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Original Research Article

SUICIDAL THOUGHTS, BEHAVIOUR AND PERSONAL SUICIDE STIGMA IN PATIENTS WITH A HISTORY OF SUICIDE ATTEMPTS: A CROSS-SECTIONAL STUDY FROM A TERTIARY CARE CENTRE IN INDIA

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ABSTRACT

Suicidal thoughts, behaviour and personal suicide stigma are clinically relevant in people presenting after suicide attempts. We examined their clinical profile and relationships with psychological distress and suicidal intent in a tertiary-care population in India. This cross-sectional analytical study reviewed 2024 medicolegal records of patients referred for psychiatric assessment at GMERS Medical College and Hospital, Vadodara. Data were collected during March 2025–January 2026; standardized questionnaires were administered to an interviewed subgroup. Of 257 identified attempt cases, 153 were referred to psychiatry, 112 were interviewed and 101 completed standardized assessments. Among the 153 cases, 87 (56.9%) were male, 137 (89.5%) involved ingestion, 119 (77.8%) reported suicidal intent and 116 (75.8%) reported guilt. In the assessed subgroup (n=101), mean PHQ-4 and SBQ-R scores were 1.09 and 6.59, respectively; 18 (17.8%) were in moderate/high SBQ-R categories. Psychological distress correlated positively with suicidality (Spearman ρ=0.611; $p<0.001$). Mean reported PSSQ score was 20.86, with self-blame having the highest subscale mean (9.38). PSSQ total score showed no significant correlation with suicidal intent (ρ=0.139; p=0.167). Psychological distress and suicidality were associated, whereas personal stigma was not significantly correlated with reported suicidal intent.

Keywords: Suicide attempt; Suicidal ideation; Personal suicide stigma; Psychological distress; India

INTRODUCTION

Suicide, defined as the intentional act of ending one's own life, is a complex and multifactorial public health concern. It is increasingly understood as part of a broader continuum of suicidality, encompassing suicidal ideation, planning, attempts, and completed suicide.[1,2] Suicidal behaviour results from interactions among biological, psychological, social, cultural, and environmental factors rather than a single identifiable cause.[3]

Globally, suicide remains a major public health challenge, accounting for approximately 700,000 deaths annually, with a substantial burden among individuals aged 15–29 years.[1] Suicide patterns vary geographically according to socioeconomic circumstances, cultural influences, and accessibility of lethal means. In India, approximately 160,000–170,000 suicide deaths are reported annually, reflecting a considerable public health burden.[4] Important contributing factors include academic pressure, unemployment, financial difficulties, interpersonal conflicts, family problems, psychiatric disorders, and social stigma.[4-6]

A significant advancement in India's approach to suicide prevention was the Mental Healthcare Act, 2017, which introduced a therapeutic rather than punitive framework for individuals attempting suicide.[7] Previously, attempted suicide was punishable under Section 309 of the Indian Penal

Code.[8] Section 115 of the Mental Healthcare Act established a presumption of severe stress among individuals attempting suicide and emphasized appropriate treatment, rehabilitation, and prevention of recurrence.[9]

Suicide attempts occur considerably more frequently than suicide deaths and represent important opportunities for preventive intervention. Their etiology involves psychiatric conditions, including depressive disorders, bipolar disorder, schizophrenia, anxiety disorders, and substance use disorders.[10] Individuals with previous suicide attempts constitute a particularly vulnerable population because a history of suicidal behaviour is an important predictor of subsequent attempts and suicide deaths.[11] Persistent psychiatric symptoms, psychosocial stressors, inadequate treatment adherence, and limited social support may contribute to recurrent suicidal behaviour.[10] Furthermore, stigma associated with suicide and mental illness can discourage disclosure, delay help-seeking, and interfere with appropriate psychiatric care.[10,12]

Therefore, understanding suicidal thoughts, suicidal behaviour, and personal suicide stigma among individuals with a history of suicide attempts is essential for identifying vulnerable populations, improving clinical risk assessment, facilitating timely psychiatric intervention, and strengthening comprehensive suicide prevention strategies.

MATERIALS AND METHODS

Study design, setting and participants

This cross-sectional study was conducted through the Department of Psychiatry, GMERS Medical College and Hospital, Gotri, Vadodara, Gujarat, India. The source population comprised medicolegal presentations with an alleged suicide attempt between 1 January and 31 December 2024 that were referred for psychiatric assessment during admission. Medical records were reviewed from March to August 2025, followed by telephone interviews and participant assessments from September 2025 to January 2026. The recorded exclusions were death during hospitalization, inability to contact the patient, refusal of informed consent; and people known to have died after discharge were excluded.

