



Original Research Article

Psychological Autopsy of Suicidal Deaths Brought for Medicolegal Autopsy: A Cross-Sectional Study from a Tertiary Care Centre in Western India.

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Abstract: **Background:** Suicide accounts for a large share of the unnatural deaths subjected to medicolegal autopsy in India. The conventional autopsy establishes the cause and manner of death but reveals little about the mental state and life circumstances that preceded it. Psychological autopsy reconstructs this context through structured informant interviews and record review. Data from tertiary medicolegal centres in Western India remain limited. **Aim:** To describe the sociodemographic profile, place of occurrence, psychosocial stressors and psychiatric antecedents of suicidal deaths, and to assess the feasibility of psychological autopsy within routine medicolegal practice at a tertiary care centre in Western India. **Materials and Methods:** A hospital-based cross-sectional study was conducted in the Department of Forensic Medicine and Toxicology over 12 months July 2025 to July 2026. Consecutive deaths in which suicide was established on the basis of police history, scene information and post-mortem findings were included. A structured psychological-autopsy proforma, adapted from published instruments, was administered to adult relatives or close associates, and police inquest papers and available medical records were reviewed. Results are presented as frequencies and percentages with Wilson 95% confidence intervals (CI); the chi-square test was used for associations ($p < 0.05$). **Results:** Of 110 cases (age range 12–78 years), 84 (76.4%; 95% CI 67.6–83.3) were aged 15–44 years, the largest group being 25–34 years (29.1%). Males comprised 61.8% (male-to-female ratio 1.62:1); the age distribution did not differ significantly by sex ($\chi^2 = 0.59$, $df = 2$, $p = 0.75$). Most decedents (91.8%) had studied up to the 12th standard or less, and 92.7% of acts occurred at home. The leading antecedents were family/marital discord (34.5%; 95% CI 26.3–43.8), financial problems or unemployment (20.0%), known psychiatric illness (16.4%), interpersonal/romantic problems (13.6%) and alcohol- or substance-related problems (12.7%); 6.4% had prior self-harm. Interviews were completed in all cases and frequently yielded information absent from the police papers. **Conclusion:** Suicidal deaths at this centre predominantly involved young adults of modest educational attainment, occurred at home, and were preceded by interpersonal and financial stressors. Psychological autopsy was feasible within the mortuary workflow and added forensic and public-health information. Structured psychosocial enquiry should be integrated into medicolegal practice and linked with family-oriented and community mental-health interventions.

Keywords: Psychological autopsy; Suicide; Medicolegal autopsy; Forensic medicine; Forensic psychiatry; Psychosocial stressors; Family conflict; Western India.

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INTRODUCTION

Suicide is a major global public-health problem. The World Health Organization (WHO) estimates that more than 720,000 people die by suicide every year; 73% of these deaths occur in low- and middle-income countries, and suicide is the third leading cause of death among people aged 15–29 years [1]. India bears a disproportionate share of this burden. The National Crime Records Bureau (NCRB) recorded 171,418 suicides in 2023, a rate of 12.3 per 100,000 population, with Maharashtra reporting the highest number of any state (22,687) [2,3]. Daily-wage earners constituted the largest occupational group, about two-thirds of decedents belonged to households earning less than ₹1 lakh per year, and roughly two-thirds were aged 18–45 years [3]. Nationally representative verbal-autopsy and burden-of-disease studies indicate that official figures under-count suicide, particularly among women and in rural areas, and document wide variation between states [4,5].

In India, every suicide is a medicolegal case. The police conduct an inquest under Section 194 of the Bharatiya Nagarik Suraksha Sanhita (BNSS), 2023 (formerly Section 174 of the Code of Criminal Procedure), and the body is forwarded for medicolegal autopsy [6]. The autopsy surgeon establishes the cause of death and advises on its manner, often in circumstances where homicide or abetment of suicide (Section 108 of the Bharatiya Nyaya Sanhita, 2023; formerly Section 306 of the Indian Penal Code) must be excluded [7]. The forensic pathologist is therefore the one professional who encounters virtually every suicide in a catchment area. However, the physical autopsy explains the mechanism of death, not the mental state, personality, relationships and circumstances that led to it. The "reason" recorded in inquest papers and NCRB statistics is based on brief police enquiry and tends to favour socially acceptable explanations such as "family problems" or "illness", while mental disorder is under-recorded [8].

