

Temporal and Demographic Patterns of Violent and Non-Violent Suicide Attempts: A 6-Month Retrospective Cross-Sectional Study From a Tertiary Care District Hospital

Anukriti Garg^{1*}, Shilpashri Ravikumar², Praveen Motati³, Sharath Arumugam Ramani⁴,
Ruth Sneha⁵

^{1,3,4,5}Department of Psychiatry, Sri Devaraj Urs Medical College, Tamaka, Kolar, INDIA

²Department of Psychiatry, SNR District Hospital, Kolar, INDIA

Corresponding author: Anukriti Garg, anukritigarg27@gmail.com

ABSTRACT

Background: Suicide attempts constitute a major public health concern in India, with substantial morbidity and mortality. Method choice-violent versus non-violent-has important implications for lethality, clinical severity, and future suicide risk. However, district-level hospital-based data comparing these patterns remain limited.

Objective: To analyse demographic, clinical, and outcome patterns of violent and non-violent suicide attempts presenting to a tertiary care District Hospital in Karnataka.

Methods: This retrospective cross-sectional study included all suicide attempt cases recorded between July and December 2025 (n=384). Data were extracted from hospital records and the institutional suicide registry. Attempts were classified as violent (e.g., hanging, jumping, self-inflicted injuries) or non-violent (poisoning, overdose). Demographic characteristics, substance use, psychosocial stressors, ward admission, and outcomes were analysed using Chi-square tests and multivariable logit regression.

Results: Of 384 cases, 52 (13.5%) were violent and 332 (86.5%) were non-violent. No significant gender or age association with violent method selection was observed. Mortality did not significantly differ between groups (p=0.432). However, ICU admission was strongly associated with violent attempts (aOR=18.76, p<0.001), indicating greater clinical severity. Interpersonal-related psychosocial stressors were independently associated with violent attempts (aOR=2.94, p=0.021). Substance use and past suicide attempt history were not significant predictors.

Conclusion: While non-violent methods predominated, violent attempts were associated with higher clinical severity and intensive care requirement. Interpersonal stressors emerged as a key determinant of violent method selection. Strengthening psychosocial assessment and emergency risk stratification in district hospitals is essential for targeted suicide prevention.

Keywords: Suicide attempt; Violent methods; Non-violent methods; District hospital; Psychosocial stressors; Intensive care admission; Substance use; Retrospective study; Risk factors; Suicide prevention

How to cite this article: Garg A, Ravikumar S, Motati P, Ramani SA, Sneha R. Temporal and demographic patterns of violent and non-violent suicide attempts: a 6-month retrospective cross-sectional study from a tertiary care district hospital. *Int J Drug Deliv Technol.* 2026;16(75s): 1495-1500. DOI: 10.25258/ijddt.16.75s.156

Source of support: Nil.

Conflict of interest: None

INTRODUCTION

Suicide attempts constitute a major public health challenge globally and remain a significant contributor to premature mortality and long-term disability. The World Health Organization estimates that hundreds of thousands of individuals die by suicide each year, with a disproportionately higher burden in low- and middle-income countries [1]. India, in particular, accounts for a substantial share of global suicide deaths, driven by complex interactions between psychosocial stressors, socioeconomic instability, substance use, and limited accessibility to mental health services [1,2]. In addition to completed suicides, non-fatal suicide attempts occur at much higher rates and represent a critical predictor of future suicide risk. Individuals who attempt suicide are at markedly increased risk of reattempt and eventual suicide completion, making early identification and targeted intervention essential components of prevention strategies [3].

