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Research Article

Descriptive Analysis in Terms of Psychiatric Morbidity and Suicidality in Individuals Six Months After a Suicide Attempt Attending a Tertiary Care Hospital.

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ABSTRACT
Background: A high suicide rate of 12.4% was reported in India in 2022. A previous suicide attempt and the presence of psychiatric disorders are risk factors for death due to suicide. Most of the existing literature is based on cross-sectional assessments in the immediate aftermath of an attempt and not much is known about the psychiatric morbidity in these individuals afterwards. This study aimed to assess the psychiatric morbidity and suicidality in individuals 6-18 months after a suicide attempt.
Methods: A hospital-based descriptive study was conducted among individuals with a history of a suicide attempt in the preceding 6-18 months. A convenient sample of 62 subjects was obtained. The presence of a psychiatric disorder and current suicidality were assessed using
M.I.N.I 5.0. Hamilton Depression Rating Scale, Hamilton Anxiety Rating Scale and Global Assessment of Functioning scale were employed to assess the levels of depression, anxiety, and functioning respectively.
Results: 90.3% of the individuals had at least one psychiatric disorder and 56.5% had multiple psychiatric disorders. 30.6% and 8.1% had moderate and high suicidal risk respectively. Majority of the participants had mild levels of depression and anxiety, and moderate difficulties in functioning. The presence of multiple psychiatric disorders and severity of depression emerged as significant predictors of suicidality.
Conclusions: A significant proportion of individuals with a suicide attempt had psychiatric disorders, moderate to high levels of suicidality, and difficulties in functioning 6-18 months after the attempt. Regular follow-ups and interventions to reduce the risk of subsequent suicides must be ensured.

Keywords: Anxiety, Depression, Suicide attempt, suicidal ideation.

INTRODUCTION

Suicide is a serious public health concern in India. 18% of the global population and 28% of the global suicides are accounted for by India. (1) The National Crime Records Bureau statistics indicate that the rate of suicides in 2022 was 12.4% which is alarming. The southern state of
Andhra Pradesh reported the highest suicidal rate (16.8%) in the country in the same year. Bengaluru (27.2%), Chennai (18.2%) and Coimbatore (17.5%) were listed among the ten cities with the highest suicidal rates in 2022. (2)
Research has consistently highlighted various factors contributing to the risk of suicide. A suicide attempt is a risk factor predicting subsequent attempts and completed suicide. (3)
In a longitudinal cohort study that explored the clinical and functional outcomes of individuals attending a primary care psychiatric service during a follow-up period of 5 years, previous suicide attempts were prospectively found to be associated with subsequent suicide attempts (Odds ratio=2.59) (4) Other factors known to confer a high risk for future attempts are the presence of psychiatric disorders and higher suicidality scores. Studies have shown that up to 90% of individuals with a suicide attempt have a comorbid psychiatric disorder, with the most frequent diagnosis being depression, followed by alcohol misuse, (5) although recent studies have also emphasized the importance of anxiety disorders.
Often individuals present to the emergency departments and medical wards of hospitals to seek care for the medical complications related to a suicide attempt. They are also referred to mental health professionals, more often for crisis intervention. Most of the available studies from India have dealt with cross-sectional

accounts obtained around the time of a suicide attempt. This period is often influenced by several issues around the clinical events following the attempt.

The real mental status of the subjects is likely to be better understood after these issues subside. This is a major lacuna in the literature on suicide in the country since previous studies from across the globe have shown that the highest risk of a repeat attempt is during the first 18 months following an attempt. The World Health Organisation (WHO) has also advocated for assessments, regular follow-ups and ongoing support to individuals who have attempted suicide as a key intervention to achieve the target of reducing global suicide mortality by one third by the year 2030. [6]

With this background, it was planned to conduct this study as it is necessary to find out how those with a prior suicide attempt are faring since then. Our study aimed to assess psychiatric morbidity, presence and severity of depression, and suicidality in an individual 6-18 months after a suicide attempt.

MATERIALS AND METHODS

Setting and design: A cross-sectional observational study was conducted at the Department of Psychiatry in a tertiary care hospital in South India. The sample included individuals who presented with a history of a suicide attempt in the preceding six to eighteen months, selected using convenient sampling. This included psychiatric inpatients, outpatients. Informed consent was obtained from all the participants. The Institutional Ethical Committee approved the study (IEC Study Ref. No.319/2024 dated 14/05/2024). The data was collected from June 2024 to June 2025.