Psychological autopsy, first developed by Shneidman and colleagues at the Los Angeles Suicide Prevention Center to help the coroner classify equivocal deaths, is a systematic retrospective reconstruction of the decedent's psychological state, recent stressors and behaviour through interviews with family members and other informants, supplemented by medical and legal records [9–11]. It has two established uses: a forensic use, in clarifying the manner of death in equivocal cases and informing questions of abetment, and a research use, in estimating the contribution of mental disorders and psychosocial factors to suicide. A systematic review of 76 psychological-autopsy studies found that about 90% of people who died by suicide had a mental disorder, with comorbid mental and substance-use disorders in 38% [12].

Evidence from India and South Asia suggests a more varied picture, in which acute interpersonal crises, family conflict, marital problems, debt, alcohol misuse and easy access to lethal means play a prominent role alongside psychiatric illness [13–15]. In a psychological autopsy of 101 suicides from Chandigarh, interpersonal stress (47.5%) was the leading stressor, psychiatric illness was identified in about one-third of cases, and fewer than half of these had ever received treatment [16]. Other Indian series from South India, Odisha and Gujarat have similarly highlighted stressful life situations, family discord and financial strain [17–19]. Autopsy-based studies from Gujarat, including a series of female suicides from Surat, have documented regional patterns in methods and precipitating factors [20], and qualitative work from an urban Mumbai community has shown how families explain suicide in terms of interpersonal and social stress [21]. Nevertheless, systematic psychological-autopsy data from tertiary medicolegal centres in Western India remain limited, and most regional series report autopsy findings without structured informant enquiry.

India decriminalised attempted suicide in effect through Section 115 of the Mental Healthcare Act, 2017 and released its first National Suicide Prevention Strategy in 2022, which calls for better surveillance and locally generated evidence on the causes of suicide [22,23]. Departments of Forensic Medicine are well placed to contribute to this effort. The present study was therefore undertaken at a tertiary care teaching hospital in Western India to characterise the sociodemographic profile of suicidal deaths, identify their psychosocial and psychiatric antecedents through structured psychological autopsy, and assess the practical value of the method within the routine medicolegal workflow.

Aims and Objectives

1. To describe the sociodemographic characteristics (age, sex, education, occupation, marital status and socioeconomic status) of persons whose deaths were concluded as suicide after medicolegal autopsy.
2. To identify psychosocial stressors, psychiatric history, substance use and other antecedents through structured psychological-autopsy interviews.
3. To document the place of occurrence and related circumstantial features.
4. To evaluate the feasibility and additional informational value of psychological autopsy within a busy tertiary medicolegal service.

MATERIALS AND METHODS

Study design and setting

A hospital-based, cross-sectional observational study was conducted in the Department of Forensic Medicine and Toxicology, at a tertiary care teaching hospital in Western India. The department performs approximately

120 medicolegal autopsies each year and receives cases from urban, peri-urban and rural areas. The study is reported in accordance with the STROBE guidelines for cross-sectional studies [24].

Study period and participants

All consecutive cases of suspected or confirmed suicidal death brought for medicolegal autopsy during a 12-month period July 2025 to July 2026 were screened.

Inclusion criteria: (i) medicolegal autopsy performed at the study centre during the study period; (ii) manner of death concluded as suicide on the combined basis of police history, scene information and post-mortem findings; and (iii) availability of an adult relative or close associate able to provide information about the decedent.

Exclusion criteria: (i) cases subsequently reclassified as accident or homicide; (ii) cases with incomplete informant data; and (iii) cases in which the family declined participation.