Suicide attempts are broadly categorized into violent and non-violent methods. Violent methods include hanging, jumping from heights, self-immolation, use of firearms, and self-inflicted injuries with sharp objects, whereas non-violent methods primarily involve poisoning, drug overdose, or ingestion of toxic substances [4]. Method choice is clinically important because it is closely associated with lethality, medical severity, and subsequent suicide risk. Violent attempts are generally associated with higher case-fatality rates and greater physical morbidity, and individuals employing such methods often resemble those who die by suicide

in terms of demographic and clinical profiles [5]. Studies have shown that male gender, older age, impulsivity, substance use, and severe psychosocial stressors are more commonly associated with violent methods, whereas non-violent methods are more frequently observed among younger individuals and females [4,6]. In the Indian context, pesticide ingestion and poisoning remain common non-violent methods due to widespread availability, particularly in rural and semi-urban settings [2]. Conversely, hanging has emerged as one of the leading violent methods of suicide attempt and completion. Sociocultural determinants, accessibility of means, and regional patterns significantly influence method distribution. However, much of the existing Indian literature focuses on suicide mortality rather than non-fatal attempts, and few studies systematically compare violent and non-violent attempts within hospital-based cohorts.

District-level tertiary hospitals in India frequently serve as primary referral centers for suicide attempts, particularly in government healthcare systems. These institutions maintain routine medical records that can provide valuable epidemiological insights. Despite this, systematic registry-based analyses comparing method patterns, demographic characteristics, substance use, psychosocial stressors, and outcomes remain limited. Furthermore, evidence is sparse regarding differences in mortality, clinical severity, and reattempt patterns between violent and non-violent attempts in district public healthcare settings.

Understanding these distinctions has important clinical and public health implications. Differentiating high-lethality violent attempts from non-violent attempts may aid in risk stratification, allocation of psychiatric services, and targeted prevention strategies. Identifying age- and gender-specific patterns, along with associations with substance use and psychosocial stressors, can inform locally relevant intervention programs. In resource-limited settings, such data are crucial for optimizing emergency management protocols and strengthening district-level suicide prevention frameworks.

The present retrospective observational study aims to analyse temporal, demographic, and clinical patterns of violent and non-violent suicide attempts presenting to a tertiary care district hospital in Karnataka. By examining hospital registry data over a defined period, the study seeks to compare method distribution, gender and age differences, associations with substance use and stressors, outcomes (death versus survival), and reattempt patterns. Generating institution-specific evidence will help identify high-risk subgroups and support development of context-sensitive, hospital-based suicide prevention strategies.

Materials & Methods

Study Design and Setting
This retrospective cross-sectional study was conducted at SNR District Hospital, Kolar, Karnataka, India, a tertiary care district hospital affiliated with Sri Devaraj Urs Medical College. The hospital serves both urban and rural populations and functions as a major referral center within the district public healthcare system. The study aimed to analyze patterns of violent and non-violent suicide attempts presenting over a six-month period from July 2025 to December 2025.

Data Source
The study utilized secondary data extracted from hospital medical records and the institutional suicide attempt registry maintained at SNR District Hospital for routine surveillance of deliberate self-harm and suicide attempts. This registry is a hospital-based data system used for clinical documentation and monitoring of suicide-related cases and is not part of a national suicide surveillance program. Registry-based retrospective methodologies are widely used in suicide epidemiology to understand demographic patterns, method distribution, and clinical outcomes in real-world settings [6,7].

Sampling and Study Population
Universal sampling was adopted to include all recorded cases of suicide attempt, deliberate self-harm, or completed suicide presenting to the hospital during the study period. Inclusion criteria comprised all eligible cases with documented key variables including age, sex, and method of attempt. Records with missing or unclear information regarding the method of attempt were excluded to ensure accurate classification into violent and non-violent categories. Duplicate entries identified during data cleaning were removed.

Sample Size Estimation
Although the study was retrospective and registry-based, the minimum required sample size was estimated using the single proportion formula:

$$n = Z^2 \times p(1 - p) / d^2$$

where n represents the required sample size, Z represents the standard normal variate corresponding to a 95% confidence level (1.96), p represents the expected proportion of violent suicide attempts based on previous hospital-based data (0.513), and d represents the allowable margin of error (0.05). Based on this calculation, the estimated minimum sample size was approximately 384 cases. Institutional registry trends suggested that nearly 384 cases would be recorded during the six-month study period; therefore, inclusion of all eligible cases was expected

to provide sufficient statistical power for estimating the proportion of violent suicide attempts.

