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Original Article

Assessment of Suicidal Ideation in Psychiatry Outpatient Department Patients: A crosssectional study

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Abstract

Background: Mental disorders occupy a premier position in the matrix of causation of suicide. Suicidal ideation among psychiatric patients is a less explored topic in India. **Aim:** The aim of this study is to study the prevalence and clinical correlates of suicidal ideation in patients attending psychiatry outpatient department (OPD). **Materials and Methods:** This cross-sectional study was conducted in the psychiatry outpatient department of a tertiary care hospital. Beck's suicide intent scale was used to quantify suicidal ideation. Beck's Hopelessness scale and Depression, Anxiety and Stress Scale were used to study levels of hopelessness, depression, anxiety, and stress in patients. Groups with and without suicidal ideations were compared on different variables. **Results:** Suicidal ideation was present in 36% of psychiatry OPD patients. Out of these 13% patients had previous suicidal attempts. Most of them attempted suicide once. Majority had either fleeting suicidal ideas or passive death wish, with poisoning noted as the most common method of attempted suicide. Suicidal ideation had a statistically significant association with levels of depression, anxiety, and stress. Highest stress levels were found in anxiety disorders. Suicidal ideation was commonly observed in patients with depression and other mood disorders and those with previous attempts. More than half of the patients with suicidal ideation never sought help. **Conclusion:** Increasing levels of depression, anxiety, stress, and hopelessness were associated with increased suicidal ideation. Substance use, history of psychiatric illness, triggering stressor, and low perceived social support were also associated with suicidal ideation in psychiatric patients.

Keywords: *Anxiety, depression, hopelessness, stress, suicidal ideation, suicidal ideation*

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Introduction

The history of suicide dates back to the history of man himself. Throughout history, suicide has been praised, glamorized, deplored, and even criticized. Suicide finds a mention in the epics like Ramayana and Mahabharata.[1] Suicide is a very important issue for India. In 2019, one Indian died by suicide every 4 min. Out of 139,123 suicidal deaths every year in India, the majority (41.97%) are committed by people who are <30 years old. Persons <45 years of age make up 73.4% of suicides in India resulting in a huge financial, social, and emotional burden on society.[2] Process models of suicide propose a continuum of risk for attempting suicide that starts with suicidal ideation. These models indicate that only a small fraction of subjects with suicidal ideation actually make a plan, and only a small percentage of persons with a plan progress to attempting suicide. Despite the limited number of studies of the impact of desire for death on the risk for future suicide, some studies indicate that desire for

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death may be a principle predictor of future suicide.[3] In addition, when the desire for death exceeds the wish to live, the seriousness of suicidal intent (SI) during a suicide attempt may be greater. These findings suggest that suicidal ideation is not the only starting point on the trajectory to making a suicide attempt, and thus assessing desire for death in people who deny suicidal thoughts would be clinically useful. Questioning persons regarding desire for death has the same significance as evaluating suicidal ideation to gauge the risk for suicide attempts. Assessing both desire for death and suicidal ideation is probably the best marker for predicting lifetime suicide attempts.[4]

A previous history of a suicide attempt is considered one of the best predictors of a future suicidal attempt and also for completed suicide. Furthermore, having made more than one suicide attempt increases the risk for further attempts. Various mechanisms have been proposed to decipher the increased risk due to multiple attempts. One explanation is that multiple attempts represent persistent on-going risk factors. Confirming and understanding the association could be of immense value because it may point to clinical features of an attempt that are indicative of greater future risk.[5] Beck noted that when depressed patients cannot foresee any way out of grave issues in life, they tend to consider suicide as an escape out of an unbearable situation. As per Beck, hopelessness is a core element of depression and it acts as the bridge connecting depression to suicide.[5] SI is more significantly associated with hopelessness than depression. Hopelessness was found to be the moderator variable which linked depression to SI.[6] A study in 384 hospitalized suicide attempters showed that hopelessness represented 76% of the association of depression and SI.[7]

