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Suicide Risk in Psychiatric Patients: An Analysis of Demographic and Psychosocial Factors

Psikiyatrik Hastalarda İntihar Riski: Demografik ve Psikososyal Faktörlerin Analizi

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ABSTRACT

The aim of this study is to assess the likelihood of suicide in patients diagnosed with psychiatric disorders and currently receiving treatment, and to examine the relationship between this likelihood and demographic data, as well as psychosocial factors. Using a descriptive and cross-sectional model, the data from 165 participants were collected and evaluated through a personal information form and the Suicide Probability Scale (SPS). The study revealed significant relationships between suicide risk and variables such as age, education level, marital status, place of residence, and types of social support. It was also highlighted that the participants generally had a negative perception of their psychological health, and individuals lacking emotional social support showed higher levels of hopelessness and negative self-concept. Furthermore, individuals receiving low social support were found to have a higher suicide risk. The findings indicate that social work professionals can play a significant role in identifying individuals at risk for suicide and developing preventive measures. These results point to the necessity of strengthening social support systems and improving psychological health services.

Keywords: Suicide, Suicide Probability, Demographic Factors, Psychosocial Factors

ÖZET

Bu çalışmanın amacı, psikiyatrik bozukluk tanısı almış ve halen tedavi görmekte olan hastalarda intihar olasılığını değerlendirmek ve bu olasılığın demografik veriler ile psikososyal faktörlerle olan ilişkisini incelemektir. Tanımlayıcı ve kesitsel bir model kullanılarak, 165 katılımcıdan elde edilen veriler kişisel bilgi formu ve İntihar Olasılığı Ölçeği (SPS) aracılığıyla toplanmış ve değerlendirilmiştir. Çalışma, intihar riski ile yaş, eğitim düzeyi, medeni durum, yaşanılan yer ve sosyal destek türleri gibi değişkenler arasında anlamlı ilişkiler olduğunu ortaya koymuştur. Katılımcıların genel olarak psikolojik sağlıklarına dair olumsuz bir algıya sahip oldukları ve duygusal sosyal desteği olmayan bireylerde umutsuzluk ve olumsuz benlik algısının daha yüksek olduğu vurgulanmıştır. Ayrıca, düşük sosyal destek alan bireylerin daha yüksek intihar riski taşıdığı belirlenmiştir. Bulgular, sosyal hizmet uzmanlarının intihar riski taşıyan bireyleri belirlemede ve önleyici tedbirler geliştirmede önemli bir rol oynayabileceğine işaret etmektedir. Bu sonuçlar, sosyal destek sistemlerinin güçlendirilmesi ve psikolojik sağlığın iyileştirilmesinin gerekliliğini ortaya koymaktadır.

Anahtar Kelimeler: İntihar, İntihar Olasılığı, Demografik Faktörler, Psikososyal Faktörler

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INTRODUCTION

Suicidal behavior encompasses a range of phenomena linked to suicide and includes actions undertaken by individuals with the intention of ending their lives, which may or may not result in death. The most relevant of these behaviors are the suicide itself (death) and suicide attempts. Suicide attempts share phenomenological characteristics with suicides, differing primarily in the non-fatal outcomes (Bertolote et al., 2010). One of the most valid classifications of suicide, the "Beck Committee Classification," addresses suicide in three fundamental dimensions: suicidal thoughts, suicide attempts, and completed suicides (Eskin, 2014).

Globally, suicide accounts for 1.4% of premature deaths (Bachmann, 2018), with more than 700,000 people dying from suicide each year. Seventy-seven percent of these deaths occur in low- and middle-income countries (World Health Organization, 2023). Suicide is recognized as a global public health issue, and psychiatric disorders constitute a significant risk factor for suicide (Bachmann, 2018; Van Orden et al., 2010).