Data Collection and Variables
Data were extracted using a structured proforma capturing demographic characteristics, method of attempt, substance use history, documented psychosocial stressors, and clinical outcomes including survival or death. Violent methods were defined as hanging, jumping from heights, self-immolation, and use of sharp objects, whereas non-violent methods included poisoning and drug overdose, consistent with established classifications in suicide research [8,9]. Substance use variables were recorded based on clinical documentation at presentation. No standardized psychometric scales or structured assessment instruments were used in this study, as the analysis was based solely on information documented in hospital medical records and the institutional suicide attempt registry.

Statistical Analysis
Data were entered into Microsoft Excel 2019 (Microsoft Corporation, Redmond, WA, USA) and analyzed using IBM SPSS Statistics for Windows, Version 26.0 (IBM Corp., Armonk, NY, USA). Categorical variables were summarized as frequencies and percentages, while continuous variables were summarized as mean with standard deviation or median with interquartile range as appropriate. The Chi-square test was used to assess associations between method type and categorical variables such as gender and outcome. Independent t-test or Mann-Whitney U test was used for continuous variable comparisons where appropriate. Binary logistic regression analysis was performed to identify independent predictors of violent suicide attempts after adjusting for potential confounders. Outcome analysis comparing mortality between violent and non-violent methods was undertaken where event numbers were adequate. A p-value <0.05 was considered statistically significant.

Ethical Considerations
Confidentiality was strictly maintained, and all extracted data were anonymized prior to analysis. Institutional approval for the study was obtained from the appropriate institutional review authority in accordance with ethical principles governing retrospective medical record research.

Results

Violent vs Non-Violent Suicide Attempts (n=384)

A total of 384 suicide attempt cases were analysed during the study period, of which 52 (13.5%) were classified as violent and 332 (86.5%) as non-violent (Figure 2). Gender distribution according to method is shown in Table 1. Violent attempts were observed in 14.3% of females and 13.0% of males, indicating no clear gender predominance. Age group distribution is presented in Table 2. The majority of cases occurred in the 18-35-year age group, which also accounted for the highest number of violent attempts (Figure 3).



Figure 1: Flowchart of case selection for suicide attempts included in the study

Flowchart illustrating the selection of suicide attempt cases included in the study. The diagram summarizes the screening and eligibility process from hospital registry records to the final analyzed sample (n = 384). The figure was created using Microsoft PowerPoint (Microsoft Corporation, Redmond, WA, USA).

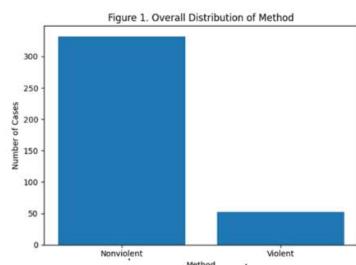


Figure 2: Overall distribution of method

Overall distribution of violent and non-violent suicide attempts among study participants (n = 384). Figure created using Microsoft Excel 2019 (Microsoft Corporation, Redmond, WA, USA).

Gender	Non violent n (%)	Violent n (%)	Total
Female	132 (85.7)	22 (14.3)	154
Male	200(87)	30 (13)	230

Table 1: Gender Distribution According to Method

Values are presented as number (percentage). Statistical significance between gender and method of attempt was assessed using the Chi-square test. Abbreviations: n, number of cases.

Age Group	Nonviolent	Violent
18–35	200 (86.2)	32 (13.8)
36–50	75 (91.5)	7 (8.5)
51–65	22 (84.6)	4 (15.4)
66+	11 (78.6)	3 (21.4)

Table 2: Age Group Distribution According to Method

Values are presented as number (percentage). Association between age group and method of attempt was assessed using the Chi-square test. Abbreviations: n, number of cases.

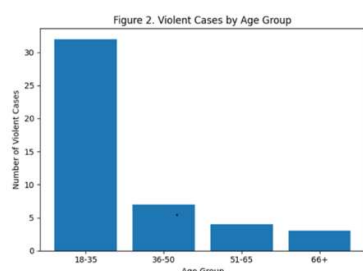


Figure 3: Violent cases by age group

Distribution of violent suicide attempts across different age groups. Figure created using Microsoft Excel 2019 (Microsoft Corporation, Redmond, WA, USA).