History of (mostly untreated) major mood disorders (particularly in the presence of prior suicide attempt) constitutes the most important of the modifiable psychiatric conditions. Although only a small minority of depressed patients die by suicide, almost one in two/three of them make a suicidal attempt. Additional contributory factors include lack of jobs and acute stressors and clinical factors such as depression, impulsivity, hopelessness, and guilt.[8] Although suicide is an intensely personal and individual act, suicidal behavior is determined by various individual and social factors. Majority of studies claim that 90% of people who die by committing suicide have a psychiatric illness.[9] Due to the paucity of Indian studies in this area, the present study was conducted to study the prevalence and clinical correlates of suicidal ideation in patients attending psychiatry outpatient department (OPD).

Materials and Methods

This cross-sectional analytical study was conducted from September 2017 to August 2019 at a tertiary care hospital attached to a medical college. Institutional Ethics Committee clearance was obtained before the start of the study (DPU/R and R(M)/31/(84)/2018 dt January 12, 2018).

Sample

All the patients attending psychiatry OPD during the period of the study and fulfilling the inclusion and exclusion criteria were included in the study.

Inclusion criteria

- Above 18 years of age
- Consenting for the study.

Exclusion criteria

- Intellectual disability
- Dementia
- Other medical illness which prevented the subjects from cooperating or participating in the study.

Tools used

Socio demographic questionnaire

This was specially designed to document sociodemographic profile and clinical details of the patients.

Beck's Suicide Intent Scale

This 19-item scale is used to identify a patient at significant risk and to monitor patient's response to interventions. Total score ranges from 0 to 38. Scores in the range of 15–19 imply low SI; 20–28 represent medium intent, whereas scores of 29 and above indicate high SI in patients. The coefficient alpha of Beck's Suicide Intent Scale (BSIS) was 0.89. The inter-rater reliability coefficient was 0.83 ($P < 0.001$).[10]

Depression, Anxiety, Stress Scale 21

The Depression, Anxiety, Stress Scale 21 (DASS 21) is a self-rated inventory comprising of 21 items. The Cronbach's alpha was 0.897 for the anxiety scale, 0.947 for the depression scale, 0.933 for the stress scale, and 0.966 for the total score. To examine the convergent and discriminant validity of the DASS, correlations were calculated between each of the DASS scales and the sAD (The Personal Disturbance Scale). The DASS depression scale correlated highly with sAD depression (0.78). The DASS anxiety scale correlated highly with sAD anxiety (0.72).[11]

Hopelessness scale of Beck et al.

It comprises of 20 statements which are answered true or false. As general, guideline 0–3 is within normal range, 4–8 is mild, 9–14 is moderate, and more than

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14 is severe. The scale has a good reliability (test-retest, $r = 0.81$) and a good internal consistency (alpha = 0.97) for depressive subjects and (alpha = 0.79) for controls. It also shows a good concurrent validity with other scales assessing depressive cognitions.[12]

Procedure

All the participants included in the study were explained the purpose of this survey, and the collected information was anonymous and confidential and written informed consent was obtained. All the patients were interviewed, and the demographic and clinical details were filled up. Patients were evaluated, and the psychiatric diagnosis was established by ICD 10 DCR[13] by two psychiatrists independently. Thereafter, all the scales were administered individually to the patients.

Statistical analysis

Data were analyzed using the SPSS software 21 (IBM, Chicago, USA). Frequency data were analyzed using the Chi-square test. Ordinal data between the two groups were compared using the Mann–Whitney U-test. Spearman's rho was used for correlation between two scales. P <0.05 was considered for statistical significance.

