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Mental health expert's perspective on risk and protective factors of suicide ideation in Patients with OCD and depression

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Abstract

Background Suicidal ideation and behavior present profound challenges in mental health care, particularly among individuals contending with Depression and Obsessive-Compulsive Disorder (OCD). While existing research has elucidated the intricate pathways through which depression and OCD independently contribute to suicide risk, there remains a critical gap in understanding the interplay between these disorders in shaping suicidal tendencies.

Aim This qualitative study aims to address this gap by exploring expert's perspective about the risk and protective factors associated with suicidal ideation among individuals diagnosed with depression and OCD.

Method Through semi-structured interviews with mental health experts, thematic analysis was employed to uncover the cognitive, emotional, and environmental stressors influencing suicidal thoughts and behaviors in this clinical population.

Results Findings reveal multifaceted cognitive vulnerabilities, adverse childhood experiences, and familial factors as prominent risk factors, while coping skills, social support, and religious beliefs emerged as key protective factors.

Conclusion By illuminating the complex interplay of factors contributing to suicidal ideation in the context of comorbid depression and OCD, this study provides valuable insights for the development of targeted interventions aimed at mitigating suicide risk and improving outcomes for affected individuals.

Keywords Suicidal ideation, Depression, OCD, Coping skills, Risk factors

Background

Suicidal ideation and behavior are grave concerns within the realm of mental health, particularly among individuals grappling with conditions such as Obsessive-Compulsive Disorder (OCD) and Depression [2]. Both depression and OCD individually contribute to heightened vulnerability to suicidal tendencies [4].

Depression, characterized by persistent feelings of sadness, hopelessness, and worthlessness, often coexists with OCD, a condition marked by intrusive thoughts and compulsive behaviors. This convergence of mental health challenges accentuates the burden on affected individuals, amplifying their susceptibility to suicidal ideation and behavior [3].

Existing research has underscored the profound impact of depression on suicide risk, elucidating multifaceted pathways involving biological, psychological, and social determinants [8]. Similarly, studies have delved into the disruptive influence of OCD on mental well-being, shedding light on the distressing nature of intrusive thoughts and compulsive behaviors. However,

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a critical gap remains in understanding how the convergence of depression and OCD heightens vulnerability to suicidal ideation [7].

Recent inquiries have begun to unravel the intricate connections between depression, OCD, and suicidal ideation [1]. For instance, cognitive vulnerabilities such as negative self-perceptions and cognitive rigidity have emerged as common threads linking depression and OCD with suicidal thoughts [6]. Moreover, burgeoning evidence suggests that experiences of childhood trauma and adverse life events may exacerbate suicide risk among individuals contending with comorbid depression and OCD [5].

The current study endeavors to elucidate the intertwined risk and protective factors associated with suicidal ideation among individuals diagnosed with both depression and OCD. By employing a qualitative approach and engaging mental health experts in semi-structured interviews, this research seeks to unravel the psychological and social determinants shaping suicidal ideation within this unique clinical population.

Central to the study's objectives is the exploration of contextual factors predisposing individuals with depression and OCD to suicidal ideation. Through an in-depth examination of lived experiences, the research aims to uncover the complex interplay of cognitive, emotional, and environmental stressors that contribute to suicidal thoughts and behaviors. Additionally, the study endeavors to identify protective mechanisms and coping strategies that mitigate suicide risk among individuals navigating the challenges of depression and OCD.

By shedding light on the nuanced dynamics of suicidal ideation in individuals with comorbid depression and OCD, this research contributes to a deeper understanding of mental health vulnerabilities within this population. Such insights have the potential to inform clinical practice by refining risk assessment protocols and guiding the development of tailored interventions to address the specific needs of individuals with complex psychiatric presentations.

Objective

The current study proposed the following research objectives:

(1) To explore the expert's perspective about the risk factors of suicidal ideation in patients with depression and OCD.
(2) To examine the expert's prospective protective factors of suicidal ideation and behavior in patients with depression and OCD.