Psychiatric disorders contribute substantially to the global disease burden. Since 1990, psychiatric disorders have increased by 4.3% per age (Wasserman et al., 2021). Mental illnesses such as depression, bipolar disorder, anxiety, and schizophrenia significantly raise the risk of suicide. Individuals with psychiatric disorders face a suicide risk 3

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to 12 times higher than the general population, with this ratio increasing 5 to 10 times in those receiving psychiatric treatment (Beghi et al., 2010; Knipe et al., 2019). A study by Karslı (2022) found that when asked, "Have you ever thought about killing yourself?" affirmative responses were given by 38.3% of psychiatric patients, 20.8% of gastroenterology patients, 11.7% of oncology patients, and 6.7% of the control group. Similarly, conditions such as borderline personality disorder, depression, opioid use, schizophrenia, anorexia nervosa, and alcohol use disorders were identified as significant factors increasing suicide risk, particularly among women (Wasserman et al., 2021). In individuals receiving psychiatric treatment, this risk is further amplified, with mood disorders identified in approximately 25% of suicide attempts (Knipe et al., 2019). Recent studies emphasize the critical role of social support systems in reducing suicide risk. Specifically, emotional support serves as an important buffer in the lives of individuals with suicidal thoughts (Alves et al., 2016). The lack of informational and instrumental support is another significant factor contributing to increased suicide risk (Wasserman et al., 2021). The WHO's 2023 report emphasizes the need to strengthen social support mechanisms, particularly in low- and middle-income countries.

The literature demonstrates a strong relationship between psychiatric disorders and suicide. Moreover, social support systems and environmental factors play a critical role in determining suicide risk. It is important to remember that suicide is a wide-reaching social issue that affects not only the individual but also their families, communities, and social circles. The communities affected by the suicide of a loved one experience significant ripple effects. Given the recent increase in psychiatric disorders within the general population, investigating the risk factors for suicide among psychiatric patients has become crucial. Social work professionals, with their ability to approach issues from an ecological perspective, can intervene at the micro, mezzo, and macro levels. Through methods such as counseling, psycho-education, and increasing social awareness, they aim to reduce suicide risk (San Too et al., 2019; Alves et al., 2016). In this context, it is essential for social workers to identify suicide risk factors, assess research findings, and apply the obtained knowledge in preventive, protective, and therapeutic services.

The dependent variable of this study is suicide risk, which is the primary outcome variable. The independent variables include participants' demographic factors (age, education level, marital status, and place of residence) and psychosocial factors (physical/psychological health perception and social support status).

The research questions are as follows:

- ✓ What is the relationship between demographic factors and suicide risk?
- ✓ What is the relationship between physical/psychological health perception and suicide risk?
- ✓ What is the relationship between types of social support and suicide risk?

MATERIALS AND METHODS

Research Design and Sample

This quantitative study was conducted using a descriptive and cross-sectional model. The study population consisted of 165 patients diagnosed with psychiatric disorders who are currently undergoing treatment. The participants were individuals aged 18 and over, without intellectual disability, possessing cognitive competency, not experiencing acute psychotic episodes, and who consented to participate in the study. The socio-demographic characteristics of the participants are presented in Table 1.

Table 1: Socio-Demographic Characteristics of Participants

Feature	Subcategory	N	%
Gender	Famele	115	69.7
	Male	50	30.3
Age	18-24	57	34.5
	25-34	40	24.2
	35-44	40	24.2
	45-54	18	10.9
	55+	10	6.1
Education	Primary School	21	12.7
	Middle School	5	3.0
	High School	61	37.0
	Bachelor's Degree	73	44.2
	Graduate Degree	5	3.0
Marital Status	Married	81	49.1
	Single	84	50.9
Parenthood	Yes	83	50.3
	No	82	49.7
Place of Residence	Rurall	19	11.5
	City	62	37.6
	Metropolis	84	50.9
Employment Status	Employed	89	53.9
	Unemployed	76	46.1
Socioeconomic Status	Low	25	15.2
	Middle	133	80.6
	High	7	4.2

As shown in Table 1, the majority of the participants were female (69.7%) and the age distribution was mostly concentrated in the 18-24 age range (34.5%). In terms of education, most participants were high school graduates (37.0%) or had a bachelor's degree (44.2%). Regarding marital status, participants were almost equally distributed between single (50.9%) and married (49.1%). The distribution of participants with children was also similar. Over half of the participants (50.9%) lived in large cities, while 37.6% lived in urban areas, and 11.5% lived in rural areas. Regarding employment status, 53.9% of the participants were employed, and 46.1% were not. In terms of socio-economic status, the majority of participants (80.6%) were in the middle-income group, 15.2% were in the low-income group, and 4.2% were in the high-income group.