Results

A total 400 patients were recruited for the study. Mean (±standard deviation [SD]) (range) of age of the patients was 37.89 (±12.69) (18–75) years. Demographic characteristics of the patients are given in Table 1. Diagnoses and clinical characteristics are given in Table 2. On the BSIS scale mean (± SD) (range) of scores was 6.95 (±7.50) (0–30). On BHS, mean (±SD) (range) of score was 7.3 (±3.57) (0–16). On the DASS mean (±SD) (range) of score of depression, anxiety, and stress were 9.03 (±6.97), (0–34); 6.64 (±5.09) (0–26); and 12.13 (±6.56) (0-36), respectively. Distribution of BSIS, BHS, and DASS scores is shown in Table 3. The correlation between BSIS, BHS, and DASS scores is given in Table 4. The association between demographic characteristics and SI as per BSIS is given in Table 5. On the BSIS, 61.7% of patients with depression had SI. Other diagnoses had lower percentage of patients showing SI [Table 6]. A multiple regression by stepwise method was run to predict suicidal ideation from age, gender, Beck's hopelessness scale scores, previous history of DSH, and past history of psychiatric illness. These variables statistically significantly predicted suicidal ideation, $F(5, 394) = 91.898$, $P < 0.000$, $R^2 = 0.538$. All five variables added statistically significantly to the prediction, $P < 0.05$ [Table 7].

Discussion

Majority of the patients were in the age group of 18–35 years, followed by the age group of 36–50 years. Psychiatric illnesses usually present in the early 20s to late 30s,[14] the age distribution can be understood in this context. The sex distribution of the patients is consistent with a pattern of male gender receiving more, better and professional health care than females, as seen in some earlier research from India.[15,16] Majority of patients in the study were married, followed by those who were unmarried while 8.5% were separated from their spouse. This can be explained by the fact that the mean age of patients was 37.89, by which time majority of men and women are married. Even in comparison with other developing nations, India has one of the lowest ages

Table 1: Demographic characteristics of the patients attending psychiatry outpatient department

	Frequency (%)
Age	
18-35	201 (50.2)
36-50	136 (34.0)
51-65	52 (13.0)
>65	11 (2.8)
Sex	
Male	212 (53)
Female	188 (47)
Marital status	
Married	242 (60.5)
Separated	34 (8.5)
Single	110 (27.5)
Widow	14 (3.5)
Education	
Illiterate	47 (11.8)
Primary	54 (13.5)
Secondary	166 (41.5)
Graduate	115 (28.7)
Postgraduate	18 (4.5)
Occupation	
Unemployed	172 (43.0)
Employed	168 (42.0)
Farmer	34 (8.5)
Student	26 (6.5)
Family type	
Joint	125 (31)
Extended	20 (5)
Nuclear	255 (64)
Domicile	
Urban	303 (76)
Rural	97 (24)
Family income (Rs./month)	
<10,000	188 (47)
10,000-25,000/	187 (46)
>25,000	25 (7)

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Table 2: Past history, family history, clinical characteristics and psychiatric diagnoses of the patientsattending psychiatry outpatient department

	Frequency (%)
Previous suicide attempt	
Yes	50 (12.5)
No	350 (87.5)
Number of suicide attempts (*n*=50)	
One attempt	30 (60)
Two attempts	14 (28)
Three or more attempts	6 (12)
Method of suicide attempt	
Poisoning	28 (36)
Drug overdose	14 (18)
Hanging	12 (16)
Jumping	12 (16)
Cutting	11 (14)
Current suicidal ideation	
Active suicidal ideation	18 (4.5)
Fleeting suicidal ideation	63 (15.75)
Passive death wish	63 (15.75)
No active/passive death wish	256 (64)
Told some one about suicidal ideation	
Yes	65 (45)
No	79 (55)
Significant stressor	
Present	114 (28)
Absent	286 (72)
Family history of psychiatric illness	
Present	58 (15)
Absent	342 (85)
Psychiatric diagnoses (ICD 10)	
Schizophrenia	79 (19.8)
Depression	94 (23.5)
BMD	39 (9.8)
Anxiety disorder	30 (7.5)
Substance use	41 (10.3)
Adjustment d/s	21 (5.3)
ATPD	15 (3.8)
Mixed A/D	15 (3.8)
Somatoform d/s	15 (3.8)
OCD	11 (2.8)
Schizoaffective d/s	11 (2.8)
Sleep disorder	9 (2.3)
Dissociative d/s	8 (2.0)
Delusional disorder	7 (1.8)
Sexual dysfunction	5 (1.3)

