	75 (28.8%)
	Primary school	31 (11.9%)
	Illiterate	31 (11.9%)

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Occupation	Housewife	44 (16.9%)
	Student	64 (24.6%)
	Semi-skilled	86 (33.1%)
	Skilled	54 (20.8%)
	Professional	12 (4.6%)
Monthly family income (₹)	≥98,000	10 (3.8%)
	49,000–97,999	4 (1.5%)
	36,750–48,999	8 (3.1%)
	29,400–36,749	17 (6.5%)
	19,600–29,399	80 (30.8%)
	13,240–19,599	79 (30.4%)
	<13,240	62 (23.8%)
Socioeconomic status (Modified Kuppuswamy)	Upper	6 (2.3%)
	Upper middle	9 (3.5%)
	Lower middle	108 (41.5%)
	Upper lower	42 (16.2%)
	Lower	95 (36.5%)
Marital status	Married	135 (51.9%)
	Unmarried	115 (44.2%)
	Widowed	3 (1.2%)
	Separated	4 (1.5%)
	Divorced	3 (1.2%)
Family type	Nuclear	207 (79.6%)
	Extended nuclear	11 (4.2%)
	Joint	37 (14.2%)
	Broken	5 (1.9%)

Substance use was reported by 79 participants (30.4%). Alcohol dependence was recorded in 57 (21.9%), tobacco dependence in 18 (6.9%), and cannabis dependence in 1 (0.4%). Alcohol had been consumed within three hours before the attempt by 43 participants (16.5%). The mean age at onset of alcohol use was 22.33 ± 7.37 years, while the mean age at onset of tobacco use was 20.19 ± 3.96 years. [Table 4]

Table 4: Substance Use Profile of People Who Attempted Suicide

Characteristic	Category	n (%)
Substance use	Yes	79 (30.4%)
	No	181 (69.6%)
Alcohol pattern of use	Dependence	57 (21.9%)
	Harmful use	2 (0.8%)
	Occasional	20 (7.7%)
	Nil	181 (69.6%)
Tobacco pattern of use	Dependence	18 (6.9%)
	Occasional	4 (1.5%)
	Nil	238 (91.5%)
Cannabis pattern of use	Dependence	1 (0.4%)
	Occasional	1 (0.4%)
	Nil	258 (99.2%)
Alcohol intake before attempt	<3 hours before	43 (16.5%)
	3–12 hours before	19 (7.3%)
	>12 hours before	13 (5.0%)
	Nil	185 (71.2%)
Age at onset of alcohol use (years), n = 79	Mean ± SD	22.33 ± 7.37
	Median (IQR)	20.0 (18.0–24.5)
Age at onset of tobacco use (years), n = 21	Mean ± SD	20.19 ± 3.96
	Median (IQR)	20.0 (17.0–23.0)

Medical comorbidities were present in 11 participants (4.2%), and surgical comorbidities in 6 (2.3%). Previous suicide attempts were reported by 14 participants (5.4%): 11 (4.2%) had one previous attempt and 3 (1.2%) had two or more. A family history of substance use was reported in 10 participants (3.8%), suicide in 4 (1.5%), and psychiatric illness in 2 (0.8%). [Table 5]

Table 5: Medical, Past, and Family History of People Who Attempted Suicide

Characteristic	Category	n (%)
Medical comorbidity	Yes	11 (4.2%)
	No	249 (95.8%)
Type of medical comorbidity	Diabetes mellitus	2 (0.8%)
	Hypertension	5 (1.9%)
	Diabetes mellitus and hypertension	2 (0.8%)
	Others	2 (0.8%)
	Nil	249 (95.8%)

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Surgical comorbidity	Yes	6 (2.3%)
	No	254 (97.7%)
Previous suicide attempts	Nil	246 (94.6%)
	1 attempt	11 (4.2%)
	2 attempts	1 (0.4%)
	>2 attempts	2 (0.8%)
Family history	Psychiatric illness	2 (0.8%)
	Suicide	4 (1.5%)
	Substance use	10 (3.8%)
	Nil	244 (93.8%)