Data Collection Tools

Data were collected using the Personal Information Form and the Suicide Probability Scale (SPS). The research tools were prepared as printed questionnaires and were provided to the participants.

- ✓ **Personal Information Form**: This form, developed by the researchers, collects demographic information such as gender, age, marital status, parental status, education and employment status, and socio-economic level. It also includes questions regarding physical and psychological health perceptions and whether participants benefit from social support systems.
- ✓ **Suicide Probability Scale (SPS)**: The SPS, developed by Cull and Gill (1990) to assess suicide risk in adolescents and adults, was adapted to Turkish by Atlı, Eskin, and Dereboy (2009). The scale measures four sub-factors: hopelessness, suicidal thoughts, hostility, and negative self-concept. The scale consists of 36 items and uses a 4-point Likert-type measurement ranging from "never or rarely (1)", "sometimes (2)", "often (3)", to "most of the time or always (4)". The score range is 36-144, with higher scores indicating a higher likelihood of suicide risk (Karslı, 2022; Atlı et al., 2009).

Data Collection and Analysis

Participants were informed about the purpose of the study, and their verbal/written consent was obtained. Data were collected through face-to-face interviews with voluntary participants in a separate room, with each interview lasting approximately 30 minutes. SPSS 22.0 statistical software was used for data analysis.

FINDINGS

In the findings of the study, the relationships between factors such as participants' age, marital status, education level, and place of residence with the probability of suicide were first analyzed. Following this, the findings related to how participants evaluated their health perceptions and social support (emotional, social, instrumental, and moral support) were presented in tables and discussed. Additionally, in this section, the relationship between participants' health perceptions, social support, and suicide probability was also analyzed.

Table 2: ANOVA Results Comparing the Mean and Standard Deviation Values of Suicide Probability with Age Distribution

Score Types	18-24 (n=57)	25-34 (n=40)	35-44 (n=40)	45-55 (n=18)	55+ (n=10)	F	p
Hopelessness	29.9 (5.5)	27.7 (6.7)	29.4 (4.9)	32.1 (6.7)	24.4 (4.9)	3.564	.008*
Suicidal Ideation	23.3 (3.9)	23.1 (4.1)	23.9 (4.1)	24.6 (4.7)	27.8 (3.4)	2.903	.024*
Negative Self-Perception	23.9 (4.6)	23.4 (5.6)	23.6 (4.5)	23.8 (4.3)	21.4 (4.1)	.613	.654
Hostility	14.4 (3.5)	12.4 (3.1)	13.3 (4.1)	13.4 (3.6)	9.9 (2.3)	4.440	.002*
Total	91.7 (11.2)	86.8 (12.9)	90.4 (10.5)	94.1 (10.3)	83.5 (8.3)	2.577	.040*

*p<.05

As seen in Table 2, the ANOVA analysis revealed significant differences between age groups in terms of hopelessness, suicidal thoughts, hostility, and total scores. The post-hoc Games-Howell test indicated that participants in the 18-24 age group ($\bar{}$=29.9, SD=5.5) experienced significantly more hopelessness compared to participants in the 55+ age group ($\bar{}$=24.4, SD=4.9). However, participants in the 55+ age group ($\bar{}$=27.8, SD=3.4) reported significantly higher suicidal thoughts than participants in the 18-24 age group ($\bar{}$=23.3, SD=3.9). Regarding hostility levels, participants in the 18-24 age group ($\bar{}$=14.4, SD=3.5) displayed more hostility compared to participants in the 25-34 age group ($\bar{}$=12.4, SD=3.1) and the 55+ age group ($\bar{}$=9.9, SD=2.3). Additionally, participants in the 35-44 ($\bar{}$=13.3, SD=4.1) and 45-55 ($\bar{}$=13.4, SD=3.6) age groups exhibited more hostility compared to those in the 55+ age group ($\bar{}$=9.9, SD=2.3).