OCD: Obsessive-compulsive disorder, ATPD: Acute and transient psychotic disorder, BMD: Bone mineral density, ICD: International classification of diseases

at marriage. Married individuals with higher levels of distress, alcohol use, or psychiatric disorders are more likely to divorce which explains the high separation rate.[17] Mental illness has an influence on marital status in two ways: Neurotic disorders significantly increase the probability of an individual remaining single; while psychosis significantly raises the probability of the person having a divorce or a separation. This relation between psychiatric disorders and marital status can also be understood in the opposite way-divorce as a stressor makes psychotic disorders and other mental illnesses more likely to occur, whereas becoming widowed can predispose to neurosis. This has an effect on individual's finances and affects his ability to get married or maintain a cordial marital relation.[18] In fact, marriage or marital conflict may sometimes itself act as a stressor, thereby predisposing to mental illness.

A large majority of the patients (76%) were from urban background since the hospital is located in an urban area. Majority of patients had completed secondary education, and the next largest group comprised of graduates. Only a small proportion of patients could complete postgraduation. The findings of the educational status can be understood in the context that the hospital caters to patients mainly belonging to lower or lower middle strata of society, where higher education is less common. The study group consisted of 43% unemployed patients. Most of the women from lower to middle class background were homemakers, which explain a significant proportion of the unemployed class of patients. Active psychosis/serious and distressing neurotic spectrum disorders are also the reasons of not being occupationally functional. These findings can also be discussed from another perspective. Young people suffering from psychiatric illness are unlikely to pursue higher education. As a result, people with SMI are deprived of opportunities in jobs that require higher education.[19] Attitude of society toward people with psychiatric illnesses, as also the nature of the psychiatric symptoms, further add to the difficulties faced by this segment of the population.[19,20] Hallucinations, depression, mania, or anxiety symptoms are all known to have an impact on functioning in major life arenas such as family, work, and education. Moreover, these symptoms frequently lead to further impairments in societal competence, proficiency of work, and the ability to take on adult roles and responsibilities. People with psychiatric disabilities encounter pre-set assumptions that these individuals are incapable of working, living in an independent manner or attending school, and often they themselves accept these assumptions as a fact. Estimates of unemployment among adults suffering from SMI range from 70% to 90%.[21]

In this study, 93% of patients had monthly family income up to 25,000 rupees. The finding is in accordance with previous studies which observed that people in lower income group were more likely than high earners

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to suffer from common mental illnesses. Low income may directly act as a predisposing factor for mental disorders (due to increased probability of known risk factors such as adverse life events and lack of any social support). In addition, people with mental disorders are more likely to lose their jobs or to be in low paying employment. Patients with mental illness experience widespread social exclusion while seeking homes, jobs, and education. Their woes may be further escalated by financial exclusion-inadequate access to recognized financial services and not being allowed to use it in an appropriate way.[22]

Table 3: Distribution of patients as per scores on Becks Suicide Intent Scale, Beck's Hopelessness Scale and Depression, Anxiety, Stress Scale

	Frequency (%)
BSIS Scale	
No intent	299 (74.8)
Low intent	71 (17.8)
Medium intent	29 (7.2)
High intent	1 (0.2)
BHS Scale	
Normal	71 (17.8)
Mild	190 (47.5)
Moderate	126 (31.5)
Severe	13 (3.2)
DASS-depression	
Normal	228 (57.0)
Mild	84 (21.0)
Moderate	59 (14.8)
Severe	25 (6.3)
Extremely severe	4 (1.0)
DASS-anxiety	
Normal	229 (57.3)
Mild	65 (16.3)
Normal	77 (19.3)
Severe	25 (6.3)
Extremely severe	4 (1.0)
DASS-stress	
Normal	265 (66.3)
Mild	65 (16.3)
Moderate	56 (14.0)
Severe	13 (3.3)
Extremely severe	1 (0.3)