Recruitment and data collection

Among 3,487 medicolegal cases, 891 records were assessed after the initial exclusions; 257 cases were identified as alleged suicide attempts, of which 153 had been referred to psychiatry. Forty-one referred patients were not interviewed because they could not be contacted or declined participation, leaving 112 interviewed individuals. Eleven interviewees reported that their index events had been accidental, resulting in 101 participants for the standardized questionnaire analyses. Sociodemographic details, attempt method, reported intent, guilt, previous attempts, clinical diagnosis, substance use and relevant hospitalization data were extracted using a semi-structured proforma. Telephone interviews were performed after consent; physical interviews were undertaken when participants attended in-person follow-up.

Measurements

The Patient Health Questionnaire-4 (PHQ-4) screened for symptoms of anxiety and depression.[13,14] The Presumptive Stressful Life Events Scale (PSLES) recorded stress-related life events.[15] The four-item Suicidal Behaviors Questionnaire-Revised (SBQ-R) assessed suicidal thoughts and behaviors, with the reporting low, moderate and high categories.[16] The 16-item PSSQ assessed rejection, minimization and self-blame.[17] Questionnaire scores and retrospectively recorded characteristics were considered separately because they came from different analytic denominators.

Statistical analysis

Data were entered in Microsoft Excel and analysed using SPSS version 19.0. The reported analyses used descriptive statistics, chi-square tests, independent-samples t tests, analysis of variance, Mann–Whitney U and Kruskal–Wallis tests, Spearman rank correlations, binary logistic regression and multiple linear regression as applicable. A p value <0.05 was the prespecified threshold for statistical significance. The stigma–intent correlations were also assessed against a Bonferroni-adjusted threshold of 0.0125.

Ethical considerations

Institutional Human Ethics Committee approval was obtained from GMERS Medical College and Hospital, Gotri (approval IHEC/25/OUT/SRPG0168, dated 18 February 2025). Written informed consent was obtained from participants. Data were handled according to institutional confidentiality requirements, and results were reported in aggregate.

RESULTS

Recruitment and demographic characteristics

The record-based cohort comprised 153 referred cases, the interview group 112 participants and the standardized-assessment subgroup 101 participants. In the record-based cohort, 87 (56.9%) were male and 66 (43.1%) were female; the reported mean age was 29.56 years. The largest age group was 20–39 years (95/153, 62.0%). Secondary-school education was recorded for 104 (67.9%), employment for 98 (64.0%) and urban residence for 94 (61.4%) (Table 1).

Attempt characteristics and psychiatric diagnoses

Ingestion was the recorded method in 137 (89.5%) cases, hanging in 9 (5.9%) and other methods in 7 (4.6%). Attempt method was not associated significantly with sex ($\chi^2=0.636$; $p=0.728$) or age group ($\chi^2=6.773$; $p=0.342$). Twelve individuals (7.8%) had a documented earlier suicide attempt; previous-attempt history was not significantly associated with the current attempt method ($\chi^2=0.591$; $p=0.744$) or its reported lethality score (Mann–Whitney $U=768.0$; $p=0.482$). No psychiatric

diagnosis was recorded for 106 (69.3%), while alcohol use disorder was recorded for 21 (13.7%) and major depressive disorder for 17 (11.1%). Diagnosis distribution differed by sex (χ^2=21.757; p=0.0006). Suicidal intent for the index episode was reported by 119 (77.78%) and guilt by 116 (75.8%) (Table 2).

Stressful life events and psychological distress

Family conflict (41; 26.8%), marital conflict (37; 24.2%) and financial difficulties (25; 16.3%) were the most frequently reported stressful life events. PSLES score was not significantly correlated with reported suicidal intent (ρ=0.170; p=0.090), nor did it differ significantly by reported attempt-lethality category (Kruskal–Wallis H=0.033; p=0.855). Among 101 assessed participants, the mean PHQ-4 score was 1.09; 81 (80.2%) were in the no-distress category, 14 (13.8%) mild, 4 (3.9%) moderate and 2 (1.9%) severe. Anxiety screening was positive in 5 (4.9%) and depression screening in 6 (5.9%) (Table 3).