Interpersonal conflict or emotional problems were reported as the reason for the attempt by 166 participants (63.8%). The most frequently recorded methods were other methods (66; 25.4%), rat killer (53; 20.4%), and tablets (35; 13.5%). Before the attempt, 70 participants (26.9%) had informed a relative and 51 (19.6%) had sought help. The median time to rescue was 30 minutes (IQR: 15–60), and the median time to reach the casualty department was 60 minutes (IQR: 30–60). [Table 6]

Table 6: Characteristics of the Current Suicide Attempt

Characteristic	Category	n (%)
Reason for the attempt	Interpersonal conflict/emotional problems	166 (63.8%)
	Financial problems	27 (10.4%)
	Spouse's substance use	14 (5.4%)
	Domestic violence	10 (3.8%)
	Failure in education	4 (1.5%)
	Health problems	12 (4.6%)
	Others	27 (10.4%)
Method of the attempt	Hanging	7 (2.7%)
	Insecticide	32 (12.3%)
	Ant killer	26 (10.0%)
	Rat killer	53 (20.4%)
	Phenol/Lysol/Harpic	11 (4.2%)
	Oleander	13 (5.0%)
	All-out (mosquito repellent)	6 (2.3%)
	Hair dye	2 (0.8%)
	Tablets	35 (13.5%)
	Cow-dung powder	9 (3.5%)
	Others	66 (25.4%)
Informed a relative before the attempt	Yes	70 (26.9%)
	No	190 (73.1%)
Help sought before the attempt	Yes	51 (19.6%)
	No	209 (80.4%)
Time taken for rescue (min)	Mean ± SD	53.96 ± 83.87
	Median (IQR)	30.0 (15.0–60.0)
	Range	5–900
Time to reach the casualty department (min)	Mean ± SD	70.10 ± 88.48
	Median (IQR)	60.0 (30.0–60

DISCUSSION

In our study, psychiatric disorders were identified in some participants who attempted suicide, while the remaining participants had no psychiatric diagnosis. Similarly, Pushpakumara et al. studied 439 self-poisoning cases in rural Sri Lanka and found a psychiatric diagnosis in 20.3%, so about 80% had none.[13] In contrast, Arafat et al. in Dhaka reported that 71% of 100 attempters had a psychiatric disorder.[14] Sahu et al. in Bhopal reported 86.5% among 710 attempters.[15] A Norwegian study of 39,534 adults found a psychiatric disorder in 58.5% of suicidal episodes.[16] Rates differed considerably across settings, which may reflect differences in study populations, clinical settings, and diagnostic assessment methods.

Regarding psychiatric diagnoses, alcohol use disorders were the most frequently recorded, followed by adjustment disorder, emotionally unstable personality disorder, and mood disorders. Schizophrenia and somatic symptom disorder were less frequently reported. Similarly, Pushpakumara et al. found that alcohol use disorder was common risk factor in their rural sample. It affected 26.7% of males aged 30 years or above, and the odds of self-poisoning were about 21 times higher.[2] Bøe et al. reported alcohol use disorder in 16.4% of suicidal episodes in Norway.[16] However, mood disorders were more common in other studies. Depression was seen in 30.2% of Nepali attempters, mood disorders in 27.5% in Bhopal, and major depression in 19% in Dhaka.[5] Arafat et al. also reported adjustment disorder in 11% and borderline personality disorder in 30%.[14] Alcohol use disorders were the most common psychiatric diagnosis in our study, whereas mood disorders were more prominent in several other studies. These differences may reflect variations in study populations, clinical settings, and diagnostic methods

