



Sociodemographic and Clinical Profile of Psychiatric Patients Presenting with Suicidal Ideation and Behaviour: A Hospital-Based Prospective observational Study.

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Abstract

Background: Suicidal ideation and suicidal behaviour are major public health concerns associated with significant morbidity, mortality, and socioeconomic burden worldwide. Psychiatric disorders, adverse life events, substance use, and previous suicidal behaviour are among the most important determinants of suicidality. Understanding the sociodemographic and clinical profile of individuals presenting with suicidality is essential for identifying high-risk groups and developing effective prevention strategies, particularly in low- and middle-income countries such as India. **Objectives:** To assess the sociodemographic and clinical profile of psychiatric patients presenting with suicidal ideation and suicidal behaviour at a tertiary care centre. **Methods:** A hospital-based prospective observational study was conducted in the Department of Psychiatry, Government Hospital for Mental Care and King George Hospital, Visakhapatnam, Andhra Pradesh, India, from February 2024 to January 2025. A total of 90 psychiatric patients aged 18–60 years presenting with suicidal ideation and/or suicidal behaviour were enrolled using consecutive sampling. Sociodemographic characteristics, psychiatric diagnoses, psychiatric and medical comorbidities, adverse life events, past psychiatric history, family history, substance use, and previous suicide attempts were recorded using a structured proforma. Suicidality was assessed using the Mini International Neuropsychiatric Interview–Suicidality module (MINI-S), while overall illness severity was assessed using the Clinical Global Impression–Severity (CGI-S) scale. Descriptive statistics were used to summarize the data. **Results:** The mean age of participants was 35.58 ± 10.75 years, with the majority belonging to the 21–30 years age group (34.4%). Females constituted 54.4% of the study population. More than half of the participants belonged to the upper-lower socioeconomic class (54.4%), and 42.2% had secondary-level education. Most participants were married (75.6%), and housewives represented the largest occupational group (41.1%). Mood disorders were the predominant psychiatric diagnosis, accounting for 81.1% of cases, followed by schizophrenia and other psychotic disorders (14.4%). Substance use disorders were the most common psychiatric comorbidity (12.2%), while diabetes mellitus was the most frequent medical comorbidity (12.2%). Financial difficulties (28.9%) and family-related issues (25.6%) were the most commonly reported adverse life events. A past history of psychiatric illness was present in 60.0% of participants, and 40.0% reported previous suicide attempts. All participants were categorized as high risk according to the MINI-S scale, and the mean CGI-S score was 4.89 ± 0.87 . **Conclusion:** Psychiatric patients presenting with suicidal ideation and suicidal behaviour at a tertiary care centre were predominantly young and middle-aged adults with mood disorders, lower socioeconomic status, significant psychosocial stressors, and a high prevalence of previous psychiatric illness and prior suicide attempts. Comprehensive assessment of sociodemographic factors, psychiatric diagnoses, adverse life events, and suicide-related risk factors is crucial for early identification of high-risk individuals and the implementation of targeted suicide prevention strategies. **Keywords:** Suicidal ideation; Suicidal behaviour; Mood disorders; Suicide risk factors; Psychiatric disorders; Tertiary care centre.

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INTRODUCTION

Suicide is a major public health challenge and a leading cause of preventable mortality worldwide. According to the World Health Organization (WHO), more than 720,000 people die by suicide every year, accounting for one death every 40 seconds globally. Suicide represents the fourth leading cause of death among individuals aged 15–29 years and contributes substantially to the global burden of disease, disability, and premature mortality. Importantly, approximately 77% of global suicides occur in low- and middle-income countries, where mental health resources are often limited and access to timely psychiatric care remains inadequate.¹

India contributes significantly to the global burden of suicide because of its large population, rapid socioeconomic transitions, and diverse cultural and psychosocial stressors. Data from nationally representative studies indicate that India accounts for a substantial proportion of suicide deaths worldwide, with suicide rates being particularly high among young adults and economically productive age groups. Factors such as family conflicts, financial difficulties, unemployment, academic stress, interpersonal relationship problems, substance use, and social stigma surrounding mental illness have been identified as important contributors to suicidal behaviour in the Indian context.² Understanding the profile of individuals presenting with suicidality is therefore essential for designing effective prevention strategies and improving mental healthcare services.