Table 3: ANOVA Results Comparing the Mean and Standard Deviation Values of Suicide Probability with Education Level

Score Types	Primary School n=21	Primary School n=5	High School n=61	Bachelor's Degree n=73	Graduate Degree n=5	F	p
Hopelessness	29.4 (6.4)	33.8 (1.4)	30.5 (6.4)	27.8 (5.8)	27.6 (5.0)	2.498	.045*
Suicidal Ideation	25.8 (4.2)	24 (2.4)	24 (4.1)	23.2 (4.2)	22.6 (4.5)	1.653	.164
Negative Self-Perception	23.1 (4.3)	25 (6.8)	24.9 (4.9)	22.6 (4.5)	20 (2)	2.928	.023*
Hostility	12.5 (3.7)	13 (1.8)	13.7 (3.2)	13.2 (3.2)	12.8 (3.3)	.440	.780
Total	91 (11.1)	96.4 (8.3)	93.2 (10.2)	87 (11.4)	83.2 (11.7)	3.526	.009*

*$p<.05$

As shown in Table 3, the ANOVA analysis by education level revealed significant differences in hopelessness, negative self-image, and total scores. The post-hoc Games-Howell test demonstrated that participants with a middle school education ($\bar{}$=33.8, SD=1.4) experienced significantly more hopelessness compared to participants with high school ($\bar{}$=30.5, SD=6.4) and university degrees ($\bar{}$=27.8, SD=5.8). Additionally, high school graduates ($\bar{}$=24.9, SD=4.9) displayed significantly more negative self-image compared to university graduates ($\bar{}$=22.6, SD=4.5) and those with postgraduate education ($\bar{}$=20, SD=2). In terms of total scores, high school graduates ($\bar{}$=93.2, SD=10.2) showed higher suicide risk compared to university graduates ($\bar{}$=87, SD=11.4).

Table 4: Results of the t-test Comparing the Mean and Standard Deviation Values of Suicide Probability by Marital Status

Marital Status	Married (n=81)	Single (n=84)	T	p
Hopelessness	27.8 (5.9)	29.6 (6.3)	-0.898	.370
Suicidal Ideation	24.1 (4.4)	23.5 (4.0)	0.953	.342
Negative Self-Perception	23.2 (4.1)	23.8 (5.3)	-0.747	.454
Hostility	12.5 (3.2)	14 (3.9)	-2.579	.011*
Total	88.8 (10.2)	91 (12.5)	-1.253	.210

*$p<.05$

As shown in Table 4, a significant difference was observed between marital status and suicide probability only in the hostility subscale. Single participants ($\bar{}$=14, SD=3.9) exhibited significantly higher hostility compared to married participants ($\bar{}$=12.5, SD=3.2) (p=.011).

Table 5: ANOVA Results Comparing the Mean and Standard Deviation Values of Suicide Probability by Place of Residence

Score Types	Rural (n=19)	City (n=62)	Metropolis (n=84)	F	P
	X̄ (SS)	X̄ (SS)	X̄ (SS)		
Hopelessness	29.5 (6.7)	28 (6.1)	30 (5.9)	1.773	.173
Suicidal Ideation	24.6 (3.5)	23.9 (4.3)	23.6 (4.2)	.421	.657
Negative Self-Perception	23.7 (4.3)	22.5 (4.5)	24.5 (5.0)	2.439	.090
Hostility	13.2 (4.0)	12.6 (3.3)	13.3 (3.7)	1.735	.180
Total	91.1 (11.5)	87.2 (11.4)	91.7 (11.3)	2.959	.048*

*$p<.05$

As presented in Table 5, the ANOVA results indicate a significant difference between the total score of suicide probability and place of residence (F (2, 162) = 2.959, p = .048). Post-hoc analysis (Games-Howell) revealed that participants residing in metropolitan areas had significantly higher suicide risk compared to those living in urban areas.