Sample size calculation: An audit of the data from individuals who were on follow-up with Department of psychiatry showed a prevalence of psychiatric diagnosis in 78% of the individuals. Assuming an expected proportion of 0.78, at absolute precision of 10%, at p-value of 0.05, a sample size of 64 was obtained.

Inclusion and Exclusion criteria: Patients between the age of 18-60 years presenting with a history of a suicide attempt having occurred at least 6 months earlier, but no later than 18 months were included in the study. Subjects with significant cognitive impairment that would preclude them from providing meaningful information were excluded from the study.

Study tools:

1) Mini International Neuropsychiatric Interview-5.0.0

The M.I.N.I is a short and structured diagnostic interview used to diagnose DSM-IV psychiatric disorders. It also assesses the intensity and frequency of suicidal ideation. Inter-rater reliability is very high, with the kappa coefficients ranging from 0.88 to 1.0. For the test-retest reliability, the range of kappa coefficients was between 0.76 and 0.93. [7] This tool has been extensively used for diagnostic interviews by Indian researchers especially in the field of research on suicide.

2) Hamilton Depression Rating Scale (HAM-D)

It is the most widely used clinician-administered depression assessment scale. It is a 21-item multiple-choice measure of depression symptom severity. Each item on the questionnaire is scored on a 3- or 5-point scale, depending on the item, and the total score is compared to the corresponding descriptor. [8] The internal reliability of this tool is adequate as various studies have reported estimates of more than 0.70. The retest reliability was found to be high, ranging from 0.81 to 0.98. [9] A study by Prasad et al demonstrated excellent inter-rater reliability
(0.9891) while using this tool in India. [10]

3) Global Assessment and Functioning Scale (GAF)

It is a numeric scale (1 through 100) used to rate subjectively the social, occupational, and psychological functioning of adults, e.g., how well or adaptively one is meeting various problems in living. This tool has been found to have adequate reliability and validity as a measure of global psychopathology. Sahoo et al has demonstrated the concurrent validity of the Indian Disability Evaluation and Assessment Scale (IDEAS) with GAF scale for use in patients with schizophrenia. [11]

3) Hamilton Anxiety Rating Scale (HAM-A)

The HAM-A is a clinician-rated scale used to measure the severity of anxiety symptoms. The scale has 14 questions and each item is scored on a 5-point scale, ranging from 0 to 4. The total score ranges from 0–56, where <17 indicates mild severity, 18–24 mild to moderate severity, and 25–30 moderate to severe. The interrater reliability as measured by the intra class coefficient was found to be adequate (0.91 for HAM-A total score). [12]

Statistical Analysis: Statistical analysis was carried out using IBM SPSS version 20.0. Descriptive statistics including frequency, percentage, mean and standard deviation (SD) were used for the variables under the study. Continuous variables were expressed using mean ± SD and median. Categorical variables were expressed using frequency and percentages. Chi-square test was used to test the association between categorical variables. To test the statistical significance of the difference in the median HAM-D, HAM-A and GAF scores with suicidality, Mann Whitney U test was used. Multiple binary logistic regression was done to estimate the predictors of the outcome (current suicidality as the dependent variable - on a dichotomous scale- high and low) and Odds ratio with 95% confidence interval was computed.

RESULTS

62 out of the 64 samples estimated to be required for adequate power were collected. The sample consisted of more females (69.4%) than males (30.6%). In the sample, 56.5% of the subjects were single and 43.5% were married. 80.6% of the individuals lived in nuclear families while 19.4% lived in joint families. A family history of psychiatric illness was present in 19.4% of the individuals. The most common psychiatric illnesses among the family members of the participants were alcohol dependence (6.5%) and psychotic illness (6.5%). 16.1% had a family history of attempted suicide. At the time of assessment, 87.1% were on medication, while 12.9% were not on medication. (Table 1)

The mean of HAM-D total score was 11.34 ± 5.374 (which suggests mild depression). The mean HAM-A total score was 14.26± 8.560 (indicative of mild anxiety). (Table 2) The mean GAF score was 63.5±15.1. 61.3% had a low current suicidal risk, 30.6% had a moderate risk and 8.1% had a high risk as assessed using the suicidality module of M.I.N.I. 90.3% of the participants had at least one psychiatric disorder according to M.I.N.I. 33.9% had only one psychiatric disorder, while 9.7% did not have any disorder. (Table 3) The most common psychiatric diagnoses were depressive illness (16.1%), followed by anxiety spectrum disorders (6.5%), psychotic illness (4.8%) and alcohol dependence (4.8%). 56.5% had multiple comorbid psychiatric disorders.