During the study period, [N] medicolegal autopsies were performed, of which [n] were suicides; after exclusion of [n] cases (reclassified: [n]; incomplete informant data: [n]; refusal: [n]), 110 cases were included in the final analysis (Figure: STROBE flow — optional).

Sample size

All eligible cases during the study period were included (total enumerative sampling). With 110 cases, a proportion of 50% can be estimated with an absolute precision of about $\pm 9.3\%$ at 95% confidence, which is adequate for a descriptive study of this kind.

Study tool

A structured psychological-autopsy proforma was developed from previously published psychological-autopsy instruments and Indian studies [10,16,17,25] and adapted to the local language and context. It was reviewed by faculty of Forensic Medicine and Psychiatry for content and pilot-tested on [n] cases that were not included in the analysis. The proforma covered:

- Sociodemographic variables: age, sex, education, occupation, marital status, religion and approximate socioeconomic status ([modified Kuppaswamy / B.G. Prasad scale — specify]).
- Circumstantial details: place of occurrence, approximate time, presence of a written note and any witnessed events.
- Psychiatric and medical history: previous psychiatric diagnoses, treatment history, earlier episodes of self-harm and chronic physical illness.
- Substance use: alcohol, tobacco and other substances.
- Recent life stressors: family or marital discord, financial difficulties or unemployment, interpersonal or romantic problems, academic or occupational failure

and other significant events in the preceding weeks or months.

- Behavioural changes: social withdrawal, expressions of hopelessness, irritability, sleep disturbance and communication of suicidal ideas.

Data collection procedure

Trained investigators from the Department of Forensic Medicine and Toxicology approached the adult relatives or close associates who accompanied the body to the mortuary, usually within 24–48 hours of death. After the purpose of the study had been explained and consent obtained, the proforma was administered in a private room, in the informant's preferred language, after completion of the medicolegal formalities so that the interview did not delay the autopsy or release of the body. Each interview took approximately 20–40 minutes. Police inquest papers and any available hospital or outpatient records were reviewed to corroborate informant information. Where several stressors were reported, all were recorded; the predominant stressor was identified by the investigators on the basis of the informant account and records.

Operational definitions

- Suicidal death: death resulting from a self-inflicted act with evidence of intent to die, concluded after considering history, scene information and post-mortem findings.
- Known psychiatric illness: a psychiatric disorder diagnosed by a medical practitioner before death, or clear informant report of symptoms consistent with depression or another mental illness, corroborated where possible by records.
- Substance-use-related problems: regular or problematic use of alcohol or other substances reported by informants to have caused health, family, occupational or financial problems.
- Prior self-harm: any previous act of deliberate self-harm or suicide attempt known to informants or recorded in medical records.

Ethical considerations

Approval was obtained from the Institutional Ethics Committee before the study began. The study followed the ICMR National Ethical Guidelines for Biomedical and Health Research Involving Human Participants (2017) and the Declaration of Helsinki [26,27]. Informed consent was obtained from each informant after the study had been explained; participation was voluntary and refusal or withdrawal had no bearing on the medicolegal process, the post-mortem report or release of the body. Interviews were conducted privately and with sensitivity to bereavement. Confidentiality was assured, and no personal identifiers were retained in the analytic dataset. Informants showing marked distress were offered referral to the Department of Psychiatry and information about the national tele-mental-health helpline (Tele-MANAS, 14416).

Statistical analysis

Data were entered in Microsoft Excel and analysed using SPSS. Categorical variables were summarised as frequencies and percentages, with 95% confidence intervals (CI) calculated by the Wilson score method [28]. Stressor categories were not mutually exclusive, so percentages were calculated against the total sample

(N = 110). The association between sex and age group was examined with the chi-square test after collapsing age into three groups (<25, 25–44 and ≥45 years) to ensure adequate expected cell counts; the sex ratio was compared with parity using an exact binomial test. A two-tailed p-value < 0.05 was considered statistically significant.

