

Clinical Predictors of Suicidal Ideation and Suicide Attempts in Patients with Major Depressive Disorder

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Abstract

Background Suicidal thoughts and attempts are closely linked to major depressive disorder (MDD), a prevalent and incapacitating mental illness. The severity of depression symptoms, past suicide behaviour, hopelessness, psychiatric comorbidities, psychosocial stressors, and other clinical variables all combine intricately to cause suicidal behaviour. In ordinary psychiatric practice, early detection of individuals at elevated risk continues to be a significant difficulty. The purpose of this study was to find clinical variables linked to suicidal thoughts and attempts among MDD patients.

Methodology

At Mayo Hospital Lahore facility's MDD patients participated in a hospital-based analytical cross-sectional study. A structured clinical proforma covering demographics, length and intensity of depression, past psychiatric history, past suicide attempts, family history of suicidal behaviour, psychotic symptoms, sleep disturbances, substance use, psychosocial stressors, treatment history, and psychiatric comorbidities was used to evaluate the participants. A validated suicide-risk assessment measure was used to gauge suicidal ideas and behaviour, while a standardised depression-rating instrument was used to gauge the severity of depression. Patients were divided into groups based on whether or not they had previously attempted suicide and had suicidal thoughts. While suitable comparison and regression analyses were carried out to find independent clinical predictors of suicidality, descriptive statistics were utilised to summarise participant characteristics. Statistical significance was defined as a p-value of less than 0.05.

Result

Compared to patients without suicidal ideation, those with suicide ideation had noticeably more severe depressive symptoms and higher degrees of hopelessness. Patients with suicidal behaviour were more likely to have a history of past suicide attempts, recurrent depressive episodes, psychotic symptoms, substantial sleep disturbance, substance use, and recent psychosocial stresses. Suicidal thoughts and/or suicide attempts were found to be significantly predicted by prior suicide attempts, higher depression severity, hopelessness, psychotic symptoms, and substantial psychosocial stressors, according to multivariable analysis. Suicidal behaviour was significantly more common in patients with several clinical risk factors than in those without these traits.

Conclusion

Suicidal thoughts and attempts are closely linked to certain clinical traits in MDD patients. Patients who need more thorough suicide-risk evaluation and monitoring may be identified by their history of suicidal behaviour, severe depressive symptoms, hopelessness, psychotic symptoms, sleep disturbance, and psychosocial stressors. Regular evaluation of these variables need to be a crucial part of treating MDD patients. Early identification of high-risk clinical profiles may help improve suicide-prevention tactics and enable prompt psychiatric intervention.

Key words

Depression severity, hopelessness, psychotic depression, psychiatric comorbidity, psychosocial stressors, major depressive illness, suicidal thoughts, suicide attempts, suicide risk, and clinical predictors.

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Introduction

Persistently depressed mood, diminished interest or pleasure, cognitive disturbances, changes in sleep and

appetite, exhaustion, impaired concentration, feelings of worthlessness, and recurrent thoughts of death or suicide are the hallmarks of major depressive

disorder (MDD), a common and crippling mental illness. MDD is one of the mental illnesses most closely linked to suicidal thoughts and actions, in addition to its significant impacts on functioning and quality of life. According to the World Health Organization, depression plays a significant role in the worldwide burden of disease, and suicide is a serious consequence that needs to be identified and treated promptly [1]. Over 700,000 people are thought to die from suicide each year, and many more have suicidal thoughts or attempt suicide [2]. Suicide itself is still a significant global public health issue.

Suicidality in MDD is a spectrum that includes passive suicidal thoughts, active suicidal ideation, suicidal intent, suicidal plan creation, and suicide attempts. Suicidal ideation is a significant clinical warning sign, even though it does not always lead to an attempt. Numerous interrelated factors, such as the intensity of psychiatric symptoms, past suicidal behaviour, hopelessness, impulsivity, comorbid psychiatric disorders, substance abuse, psychosocial stressors, and the availability of social support, can influence the shift from suicidal thoughts to suicidal behaviour. Therefore, rather than depending solely on the intensity of depressive symptoms, screening of several clinical categories is necessary to identify patients at elevated risk [2, 3].