Methodology and Materials

Study design

This study employed a qualitative approach utilizing semi-structured, audio-recorded interviews to explore the influence of psychological and social factors, specifically suicidal ideation and behavior, of patients with depression and anxiety. The interview questions were developed based on a comprehensive review of the literature and the biopsychosocial model.

Participants, setting, and procedures

Clinicians who had previously provided consent and completed demographic information were selected using a convenient sampling method. The data were collected from clinical psychologists and psychiatrists practicing in five major cities of Pakistan: Lahore, Multan, Faisalabad, Karachi, and Pakpattan. A total of eight participants, comprising four clinical psychologists and four psychiatrists, were included in the study, with ages ranging from 35 to 52 years. The interviews were conducted by the primary author at mutually convenient times, respecting participants' privacy and confidentiality. Permission to record audio was obtained, and interviews were conducted in Urdu (Table 1).

Inclusion criteria

1. Psychiatrists must hold a valid Pakistan Medical Council (PMC) registration and have a minimum of five years of clinical experience.
2. Clinical psychologists must possess an MS Clinical Psychology degree recognized by the Higher Education Commission (HEC) and have at least five years of professional experience.
3. Participants must have experience working with patients from diverse socioeconomic backgrounds.

Table 1 Demographic characteristics of clinical experts ($N=8$)

Sr. no	Age	Gender	Profession	Experience	City
1.	35 Years	Male	Psychiatrist	8 Years	Lahore
2.	38 Years	Female	Psychiatrist	9 Years	Faisalabad
3.	45 Years	Female	Psychiatrist	12 Years	Multan
4.	42 Years	Female	Psychiatrist	10 Years	Karachi
5.	35 Years	Female	Clinical Psychologist	6 Years	Pakpattan
6.	38 Years	Male	Clinical Psychologist	8 Years	Pakpattan
7.	47 Years	Male	Clinical Psychologist	12 Years	Multan
8.	52 Years	Male	Clinical psychologist	14 Years	Faisalabad

Ethical considerations

The study received approval from the Institutional Review Board of the University of Central Punjab, Lahore, Pakistan.

Data analysis

The interviews were conducted in Urdu and subsequently translated into English by the interviewer. An independent bilingual researcher cross-checked all translated English transcriptions against the original Urdu recordings to ensure translation accuracy. Additionally, another research expert conducted a back translation of the scripts to ensure clarity and precision. The entire dataset was then imported into NVIVO (v14) software for analysis. Thematic analysis was conducted in three steps. Step one involved gathering expressions relevant to the research goal and categorizing them under key themes (codes). These codes were generated both inductively (from interview data) and deductively (drawing from prior knowledge and existing literature). Step two, aimed to condense the initial codes by grouping similar ones under second-level sub-themes. Step three refined the codes further by comparing the codes, interpreting the data, and making necessary reductions to align with the overall themes. To enhance the trustworthiness of the research, several strategies were employed. Member checking was conducted, allowing participants to review and validate the accuracy of their contributions. Triangulation of data sources was implemented by gathering information from multiple sources, such as interviews, observations, and documents, to corroborate findings.

Results

To analyses themes from the semi structured interviews with mental health experts, the study used Braun and Clarke (2006) for thematic analysis. NVIVO 14 software was used as a corpus tool for conducting the thematic analysis and all the phases of the analysis were carried out within this software. Initially the interviews were transcribed and manually coded in NVIVO 14. Next, the relevant themes were identified by the researchers and then linked them to the codes which were the main themes of the study. The data coding process focused on the risk, protective, cultural and personality factors association with patients with PGD.

Overreaching themes

Clinicians described the risk factors of suicide ideation in patients with depression under eight subthemes: academic failure, adverse childhood experiences, financial hurdles, hopelessness, lack of mental health, parenting style and poor coping skills while for the protective factors are subtheme as (problem solving, social support, combatting discrimination and stigma, self-esteem, positive parental relationship, promoting mental health services, religious activities).