RESULTS

Age and sex distribution

A total of 110 cases fulfilled the inclusion criteria. The age of the decedents ranged from 12 to 78 years. Eighty-four decedents (76.4%; 95% CI 67.6–83.3) were aged 15–44 years. The largest single group was 25–34 years (32 cases, 29.1%), followed by 15–24 years (28, 25.5%) and 35–44 years (24, 21.8%). Only two cases (1.8%) were younger than 15 years, and four (3.6%) were aged 65 years or older (Table 1, Figure 1).

Males accounted for 68 cases (61.8%; 95% CI 52.5–70.4) and females for 42 (38.2%), giving a male-to-female ratio of 1.62:1; the excess of males was statistically significant (exact binomial test, $p = 0.017$). The age distribution did not differ significantly between males and females ($\chi^2 = 0.59$, $df = 2$, $p = 0.75$; Table 2).

Table 1. Age and sex distribution of suicidal deaths (N = 110)

Age group (years)	Male n	Female n	Total n	Total %
0–14	1	1	2	1.8
15–24	16	12	28	25.5
25–34	20	12	32	29.1
35–44	15	9	24	21.8
45–54	8	4	12	10.9
55–64	5	3	8	7.3
≥65	3	1	4	3.6
Total	68 (61.8%)	42 (38.2%)	110	100.0

Table 2. Comparison of age distribution by sex (collapsed age groups)

Age group (years)	Male n (%)	Female n (%)	Total n (%)
<25	17 (25.0)	13 (31.0)	30 (27.3)
25–44	35 (51.5)	21 (50.0)	56 (50.9)
≥45	16 (23.5)	8 (19.0)	24 (21.8)
Total	68 (100)	42 (100)	110 (100)

$\chi^2 = 0.59$, $df = 2$, $p = 0.75$ (not significant). Column percentages shown.

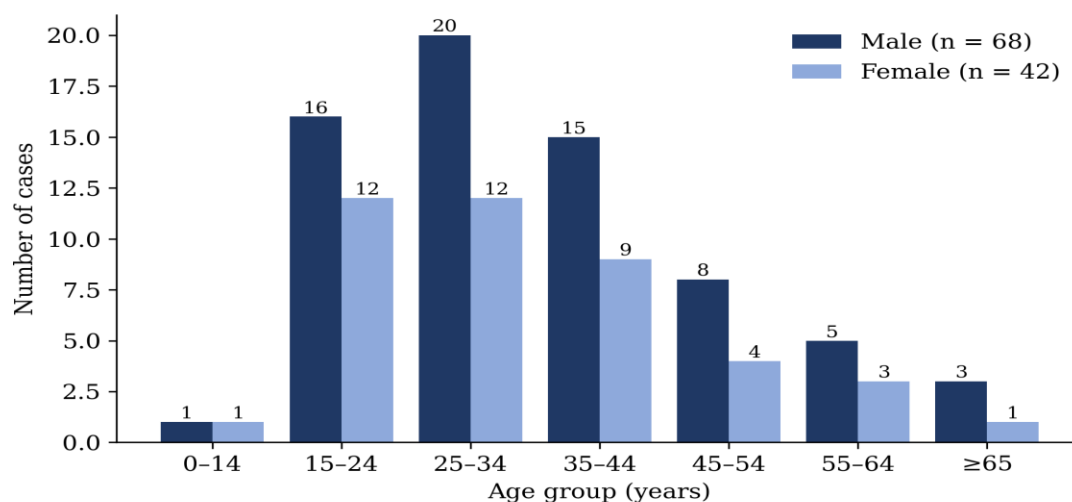


Figure 1. Age and sex distribution of suicidal deaths (N = 110).

Educational status

Educational attainment was generally modest. Nine decedents (8.2%) were illiterate, 44 (40.0%) had studied up to the 7th

standard and 48 (43.6%) up to the 12th standard. Thus, 101 decedents (91.8%; 95% CI 85.2–95.6) had not studied beyond the 12th standard. Only nine (8.2%) were graduates, and none held a postgraduate qualification (Table 3, Figure 2).