One of the most reliable indicators of future suicide attempts is prior suicidal behaviour. A history of suicide attempts should be included in standard psychiatric evaluation since it identifies a particularly vulnerable subgroup of depressed patients. Lifetime suicidal ideation with purpose and prior suicide behaviour provided clinically significant information about subsequent suicidal behaviour in a clinical investigation employing the Columbia-Suicide Severity Rating Scale (C-SSRS) [4]. A thorough history of prior self-harm and suicidal behaviour in individuals with MDD is crucial, since systematic studies have shown that prior suicide attempts are linked to an elevated risk of future suicidal behaviour and suicide mortality [3].

Suicidality may also be influenced by the intensity and phenomenology of depressive symptoms. Deep hopelessness, guilt, worthlessness, psychomotor disruption, agitation, anhedonia, and persistent thoughts of death are all possible symptoms of severe depressive episodes. Hopelessness is one of these symptoms that has drawn the most attention as a predictor of suicidal behaviour. In depressive disorders, hopelessness was linked to suicidal thoughts and attempts, while more severe depression was linked to a higher likelihood of suicidal behaviour, according to a systematic review and meta-analysis by Riera-Serra et al. [3]. These results imply that assessing specific depressive symptoms

may yield more information than a total depression score.

Another potentially significant clinical predictor is psychotic symptoms. Psychotic depression patients may suffer from substantial impairment in judgement and reality testing, as well as thoughts of guilt, persecution, poverty, or just retribution. The significance of examining psychotic features when assessing suicide risk is supported by a study by Riera-Serra et al. that found a correlation between psychotic symptoms and subsequent suicide attempts in individuals with depressive disorders [3]. Because these patients may need more rigorous monitoring and treatment, the identification of psychotic symptoms is therefore clinically relevant.

Patients with MDD frequently experience sleep disturbances, which may be a contributing factor to suicide thoughts on their own. Emotional regulation, cognitive performance, and depressive symptoms can all be made worse by insomnia, fragmented sleep, early morning awakenings, and other disruptions. Sleep difficulties may be linked to subsequent suicide behaviour in depressive disorders, according to evidence compiled in recent systematic reviews [3]. Because sleep issues may be treatable with therapeutic intervention, sleep assessment is therefore a potentially helpful part of a thorough suicide-risk assessment.

Suicidal risk may also be influenced by the length and progression of depression. Suicidal thoughts and related risk factors may be prolonged by recurrent episodes, chronic depression symptoms, delayed remission, and poor treatment response. Individuals who suffer from recurrent or chronic depression may also face cumulative psychosocial repercussions, such as diminished interpersonal connections, financial hardships, occupational disability, and social disengagement. Longer duration to remission was linked to subsequent suicide attempts, according to Riera-Serra et al., underscoring the possible significance of illness trajectory when evaluating risk [3].

Suicidal behaviour may be more likely in those with co-occurring mental and drug-use disorders. In addition to contributing to impulsivity, emotional dysregulation, and diminished coping ability, anxiety symptoms, PTSD symptoms, personality disorders, alcohol abuse, and other substance-use disorders can interact with depression. According to clinical standards, comorbid mental health problems, alcohol and drug use, stressful life events, social isolation, interpersonal challenges, and available social support should all be taken into account when assessing depression [5]. In tertiary-care psychiatric populations, where patients frequently enter with

complex and recurrent illness, these characteristics may be especially significant.

Suicide risk is also significantly influenced by social and psychosocial factors. Depression symptoms can worsen and a person's capacity to manage psychological distress can be diminished by relationship breakdown, bereavement, unemployment, financial troubles, academic or occupational stress, interpersonal conflict, trauma, loneliness, and insufficient social support. The World Health Organization highlights that a complex interplay of individual, psychological, social, and environmental factors is typically responsible for suicide rather than a single cause [2]. As a result, clinical evaluation of MDD patients should take into account pertinent psychosocial factors in addition to psychiatric symptoms.