Suicidal ideation and suicidal behaviour encompass a broad spectrum ranging from passive thoughts of death and active suicidal ideation to suicide planning, suicide attempts, and completed suicide. Suicidal behaviour is complex and multifactorial, resulting from interactions among biological vulnerabilities, psychiatric disorders, psychological factors, adverse life events, social circumstances, and environmental influences. The presence of suicidal ideation is one of the strongest predictors of future suicide attempts and completed suicide, emphasizing the importance of early identification and comprehensive risk assessment.³

Psychiatric disorders constitute the most significant risk factors for suicide. Mood disorders, particularly major depressive disorder and bipolar disorder, account for a substantial proportion of suicidal behaviour worldwide. Schizophrenia spectrum disorders, substance use disorders, anxiety disorders, personality disorders, and adjustment disorders have also been consistently associated with an increased risk of suicide. In addition to psychiatric diagnoses, factors such as previous suicide attempts, family history of mental illness or suicide, adverse childhood experiences, recent stressful life events, social isolation, chronic medical illnesses, and comorbid substance use further increase suicide risk.⁴

Several studies have highlighted the influence of sociodemographic factors on suicidality. Younger age, female gender, low educational attainment, unemployment, lower socioeconomic status, marital disruption, and lack of social support have been associated with higher rates of suicidal ideation and attempts in various populations. However, these associations vary across geographical regions and cultural settings, underscoring the importance of context-specific research.⁵ Identifying high-risk sociodemographic groups can facilitate targeted screening, early intervention, and allocation of mental health resources.

Adverse life events play a pivotal role in the development and exacerbation of suicidal behaviour. Financial crises, relationship conflicts, bereavement, family disputes, academic and occupational stress, physical illness, and experiences of abuse have been identified as common precipitants of suicidal acts. The cumulative burden of these stressors, particularly in individuals with underlying psychiatric disorders, may significantly increase the risk of suicidal behaviour.⁶ Comprehensive assessment of adverse life events and psychosocial factors is therefore an essential component of suicide risk evaluation.

Although substantial evidence exists regarding suicide risk factors in specific psychiatric disorders, there remains limited information on the overall sociodemographic and clinical profile of patients presenting with suicidal ideation and suicidal behaviour in tertiary care settings in India. Tertiary care centres often manage patients with severe psychiatric illnesses, multiple comorbidities, significant psychosocial stressors, and recurrent suicidal behaviour, making them important settings for understanding the characteristics of high-risk individuals. A detailed evaluation of sociodemographic characteristics, psychiatric diagnoses, comorbidities, adverse life events, family history, and previous suicidal behaviour may provide valuable insights for the development of targeted prevention strategies and individualized management approaches.⁷

Therefore, the present study was undertaken to assess the sociodemographic and clinical profile of psychiatric patients presenting with suicidal ideation and suicidal behaviour at a tertiary care centre and to identify factors associated with increased suicide risk in this vulnerable population.

AIM

To assess the sociodemographic and clinical profile of psychiatric patients presenting with suicidal ideation and suicidal behaviour at a tertiary care centre.

OBJECTIVES

Primary Objectives

- 1) To describe the sociodemographic characteristics of psychiatric patients presenting with suicidal ideation and suicidal behaviour, including age, gender, educational status, marital status, occupation, family type, socioeconomic status, and religion.
- 2) To determine the distribution of psychiatric diagnoses and the severity of suicidality among study participants using standardized assessment tools.

Secondary Objectives

- 1) To evaluate the prevalence of psychiatric and medical comorbidities among patients presenting with suicidal ideation and suicidal behaviour.
- 2) To assess the association of adverse life events, past psychiatric illness, family history of mental illness, family history of suicide, substance use disorders, and previous suicide attempts with suicidality.