Table 3. Educational status of decedents (N = 110)

Educational level	n	%
Illiterate	9	8.2
Up to 7th standard	44	40.0
Up to 12th standard	48	43.6
Graduate	9	8.2
Postgraduate or higher	0	0.0
Total	110	100.0

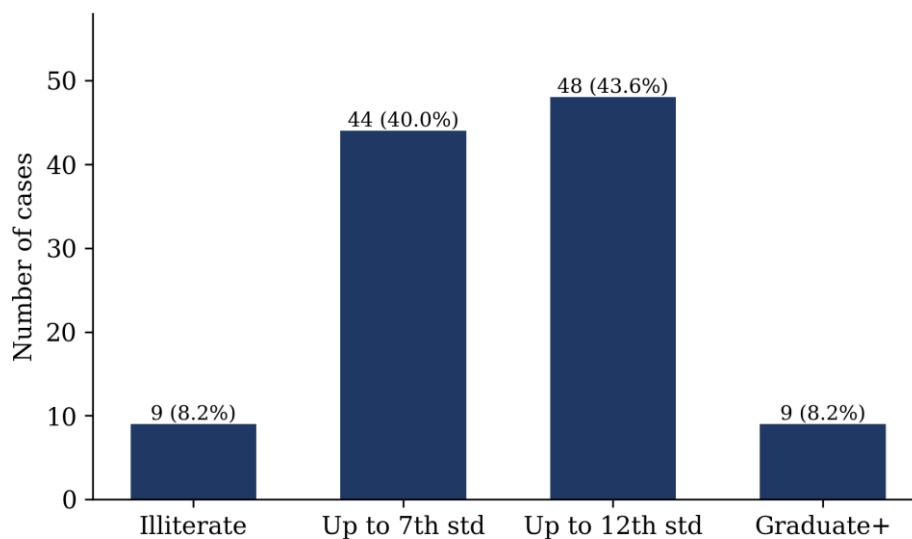


Figure 2. Educational status of decedents (N = 110).

Marital status, occupation and circumstantial features

Approximately 58% of decedents were married ([n]), 32% were unmarried ([n]) and the remainder ([n]) were widowed, separated or divorced. Occupations included students, agricultural workers, daily-wage labourers, homemakers, small traders and unemployed persons. Decedents came predominantly from lower- and middle-income households. A written suicide note was recovered in fewer than 15% of cases ([n]). Informants reported recent behavioural changes — social withdrawal, expressions of hopelessness, irritability or sleep disturbance — in roughly half of the interviews ([n], [%]).

Place of occurrence

The great majority of acts (102 cases, 92.7%; 95% CI 86.3–96.3) took place at the decedent's own residence. The remaining cases occurred on farms or agricultural land (4, 3.6%), at the workplace (2, 1.8%) or at roadside or other public places (2, 1.8%) (Table 5, Figure 3).

Table 5. Place of occurrence (N = 110)

Place	n	%
Home / residence	102	92.7
Farm / agricultural land	4	3.6
Workplace	2	1.8
Roadside / other public place	2	1.8
Total	110	100.0

Percentages may not total exactly 100 because of rounding.