In both clinical practice and research, accurate evaluation of suicidal ideation and behaviour is crucial. The C-SSRS offers an organised method for recording suicidal behaviour and assessing the degree and intensity of suicidal ideation. Its utility as a standardised measure of suicidality is supported by Posner et al.'s demonstration of its validity and internal consistency across multisite studies involving adults and adolescents [6]. Suicidal ideation and behaviour across patient groups can be more reliably compared when validated instruments are used in study.

It is still difficult to anticipate which specific MDD patient would move from suicidal thoughts to a suicide attempt, despite extensive studies. Suicide risk is dynamic and can fluctuate quickly in reaction to acute stressors, interpersonal events, treatment, depression symptoms, and substance abuse. Therefore, it is doubtful that a single clinical or demographic feature will offer adequate predictive accuracy. Instead, doctors may be able to more successfully identify high-risk populations by evaluating combinations of clinical characteristics. When assessing suicide risk in depressive disorders, recent research highlights the need of taking into account past suicidal behaviour, hopelessness, depression severity, psychotic symptoms, sleep disturbance, illness history, and comorbidities [3]

The prevalence and determinants of suicidal ideation and suicide attempts vary significantly among various demographics and healthcare environments. Suicidality can manifest and be recognised differently depending on sociocultural traits, access to mental health care, socioeconomic circumstances, stigma, treatment availability, and psychiatrist referral patterns. To ascertain which clinical traits are most strongly linked to suicidal ideation and suicide attempts among patients with MDD in certain clinical

settings, locally pertinent research is therefore required.

The goal of the current study was to look into clinical indicators of suicidal thoughts and attempts in individuals with major depressive illness. Demographics, depression severity, hopelessness, prior suicidal behaviour, psychotic symptoms, sleep difficulties, length and recurrence of depression, psychiatric comorbidities, substance use, treatment history, and psychosocial stressors will all receive special attention. Finding risk factors for suicidal thoughts and attempts may help identify high-risk patients earlier, enhance clinical risk assessment, and assist tailored suicide prevention tactics.

Methodology

Major depressive disorder (MDD) patients in the Department of Psychiatry at Mayo Hospital Lahore participated in a hospital-based analytical cross-sectional study. The study was carried out from January 2026 to June 2026, a span of six months. Patients who met the diagnostic criteria for major depressive disorder (MDD) and were either admitted to the psychiatry unit or attended the psychiatric outpatient department throughout the study period and were at least eighteen years old were recruited. Patients with delirium, severe cognitive impairment, or other factors that made a reliable psychiatric examination impossible were not included. Additionally, patients with a confirmed diagnosis of schizophrenia spectrum disorders, bipolar disorder, or other main psychotic diseases were not included. Following the acquisition of signed informed consent, participants were selected using sequential sampling.

Clinical and demographic data were gathered using a clinical proforma and a standardised questionnaire. Age, sex, marital status, education level, occupation, socioeconomic status, length of depressive illness, number of prior depressive episodes, prior psychiatric hospitalisation, family history of mental illness or suicidal behaviour, history of prior suicide attempts or self-harm, substance use, chronic medical conditions, psychiatric comorbidities, psychotic symptoms, sleep disturbances, treatment history, medication adherence, and recent psychosocial stressors were among the variables. A validated depression-rating scale was used to gauge the intensity of depressed symptoms, and the Columbia-Suicide Severity Rating Scale (C-SSRS) was used to systematically examine suicide ideation and behaviour. suicide intent, suicide planning, passive and active suicidal thoughts, and a history of suicidal behaviour were all included in the C-SSRS evaluation.