Table 6: Participants' Perceptions of Health

Health Perception	Perceived Condition	N	%
Physical Health Perception	Very Poor	2	1,2
	Poor	30	18,2
	Normal	56	33,9
	Good	71	43,1
	Very Good	6	3,6
Psychological Health Perception	Very Poor	28	17,0
	Poor	55	33,3
	Normal	56	33,9
	Good	25	15,2
	Very Good	1	0,6

As shown in Table 6, 43.1% of participants rated their physical health as "Good," indicating a generally positive perception of physical health. Additionally, 33.9% perceived their physical health as "Average." On the other hand, 18.2% of participants rated their physical health as "Poor," and 1.2% described it as "Very Poor." In contrast, findings regarding psychological health perceptions were more negative compared to physical health. While 33.3% of participants described their psychological health as "Poor," 17% rated it as "Very Poor." Meanwhile, 33.9% perceived their psychological health as "Average," and 15.2% considered it "Good." The percentage of participants who classified their psychological health as "Very Good" was notably low, at only 0.6%.

Table 7: Participants' Social Support Status

Social Support	Perceived Status	N	%
Emotional Social Support Status	**Available**	114	69,1
	Not Available	51	30,9
Informational Support Status	Available	113	68,5
	Not Available	52	31,5
Instrumental Social Support Status	Available	83	50,3
	Not Available	82	49,7
Trust-Moral Support Status	Available	117	70,9
	Not Available	48	29,1

As shown in Table 7, 69.1% of participants reported receiving emotional social support, while 30.9% indicated a lack of such support. A similar distribution was observed for informational support, with 68.5% of participants stating they received this type of support, whereas 31.5% did not. Instrumental social support demonstrated a more balanced distribution, with 50.3% reporting they received it and 49.7% stating they did not. Notably, 70.9% of participants reported receiving trust and morale support, making it the most prevalent type of social support compared to others.

Table 8: Pearson Correlation Results Examining the Relationship Between Suicide Probability and Physical Health Perception

		Hopelessness	Suicidal Ideation	Negative Self-perception	Hostility	Total	Perceived Physical
Hopelessness	Pearson r	1	-,334**	,579**	,570**	,837**	-,202**
	P		,000	,000	,000	,000	,009
	N	165	165	165	165	165	165
Suicidal Ideation	Pearson r	-,334**	1	-,191*	-,409**	-,023	,025
	P	,000		,014	,000	,771	,752
	N	165	165	165	165	165	165
Negative Selfperception	Pearson r	,579**	-,191*	1	,506**	,819**	-,113
	P	,000	,014		,000	,000	,150
	N	165	165	165	165	165	165
Hostility	Pearson r	,570**	-,409**	,506**	1	,685**	-,179*
	P	,000	,000	,000		,000	,021
	N	165	165	165	165	165	165
Total	Pearson r	,837**	-,023	,819**	,685**	1	-,203**
	P	,000	,771	,000	,000		,009
	N	165	165	165	165	165	165
Perceived Physical	Pearson r	-,202**	,025	-,113	-,179*	-,203**	1
	P	,009	,752	,150	,021	,009	
	N	165	165	165	165	165	165

** p< 0.01. * p< 0.05

As shown in Table 8, Pearson correlation analysis revealed significant negative relationships between physical health perception and the subscales of suicide probability. Low-level negative correlations were found with hopelessness (r = -.202, p = .009), hostility (r = -.179, p = .021), and the total score (r = -.203, p = .009).

Table 9: Pearson Correlation Results Examining the Relationship Between Suicide Probability and Psychological Health Perception

		Hopelessness	Suicidal Ideation	Negative Self-Perception	Hostility	Total	Perceived Psychological Health
Hopelessness	Pearson r	1	-,334**	,579**	,570**	,837**	-,508**
	P		,000	,000	,000	,000	,000
	N	165	165	165	165	165	165
Suicidal Ideation	Pearson r	-,334**	1	-,191*	-,409**	-,023	,151
	P	,000		,014	,000	,771	,053
	N	165	165	165	165	165	165
Negative Self-Perception	Pearson r	,579**	-,191*	1	,506**	,819**	-,383**
	P	,000	,014		,000	,000	,000
	N	165	165	165	165	165	165
Hostility	Pearson r	,570**	-,409**	,506**	1	,685**	-,299**
	P	,000	,000	,000		,000	,000
	N	165	165	165	165	165	165
Total	Pearson r	,837**	-,023	,819**	,685**	1	-,472**
	P	,000	,771	,000	,000		,000
	N	165	165	165	165	165	165
Perceived Psychological Health	Pearson r	-,508**	,151	-,383**	-,299**	-,472**	1
	P	,000	,053	,000	,000	,000	
	N	165	165	165	165	165	165