Individuals with multiple psychiatric disorders had a significantly higher risk of moderate to high suicidality (60%) as compared to individuals with only one psychiatric disorder (14.3%). (p=<0.001) (Table 4)

The relationship between the independent variables-presence of multiple psychiatric disorders, HAM-D scores, HAM-A scores, and GAF scores with the current suicidality (low risk versus moderate or high risk) was analysed. Univariate regression analysis was done initially. (Table 5). HAM-D score (p=<0.001), HAM-A score(p=0.005), GAF score (p=<0.001), and the presence of more than one psychiatric diagnosis (p=<0.001) were found to be statistically significant.

The severity of depression as measured by HAM-D scores (p=0.013), and the presence of multiple psychiatric disorders (p=0.025) remained statistically significant predictors of current suicidality in the logistic regression analysis. Among individuals with a history of a suicide attempt in the preceding 6-18 months, those with multiple psychiatric disorders were seven times more likely to have moderate to high current suicidal risk. (Odds ratio=7.045; 95% CI: 1.27-38.79) Greater severity of depression (HAM-D scores) also predicted a higher risk of suicidality in these individuals. (Odds ratio=1.256; 95% CI: 1.050-1.502) (Table 6)

DISCUSSION

A literature searches for studies from India which have assessed suicidality and psychiatric morbidity in suicide attempters 6-18 months after the suicide attempt, did not yield any results. It is here that the findings of our study find relevance as the risk of a repeat attempt is especially high during the first 18 months after an attempt.

Among the subjects recruited in the study, there was a greater number of females (69.4%) compared to males (30.6%). The global rate of attempted suicide is found to be higher in women and that of death due to suicide is higher in men. In a study by Rygnestad et al, it was observed that a higher proportion of females (56%) consented to follow-up assessments after a suicide attempt as compared to males (42%). [13] Better help-seeking in women is evident in the greater participation of women in follow-up assessments as shown in the current study and other long-term studies on suicide outcomes. There was a greater number of single individuals

(56.5%, out of which 2 patients were divorced) compared to married individuals in this study (43.5%). This is in concordance with the

Western literature which has shown marriage to be a protective factor for suicide, especially among men. [14] According to the 'Sociological theory of suicide' proposed by Emil Durkheim theory, levels of social integration and regulation are higher in married individuals which proves to be a protective factor from suicide.

16.1% had a family history of attempted suicide. Family studies in the literature have shown evidence for increased risk for suicidal behaviour in first- and second-degree relatives of suicide victims. In two cohort studies of 181 individuals who were on follow-up care after a suicide attempt, it was observed that 20% of the suicide attempters had a positive family history of suicide and 5% had a family history of both attempted and completed suicide. [15] At the time of assessment, 87.1% of our subjects were on psychotropic medications. This indicates that a majority of the participants continued to have psychiatric disorders of a severity which necessitated ongoing pharmacological management. Fridell et al in a 5-year follow-up study of suicide attempters reported that 71% of the individuals were on pharmacological treatment during the follow-up period. [16] This information highlights the presence of psychiatric morbidity in a majority of suicide attempters persisting well beyond the period of the attempt. It also casts light upon the better awareness and openness to access psychiatric services among individuals who have attempted suicide.

In the current study, 90.3% of the subjects had a psychiatric disorder according to M.I.N.I which is a standardised and structured assessment tool. 56.5% had multiple comorbid psychiatric disorders, 16.1% had a depressive illness, 6.5% had anxiety spectrum disorders, 4.8% had a psychotic illness and 4.8% had alcohol dependence. Grisham et al conducted a study to investigate the long-term outcomes of 91 subjects with a suicide attempt in a birth cohort consisting of 1037 members, who were followed up to the age of 38 years. It was observed that during the follow-up period, those with a suicide attempt were found to have persistent psychiatric disorders, especially major depression and substance dependence. [17] A study by Sreedaran et al based on findings from AMAS services observed that individuals with substance use disorders had the lowest follow-up rates with mental health services following a suicide attempt. [18] The findings of our study also highlight the need to ensure that individuals with substance use disorders receive long-term follow-up care on par with other disorders like major depression and psychotic disorders.