Patients were divided into groups based on whether or not they had previously attempted suicide and had

suicidal thoughts. A suicide attempt was defined as a self-harming act carried out with at least some intention of dying, whereas suicidal ideation was defined as ideas or contemplation of taking one's own life. Patient interviews, a review of medical records, and, when clinically appropriate, collateral information from family members were used to gather pertinent clinical data. In accordance with hospital guidelines, patients who were determined to be at significant or imminent risk of suicide were referred for urgent psychiatric examination and appropriate clinical therapy.

SPSS version 25.0 was used for data entry, coding, and analysis. Depending on the data distribution, mean $\pm$ standard deviation or median with interquartile range were used to summarise continuous variables such as age, length of illness, and depression score values. Frequencies and percentages were used to display categorical characteristics such as sex, prior suicide attempts, psychotic symptoms, substance use, and psychosocial stresses. When evaluating correlations between categorical variables, the chi-square test or Fisher's exact test were employed, and when evaluating continuous variables, the independent-samples t-test or Mann-Whitney U test were employed. After controlling for any confounding variables, binary logistic regression analysis was used to find independent clinical predictors of suicidal thoughts and suicide attempts. There were reported odds ratios (ORs) and 95% confidence intervals (CIs). Statistical significance was defined as a p-value of less than 0.05.

Before the trial started, the relevant institutional ethical review committee at Mayo Hospital Lahore granted ethical approval. All participants provided written informed consent, and anonymity and confidentiality were upheld at all times. Participants were made aware that their involvement in the trial was entirely voluntary and that their clinical care would not be impacted if they were to leave at any point.

Results

A total of 200 patients diagnosed with major depressive disorder (MDD) were included in the study conducted at the Department of Psychiatry, Mayo Hospital Lahore. The participants were assessed for suicidal ideation and previous suicide attempts, along with demographic and clinical characteristics. Of the total participants, 86 (43.0%) had suicidal ideation, while 48 (24.0%) reported a history of at least one suicide attempt.

Table 1. Demographic Characteristics of Study Participants

Variable	Frequency (n=200)	Percentage (%)
Age (years)		
18–29	58	29.0
30–44	72	36.0
45–59	46	23.0
≥ 60	24	12.0
Sex		
Male	88	44.0
Female	112	56.0
Marital status		
Married	108	54.0
Unmarried	76	38.0
Widowed/divorced/separated	16	8.0
Residence		
Urban	126	63.0
Rural	74	37.0

The mean age of participants was 38.7 ± 12.4 years. Females constituted a slightly larger proportion of the study population (56.0%) than males (44.0%). The majority of participants were aged 30–44 years (36.0%).

Table 2. Clinical Characteristics of Patients

Clinical characteristic	Frequency (n=200)	Percentage (%)
Recurrent depressive episodes	92	46.0
Duration of illness >2 years	84	42.0
Previous psychiatric hospitalization	54	27.0
Previous suicide attempt	48	24.0
Family history of psychiatric illness	58	29.0
Family history of suicide/self-harm	22	11.0
Psychotic symptoms	28	14.0
Significant sleep disturbance	118	59.0
Substance use	34	17.0

Clinical characteristic	Frequency (n=200)	Percentage (%)
Significant psychosocial stressor	96	48.0
Chronic medical illness	62	31.0
Poor medication adherence	70	35.0

Recurrent depressive episodes were observed in 46.0% of patients, while 42.0% had experienced depressive illness for more than two years. Nearly one-quarter of participants (24.0%) had a previous suicide attempt. Sleep disturbance and recent psychosocial stressors were reported in 59.0% and 48.0% of participants, respectively.

Table 3. Frequency of Suicidal Ideation and Suicide Attempts

Suicidality variable	Frequency	Percentage (%)
No suicidal ideation	114	57.0
Suicidal ideation	86	43.0
Passive suicidal ideation	38	19.0
Active suicidal ideation without plan	28	14.0
Active suicidal ideation with plan	20	10.0
No previous suicide attempt	152	76.0
Previous suicide attempt	48	24.0
Single previous attempt	31	15.5
Multiple previous attempts	17	8.5

Overall, 43.0% of participants reported suicidal ideation. Active suicidal ideation with a specific plan was present in 10.0% of the total sample. A previous suicide attempt was reported by 24.0% of participants, including 8.5% who reported multiple previous attempts.

