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# SOCIODEMOGRAPHIC FACTORS AND CLINICAL FACTORS OF SUICIDAL ATTEMPTS IN TERTIARY CARE CENTER

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ABSTRACT Backgro	und: The objective was to study the sociodemographic data, psychiatric disorder and mode in suicide attempted patients referred to department of psychiatry tertiary care center.Ranc

Materials and Methods: During the 3-month period 140 referrals were screened for the presence of suicide attempters in the department of psychiatry. **Results:** Adult age, male, urban background, employed were more represented in this study. More than 66.4% of all attempters had psychiatric disorder. The most common method of attempt was by use of insecticide. **Conclusions:** Majority of suicide attempter patients had mental illness. Early identification and treatment of these disorders would have prevented morbidity and mortality associated with this.

# **KEYWORDS**:

## INTRODUCTION

Suicide is a complex, multidimensional phenomenon that has been studied from philosophical, sociological, and clinical perspective. Suicidal behavior and suicidality can be conceptualized as a continuum ranging from suicidal ideation to suicide attempts and completed suicide. Attempted suicide is defined as a potentially self-injurious action with a nonfatal outcome for which there is evidence, either explicit or implicit that the individual intended to kill himself or herself. The action may or may not result in injuries.[1] More than one lakh lives are lost every year due to suicide in India. However, the male-female ratio has been stable at around 1.4-1. Majority of the suicides (37.8%) in India are by those below the age of 30 years. The fact that 71% of suicides in India are by persons below the age of 44 years imposes a huge social, emotional, and economic burden on society.[2] In India, suicide attempts are more common in females, majority were Hindus, married, and the suicide rate is three times higher in rural areas than the overall national rate.[3-4] Poisoning (36.6%), hanging (32.1%), and selfimmolation(7.9%) were the common methods used to commit suicide and poisoning is the commonest mode of attempt by the Indian population.[5-6] Divorce, dowry, love affairs, cancellation or the inability to get married, illegitimate pregnancy, extra-marital affairs, and such conflicts relating to the issue of marriage, play a crucial role, particularly in the suicide of women in India. A distressing feature is the frequent occurrence of suicide pacts and family suicides, which are more due to social reasons and can be viewed as a protest against archaic societal norms and expectations.[7] Suicide attempts ranging from 10 to 40 times more frequent than completed suicide.[8] It is estimated that there will be at least 5 million suicide attempts each year and hence suicide attempts will be a major public and mental health concern in India. Hence, it is important to understand the psychosocial profile of patients who harm themselves. With this background, the aim of our study was to study the sociodemographic and clinical profile of subjects with suicidal attempt, referred to psychiatric outdoor for psychological evaluation.

# MATERIAL AND METHODS

The study design was hospital-based cross-sectional study and sampling technique used was purposive sampling. Over a period of 3 months (November 2020–January 2021), 140 of suicide attempters were gathered from medical, surgical departments and casualties referred for psychiatric evaluation. The study was explained to selected individuals, and those who fulfilled the criterion and agreed to participate were included in the study. The study protocol was approved by the Institutional Ethics Committee. Informed consent was collected from the participants. A semi-structured pro forma was used for recording the sociodemographic profile, method, and clinical profile of the patient. Psychiatric diagnoses were made according to diagnostic criteria for research of International Classification of Diseases-10 Classification of Mental and Behavioral Disorders.[9]

## RESULT

Sociodemographic profile: Males (57.9%) were more than females (42.1%) among suicidal attempters. Majority of the subjects were unmarried (57.1%), employed (38.6%), lower socio economic status (47.1%) and came from urban background (62.1%). The mean age at suicide attempt was 25.95 years (SD 9.38), with a range of 12-55 years. The mean education at suicide attempt was 9.67 years (SD 4.06) [Table 1].