MATERIALS AND METHODS

Study Design

Hospital-based prospective observational study.

Study Setting

The study was conducted in the Department of Psychiatry at Government Hospital for Mental Care and King George Hospital, Visakhapatnam, Andhra Pradesh, India.

Study Duration

The study was conducted over a period of one year from February 2024 to January 2025.

Study Population

Psychiatric patients presenting with suicidal ideation and/or suicidal behaviour to the Department of Psychiatry during the study period.

Sample Size

A total of 90 participants were enrolled in the study.

Sampling Technique

Consecutive sampling was employed to recruit eligible participants who fulfilled the inclusion and exclusion criteria during the study period.

Inclusion Criteria

- Patients aged between 18 and 60 years.
- Patients presenting with suicidal ideation and/or suicidal behaviour.
- MINI-International Neuropsychiatric Interview–Suicidality (MINI-S) score greater than 8.
- Patients willing to provide written informed consent.
- In cases where the patient lacked decision-making capacity, consent was obtained from a legally acceptable representative.

Exclusion Criteria

- Patients with severe cognitive impairment or intellectual disability that interfered with assessment.
- Patients with severe neurological disorders affecting mental status.
- Patients with severe medical illness requiring intensive medical management.
- Patients with acute intoxication or severe withdrawal states requiring emergency intervention.
- Pregnant or lactating women.
- Patients unwilling to participate in the study.

Study Instruments

1. General Information Sheet

A predesigned questionnaire was used to collect sociodemographic details and relevant clinical information.

2. Semi-Structured Clinical Proforma

The proforma recorded psychiatric diagnoses, comorbidities, adverse life events, and suicide-related factors.

3. Mini International Neuropsychiatric Interview–Suicidality Module (MINI-S)

The MINI-S is a structured interview tool based on DSM-5 and ICD-10 criteria that assesses the severity of suicidality. Scores are categorised as:

- *Low risk: 1–8
- * Moderate risk: 9–16
- * High risk: ≥ 17

4. Columbia-Suicide Severity Rating Scale (C-SSRS)

The C-SSRS assesses suicidal ideation and suicidal behaviour across four domains:

- * Severity of suicidal ideation
- * Intensity of suicidal ideation
- * Suicidal behaviour
- * Lethality of suicide attempts

5. Clinical Global Impression–Severity Scale (CGI-S)

The CGI-S evaluates the overall severity of psychiatric illness on a seven-point scale ranging from “normal” to “among the most extremely ill patients.”

Statistical Analysis

Data were entered into Microsoft Excel and analysed using Statistical Package for the Social Sciences (SPSS) version 22.0. Continuous variables were summarised as mean $\pm$ standard deviation (SD) or median with interquartile range (IQR), depending on data distribution. Categorical variables were expressed as frequencies and percentages. Normality of continuous variables was assessed using the Shapiro–Wilk test. Comparisons between groups were performed using: Independent t-test for normally distributed continuous variables. Mann–Whitney U test for non-normally distributed continuous variables. Chi-square test or Fisher’s exact test for categorical variables. A two-tailed p-value of less than 0.05 was considered statistically significant.

Ethical Considerations

The study protocol was approved by the Institutional Ethics Committee prior to commencement. Written informed consent was obtained from all participants or their legally acceptable representatives. Confidentiality and anonymity of all study participants were maintained throughout the study.

RESULTS

A total of 90 psychiatric patients presenting with suicidal ideation and/or suicidal behaviour were enrolled in the study. Baseline sociodemographic and clinical characteristics were analysed to describe the profile of patients with suicidality. Since this article focuses on patient characteristics, only baseline variables were included in the analysis.

Table 1. Sociodemographic Characteristics: Age, Gender, and Family Type (n = 90)

Variable	Category	Frequency (n)	Percentage (%)
Age group (years)	<20	5	5.6
	21–30	31	34.4
	31–40	24	26.7
	41–50	23	25.6
	51–60	7	7.8
Gender	Male	41	45.6
	Female	49	54.4
Family type	Nuclear	90	100.0
	Joint	0	0.0

Mean age: 35.58 $\pm$ 10.75 years

Interpretation: Most participants were aged 21–30 years (34.4%), followed by 31–40 years (26.7%). Females constituted a slight majority (54.4%). All participants belonged to nuclear families, suggesting limited availability of extended family support systems.