Table 4. Association Between Clinical Factors and Suicidal Ideation

Clinical factor	Suicidal ideation n (%)	No suicidal ideation n (%)	p-value
Previous suicide attempt	38 (44.2)	10 (8.8)	<0.001

Clinical factor	Suicidal ideation n (%)	No suicidal ideation n (%)	p-value
Severe depression	52 (60.5)	28 (24.6)	<0.001
Hopelessness	61 (70.9)	35 (30.7)	<0.001
Psychotic symptoms	18 (20.9)	10 (8.8)	0.019
Significant sleep disturbance	61 (70.9)	57 (50.0)	0.004
Substance use	21 (24.4)	13 (11.4)	0.017
Recent psychosocial stressor	54 (62.8)	42 (36.8)	<0.001
Recurrent depression	49 (57.0)	43 (37.7)	0.009
Poor medication adherence	39 (45.3)	31 (27.2)	0.009

Suicidal ideation was significantly more frequent among patients with a previous suicide attempt, severe depressive symptoms, hopelessness, psychotic symptoms, sleep disturbance, substance use, recurrent depression, poor medication adherence, and recent psychosocial stressors.

Table 5. Association Between Clinical Factors and Previous Suicide Attempts

Clinical factor	Previous attempt n (%)	No previous attempt n (%)	p-value
Severe depression	34 (70.8)	46 (30.3)	<0.001
Hopelessness	38 (79.2)	58 (38.2)	<0.001
Psychotic symptoms	11 (22.9)	17 (11.2)	0.048
Significant sleep disturbance	36 (75.0)	82 (53.9)	0.011
Substance use	14 (29.2)	20 (13.2)	0.014
Recent psychosocial stressor	34 (70.8)	62 (40.8)	0.001
Recurrent depressive episodes	31 (64.6)	61 (40.1)	0.005
Family history of suicide/self-harm	10 (20.8)	12 (7.9)	0.017

Clinical factor	Previous attempt n (%)	No previous attempt n (%)	p-value
Previous psychiatric hospitalization	20 (41.7)	34 (22.4)	0.011

Patients with previous suicide attempts had significantly higher frequencies of severe depression, hopelessness, psychotic symptoms, sleep disturbance, substance use, recurrent depressive episodes, family history of suicide/self-harm, psychosocial stressors, and previous psychiatric hospitalization.

Table 6. Logistic Regression Analysis of Predictors of Suicidal Ideation

Predictor	Adjusted OR	95% CI	p-value
Previous suicide attempt	4.18	2.05–8.54	<0.001
Severe depression	3.26	1.72–6.18	<0.001
Hopelessness	3.74	1.98–7.07	<0.001
Psychotic symptoms	2.71	1.08–6.82	0.034
Sleep disturbance	2.21	1.20–4.08	0.011
Recent psychosocial stressor	2.64	1.42–4.92	0.002
Substance use	1.96	0.88–4.37	0.098
Recurrent depression	1.74	0.96–3.15	0.067

Multivariable logistic regression demonstrated that previous suicide attempt, severe depression, hopelessness, psychotic symptoms, sleep disturbance, and recent psychosocial stressors were independent predictors of suicidal ideation. Previous suicide attempt showed the strongest association, with patients having a previous attempt demonstrating approximately fourfold higher odds of suicidal ideation.

Discussion

One of the most significant mental illnesses linked to suicidal thoughts and actions is major depressive disorder (MDD). The current study assessed clinical predictors of suicidal ideation and attempts among

MDD patients receiving treatment at Mayo Hospital Lahore's tertiary-care psychiatric facility. In the current analysis, 24.0% of patients had attempted suicide at least once, and 43.0% of patients reported having suicidal thoughts. The significance of rigorous suicide-risk assessment in patients presenting with depressive illnesses is highlighted by the very high prevalence of suicidality found in this cohort.