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In the present study, most participants were young adults, female, and from rural areas. The majority were Hindu, had middle-school education, belonged to the lower-middle or lower socioeconomic groups, were married, and lived in nuclear families. Regarding occupation, semi-skilled workers contributed the most, followed by students. Similarly, Sharma et al. in Nepal reported that 56.05% of attempters were female, 43.55% were aged 20–29 years, and 51.21% were married.[17] Arafat et al. found that 72% of attempters were female, with a mean age of 23.1 years.[14] Pushpakumara et al. reported a median age of 20 years in rural Sri Lanka.[13] Balaji et al. found that low socioeconomic status (aOR 3.5) and partner or family problems (aOR 4.8) increased the risk of attempts in people aged 15–29 years.[18] Sahu et al. differed from us, with 51.4% urban attempters and 52.39% males.[15] Our participants were predominantly young adults, and many belonged to the lower socioeconomic groups. The large number of rural participants may be because our hospital mainly serves people from rural areas.

Students constituted the second-largest occupational group in our study, accounting for 64 (24.6%) participants, after semi-skilled workers (86; 33.1%).

In substance use, alcohol was most commonly reported substance, followed by tobacco and cannabis. Some participants had consumed alcohol before the attempt. Alcohol and tobacco use commonly began in early adulthood. Similarly, Sharma et al. found that 18.55% of Nepali attempters were under effect of a substance at time of attempt.[17] Balaji et al. in Pune found that increased in alcohol use raised odds of an attempt about two-fold (a OR 2.0), and the link was significant only in males.[18] Arafat et al. reported a substance-related disorder in 17% of attempters in Dhaka.[14] Recent alcohol intake was reported by approximately one in six participants, highlighting the importance of assessing recent substance use in people presenting after a suicide attempt.

On reviewing medical and past history, most participants had no medical or surgical comorbidities and no history of previous suicide attempts. A family history of substance use was more commonly reported than a family history of suicide or psychiatric illness. Similarly, Sahu et al. found previous attempts in 7.75% (55 of 710) of their attempters.[15] Other studies reported much higher rates. Previous attempts were present in 26.5% in Pune,[18] 33.87% in Nepal,[15] and 54% in Dhaka.[16] Sharma et al. also found a family history of mental illness in 14.11% and of suicide in 5.24%.[17] Most participants had no history of previous suicide attempts, and a family history of psychiatric illness, suicide, or substance use was infrequently reported

In relation to current attempt, interpersonal conflict or emotional problems were the most commonly reported reasons. The methods varied, with other methods, rat killer, and tablets frequently recorded. Most participants had not informed a relative or sought help before the attempt. Similarly, Balaji et al. found pesticide ingestion in 60.3% of attempters in Pune, and about half had faced a stressful event within the previous 48 hours.[18] Sahu et al. reported poisoning in 75.35%,[15] and Sharma et al. in 36.29%, with 73.79% of attempts being impulsive and 23.79% having communicated their plan.[17] Arafat et al. found family conflict behind 30% of attempts in Dhaka.[14] Pushpakumara et al. found that 76.4% of their rural cases had never sought care.[13] In contrast, hanging was the commonest method (55.8%) across South Asian studies reviewed by Arafat, though that review mostly covered suicide deaths.[20] The findings highlight the importance of addressing interpersonal conflicts, improving awareness of available support services, and considering access to toxic substances in local suicide-prevention efforts.

CONCLUSION

Psychiatric disorders were identified in 36.9% of participants who attempted suicide, with alcohol use disorders being the most common. Approximately two-thirds had no diagnosed psychiatric disorder, and interpersonal conflict was the leading reason for the attempt. These findings highlight the need to extend suicide prevention beyond hospital-based psychiatric assessment to community-level awareness, early identification of emotional distress, and support for interpersonal difficulties. The substantial proportion of student participants (approximately one-fourth) also emphasizes the importance of life skills training and stronger support systems in schools and colleges. A multidisciplinary approach addressing both psychiatric and psychosocial factors is essential for effective suicide prevention.

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