According to M.I.N.I, 61.3% of the sample had low suicidal risk, while 30.6% had a moderate risk and 8.1% had a high risk. According to the results of the National Mental Health Survey (NMHS) of India, 2015-16, 5.1% of the participants experienced suicidality in the preceding month. Among the participants, 3.5% reported low, 0.7% reported moderate and 0.9% reported high levels of suicidality. This study which included a community sample of 34,748 participants used the suicidality module of MINI; version 6.0 to assess suicidality. NMHS also observed that the ratio of suicidality to completed suicide was 211·98. This implies that for every person who dies by suicide in India, 211 people have experienced suicidality. [19] Hence, our finding that moderate to high suicidality persists beyond 6 months following an attempt is striking. Prinstein et al conducted a study of 143 suicide attempters admitted to the inpatient unit of a psychiatric hospital who were followed up after discharge and assessed at 3,6,9,15 and 18 months. An initial decline in suicidality was observed over the first 6 months' post discharge, followed by a re-emergence in the subsequent year. The study proposed that suicidality might not show a gradual decline with time and exhibits a cyclical course. [20]

The mean HAM-D total score in the current study was 11.34± 5.374, which suggests mild depression. The mean HAM-A total score was 14.26± 8.560 which is indicative of mild anxiety. A 5-year follow-up study conducted in a university hospital in Sweden observed that among those who did not have a repeat attempt during the follow-up period, 36% reported depression, 32% reported anxiety and 44% reported persisting suicidal thoughts. [16]

The mean GAF score in the current study was 63.5±15.1which translates to moderate symptoms and moderate difficulty in social and occupational functioning. This finding is worthy of note as it suggests that the current sample of patients who had a history of a suicide attempt continued to have moderate levels of psychiatric morbidity and socio-occupational dysfunction 6-18 months after the attempt. Similar findings have been observed in a follow-up study of 24 suicide attempters wherein the psychosocial functioning of the individuals was assessed on the Global Assessment Scale (GAS). This study reported a mean score of

65.62 which indicates moderate symptoms and difficulty in functioning. [21]

Our study showed that 60% of the individuals who had multiple psychiatric disorders had a moderate to high suicidal risk. 85.7 % of the individuals with only one psychiatric disorder and those without a psychiatric disorder had low current suicidality. On logistic regression, the presence of multiple psychiatric disorders and severity of depression (HAM-D scores) remained significant predictors of current suicidality. Cross-national surveys conducted in 17 countries across the world which explored the risk factors for suicidal behaviours reported a strong dose-response relationship between the number of psychiatric diagnoses and the risk of suicidal ideations and attempts. [22] Most studies on suicide have unequivocally demonstrated the role of depression in predicting suicide attempts and completed suicide which is a notable finding in this study also. A noteworthy finding of NMHS 2015-16 is that the risk for suicidality is higher in subjects with depressive disorders (odds ratio 28·78; p<0·0001) and those with alcohol use disorders (6·52; p<0·0001). A study of 1052 suicide attempters who were followed up for 6 years and 5 months reported that the presence of major depression for both sexes and a higher suicide intent score for females were significant predictors for the risk of subsequent suicide. [23]

The results of our study draw attention to the need for long-term follow-up care for attempters of suicide. [20] This finding has been reflected in the objectives of the National Suicide Prevention Strategy (NSPS) which was launched in India in 2022. The proposed action plan is to ensure that all hospitals and mental health institutions provide psychosocial support and regular follow-ups for all patients with attempted suicide for at least 18 months. The recently launched Tele Mental Health Assistance and Networking Across States (TeleMANAS) services is a welcome step in facilitating a smooth transition of care for patients with acute suicidal behaviours to specialised mental health services for follow-up care. Our study finding that a large proportion of individuals with a suicide attempt have psychiatric disorders and moderate to high suicidality 6-18 months following an attempt is important from a suicide prevention perspective and has crucial public health policy implications. It provides impetus to reflect on the need to develop mechanisms for surveillance and follow-up care at the regional, state and national levels.