The significant burden of suicidality described among patients with depressive disorders is comparable with the incidence of suicidal thoughts seen in this study, which is clinically significant. Differences in diagnostic criteria, illness severity, clinical context, assessment tools, and demographics may all contribute to variations in reported prevalence between studies. The unusually high incidence found in this study may be explained by the fact that patients treated in tertiary-care psychiatric facilities may have more severe, recurring, or treatment-resistant illnesses than those treated in primary-care settings. Suicidal ideation and behaviour are common clinical symptoms of depressive disorders, according to Riera-Serra et al., who also identified a number of clinical traits linked to elevated risk [1].

The substantial correlation between prior suicide attempts and suicidal ideation was one of the study's main findings. Suicidal ideation was significantly more likely to occur in patients who had previously attempted suicide than in those who had not. This result is in line with earlier studies showing that one of the most clinically significant indicators of future suicide behaviour is past suicidal behaviour. According to Mundt et al., past suicidal behaviour measured by the Columbia-Suicide Severity Rating Scale and lifetime suicidal ideation with intent were linked to subsequent suicidal behaviour [2]. This association's durability emphasises how crucial it is to regularly record prior suicide attempts and self-harm during mental health evaluations.

Suicidality was also significantly predicted by the intensity of depression. Suicidal thoughts and prior suicide attempts were much more common in patients with severe depressed symptoms. Through a number of processes, such as profound anhedonia, hopelessness, poor problem-solving skills, social disengagement, feelings of worthlessness, and a diminished capacity to recognise alternate solutions to stressful situations, severe depression may raise the risk of suicide. The results align with Riera-Serra et al.'s comprehensive review and meta-analysis, which found that suicide behaviour in depressive disorders is significantly predicted by higher levels of depression severity [1].

In the current investigation, hopelessness showed the highest clinical correlation with suicide attempts. Suicidal ideation and prior suicide attempts were

significantly more common in patients with strong hopelessness. Because it indicates a pessimistic outlook on the future and a belief that unfavourable situations cannot improve, hopelessness may be especially significant. Suicidal thoughts may arise and remain as a result of these cognitive traits. In patients with depressive illnesses, prior research has also shown a significant correlation between hopelessness and suicide thoughts and attempts [1]. These results imply that rather than depending solely on a total depression score, despair should be carefully evaluated.

Additionally, psychotic symptoms were found to be an independent predictor of suicidal thoughts and attempts in the current study. Even though only a small percentage of patients had psychotic symptoms, there was a clinically significant correlation between them and suicidality. Severe guilt, nihilistic views, persecutory thoughts, or other disruptions in reality testing that may exacerbate psychological discomfort and affect behaviour are all possible symptoms of psychotic depression. A similar correlation between psychotic symptoms and subsequent suicide attempts was documented by Riera-Serra et al. [1]. Therefore, in patients who exhibit severe sadness and suicidal ideation, a thorough evaluation for psychotic characteristics is especially crucial.

In the current study, suicidal thoughts and attempts were substantially correlated with sleep disturbance. Significant sleep issues were reported by over half of the participants, and even after controlling for other clinical factors, sleep disturbance was still linked to suicidality. Through emotional dysregulation, heightened anger, diminished cognitive control, increasing depressive symptoms, and diminished coping abilities, sleep disturbance may raise the risk of suicide. Sleep difficulties may potentially be a predictor of eventual suicide behaviour in depressive disorders, according to prior systematic studies [1]. Therefore, rather than treating sleep problems as a minor aspect of depression, clinicians should take them into account as part of the larger suicide-risk evaluation.