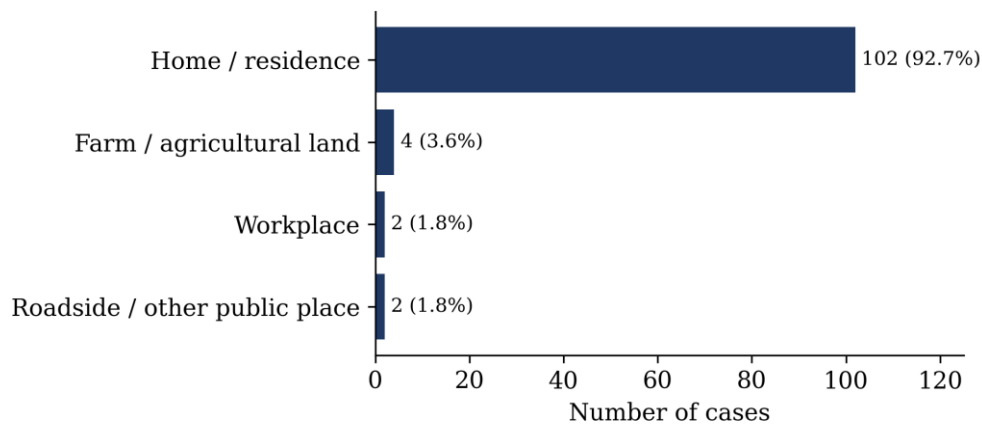


Figure 3. Place of occurrence of the act (N = 110).

Psychosocial stressors and psychiatric antecedents

More than one stressor was identified in many cases, so the categories are not mutually exclusive. Family or marital discord was the most frequently reported factor (38 cases, 34.5%; 95% CI 26.3–43.8), followed by financial problems or unemployment (22, 20.0%) and known psychiatric illness, mainly depression (18, 16.4%). Interpersonal or romantic relationship problems were reported in 15 cases (13.6%) and substance-use-related problems, chiefly alcohol, in 14 (12.7%). Chronic physical illness was present in 12 cases (10.9%), academic or occupational failure in 8 (7.3%) and a history of prior self-harm in 7 (6.4%). In nine cases (8.2%) the principal precipitant remained unclear despite the interview (Table 6, Figure 4).

Table 6. Psychosocial stressors and psychiatric antecedents (N = 110; multiple responses possible)

Factor / antecedent	n	%	95% CI
Family / marital discord	38	34.5	26.3–43.8
Financial problems / unemployment	22	20.0	13.6–28.4
Known psychiatric illness (incl. depression)	18	16.4	10.6–24.4
Interpersonal / romantic relationship problems	15	13.6	8.4–21.3
Substance-use-related (mainly alcohol)	14	12.7	7.7–20.2
Chronic physical illness	12	10.9	6.4–18.1
Academic or occupational failure	8	7.3	3.7–13.7
History of prior self-harm	7	6.4	3.1–12.6
Other / unclear after interview	9	8.2	4.4–14.8

Percentages calculated against N = 110; categories are not mutually exclusive. CI, confidence interval (Wilson method).

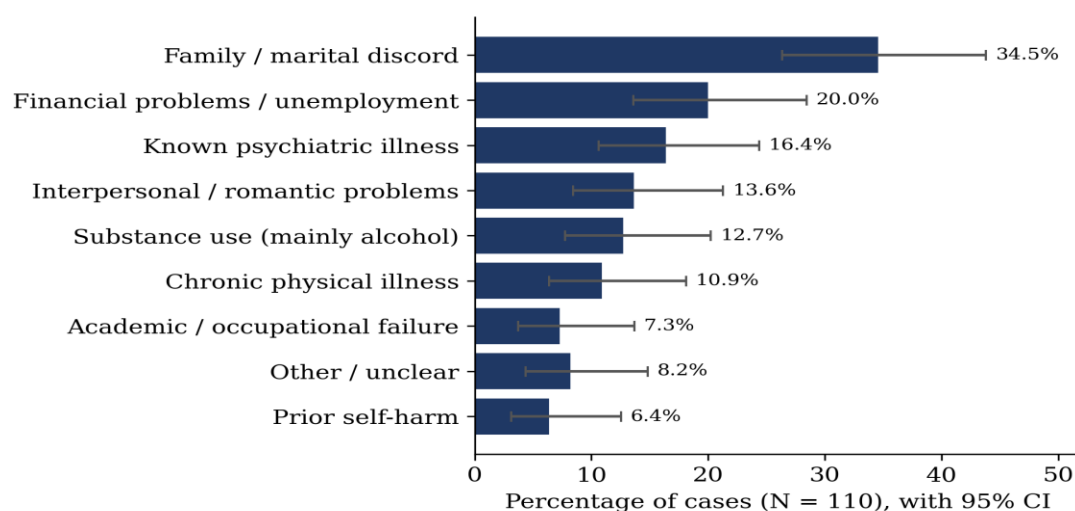


Figure 4. Psychosocial stressors and psychiatric antecedents identified on psychological autopsy, with 95% confidence intervals (N = 110; multiple factors possible).