Clinical features: More than three-fourth of the sample (74%) had not consulted any psychiatrist in the past. When the subjects were assessed for psychiatric illness, nearly two third (66.4%) of them were diagnosed to have some psychiatric disorder, with depression (22.9%) being the most common and next was alcohol dependence syndrome, mostly in delirious condition(19.3%) .[Table 2]. About one-third (33.6%) of the sample did not fulfill any axis I and axis II diagnosis and they were impulsive in nature to fulfill their demand. [Table 3].

Mode of suicide attempt and precipitating events: Majority of the subjects had a suicidal attempt out of impulsivity or anger impulse (35.7%). Most common of atempters were those having psychiatric illness (23.6) followed by interpersonal problems with spouse (16.4%). The most common method of suicidal attempt was consumption of insecticides (48.6%) followed by cut throat by alcoholic during delirious condition (18.6%), and use of drug overdose(11.4%) [Table 3].

### Table 1: Sociodemographic details

	Mean (SD)	Min	Max	
Āge	$25.95 \pm 9.38$	12	55	
Education (in years)	$9.67\pm4.06$	00	17	
		n	%	
Gender	Male	81	57.9	
	Female	59	42.1	

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Marital Status	Unmarried	80	57.1
	Married	60	42.8
Occupation	Student	50	35.7
	Employed	54	38.6
	Unemployed	36	25.7
Habitat	Urban	87	62.1
	Rural	53	37.9
Religion	Hindu	71	50.7
	Muslim	18	12.9
	Christian	24	17.1
	Others	27	19.3
Economic status	Low	66	47.1
	Middle	64	45.7
	High	10	7.1

#### Table 2: Psychiatric diagnosis

	n	%
No diagnosis	47	33.6
Depression	32	22.9
Alcohol dependence syndrome	27	19.3
Emotional unstable personality	17	12.1
Stress and anxiety disorder	12	8.6
Schizophrenia and delusional disorder	5	3.6

### Table 3: Mode of Suicide

	n	%
Poisoning	68	48.6
Cut throat	26	18.6
Drug overdose	16	11.4
Wrist slashing	15	10.7
Hanging	9	6.4
Burn	6	4.3

#### DISCUSSION

The study obtained data on the sociodemographic and clinical profile of subjects with suicide attempters presenting to a tertiary care hospital referred to department of psychiatry for psychiatric evaluation. The sociodemographic profile of our sample was similar to that in other studies from India.[10] Majority of our sample comprised adults (mean age 25.95 years) suggesting that they constitute a vulnerable group. Majority of the suicides in these age groups denote that the most productive age groups of being at risk and thus imposing a huge social, emotional, and economic burden on society. The study showed more male attempters compared to their female counterparts. Globally, attempted suicide is more common in women and completed suicide is more common in men.[11] Men commonly use more lethal modes and plan the act more meticulously to avoid detection. In contrast, women commonly use less lethal modes and are more impulsive, less well planned, and more likely to be found and rescued. Although some Indian studies have found a higher incidence of suicide in men than in women, others have found the contrary.[12] In the present study, married constituted around 42.8% and single constituted to be 57.1%. In the current study, the sample predominantly comprised younger population and students. Being single, divorced or separated, or widowed has been found to be risk factors in many Western studies although it may not be predictive in developing countries.[13] Predominant cases were employed and employed attempters had significantly higher stress scores than the unemployed, which might explain partly their reason for attempt. The fact that predominance cases were from urban backgrounds also perhaps reflects the transition of the Indian society and the stress associated with it, also accessibility to the hospital leading to greater treatment seeking behavior.