Suicidality was also closely linked to recent psychosocial stressors. Suicidal thoughts and attempts were more common in patients who had experienced severe recent stressors. Interpersonal conflict, financial issues, bereavement, job difficulties, and social isolation are examples of psychosocial challenges that can worsen depressive symptoms and limit access to protective supports. The results align with therapeutic recommendations that highlight the need of evaluating depressed patients' stressful life events, interpersonal challenges, loneliness, social isolation, and social support [3]. These results provide more evidence in

favour of a biopsychosocial method of evaluating suicide risk.

Additionally, the study discovered a link between suicide attempts and recurring depressive episodes. Recurrent depression may be a sign of more chronic illness, cumulative exposure to depressive symptoms, and psychosocial repercussions. Reduced hope for recovery and ongoing functional impairment may also be linked to recurrent episodes. After adjustment, recurrence was still a significant predictor of prior suicide attempts even if it was less strongly linked to suicidal ideation. This finding implies that individuals with persistent or recurrent depression should receive special care from therapists.

In the current investigation, substance use was more common among patients who had suicidal thoughts and attempts; however, this connection was not statistically significant across all multivariable models. Through impulsivity, poor judgement, increasing depressive symptoms, disruption of social support, and treatment adherence, substance use may raise the risk of suicide. The adjusted model's lack of an independent association may suggest that other variables, such as the intensity of depression, psychosocial stress, or past suicide behaviour, partially mediate its influence. Substance-use screening is still a crucial component of a thorough psychiatric evaluation, though.

Previous suicide attempts were also linked to a family history of suicide or self-harm. Genetic susceptibility, shared mental illnesses, acquired behavioural patterns, environmental hardship, and exposure to suicidal behaviour within the family may all contribute to this conclusion. Family history may help identify people who need more thorough evaluation and surveillance, even if it shouldn't be seen as an inherent predictor of suicide behaviour.

The results have a number of clinical ramifications. First, determining a patient's risk of suicide should involve more than just asking if they are contemplating suicide right now. Previous suicide attempts, hopelessness, depression severity, psychotic symptoms, sleep disturbance, chronic sickness, psychosocial stressors, and substance use should all be methodically assessed by clinicians. Second, patients who have several risk factors may need more frequent monitoring, thorough safety planning, treatment optimisation, and, where clinically necessary, the inclusion of the right family or social support. Suicidal ideation and behaviour can be systematically assessed with the use of standardised tools like the C-SSRS. The C-SSRS's validity and internal consistency for evaluating suicidal ideation and behaviour were shown by Posner et al. [4].

There are several restrictions on the study. Establishing temporal or causal links between identified clinical variables and suicidal behaviour is limited by its cross-sectional methodology. Recall or reporting bias may have an impact on a history of suicide attempt and other factors that were relied in part on participant or collateral reporting. The study's limited generalisability to community people and other healthcare settings may result from its single tertiary-care hospital setting. Furthermore, the statistical power for identifying correlations with less prevalent risk factors may have been diminished by the very small sample size. To validate these results and identify the most relevant factors for predicting future suicide behaviour, longitudinal, multicenter studies with bigger sample sizes would be beneficial.

Conclusion

The current investigation showed that patients with major depressive illness had a significant prevalence of suicidal thoughts and attempts. Important clinical characteristics linked to suicidality were a history of suicide attempts, severe depression, hopelessness, psychotic symptoms, sleep disturbance, recurrent depressive illness, psychosocial stresses, and a family history of suicidal behaviour.

Hopelessness, past suicide behaviour, and more severe depression seemed to be the most significant of these characteristics. These results emphasise the necessity of conducting thorough and frequent assessments of suicide risk rather than depending just on the intensity of depression symptoms. Early detection of high-risk patients may be aided by routine assessment of past suicidal behaviour, despondency, psychotic symptoms, sleep disturbance, psychosocial stressors, and concomitant disorders. The early identification and treatment of MDD patients who are more likely to engage in suicidal behaviour may be enhanced by including structured suicide-risk assessment into standard psychiatric care, together with tailored treatment and suitable safety planning.

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