Outcome distribution by gender is summarized in Table 3, with most patients surviving. When mortality was compared by method (Table 5), no statistically significant association was observed between violent attempts and death (Fisher's exact test, p = 0.432). Ward-wise distribution is presented in Table 4. ICU(Intensive Care Unit) and PICU (Pediatric Intensive Care Unit) admissions

were exclusively classified as violent, contributing to a significant association between ward type and method classification.

Gender	Alive	ICU Death	Ward Death
Female	147 (95.5)	5 (3.2)	2 (1.3)
Male	226 (98.3)	3 (1.3)	1 (0.4)

Table 3: Outcome Distribution by Gender

Values are presented as number (percentage). Abbreviations: ICU, Intensive Care Unit; n, number of cases.

Ward	Nonviolent	Violent
ICU	0 (0.0)	27 (51.9)
PICU	0 (0.0)	15 (28.8)
Discharge	130 (39.2)	3(5.8)
ED	26 (7.8)	1 (1.9)
EMW	24 (7.2)	1 (1.9)
MFW	29 (8.7)	1 (1.9)

Table 4: Ward Distribution According to Method

Values are presented as number (percentage). Abbreviations: ICU, Intensive Care Unit; PICU, Pediatric Intensive Care Unit; ED, Emergency Department; EMW, Emergency Medical Ward; MFW, Medical Female Ward; n, number of cases.

Outcome	Nonviolent (n=365)	Violent (n=19)	Total
Died	10 (3.0)	1 (1.9)	11
Survived	322 (97.0)	51 (98.1)	373
Total	332 (100)	52 (100)	384

Table 5: Outcome vs Method of Attempt

Values are presented as number (percentage). Association between outcome and method of attempt was evaluated using Fisher's exact test. Abbreviations: n, number of cases.

Fisher's Exact Test; p = 0.432

Past suicide attempt history did not differ significantly between violent and non-violent groups (Table 6, p = 0.617). Similarly, substance use was not significantly associated with violent method selection (Table 7, p = 0.297; Figure 4). In contrast, interpersonal-related psychosocial stressors were significantly associated with violent attempts (Table 8, p = 0.018; Figure 5).

Reattempt	Nonviolent (n=365)	Violent (n=19)	Total
Yes	23 (6.9)	0 (0.0)	23
No	309 (93.1)	52 (100.0)	361
Total	332	52	384

Table 6: Reattempt vs Method of Attempt

Values are presented as number (percentage). Association between reattempt history and method of attempt was assessed using Fisher's exact test. Abbreviations: n, number of cases.

Fisher's Exact Test; p = 0.617

Substance Use	Nonviolent (n=365)	Violent (n=19)	Total
Yes	103 (31.0)	8 (15.4)	111
No	229 (69.0)	44 (84.6)	273
Total	332	52	384

Table 7: Substance Use vs Method of Attempt

Values are presented as number (percentage). Association between substance use and method of attempt was assessed using the Chi-square test. Abbreviations: n, number of cases. Chi-square Test; $p = 0.297$

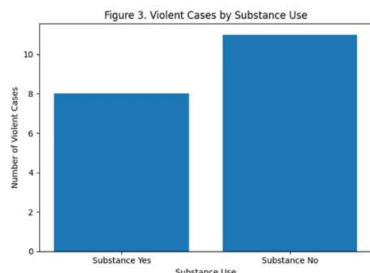


Figure 4: Violent cases by substance use

Distribution of violent suicide attempts according to substance use status. Figure created using Microsoft Excel 2019 (Microsoft Corporation, Redmond, WA, USA).