Limitations

The study sample involved individuals who were on follow-up with AMAS services, psychiatry in-patients, and outpatients. This sample which included predominantly patients seeking care from psychiatric services might have influenced the finding of a very high proportion of psychiatric diagnoses in the study. We did not have baseline clinical assessment data of all the subjects at the time of the suicide attempt as this study followed a cross-sectional design. The sample was recruited from among the individuals seeking care at a tertiary care hospital. This may reduce the generalizability of the findings.

CONCLUSIONS

Individuals with a history of attempted suicide continued to have psychiatric comorbidities, the most prominent among which were depression and anxiety as well as moderate levels of difficulties in functioning when assessed at a period 6-18 months after the attempt. It is important for mental health professionals to emphasize the need for regular follow-up in individuals with a history of a suicide attempt and to ensure that they get adequate pharmacological and psychosocial interventions.

Declaration of Conflicting Interests

The Authors declare that there is no conflict of interest

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Table 1. Socio-Demographic and Clinical Variables (N=62)

Sl. No	Variables		Frequency (%)
1.	Gender	Male	19 (30.6)
		Female	43 (69.4)
2.	Age group	18 to 25	31 (50)
		25 to 35	18 (29)
		35 to 45	11 (17.7)
		45 to 60	2 (3.2)
3.	Marital status	Single	35 (56.5)
		Married	27 (43.5)
4.	Family history of psychiatric illness	Present	12 (19.4)
		Absent	50 (80.6)
5.	Family history of suicide attempt	Present	10 (16.1)
		Absent	52 (83.9)
6.	Pharmacological treatment	Not on psychotropics	8 (12.9)
		On psychotropics	54 (87.1)

Table 2. Depression and Anxiety in the Study Population (N=62)

Variable	Mean ± SD	Median (Q1-Q3)
HAM-D total score	11.34± 5.374	11 (7-14)
HAM-A total score	14.26± 8.560	13.5 (8-19)

Table 3. Suicidality and Presence of Psychiatric Disorders in the Sample

Variables (n=62)		n (%)
Current Suicidality (according to 'Suicidality' module of M.I.N.I)	Low risk	38 (61.3)
	Moderate risk	19 (30.6)
	High risk	5 (8.1)
Psychiatric diagnosis (according to M.I.N.I)	Absent	6 (9.7)
	Present	56 (90.3)
Number of psychiatric diagnoses	No diagnosis	6 (9.7)
	1 diagnosis	21 (33.9)
	>1 diagnosis	35 (56.5)

Table 4. Comparison of the Number of Psychiatric Diagnoses across Current Suicidality (N=56)

Number of psychiatric disorders	Suicidality		Chi-square value	P
	Low risk	Moderate to high risk		
One disorder (n=21)	18 (85.7%)	3 (14.3%)	11.200	<0.001*
Multiple disorders (n=35)	14 (40%)	21 (60%)		

*P value <0.05 is considered significant

Table 5. Association of HAM-D, HAM-A and GAF Scores with Suicidality

Variable	Suicidality	Median (Q1-Q3)	P value
HAM-D total	Low (n=38)	9 (6.8-12.3)	<0.001*
	Moderate or high (n=24)	14 (10.3-18.6)	
HAM-A total	Low (n=38)	10 (7.8-16.3)	0.005*
	Moderate or high (n=24)	18 (14-21.8)	
GAF	Low (n=38)	70.5 (58.8-80)	<0.001*
	Moderate or high (n=24)	55 (46.3-64)	

*P value <0.05 is considered significant

Table 6. Multiple Regression Analysis With Suicidality As The Dependent Variable

Independent variable	B	S.E	Wald	P value	Odd's ratio	95% C.I for Odd's ratio	
						Lower	Upper
HAM-D total score	.228	.091	6.220	**.013***	1.256	1.050	1.502
GAF	-.017	.029	.356	.551	.983	.929	1.040
Presence of multiple psychiatric disorders	1.952	.870	5.031	**.025***	7.045	1.279	38.792
HAM-A total score	-.017	.051	.115	.734	.983	.889	1.086

*P value <0.05 is considered significant