** p< 0.01-* p< 0.05

As shown in Table 9, Pearson correlation analysis identified moderate negative relationships between psychological health perception and the subscales of suicide probability. Significant negative correlations were observed with hopelessness (r = -.508, p = .000), negative self-concept (r = -.383, p = .000), hostility (r = -.299, p = .000), and the total score (r = -.472, p = .000).

Table 10: t-test Results Comparing the Mean and Standard Deviation Values of Suicide Probability by Emotional Social Support Status

Receiving Emotional Support	M (SD)-YES (n=114)	M (SD)-NO (n=51)	t	P
Hopelessness	27.8 (5.9)	32.2 (5.6)	-4.5	.000**
Suicidal Ideation	23.9 (4.3)	23.6 (3.9)	.526	.599
Negative Self-Perception	22.7 (4.4)	25.3 (5.1)	-3.21	.002*
Hostility	12.9 (3.3)	14.1 (4.1)	-2.04	.043*
Total	87.5 (10.3)	95.4 (12.2)	-4.2	.000**

** p< 0.01-* p< 0.05

As presented in Table 10, t-test results revealed significant differences in hopelessness, negative self-concept, hostility, and total scores between participants who received emotional social support and those who did not. Participants without emotional support reported significantly higher mean scores for hopelessness (M = 32.2, SD = 5.6), negative self-concept (M = 25.3, SD = 5.1), hostility (M = 14.1, SD = 4.1), and total score (M = 95.4, SD = 12.2) compared to those with emotional support.

Table 11: t-test Results Comparing the Mean and Standard Deviation Values of Suicide Probability by Informational Support Status

Receiving Informational Support	M (SD) -YES (n=113)	M (SD) -NO (n=52)	t	p
Hopelessness	27.8 (6.0)	32.2 (5.4)	-4.4	.000**
Suicidal Ideation	24.1 (4.3)	23.2 (4.1)	1.3	.189
Negative Self-Perception	22.5 (4.3)	25.5 (5.1)	-4.06	.000**
Hostility	12.8 (3.4)	14.2 (3.9)	-2.2	.025*
Total	87.4 (10.6)	95.4 (11.6)	-4.3	.000**

** p< 0.01-* p< 0.05

As shown in Table 11, the t-test revealed significant differences in hopelessness, negative self-concept, hostility, and total scores between participants who received informational support and those who did not. Participants without informational support reported significantly higher mean scores for hopelessness (M = 32.2, SD = 5.4), negative self-concept (M = 25.5, SD = 5.1), hostility (M = 14.2, SD = 3.9), and total score (M = 95.4, SD = 11.6) compared to those with informational support.

Table 12: t-test Results Comparing the Mean and Standard Deviation Values of Suicide Probability by Instrumental Support Status

Receiving Instrumental Social Support	M (SD) YES (n=83)	M (SD) NO (n=82)	t	p
Hopelessness	27.7 (6.1)	30.7 (5.9)	-3.1	.002*
Suicidal Ideation	23.9 (4.6)	23.8 (3.7)	.150	.881
Negative Self-Perception	22.7 (4.6)	24.4 (4.8)	-2.6	.025*
Hostility	12.7 (3.2)	13.8 (3.8)	-2.02	.044*
Total	87.1 (11.3)	92.8 (10.9)	-3.25	.001*

**p<.05*

As shown in Table 12, t-test results identified significant differences in hopelessness, negative self-concept, hostility, and total scores between participants who received instrumental social support and those who did not. Participants without instrumental support reported significantly higher mean scores for hopelessness (M = 30.7, SD = 5.9), negative self-concept (M = 24.4, SD = 4.8), hostility (M = 13.8, SD = 3.8), and total score (M = 92.8, SD = 10.9) compared to those with instrumental support.