Suicidality and associations with distress

The mean SBQ-R score was 6.59 among the 101 assessed participants. Eighty-three (82.2%) were classified as low, 15 (14.8%) as moderate and 3 (3.0%) as high in the risk categorization (Table 3). PHQ-4 and SBQ-R scores correlated positively (ρ=0.611; p<0.001). In the reported binary logistic model, PHQ-4 score was associated with the dichotomized SBQ-R outcome (β=0.717; reported odds ratio 2.05; p<0.001), whereas age was not (β=0.035; p=0.196). Intent and attempt lethality did not show a significant correlation (ρ=−0.093; p=0.253), nor did reported guilt and SBQ-R score (ρ=−0.072; p=0.477) (Table 4).

Personal suicide stigma

The reported mean PSSQ total score was 20.86, with subscale means of 9.38 for self-blame, 6.26 for rejection and 5.20 for minimization (Table 3). The multiple-linear-regression results associated female sex with a higher PSSQ score (β=4.276; p=0.041), although the overall model was not statistically significant (F=1.612; p=0.122). PSSQ total score was not significantly correlated with reported index-episode suicidal intent among the 101 assessed participants (ρ=0.139; p=0.167); neither were rejection (ρ=0.126; p=0.208), minimization (ρ=0.083; p=0.409) or self-blame (ρ=0.158; p=0.114). None satisfied the Bonferroni-adjusted significance criterion (Table 5).

Table 1: Sociodemographic Profile of Hospital-Record Cohort (N = 153)

Characteristic	Category	n (%)
Sex	Male	87 (56.9)
	Female	66 (43.1)
Age group	10–19 years	29 (19.0)
	20–39 years	95 (62.0)
	40–59 years	25 (16.4)
	≥60 years	4 (2.6)
Education	No formal education	6 (3.9)
	Primary school	29 (18.9)
	Secondary school	104 (67.9)
	ITI/diploma	4 (2.6)
	Graduate/postgraduate	10 (6.5)
Occupation	Student	7 (4.6)
	Housewife	21 (13.7)
	Unemployed	24 (15.7)
	Employed	98 (64.0)
	Retired	3 (2.0)
Residence	Rural	59 (38.6)
	Urban	94 (61.4)

Table 2: Selected Attempt Characteristics and Recorded Diagnoses (N = 153)

Measure	Category	n (%)
Attempt method	Ingestion	137 (89.5)
	Hanging	9 (5.9)
	Other methods	7 (4.6)
Previous suicide attempts	Yes	12 (7.8)
	No	141 (92.2)
Suicidal intent for index episode	Reported	119 (77.78)
	Not reported	34 (22.22)
Guilt after index attempt	Reported	116 (75.8)
	Not reported	37 (24.2)
Psychiatric diagnosis	No diagnosis recorded	106 (69.3)
	Alcohol use disorder	21 (13.7)
	Major depressive disorder	17 (11.1)
	Schizophrenia/psychotic-spectrum disorders	5 (3.3)
	Adjustment disorder	3 (2.0)
	Intellectual disability with behavioural disturbances	1 (0.7)

Note: "No diagnosis recorded" denotes an undocumented diagnosis and cannot be interpreted as confirmed absence of psychiatric morbidity.

Table 3: Questionnaire Results Among Participants with Standardized Assessments (N = 101)

Measure	Statistic/category	Value
PHQ-4 total	Mean score	1.09
	None (0–2)	81 (80.2%)
	Mild (3–5)	14 (13.8%)
	Moderate (6–8)	4 (3.9%)
	Severe (9–12)	2 (1.9%)
PHQ-4 anxiety subscale	Mean; positive screen	0.53; 5 (4.9%)
PHQ-4 depression subscale	Mean; positive screen	0.54; 6 (5.9%)
SBQ-R	Mean score	6.59
	Low risk	83 (82.2%)
	Moderate risk	15 (14.8%)
	High risk	3 (3.0%)
PSSQ	Reported mean total score	20.86
	Rejection mean	6.26
	Minimization mean	5.20
	Self-blame mean	9.38

Table 4: Selected Associations Involving Suicidality, Distress and Attempt Characteristics

Variables/analysis	Reported effect/test	p value
PHQ-4 vs SBQ-R (n=101)	Spearman $\rho = 0.611$	<0.001
PHQ-4 predicting dichotomized SBQ-R	$\beta = 0.717$; OR = 2.05	<0.001
Age in same logistic model	$\beta = 0.035$; OR = 1.04	0.196
PSLES vs reported suicidal intent	Spearman $\rho = 0.170$	0.090
PSLES by lethality	Kruskal–Wallis H = 0.033	0.855
Intent vs lethality (n=153)	Spearman $\rho = -0.093$	0.253
Guilt vs SBQ-R	Spearman $\rho = -0.072$	0.477
Method vs sex (n=153)	$\chi^2 = 0.636$; df = 2	0.728
Method vs age group (n=153)	$\chi^2 = 6.773$; df = 6	0.342
Previous attempt vs method (n=153)	$\chi^2 = 0.591$; df = 2	0.744