Risk factors of depression

Academic failure

Depression after academic failure increases the probability of suicidal thoughts in patients. The experts considered it as one of the most important factor,

> *When one does poorly in his or her studies, he or she allows self-esteem and self-worth to take a major bashing. Meaning when adults fail, they develop negative self concept since they are embarrassed of their illiteracy and consequently they can be described as being inadequate and worthless. Thus, negative self-attitude can cause depressive manifestations since these failures turn into individually experienced failures, and, therefore affect the quality of mental health [C. P].*

> *School failure may be a chronic stress that in return leads to development of depression in adults. They convey that stress arising from poor grades can alter the level of the chemicals in the brain commonly referred to as neurotransmitters-sorotonin and dopamine. In the long run, it results to clinical depression particularly to persons with hereditary predisposition to mood disorders [P].*

> *This is with regard to the social relations and support that one is obliged to when he or she fails academically. The social impact which academic failure has on students consequently see them denied privileges in their peers group and or families as they feel embarrassed or stigmatized. This social isolation may in turn lead to the member or members concerned being more lonely and helpless; some of these causes of depression. However, there can be negative consequences of the lack of support from the social network on the subject's probability of a speedy recovery and resilience [C. P].*

> *Consequently, school failure results in negative thinking style characterized by pessimism, catastrophizing and over generalizing. There are questions of despair; people will begin having a concept that if they are going to fail in one specific academic endeavor then they will fail in all the activities they embark on. It perpetuates the process of negative thinking and they are all forms of negative thinking that can make a person feel helpless and hopeless those are all signs of depression [C. P].*

Adverse childhood experiences

Specifically regarding the patients experiencing depression, adverse childhood experiences notably increase the risk of suicidal ideation.

> *ACE that consists of the stressful events or experiences in childhood such as abuses, neglects, and dysfunctional families, have the rather negative impact to impact one's psychological well-being. Such experiences lead to maintaining state of hopelessness, belief of insignificance, and hopelessness. These negative emotions are seeded right in the heart of a person's psyche; thus, when people with depression, these negative emotions are capable of aggravating the depressive manifestations and can even draw the probability of suicide closer [C. P].*

> *Aces result in changes to the physical form and neural mechanisms of the brain namely, aspects of the brain that have been linked to regulation of moods, stress and impulses. Such neurological alterations are likely to place persons at risk for contracting conditions such as depressions – mood disorders [P].*

> *Adverse childhood events have huge impacts in determining the psychological entity of an individual in aspects such as physical abuse, sexual abuse, lack of adequate medical care and household dysfunction. Thus, it is possible to observe the constant sense of hopelessness and worthlessness as they struggle through the days [C. P].*

> *These, therefore, attribute adverse childhood experiences with changes in the structure and functioning of the brain in the areas related to emotions, stress, and impulses. They also lead to the modifications of the neurological properties that may shift a person to mood disorder including a depressive state [P].*

Financial hurdles

Financial barriers also prove to be barriers to the treatment of depression and consequently heighten the chances of suicidal thoughts among depressed patients. They said that it was.

> *The act of managing few resources is likely to trigger hopelessness and or despair and these are criteria for depression but not part of the DSM. When a human being cannot search for methods to feed himself or has accumulated loans that appear to be unpayable, sensations of being locked up and with no chances of getting out can be felt. It can actually contribute to an aggravation of the suicidal intentions as a perceived method of tackling an 'unloseable' scenario [C.P].*

> *This cannot be categorically ruled out because existing micro manic episodes can be exacerbation by financial issues leading to a worsening of the existing mild depressive period and a push towards the thinking of suicide. Stress derived from compromise of this aspect results in cortisone release, which is among the hormones that negatively affect mood disorders. With refer to the subject of the research, it can be stated that for those in whom depression is a potential issue, the stress related to financial troubles alone may be sufficient to drive a person into condition of severe depression and higher risk of suicidal attempts [P].*

> *Consequently, high financial pressure produces relabelling or stigmatization, expulsion, degeneration of other pivotal relationship, and emotional isolation all of which are standard suicide dangers [C. P].*

> *Sometimes, individuals in such a situation may lack the required clemency and hence depressive symptoms are made worse by even suicidal intentions among the affected adults. Depressive symptoms come up from perceived burdensomeness, meaning that there is no other way of addressing the given problem that leads to the consideration of suicide [C. P].*