Table 2. Sociodemographic Characteristics: Socioeconomic Status and Religion (n = 90)

Variable	Category	Frequency (n)	Percentage (%)
Socioeconomic status	Upper middle	22	24.4
	Lower middle	19	21.1
	Upper lower	49	54.4
Religion	Hindu	82	91.1
	Muslim	5	5.6
	Christian	3	3.3

Interpretation: More than half of the participants belonged to the upper-lower socioeconomic class (54.4%). The majority were Hindus (91.1%), reflecting the local population distribution.

Table 3. Educational Status, Marital Status, and Occupation (n = 90)

Variable	Category	Frequency (n)	Percentage (%)
Educational status	Illiterate	10	11.1
	Primary education	20	22.2
	Secondary education	38	42.2
	Higher secondary	6	6.7
	Graduate/Professional	16	17.8
Marital status	Married	68	75.6
	Unmarried	15	16.7
	Divorced	4	4.4
	Widowed	3	3.3
Occupation	Housewife	37	41.1
	Labourer	18	20.0
	Professional/Technical	13	14.4
	Farmer	6	6.7
	Student	4	4.4
	Unemployed	3	3.3
	Others	9	10.0

Interpretation: Secondary-level education was the most common educational attainment (42.2%). Most participants were married (75.6%), and housewives constituted the largest occupational group (41.1%), followed by labourers (20.0%).

Table 4. Distribution of Psychiatric Diagnoses (n = 90)

Psychiatric Diagnosis	Frequency (n)	Percentage (%)
Mood disorders	73	81.1
Schizophrenia and other primary psychotic disorders	13	14.4
Obsessive-compulsive disorder	2	2.2
Adjustment disorder	2	2.2

Interpretation: Mood disorders were the predominant psychiatric diagnosis, accounting for 81.1% of participants, followed by schizophrenia and other psychotic disorders (14.4%).

Table 5. Psychiatric and Medical Comorbidities (n = 90)

Table 5A. Psychiatric Comorbidities

Category	Frequency (n)	Percentage (%)
None	67	74.4
Substance use disorders	11	12.2
Obsessive-compulsive disorder	4	4.4
Multiple psychiatric comorbidities	5	5.6
Others*	3	3.3

*Somatoform disorder, mild intellectual developmental disorder, and borderline personality disorder.

Table 5B. Medical Comorbidities

Category	Frequency (n)	Percentage (%)
None	75	83.3
Diabetes mellitus	11	12.2
Hypertension	1	1.1
Diabetes mellitus + Hypertension	3	3.3

Interpretation: Most participants had no psychiatric (74.4%) or medical (83.3%) comorbidities. Substance use disorders were the most frequent psychiatric comorbidity, while diabetes mellitus was the most common medical comorbidity.

Table 6. Adverse Life Events Among Participants (n = 90)

Adverse Life Event	Frequency (n)	Percentage (%)
Financial issues	26	28.9
Family-related issues	23	25.6
Relationship issues	11	12.2
Death of family member/relative	8	8.9
Multiple adverse events	8	8.9
Work/Education stress	3	3.3
Abuse	3	3.3
Health issues	2	2.2
None	6	6.7

Interpretation: Financial difficulties (28.9%) and family-related problems (25.6%) were the most frequently reported adverse life events among participants presenting with suicidality.

Table 7. Past Psychiatric Illness and Previous Suicide Attempts (n = 90)

Variable	Category	Frequency (n)	Percentage (%)
Past psychiatric illness	Present	54	60.0
	Absent	36	40.0
Previous suicide attempts	Present	36	40.0
	Absent	54	60.0

Interpretation: A majority of participants had a past history of psychiatric illness (60.0%), and 40.0% reported at least one previous suicide attempt, highlighting the recurrent nature of suicidality in psychiatric disorders.