Feasibility of psychological autopsy

Structured interviews were completed in all 110 included cases. When approached privately and with sensitivity, informants were generally cooperative. Interviews took approximately 20–40 minutes and could be accommodated within the routine mortuary workflow without significant disruption. The information obtained frequently clarified intent, brought to light previously unrecognised psychiatric symptoms and identified modifiable social stressors that were not recorded in the police papers.

DISCUSSION

This study describes 110 suicidal deaths examined by psychological autopsy at a tertiary medicolegal centre in Western India. Its main findings are that suicide mainly affected young adults of modest educational attainment, that nine in ten acts occurred at home, and that family or marital discord and financial problems were the most common identifiable antecedents, whereas recognised psychiatric illness was reported in only about one in six cases. The study also shows that a brief structured psychological autopsy can be carried out within routine medicolegal work.

Sociodemographic profile

About three-quarters of decedents were aged 15–44 years, and the peak was in the 25–34-year group. This agrees with national data showing that roughly two-thirds of suicides in India occur between 18 and 45 years of age [3], and with the Chandigarh psychological-autopsy series, in which 59.4% of victims were aged 20–29 years [16]. Deaths in this productive age group carry a heavy social and economic cost, because they often leave behind dependants and remove earning members from vulnerable households.

Males outnumbered females by 1.6 to 1, a ratio close to that reported from Chandigarh (57.4% vs 42.6%) [16] and lower than the national ratio, in which men account for about seven in ten recorded suicides [2]. The relatively high proportion of women in this series is consistent with evidence that India has one of the highest female suicide rates in the world [5], and with autopsy data from South Gujarat showing that female suicides form a substantial group with distinct methods and precipitants [20]. The similar age distribution in the two sexes ($p = 0.75$) suggests that young women and young men are at comparable relative risk in this region.

More than 90% of decedents had not studied beyond the 12th standard, and most belonged to lower- and middle-income households. This mirrors the NCRB finding that two-thirds of suicides occur among people from households earning less than ₹1 lakh per year [3]. Prevention messages and services therefore need to be simple, delivered in local languages, and accessible to people with limited formal education.

Place of occurrence

The home was the site of 92.7% of acts, which is typical of Indian autopsy series. The home is where means such as ligature points, pesticides and medicines are most

readily available, and it is also where family members are best placed to notice distress. This finding supports means-restriction measures at household level, such as safe storage of pesticides and medicines [29], together with education of families to recognise warning signs.

Psychosocial stressors and psychiatric antecedents

Family or marital discord was the single most frequent stressor (34.5%), followed by financial problems (20.0%). Interpersonal stress was likewise the leading stressor in Chandigarh (47.5%) [16], and earlier Indian psychological-autopsy studies have repeatedly highlighted stressful life situations, family conflict and economic strain [13,17,18]. Qualitative research in Mumbai has shown that families and communities themselves explain suicide mainly in terms of these social pressures [21]. Together these findings support the view that, in India, suicide frequently arises from acute interpersonal crises in people with limited coping resources and social support.

Known psychiatric illness was identified in 16.4% of decedents, about half the one-third reported from Chandigarh [16] and far below the approximately 90% found in Western psychological-autopsy studies that used structured diagnostic interviews with a delay of several months [12]. Part of this gap is likely to be methodological. Our interviews were conducted within 24–48 hours of death, recorded mainly known psychiatric illness, and did not use a standardised diagnostic instrument. Mental illness is also heavily stigmatised, and families may be unwilling to disclose it in the immediate aftermath of death. The true proportion of decedents with untreated or unrecognised depression, alcohol-use disorder or other mental illness is therefore probably higher. Even so, the Chennai case-control study showed that the pattern of risk factors in India differs from that in Western countries [13], and reviews of South and South-East Asian psychological-autopsy studies report a wide range of estimates [14,15]. The low proportion of recognised psychiatric illness in this series underlines the large treatment gap and the need for early identification of mental illness in primary care.