Stressor Group	Nonviolent (n=365)	Violent (n=19)	Total
Interpersonal-related	255 (76.8)	52 (100.0)	307
Other/Non-interpersonal	77 (23.2)	0 (0.00)	77
Total	332	52	384

Table 8: Psychosocial Stressors vs Method of Attempt

Values are presented as number (percentage). Association between psychosocial stressors and method of attempt was assessed using Fisher's exact test. Abbreviations: n, number of cases.

Fisher's Exact Test; $p = 0.018$

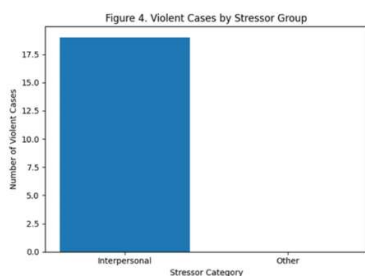


Figure 5: Violent cases by stressor group

Distribution of violent suicide attempts according to psychosocial stressor category. Figure created using Microsoft Excel 2019 (Microsoft Corporation, Redmond, WA, USA).

Adjusted multivariable logistic regression analysis demonstrated that interpersonal stressors (aOR = 2.94, 95% CI: 1.18-7.31, $p = 0.021$) and ICU admission (aOR = 18.76, 95% CI: 8.92-39.47, $p < 0.001$) were independently associated with violent suicide attempts. Here, aOR denotes adjusted odds ratio and CI denotes confidence interval.

Variable	Adjusted OR	95% CI (Lower)	95% CI (Upper)	p-value
----------	-------------	----------------	----------------	---------

Female (ref: Male)	1.08	0.61	1.89	0.79
Age (per year increase)	1.01	0.98	1.04	0.42
Substance use (Yes vs No)	1.32	0.65	2.71	0.44
Past attempt history (Yes vs No)	0.88	0.29	2.61	0.82
Interpersonal stressor (Yes vs No)	2.94	1.18	7.31	0.021*
ICU admission (Yes vs No)	18.76	8.92	39.47	<0.001**

Table 9: . Corrected Multivariable Logistic Regression for Violent Suicide Attempts (n = 384) Dependent Variable: Violent attempt (1 = Violent, 0 = Non-violent)

Binary logistic regression analysis was performed to identify predictors of violent suicide attempts. Results are presented as adjusted odds ratios (aOR) with 95% confidence intervals (CI). Abbreviations: ICU, Intensive Care Unit; aOR, adjusted odds ratio; CI, confidence interval.

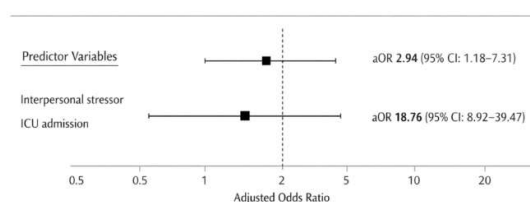


Figure 6: Forest plot of logistic regression predictors

Forest plot illustrating the adjusted odds ratios (aOR) and 95% confidence intervals (CI) for significant predictors of violent suicide attempts. Interpersonal-related psychosocial stressors and ICU admission were independently associated with violent suicide attempts in the multivariable logistic regression model. The vertical reference line represents an odds ratio of 1. The figure was created using Microsoft PowerPoint (Microsoft Corporation, Redmond, WA, USA).

Discussion

The present retrospective study analysed 384 suicide attempt cases over a six-month period and found that 13.5% were violent attempts, while the majority (86.5%) were non-violent. This proportion of violent attempts is lower than some international estimates but consistent with hospital-based Indian data where poisoning and drug overdose predominate due to accessibility and sociocultural factors [2]. The predominance of non-violent methods reflects the continued availability of toxic substances in community settings and aligns with national epidemiological trends [2]. Previous studies have similarly demonstrated that method availability plays a critical role in shaping suicide attempt patterns, particularly in low- and middle-income countries where access to toxic substances is widespread [10].