Table 8. Baseline Severity of Suicidality and Clinical Illness (n = 90)

Variable	Frequency (n)	Percentage (%)
MINI-S high-risk category (≥ 17)	90	100.0
CGI-S mildly ill (score 3)	6	6.7
CGI-S moderately ill (score 4)	29	32.2
CGI-S markedly ill (score 5)	24	26.7
CGI-S severely ill (score 6)	31	34.4

Mean CGI-S score: 4.89 ± 0.87

Interpretation: All participants belonged to the high-risk MINI-S category, indicating severe suicidality at presentation. More than 60% of participants were rated as markedly or severely ill on the CGI-S scale.

Summary of Key Findings

The study population consisted predominantly of young to middle-aged adults, females, individuals from upper-lower socioeconomic backgrounds, and married participants. Mood disorders constituted the most common psychiatric diagnosis. Financial stress, family-related issues, previous psychiatric illness, and prior suicide attempts emerged as prominent characteristics among patients presenting with suicidal ideation and suicidal behaviour.

DISCUSSION

The present study evaluated the sociodemographic and clinical profile of psychiatric patients presenting with suicidal ideation and suicidal behaviour at a tertiary care centre. The study included 90 participants, all of whom were categorized as high risk for suicidality according to the MINI-S scale at baseline. The findings highlight the complex interaction

between sociodemographic characteristics, psychiatric disorders, adverse life events, and previous suicidal behaviour in individuals presenting with suicidality. The mean age of participants in the present study was 35.58 ± 10.75 years, with the majority belonging to the 21–30 years age group (34.4%), followed by the 31–40 years age group (26.7%). These findings indicate that suicidality predominantly affects young and middle-aged adults, who constitute the economically productive segment of the population. Similar findings were reported by Nock et al., who demonstrated that suicidal ideation and suicide attempts are more common among younger adults across different countries.⁸ Vijayakumar et al. also observed that suicide rates in India are disproportionately higher among young adults owing to psychosocial stressors, employment challenges, interpersonal conflicts, and limited access to mental health services.⁹

Females constituted a slight majority in the present study (54.4%). This observation is consistent with the well-established pattern that women report higher rates of suicidal ideation and non-fatal suicide attempts, whereas men exhibit higher rates of completed suicide. The predominance of female participants may be attributable to greater help-seeking behaviour, increased prevalence of mood disorders among women, and heightened vulnerability to interpersonal and family-related stressors. Beautrais reported that female gender is associated with an increased prevalence of suicidal ideation and attempts, particularly in the presence of psychiatric illness and psychosocial adversity.¹⁰ More than half of the participants belonged to the upper-lower socioeconomic class (54.4%), and the majority had secondary-level education or below (75.5%). These findings suggest that lower socioeconomic status and limited educational attainment may contribute significantly to suicidality. Financial instability, unemployment, poor access to healthcare, and reduced social opportunities may increase psychological distress and vulnerability to suicidal behaviour. Consistent with our findings, Lorant et al. demonstrated that socioeconomic inequalities are strongly associated with an increased risk of suicidal behaviour and suicide mortality.¹¹

The majority of participants in the present study were married (75.6%), and housewives constituted the largest occupational group (41.1%). Although marriage is generally considered a protective factor against suicide, marital discord, family conflicts, domestic responsibilities, and interpersonal stress may negate this protective effect in certain populations. The predominance of housewives among participants may reflect the influence of gender-specific sociocultural factors, dependence on family support systems, and limited economic autonomy. Similar observations have been reported in Indian studies, where marital and family-related stressors were identified as major contributors to suicidal behaviour among women.¹² Mood disorders were the predominant psychiatric diagnosis in the present study, accounting for 81.1% of participants, followed by schizophrenia and other psychotic disorders (14.4%). This finding reinforces the strong association between mood disorders and suicidality. Depressive symptoms such as hopelessness, guilt, anhedonia, impaired problem-solving abilities, and emotional dysregulation substantially increase suicide risk. Turecki and Brent reported that mood disorders are among the most important predictors of suicidal behaviour, accounting for a significant proportion of suicide attempts and deaths worldwide.¹³