Table 13: t-test Results Comparing the Mean and Standard Deviation Values of Suicide Probability by Trust-Moral Support Status

Receiving Trust-Moral Support	M (SD) – YES (n=117)	M (SD) – NO (n=48)	t	p
Hopelessness	28.5 (6.2)	32.1 (4.8)	-3.9	.000**
Suicidal Ideation	23.9 (4.4)	23.6 (3.6)	.51	.610
Negative Self-Perception	22.6 (4.4)	25.8 (5.6)	-4.02	.000**
Hostility	13.0 (3.4)	14.0 (4.0)	-1.54	.124
Total	87.7 (11.0)	95.5 (10.7)	-4.15	.000**

***p<.001, *p<.05*

As shown in Table 13, t-test results revealed significant differences in hopelessness, negative self-concept, and total scores between participants who received trust-moral support and those who did not. Participants without trust-moral support reported significantly higher mean scores for hopelessness (M = 32.1, SD = 4.8), negative self-concept (M = 25.8, SD = 5.6), and total score (M = 95.5, SD = 10.7) compared to those with trust-moral support.

DISCUSSION

This study examined the relationships between some socio-demographic characteristics, physical and psychological health perceptions, social support receipt, and suicide probability in psychiatric patients who are currently undergoing treatment. The findings indicate significant relationships between suicide probability and demographic characteristics, health perceptions, and social support receipt among psychiatric patients. These findings are consistent with the existing literature, yet they can also be seen as contributing to expanding the literature in certain areas.

This study explored the effects of age groups, education level, marital status, place of residence, health perceptions, and types of social support on suicide probability. According to the findings, significant differences were found in hopelessness, suicidal ideation, and hostility levels between age groups. The higher levels of hopelessness and hostility among the younger age group are consistent with literature indicating that suicide risk is higher in younger individuals. Psychological difficulties experienced by young adults can be more pronounced, and these individuals are at higher risk due to increasing stress (Hawton & van Heeringen, 2009; Arnett, 2000). Twenge (2020) highlights the relationship between increasing suicidal thoughts and attempts among young people with the use of digital media and social pressures. On the other hand, the finding that older participants exhibited more suicidal thoughts aligns with the literature indicating an increased suicide risk in older individuals (Conwell & Thompson, 2008). This finding is also supported by studies that associate the elderly with physical health problems, social isolation, and life dissatisfaction (Blazer, 2009; Cairney & Krause, 2008).

In the analysis conducted based on education level, it was found that lower education levels are associated with higher levels of hopelessness and negative self-concept, increasing suicide risk. These findings align with studies indicating that individuals with higher education levels generally experience better mental health and lower suicide risk (Montez & Hayward, 2014). Stack (2000) notes that lower education levels are linked to social isolation, economic difficulties, and reduced coping abilities. Conversely, there are studies suggesting that higher education levels can enhance individuals' psychological resilience (Lo et al., 2016). Research has shown that improved problem-solving skills can reduce suicide risk. Individuals with higher problem-solving abilities are more successful in coping with stressful situations, which may lower their likelihood of resorting to suicide (Darvishi et al., 2023). Thus, these findings suggest that education could act as a protective factor against suicide risk. Pompili et al. (2012) state that increased education levels help individuals find more resources and support to maintain their mental health.

Findings related to marital status reveal that single individuals have significantly higher levels of hostility compared to married individuals. This finding supports the idea that marriage serves as a protective factor against suicide risk (Kposowa, 2000). The result is consistent with literature indicating that marriage helps protect mental health by providing social support and attachment, thereby reducing suicide risk (Umberson & Montez, 2010).

The impact of living environment on suicide risk was investigated, and the findings showed that participants living in metropolitan areas have a higher suicide risk. Reeves et al. (2015) note that individuals in large cities experience higher levels of stress and social isolation compared to those in rural areas. Urbanization is also suggested in the literature as a factor that may weaken community bonds, which could, in turn, increase suicide risk (Satherley et al., 2022; Qin, 2005).