DASS: Depression, Anxiety, Stress Scale, BSIS: Becks Suicide Intent Scale, BHS: Beck's Hopelessness Scale

Previous suicidal attempt

Previous suicidal attempt was present in 12.5% of the patients. Poisoning was the most common method of attempted suicide, followed by drug overdose, hanging, jumping, and cutting. Previous suicide attempt is a major risk factor for eventual suicide, and those who attempt suicide are at a higher risk of further attempts.[23] A large proportion of people who attempted suicide will reattempt in the 6 months, and as a group, they have a high risk of eventually killing themselves.[24] Over a follow-up period of 5–35 years, it is seen that the risk of suicide after an unsuccessful previous attempt is approximately 10%.[25] Most attempted suicides involve self-poisoning or cutting.[26] The findings of this study are in congruence with the findings of an earlier study, where poisoning, hanging, cutting, and jumping were the common methods of suicidal attempts and poisoning was found to be the most common method.[16,27,28] However, in addition to the above-mentioned methods, firearms/explosives, drowning, and gassing were also noted which was not found in our study due to differences in population studied.[27,29]

Current suicidal ideation

The finding of 36% of patients having suicidal ideation is in agreement with the findings of an earlier study which observed that suicidal ideation in 55% of psychiatric outpatients.[30] The high prevalence of suicide ideation in this study is in contrast to the findings of low prevalence rates of 4% and 10%, respectively, in few studies.[31,32] Suicidal ideation/attempts are predominately a secretive event. In the present study, merely, 45% of individuals ever told someone about their suicidal ideation. This is similar to the finding of an earlier study that only 22% of the patients communicated their SI.[30] Another study also found that approximately two-thirds of adolescent suicide attempters in a high school did not inform anyone before their attempt and one-third did not tell anyone even after their attempt.[33] Since patients are noncommunicative regarding suicide attempts, clinicians must inquire directly about suicidal behaviors and ideations. This suggests that a self-rating survey of suicidal behaviors might be particularly useful to address this area.[30]

The finding of 28% of patients having a significant stressor at the time of evaluation is in consonance with the observation that different interpersonal stressors

Table 4: Correlation between Becks Suicide Intent Scale, Beck's Hopelessness Scale and Depression, Anxiety, Stress Scale

Correlation between	Spearman's rho	*P*	Significance
BSIS and BHS	0.696	0.000	Significant at 0.01 level
BSIS and DASS depression	0.354	0.000	Significant at 0.01 level
BSIS and DASS anxiety	0.104	0.038	Significant at 0.05 level
BSIS and DASS stress	0.211	0.000	Significant at 0.01 level

BSIS: Becks Suicide Intent Scale, BHS: Beck's Hopelessness Scale, DASS: Depression, Anxiety, Stress Scale

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Table 5: Association between demographic and clinical characteristics and suicidal ideation

Characteristics	No intent	Low suicidal intent	Medium to high	Chi square test	*P*
Age (years)					
18-35	143	58	-	3.77	0.287 (NS)
36-50	106	30	-		
51-65	40	12	-		
65	10	1	-		
Gender					
Male	164	31	17	3.06	0.217 (NS)
Female	135	40	12		
Marital status					
Single	76	34	-	2.74	0.434 (NS)
Married	185	57	-		
Separated	27	7	-		
Widow	11	3	-		
Education					
Illiterate	39	7	1	7.54	0.479 (NS)
Primary	41	7	6		
Secondary	121	32	13		
Graduate	87	19	9		
Postgraduate	11	6	1		
Domicile					
Rural	80	13	4	4.33	0.115 (NS)
Urban	219	58	26		
Family type					
Joint	93	23	9	2.81	0.590 (NS)
Extended	18	1	1		
Nuclear	188	47	20		
Family income					
<10,000	141	32	15	10.84	0.028 (S)
10,000-25,000	146	30	11		
25,000	12	9	4		
Previous attempt					
Yes	27	6	17	57.86	<0.00001 (S)
No	272	65	13		
Ever sought help from others					
Yes	42	7	9	7.09	0.029 (S)
No	257	64	21		
Family history of psychiatric illness					
Yes	45	7	6	2.04	0.361 (NS)
No	254	64	24		