Table 5: Personal Suicide Stigma: Group Comparisons and Associations with Suicidal Intent

PSSQ analysis	Reported statistic	p value
Female PSSQ total (sex-comparison table)	20.74	
Female sex (linear regression)	$\beta = 4.276$	0.041
Age (linear regression)	$\beta = -0.062$	0.118
Overall linear model	$F = 1.612$; $R^2 = 0.082$	0.122
PSSQ total vs intent (n=101) *(After Bonferroni-adjusted α=0.0125)*	Spearman $\rho = 0.139$	0.167
Rejection vs intent (n=101) *(After Bonferroni-adjusted α=0.0125)*	Spearman $\rho = 0.126$	0.208
Minimization vs intent (n=101) *(After Bonferroni-adjusted α=0.0125)*	Spearman $\rho = 0.083$	0.409
Self-blame vs intent (n=101) *(After Bonferroni-adjusted α=0.0125)*	Spearman $\rho = 0.158$	0.114

DISCUSSION

The study combined hospital-record assessment of index suicide attempts with questionnaire evaluation of surviving participants. Ingestion predominated among recorded attempts, and many patients reported suicidal intent and guilt. In the questionnaire subgroup, psychological distress correlated strongly with suicidality scores, while total and domain-specific personal suicide stigma were not significantly correlated with reported suicidal intent.

The predominance of young adults and ingestion methods resembles patterns described in Indian literature on suicidal behaviour.[18,19] Although alcohol use disorder and major depressive disorder were the most frequent documented diagnoses, nearly seven in ten records had no psychiatric diagnosis recorded. Absence of a recorded diagnosis cannot be equated with absence of a psychiatric disorder and limits interpretation of comorbidity patterns. The low prevalence of documented previous attempts must also be considered against possible self-report and record-completeness limitations. A past suicide attempt remains an important clinical history feature, regardless of the non-significant within-cohort comparisons.[20,21]

Family and marital conflict and financial difficulties were common reported stressors, consistent with descriptions of interpersonal and psychosocial adversity in Indian populations.[18,22] The analysis did not identify a significant association of PSLES score with index-event suicidal intent or reported lethality. Stress exposure may still be clinically relevant even when a particular association does not attain statistical significance in a selected sample; no causal conclusion is supported by this design.

The observed association between PHQ-4 and SBQ-R scores suggests that contemporary symptoms of

depression and anxiety co-occurred with greater reported suicidality. This is directionally consistent with literature discussing psychological distress and suicidal thoughts, although a screening-scale association does not establish prediction of future suicide attempts.[23-27] The regression used categories derived from SBQ-R rather than a separately verified direct measure of current suicidal ideation. Accordingly, its reported odds ratio should not be interpreted as the effect of distress on a prospectively observed clinical event.

The PSSQ provides a multidimensional account of personal stigma, with self-blame, minimization and rejection as distinct domains. The lack of statistically significant relationships with reported suicidal intent does not establish an absence of any potential clinical relationship between stigma, distress and treatment engagement. Prior literature links suicide-related stigma with psychological and social experiences and help-seeking.[28-30]

The study used standardized instruments within a real-world tertiary care setting; however, important limitations remain. It was single-centre and cross-sectional, some information was retrospectively abstracted or self-reported, and unreachable or non-consenting individuals were not represented in questionnaire analyses. Telephone assessments could not substitute for complete in-person psychiatric evaluation. A large fraction of records lacked a documented psychiatric diagnosis, and the small size of some comparison groups limited precision. The current findings support attention to both psychological distress and patient experiences of stigma during assessment, without justifying causal claims or a validated individual risk-prediction rule.

CONCLUSION

In patients with a recorded history of suicide attempts at a tertiary care centre in India, ingestion was the most frequently documented attempt method, and many individuals reported suicidal intent and guilt. Psychological distress was positively associated with the SBQ-R measure of suicidality in the assessed subgroup. Personal suicide stigma was measurable across rejection, minimization and self-blame domains but was not significantly correlated with index-episode suicidal intent. These cross-sectional findings support multidimensional clinical assessment but not causal inference.

Declarations

Ethical approval: Institutional Human Ethics Committee, GMERS Medical College and Hospital, Gotri; approval IHEC/25/OUT/SRPG0168, dated 18 February 2025.

Informed consent: Written informed consent was obtained from participants. Data were handled according to institutional confidentiality requirements, and results were reported in aggregate.

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