Alcohol- and substance-related problems were reported in 12.7% of cases and, according to informants, occurred mainly among men. Alcohol misuse increases impulsivity, worsens family conflict and financial problems, and is a well-recognised risk factor for suicide [30]. Only 6.4% of decedents had a known

history of self-harm, which suggests that many deaths were first-ever acts and underlines the need for prevention strategies that do not rely solely on identifying previous attempters.

Forensic significance and feasibility

Psychological autopsy was completed in every included case and took less than an hour per case. The information it produced — on intent, psychiatric symptoms and stressors — was often not available in the inquest papers. For the forensic expert, this has practical value. In equivocal deaths, such as partial hanging, drowning without witnesses, falls from height or poisoning in a recently married woman, a structured account of the decedent's mental state, previous behaviour and communication of intent can support or challenge the opinion on manner of death. It may also inform investigations of alleged abetment of suicide or dowry death under the Bharatiya Nyaya Sanhita [7], although the evidentiary status of psychological autopsy in Indian courts is not yet settled and it should be used cautiously [15].

Public-health implications

The findings support several priorities of the National Suicide Prevention Strategy [23]: family-oriented counselling and conflict-resolution services; screening for depression and alcohol-use problems among young adults in primary care; strengthening of the District Mental Health Programme and Tele-MANAS; and household-level restriction of access to lethal means. Routine collection of structured psychosocial data by forensic departments could also improve on the limited cause categories currently recorded by the NCRB [8].

Strengths and limitations

The strengths of this study are the consecutive inclusion of all eligible cases from a medicolegal centre that receives every suicide in its jurisdiction, the combination of informant interviews with inquest papers and medical records, and the demonstration of feasibility in routine practice. The following limitations should be considered:

1. Reliance on informant report introduces the possibility of recall and reporting bias; stigma may have led to under-reporting of mental illness, alcohol use and family conflict.
2. Interviews were conducted within 24–48 hours of death, when informants were acutely bereaved. International recommendations favour an interval of about 2–6 months to allow more complete and reflective reporting [10,25].
3. Psychiatric antecedents were based on collateral history of known illness rather than a standardised diagnostic interview, so the prevalence of mental disorder is likely to be underestimated.
4. The study was conducted at a single tertiary centre without a control group; the findings describe decedents but cannot establish risk relative to the living population and may not be generalisable to

other regions.

5. Several stressors often coexisted, so attributing a death to a single "cause" was not possible in many cases.

CONCLUSION

Psychological autopsy of suicidal deaths at a tertiary care centre in Western India showed that most decedents were young adults with modest education, that the great majority of acts occurred at home, and that family or marital discord, financial strain and psychiatric illness were the leading identifiable antecedents. The technique was feasible within routine medicolegal practice and provided information of both forensic and public-health value. Integrating structured psychosocial enquiry into the medicolegal autopsy, together with stronger community mental-health services and family-level support, offers a practical way to reduce the burden of suicide in the region.

Recommendations

1. Incorporate a brief structured psychological-autopsy module into the routine evaluation of confirmed or suspected suicidal deaths at tertiary medicolegal centres, with follow-up interviews after an appropriate interval.
2. Strengthen screening for depression, alcohol-use problems and high-risk life stressors in primary care, with a particular focus on young adults.
3. Develop accessible family counselling and conflict-resolution services, given the prominence of interpersonal stressors.
4. Promote safe storage of pesticides, medicines and other lethal means at household level.
5. Improve linkage between Forensic Medicine, Psychiatry and public-health surveillance systems, including feedback of findings to the District Mental Health Programme.
6. Conduct larger, multicentre, preferably case-control psychological-autopsy studies using standardised diagnostic instruments to allow robust regional comparisons.

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