NS: Not significant, S: Significant

can increase the risk of suicidal behavior, even after controlling for the effect of mental illness. Interpersonal stressors can manifest in various ways, and several different types of stressors have been linked with suicidal behavior, including romantic issues, family disputes, legal problems, financial loss, non-heterosexual orientation, bullying, etc.[16,28,34,35]

In this study, 15% of those evaluated had a family history of psychiatric illness. A history of psychiatric illness in the family increases suicide risk possibly by increasing the risk for developing a mental illness.[36] However, another study found that a family history of suicide increases risk of suicide and that this effect is independent of familial history of mental disorder.[34]

Out of the total patients assessed for this study, the major group (23.5%) had depression followed by schizophrenia (19.8%), substance abuse disorder (10.3%), bipolar mood disorders, (9.8%) and anxiety disorders (7.5%). This is in agreement with an earlier studies.[16,28,29]

Correlates of suicidal ideation

On the BSIS, 25.2% of the total patients had varying degrees of SI. As per scores on Beck's hopelessness

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Table 6: Percentage of patients having suicidal ideation classified as per their diagnosis

Psychiatric diagnosis according to ICD-10	Total patients	Patients with suicidal intent	Percentage of patients with suicidal intent
Schizophrenia	79	10	12.66
Depression	94	58	61.70
BMD	39	3	7.69
Anxiety disorder	30	2	6.67
Substance use disorder	41	9	21.95
Adjustment disorder	21	3	14.29
ATPD	15	3	20.00
Mixed A/D	15	6	40.00
Somatoform disorder	15	0	0.00
OCD	11	1	9.09
Schizoaffective disorder	11	6	54.55
Sleep disorder	9	0	0.00
Dissociative disorder	8	0	0.00
Delusional disorder	7	0	0.00
Sexual dysfunction	5	0	0.00

OCD: Obsessive-compulsive disorder, ATPD: Acute and transient psychotic disorder, BMD: Bone mineral density, ICD: International classification of diseases

Table 7: Multiple regression for predicting suicidal ideation: Coefficients[a]

Model 5	Unstandardized coefficients		Standardized coefficients	*t*	Significant	95.0% CI for B		Collinearity statistics	
	B	SE	Beta			Lower bound	Upper bound	Tolerance	VIF
Constant	−0.189	1.000		−0.189	0.850	−2.154	1.776		
BHS	1.389	0.074	0.660	18.798	0.000	1.244	1.534	0.950	1.053
Prevdsh	2.483	0.459	0.190	5.406	0.000	1.580	3.386	0.944	1.060
Age	−0.059	0.020	−0.100	−2.904	0.004	−0.099	−0.019	0.988	1.012
Sex	−1.339	0.515	−0.089	−2.598	0.010	−2.351	−0.326	0.994	1.006
Histpsy	−1.033	0.398	−0.090	−2.593	0.010	−1.816	−0.250	0.966	1.035

[a]Dependent variable BSIS. BSIS: Becks suicide intent scale; BHS: Beck's hopelessness scale; Prevdsh: Previous history of deliberate selfharm; Histpsy: Past history of psychiatric illness; SE: Standard error; CI: Confidence interval; VIF: Variance inflation factor

scale, a mere 82.2% some degree of hopelessness, though only a small proportion (3.2%) had severe hopelessness. The association between BHS and BSIS was highly significant statistically, implying that as hopelessness increases, SI also increases. This finding is in agreement with an earlier Indian study.[37]