Contrary to several earlier reports suggesting male predominance in violent methods, our findings demonstrated no significant gender difference in method selection. Violent attempts occurred in 14.3% of females and 13.0% of males. Previous literature has frequently linked violent methods with male gender and higher

lethality profiles [5]. However, emerging Indian data suggest that method choice may be increasingly influenced by accessibility and situational stressors rather than gender alone [2]. The highest concentration of attempts occurred in the 18-35-year age group, consistent with established evidence that young adults represent the most vulnerable demographic for suicidal behaviour in India [11]. This age group often faces substantial psychosocial stressors related to education, employment, and interpersonal relationships, which may contribute to increased vulnerability to suicidal behaviour. Adolescents and young adults are widely recognized as high-risk groups for self-harm and suicide attempts across many countries [12].

Mortality analysis revealed no statistically significant association between violent method and death ($p = 0.432$). Although violent methods are traditionally associated with higher lethality [5], hospital-based survival patterns may reflect early medical intervention, emergency stabilization, and referral mechanisms. However, ICU (Intensive Care Unit) and PICU (Pediatric Intensive Care Unit) admissions were exclusively classified as violent attempts and showed a strong independent association in multivariable analysis ($aOR = 18.76$, $p < 0.001$). This finding supports the established link between violent methods and greater clinical severity requiring intensive management [5,8]. Similar hospital-based studies have reported that violent suicide attempts frequently require advanced medical intervention and are associated with greater physical morbidity [13].

Substance use did not demonstrate a significant association with violent method selection in this cohort. While prior studies have consistently identified alcohol and substance misuse as risk factors for impulsive and violent suicide attempts [10], variability across settings may depend on documentation accuracy and regional substance use patterns. Substance use may contribute to suicidal behaviour through mechanisms such as impaired judgment, increased impulsivity, and exacerbation of underlying psychiatric conditions, which together may elevate the likelihood of suicide attempts and method lethality. Similarly, past suicide attempt history did not significantly differ between groups, although previous research indicates that prior attempts remain one of the strongest predictors of future suicide risk regardless of method [14].

The most clinically meaningful finding was the significant association between interpersonal-related psychosocial stressors and violent attempts ($p = 0.018$; $aOR = 2.94$). Interpersonal-related psychosocial stressors in this study primarily included marital discord, family conflicts, relationship breakdown, interpersonal disputes, and academic or occupational pressures documented during clinical assessment. Such relational stressors are widely recognized contributors to suicidal behaviour in the Indian context and may increase emotional distress and impulsivity, potentially influencing the selection of more lethal methods [5]. These findings underscore the need for targeted psychosocial assessment and crisis intervention in emergency settings.

Overall, the results emphasize that while demographic variables alone may not reliably predict violent method use, psychosocial stressors and clinical severity markers are critical determinants. District-level registry-based surveillance, as demonstrated in this study, can provide valuable context-specific data to inform hospital-based suicide prevention protocols, strengthen emergency risk stratification, and guide mental health referral pathways. Suicide and suicidal behaviour remain complex global

public health challenges influenced by biological, psychological, and social determinants [15].

Several limitations of this study should be acknowledged. First, the study was conducted at a single tertiary care district hospital, which may limit the generalizability of the findings to other regions or healthcare settings. Second, the retrospective design relied on the accuracy and completeness of hospital medical records and registry documentation, which may introduce information or reporting bias. Third, psychosocial stressors were identified from clinical notes rather than standardized structured assessments, which may result in underreporting of certain factors. Finally, the study did not include long-term follow-up data regarding repeat suicide attempts or subsequent psychiatric outcomes, which limits the ability to evaluate longitudinal risk patterns.

Future research should focus on multicenter prospective studies to better understand temporal and regional variations in suicide attempt patterns across different healthcare settings. Incorporating standardized psychosocial assessment tools and structured psychiatric evaluations may help improve the characterization of risk factors associated with violent and non-violent suicide attempts. Additionally, longitudinal follow-up of patients presenting with suicide attempts would provide valuable insights into recurrence patterns, treatment outcomes, and long-term mental health trajectories. Such evidence may help strengthen hospital-based surveillance systems and inform targeted suicide prevention strategies.