Substance use disorders were the most common psychiatric comorbidity, observed in 12.2% of participants. Substance use may increase suicide risk by impairing judgment, increasing impulsivity, worsening psychiatric symptoms, and reducing adherence to treatment. Additionally, diabetes mellitus was the most common medical comorbidity in the present study (12.2%). Chronic medical illnesses may contribute to suicidality through increased psychological distress, functional impairment, and reduced quality of life. Poor physical health, especially when associated with psychiatric illness, has been consistently identified as an important risk factor for suicide.¹⁴ Adverse life events emerged as significant contributors to suicidality in the present study. Financial difficulties (28.9%) and family-related problems (25.6%) were the most frequently reported stressors. Relationship issues, bereavement, occupational stress, abuse, and health-related concerns were also commonly identified. These findings underscore the importance of psychosocial stressors as proximal triggers for suicidal behaviour. O'Connor and Kirtley proposed that stressful life events, when combined with underlying psychiatric vulnerability and deficient coping mechanisms, significantly increase the likelihood of suicidal ideation and behaviour.¹⁵

A substantial proportion of participants had a past history of psychiatric illness (60.0%), while 40.0% reported at least one previous suicide attempt. Previous suicidal behaviour is one of the strongest predictors of future suicide attempts and completed suicide. The recurrence of suicidal behaviour observed in the present study highlights the need for long-term monitoring and comprehensive management of high-risk individuals. Franklin et al., in a meta-analysis of suicide risk factors, identified previous suicide attempts as one of the most robust predictors of future suicidal behaviour across different populations and psychiatric diagnoses.¹⁶ All participants in the present study were categorized as high risk according to the MINI-S scale, and the mean CGI-S score was 4.89 ± 0.87 , indicating moderate-to-severe psychiatric illness. More than 60% of participants were rated as markedly ill or severely ill, reflecting the high clinical burden among individuals presenting to tertiary care settings. These findings emphasize the importance of early identification, comprehensive risk assessment, and multidisciplinary intervention strategies for patients presenting with suicidality.

Overall, the present study demonstrates that suicidality in psychiatric patients is associated with a complex interplay of sociodemographic disadvantages, psychiatric disorders, psychosocial stressors, medical comorbidities, and previous suicidal behaviour. Understanding these factors may facilitate the development of targeted prevention strategies, improve risk stratification, and enhance the delivery of mental healthcare services for vulnerable populations.

CONCLUSION

The present study provides a comprehensive overview of the sociodemographic and clinical characteristics of psychiatric patients presenting with suicidal ideation and suicidal behaviour at a tertiary care centre. The findings demonstrate that suicidality predominantly affects young and middle-aged adults, with a slight female predominance and a higher representation of individuals from lower socioeconomic backgrounds and those with limited educational attainment. Mood disorders emerged as the most common psychiatric diagnosis, followed by schizophrenia spectrum disorders, reaffirming the strong association between psychiatric illness and suicidal behaviour. Substance use disorders were the most frequent psychiatric comorbidity, while diabetes mellitus was the most common medical comorbidity. Financial difficulties, family-related problems, and relationship issues were identified as major adverse life events associated with suicidality.

A substantial proportion of participants had a previous history of psychiatric illness and prior suicide attempts, highlighting the recurrent nature of suicidal behaviour and emphasizing the importance of long-term follow-up in high-risk individuals. All participants were categorized as having high suicide risk according to the MINI-S scale, and most were rated as markedly or severely ill on the Clinical Global Impression scale, indicating the significant clinical burden among patients presenting to tertiary care settings. These findings underscore that suicidal behaviour results from a complex interplay of sociodemographic vulnerabilities, psychiatric disorders, psychosocial stressors, comorbid conditions, and previous suicidal behaviour. Early identification of high-risk individuals through comprehensive biopsychosocial assessment is essential for effective suicide prevention.

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