The most common modes of suicide were consumption of a poison (48.6%), cut throat(18.6%), and drug overdose(8.8%) found in our study. This pattern is recapitulated in the NCRB

2013 report. Studies show that consumption of pesticides, such as the readily available agricultural pesticides in rural areas, is the most common means of suicide and attempted suicide in India [14]. Studies in India show varying results with rates of psychiatric disorders, few studies ranging from 9.5% to 24.9%. Mood disorders, particularly depressive disorders, were the most common diagnosis followed by alcohol abuse. In the index study, the percent of psychiatric diagnosis which was around 66.4% where depressive disorders were the most common followed by alcohol dependence syndrome. Mental disorders (particularly depression and alcohol use disorders) are a major risk factor for suicide in Europe and North America; however, in Asian countries, impulsiveness plays an important role. This implies that there is an urgent need to promote education regarding the nature of psychiatric disorders and their treatability across the community to allow their early detection and timely treatment thereby minimizing suicide attempt. Stigma reduction programs, effective skills on the part of primary care and family physicians for identification and management of potential suicidal persons, should be promoted. Suicide prevention must form an integral part of community-based mental healthcare activities.

#### CONCLUSION

Two third of the patients were diagnosed with psychiatric illness at presentation, which clearly argues for need of early, prompt diagnosis and treatment of such cases so as to prevent such attempts. Public education for early identification and help seeking for mental disorders, awareness regarding this in the healthcare staff, and facilities for management of common mental disorders in rural and urban would probably help. Supportive measures for various stressors and interventions for many modifiable risk factors identified seem plausible and might be considered as a priority in local suicide prevention strategies.

### REFERENCES

- Kumar, D. N. (2017). A Study on Clinical Profile and Trend in Suicide Attempters in Psychiatry Consultation. Indian Journal of Public Health Research & Development, 8(4).
- Vijayakumar, L. (2010). Indian research on suicide. Indian journal of psychiatry, 52(Suppl1), S291.
- Kumar, P. S. (2004). An analysis of suicide attempters versus completers in Kerala. Indian journal of psychiatry, 46(2), 144.
- Gouda, M. N., & Rao, S. M. (2008). Factors related to attempted suicide in Davanagere. Indian journal of community medicine: official publication of Indian Association of Preventive & Social Medicine, 33(1), 15.
- 5. Government of India. (2005). Accidental deaths and suicides in India. National Crime Records Bureau. Ministry of Home Affairs
- Kumar, C.T., Chandrasekaran R.(2000). A study of psychosocial and clinical factors associated with adolescent suicide attempts. Indian Journal of Psychiatry, 42(1), 237-42.
- Vijaykumar, L. (2007). Suicide and its prevention: The urgent need in India. Indian journal of psychiatry, 49(2), 81.
- Ramdurg, S., Goyal, S., Goyal, P., Sagar, R., & Sharan, P. (2011). Sociodemographic profile, clinical factors, and mode of attempt in suicide attempters in consultation liaison psychiatry in a tertiary care center. *Industrial psychiatry journal*, 20(1), 11.
- World Health Organization. (1992). The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines. World Health Organization.
- Latha, K. S., Bhat, S. M., & D'souza, P. (1996). Suicide attempters in a general hospital unit in India: their socio-demographic and clinical profile emphasis on cross-cultural aspects. *Acta Psychiatrica Scandinavica*, 94(1), 26-30.
- Phillips, M. R., Yang, G., Li, S., & Li, Y. (2004). Suicide and the unique prevalence pattern of schizophrenia in mainland China: a retrospective observational study. *The Lancet*, 364(9439), 1062-1068.
- Gururaj, G., & Isaac, M. K. (2001). Epidemiology of suicides in Bangalore. National Institute of Mental Health & Neuro Sciences.
- Vijayakumar, L., John, S., Pirkis, J., & Whiteford, H. (2005). Suicide in developing countries (2): risk factors. Crisis: The Journal of Crisis Intervention and Suicide Prevention, 26(3), 112.
- Srivastava, M. K., Sahoo, R. N., Ghotekar, L. H., Dutta, S., Danabalan, M., Dutta, T.K., & Das, A. K. (2004). Risk factors associated with attempted suicide: A case control study. *Indian Journal of Psychiatry*, 46(1), 33.