The association between depression and SI was highly significant, proving that SI increases with rising levels of depression. This is in agreement with earlier studies.[16,28,29,32] The relation between anxiety and SI also was significant statistically, implying that SI increased as anxiety increased, which is in agreement with previous studies.[16,28,29] This finding match the findings that anxiety spectrum disorders are themselves risk factors for suicidal behavior, even if we take into account the comorbid psychiatric illnesses; that the occurrence of a minimum of one single anxiety disorder not accompanied by mood disorder raised the probability of suicidal behavior; and the combination of anxiety disorder and mood disorder increased the possibility of suicidal behavior relative to those with just mood disorder.[38]

Similarly, the association between stress and SI was statistically significant, which shows that increased stress leads to increase in suicidal tendencies. Life stress in general, and family stress in particular, in the form of negative life events and persistent difficulties, are associated with SI.[16,28,29] People who have domestic, financial, or legal issues and who are facing extensive physical health issues are more likely to contemplate suicide.[39]

SI had no statistically significant association with age, gender, marital status, level of education, domicile, and family type in the present study. This is in agreement with two previous Indian studies where level of education, occupation, marital status, or type of family were not associated with suicidal ideation or attempt.[40,41] In the present study, significant statistical association was found between SI and family income, i.e., suicidal ideation was more common in patients whose monthly family income was less than Rs. 10,000 per month. This is in agreement with previous Indian studies.[16,28] and a Malaysian Study.[42] Low level of income increases

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personal problems and reduces well-being resulting in increasing suicidal behavior.[43]

The association of SI with previous attempts was statistically significant, implying that having previous suicidal attempts significantly increases risk of SI in the subjects. This is in agreement with earlier studies which found that previous attempts are the strong predictors of future attempts and also that some ideators, often those with early onset, experience persistent ideation.[44,45]

Suicide attempts are predominately a secretive event: In an American study, only 22% of the patients communicated their intent to commit suicide before making an attempt and only 56% communicated the fact that they had made an attempt after doing so.[30] Another study reported that approximately two-thirds of adolescent suicide attempters in a high school did not inform anyone before their attempt and that approximately one-third did not tell anyone after their attempt.[46] Since patients are noncommunicative regarding suicide attempts, clinicians must inquire directly about suicidal behaviors. This study suggested that a self-rating survey of suicide behaviors might be particularly useful to address this area. Patients who had previously failed to communicate their attempts, may provide this information in response to survey questions.[30]

The findings of the current study differ from previously published work which shows that the risk of suicidal behavior tends to be associated with familial psychopathology.[47] It was further suggested that having a history of psychiatric illness in the family increases suicide risk by increasing the risk for developing a psychiatric illness.[47] An association between suicidal ideation and/or attempt with poor family environment and parental history of psychiatric disorder in addition to other parameters has been reported.[48] However, no such association was found in the present study.

The highest percentage of patients with SI was found in those having depressive disorder (61.6%), followed by schizoaffective disorder (54.55%), mixed anxiety-depression (40%), and substance use disorders (21.95%). Probably, the component of mood feature led to this significantly high proportion. These findings are in agreement with earlier studies which found that patients with mood disorders and alcohol/substance abuse, had high rates of suicidal ideation, and patients with anxiety disorder had relatively lower proportion of suicidal ideation.[16,28,30]

Limitations

This is a hospital-based study, and the findings cannot be generalized to a larger population. Comorbid disorders and their association with suicidal ideation could not be explored in this study; also, the personality correlates of the patients were not evaluated.

Conclusion

Suicidal ideation was reported by 36% of the patients attending psychiatry OPD. Out of these 13% patients had a history of previous suicidal attempts, and most of them attempted suicide only once. The most common method of attempted suicide was poisoning. Increasing levels of depression, anxiety, stress, and hopelessness were associated with increased suicidal ideation in the patients. Suicidal ideation was commonly observed in patients with depression and other mood disorders as well as those with previous suicide attempt/s. Substance use/addictions, a past history of psychiatric illness, and triggering stressor are also associated with suicidal ideation in psychiatric patients.

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Conflicts of interest

There are no conflicts of interest.

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