The study also examined participants' perceptions of their physical and psychological health. The results revealed that most participants had a generally positive perception of their physical health, which points to an overall favorable view of their physical well-being. However, the presence of participants who rated their physical health negatively indicates that some individuals had negative health perceptions. It has been widely addressed in the literature that individuals with psychiatric disorders tend to have a lower perception of physical health compared to the general population (Doherty & Gaughran, 2014; Moreno et al., 2013).

More than half of the participants, however, rated their psychological health negatively. This finding aligns with existing studies suggesting that individuals with depression, anxiety disorders, and other mental health conditions often have a negative perception of their psychological health (Ohrnberger et al., 2017).

In analyses conducted to identify the relationship between physical and psychological health perceptions and suicide probability, a low-level negative relationship was found between physical health perception and suicide risk. This finding is consistent with studies showing that physical health problems can have a significant impact on psychological well-being and that individuals' perceptions of their health can influence their suicide risk (Breslow et al., 1980). A moderate negative relationship was found between psychological health perception and suicide risk, which supports findings that psychological health perceptions can have a significant impact on mental health (DeLongis et al., 1988; Gove et al., 1989). Additionally, these findings highlight that the effect of psychological health perception on suicide risk may be more pronounced (Cohen et al., 2007).

Social support is widely recognized in the literature as an important factor that positively influences both physical and psychological health (Thoits, 2011). Social support can facilitate individuals' coping with stress and reduce suicide risk (Thoits, 2011; Berkman et al., 2000). The study found that the vast majority of participants received emotional support, informational support, and security-moral support, and those who received these forms of support had lower suicide risks. These findings align with literature that emphasizes the positive effects of social support on individuals' well-being (Abbey et al., 1985). Conversely, the distribution of instrumental social support

was nearly equal between those who received it and those who did not. The literature highlights that psychiatric patients' insufficient use of instrumental support can negatively affect their independent living skills and overall health (Corrigan & Phelan, 2004). Instrumental support is considered crucial, especially during times of crisis and in coping with daily life challenges (Kaniasty, 2012).

Emotional social support appears to have a significant impact on individuals' suicide risk. Individuals who did not receive emotional support were found to have significantly higher levels of hopelessness, negative self-image, and hostility compared to those who received emotional support. These findings suggest that emotional support has a positive effect on psychological well-being and plays an important role in reducing suicide risk. The literature suggests that emotional support increases individuals' capacity to cope with stress, thus positively impacting their psychological well-being (Otsuka et al., 2019).

The relationship between informational support and suicide risk is also noteworthy. Individuals who did not receive informational support were observed to be at higher risk in terms of hopelessness and negative self-image. These findings indicate that informational support positively affects individuals' psychological well-being and their ability to cope with stress. Furthermore, the impact of instrumental social support on reducing suicide risk was also significant. Individuals who did not receive instrumental support experienced higher levels of hopelessness and negative self-image compared to those who did receive support. Instrumental support can ease individuals' ability to cope with daily life challenges, thus enhancing their stress management abilities. These findings are consistent with literature that suggests informational and instrumental social support increase coping capacity and support individuals' psychological well-being (Miller et al., 2015).

The relationship between security-moral support and suicide risk was also clearly evident. Individuals who did not receive security-moral support were found to have higher levels of hopelessness and negative self-image compared to those who did. Security-moral support can help individuals feel safer and more supported, which may reduce negative psychological states such as stress and hopelessness (Yang & Jiang, 2020).

These findings indicate that suicide risk is associated with various individual and environmental factors, such as age, education level, marital status, living area, and types of social support. Considering these factors in clinical practice is important for better supporting individuals at risk and developing effective intervention strategies. Future studies can provide valuable insights by examining these factors in more detail and evaluating the effectiveness of intervention programs. Additionally, developing personalized support and therapy approaches that take individual differences into account could be an important step in reducing suicide risk.

LIMITATIONS

This study has several limitations. First, the data is limited to a specific geographic region and cultural context, and the sample size does not cover the entire population, thus limiting the generalizability of the findings. Additionally, the sample size was restricted as participation was based on voluntary consent, and only individuals who were mentally prepared were included. The face-to-face data collection method may have increased the risk of bias. Since the study employs a cross-sectional design, it may have limitations in establishing causal relationships.

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