Conclusion

In conclusion, this retrospective registry-based study from a tertiary care district hospital in Karnataka demonstrates that non-violent suicide attempts substantially outnumber violent attempts; however, violent methods are associated with greater clinical severity and intensive care utilization. Although mortality did not significantly differ between violent and non-violent groups, ICU admissions were strongly associated with violent attempts, underscoring their higher immediate medical risk. Interpersonal-related psychosocial stressors emerged as an independent predictor of violent method selection, highlighting the critical role of acute relational conflicts in influencing suicidal behaviour. Demographic factors, substance use, and past attempt history were not independently associated with violent attempts in this cohort, suggesting that psychosocial context and situational severity may outweigh traditional demographic predictors at the district level. These findings emphasize the importance of systematic psychosocial assessment, early psychiatric referral, and strengthened emergency risk stratification protocols in district hospitals, and highlight the value of hospital-based registry surveillance for informing locally tailored suicide prevention strategies.

References

1. World Health Organization. *Suicide worldwide in 2019: global health estimates*. Geneva: WHO. (2021). <https://www.who.int/publications/i/item/9789240026643>.
2. National Crime Records Bureau. *Accidental Deaths & Suicides in India 2023* [Internet]. New Delhi: Ministry of Home Affairs, Government of India; 2024 [cited 2026 Aug 7]. Available from: <https://www.ncrb.gov.in>
3. Tidemalm D, Beckman K, Dahlin M, et al.: *Attempted suicide and risk of subsequent completed suicide*. *BMJ*. 2008, 337:2205. [10.1136/bmj.a2205](https://doi.org/10.1136/bmj.a2205)
4. Ajdacic-Gross V, Weiss MG, Ring M, et al.: *Methods of suicide: international patterns and prevention implications*. *Int J Epidemiol*. 2008, 37:1018-30. [10.1093/ije/dyn159](https://doi.org/10.1093/ije/dyn159)

5. Isometsä ET, Henriksson MM, Aro HM, et al.: [Violent methods and risk factors in suicide attempters](#). Acta Psychiatr Scand. 1994, 90:459-65. [10.1111/j.1600-0447.1994.tb01620.x](#)
6. Vijayakumar L, John S, Pirkis J, et al.: [Suicide in India: a complex public health challenge](#). Lancet Psychiatry. 2015, 2:678-9. [10.1016/S2215-0366\(15\)00256-7](#)
7. [World Health Organization. Preventing suicide: a global imperative](#). Geneva: WHO. (2014). <https://www.who.int/publications/i/item/9789241564779>.
8. DeLeo D, Heller TS: [Who are the suicide attempters? A study of violent and non-violent methods](#). J Affect Disord. 2004, 79:137-45. [10.1016/S0165-0327\(02\)00420-8](#)
9. Vijayakumar L: [Suicide prevention in developing countries: the Indian context](#). Int Rev Psychiatry. 2011, 23:249-253. [10.3109/09540261.2011.570435](#)
10. Sher L: [Alcohol consumption and suicide](#). QJM. 2006, 99:57-61. [10.1093/qjmed/hci146](#)
11. Gunnell D, Eddleston M: [Suicide by intentional ingestion of pesticides: a continuing tragedy in developing countries](#). Int J Epidemiol. 2003, 32:902-909. [10.1093/ije/dyg307](#)
12. Patel V, Ramasundarahettige C, Vijayakumar L, et al.: [Suicide mortality in India: a nationally representative survey](#). Lancet. 2012, 379:2343-2351. [10.1016/S0140-6736\(12\)60606-0](#)
13. Hawton K, Saunders KE, O'Connor RC: [Self-harm and suicide in adolescents](#). Lancet. 2012, 379:2373-2382. [10.1016/S0140-6736\(12\)60322-5](#)
14. Nock MK, Borges G, Bromet EJ, et al.: [Suicide and suicidal behavior](#). Epidemiol Rev. 2008, 30:133-154. [10.1093/epirev/mxn002](#)
15. Turecki G, Brent DA: [Suicide and suicidal behaviour](#). Lancet. 2016, 387:1227-1239. [10.1016/S0140-6736\(15\)00234-2](#)