> *Problems connected with finance also become an obstacle that can hamper people, necessary to address depression, to seek professional help. He also said that, if people cannot afford to pay for treatment, then their depressive conditions worsen with time and with little or no treatment intended at all, including the chances of suicide. That deepens the depression when people cannot go to their nearest and dearest and ask for help because they have no money [C. P].*

> *The matter is that economic factors can result not only in the limitation of the workforce productivity, but also affect one's perception of the vocation. This is perhaps the reason many middle-aged persons experience the feeling of useless and an unemployment or economic insecurity in mid- age encourages persons to presume thoughts of suicide. Not to be able to give or not to be able to succeed financially*

is one of the biggest disappointments in life that can influence severely the worth of life and the psychology of a person [P].

The financial issues give rise to acquisition of apprehensive attitudes and cognitive distortions. The participants stated that, as the result of disregarding the individual details, they might start to think the ugly 'L' word and/ or conclude that their financial issues are beyond redemption [P].

Hopelessness

One of the other related aspects raised by the study is hopelessness in depressed patients is a factor that leads to suicidal ideation. The experts described it as,

It can be cited as hopelessness about the future, while at the same time negating the probability of changes in the current situations for the better. Of such an outlook puts a person in a position where he/she feels that the only option is to commit suicide [C. P].

Pessimism is among the leading indicators of possible incidences of suicide among the patient. It is usually felt in the course of major depressive disorder, during which the patient feels helpless regarding the life. Such feelings can however be worsened when their signals get transferred by substances that are abnormal in the biochemical nature [C. P].

The state of hopelessness originates from social and environmental stresses, lack of social support, and trauma [P].

Hopelessness then results from the negative ideologies and distorted thinker. In this case, people with depression will be disposed towards a negative disposition particularly in aspects including black and white thinking, catastrophizing, and, overgeneralization, and hence grow into a conclusion that their lives cannot get any better [P].

Lack of mental health

The primary reason identified hence escalated suicidal ideology in depressed patients was lack of mental health. The professionals described it as:

If there is no mental health care, individuals suffering from psychosis, symptoms of depression do not get appropriate management put in place for their condition. When no professional assistance is received one may not be able to regulate one emotions hence being vulnerable to have an intense feeling of wanting to die or even behaving in such a manner [C. P].

Psychiatrically, such symptoms and signs worsen the conditions if they are not treated; regarding the case, the suicidal thoughts are becoming even worse. Therefore, many times the patient needs prescription medicine and psychiatric help to get the chemical imbalance right, what is typical for depression. If one is unable to secure this treatments, she or he will develop very alarming, chronic depressive conditions, thus, sharply raising the per chance of suicide [P].

Parenting style

Parenting style also augments the risk of suicidal ideation in the depressed patients. The proffered accounts that elicited such behaviour were described by the experts as,

Parents will decide the sort of emotional self-esteem and regulation that a child will have. Parenting style that involves demanding much from kids and again children's needs are not recognized by parents can lead to a feeling of worthlessness in children. They may remain throughout adulthood, increasing the risk of depression and thoughts of suicide [C. P].

Psychiatry in the reproductive period of the psychologically illuminated epoch has established that disregarding or criticizing, which forms the typical style of parents who neglect their children, succeed in provoking and consolidating mood disorder [P].

It is, therefore, evident that parenting styles regulate a person's belief systems and cognitive structures. Some of the maladaptive schemas are; unlovability, and incompetence, and some of the negative parenting that may cause them are; emotional abuse or neglect. These schemas can keep people engaged with depressive cognitions and hopelessness, which can further envious the suicidal concepts [C. P].

Poor coping skills

Said depressed patients with poor coping also are also at a high risk of suicidal ideation. The experts termed it as,

Lack of coping capacity leads to when individuals are said to lack appropriate methods of handling stress, pain, and some of the problems in life. As a result, the level of stressors increases, and the individuals, who initially showed such tendencies, do not possess the means to handle stress properly and

experience an overload. This could cause depression and, in severe cases, lead to hopelessness and despairing – the main threats to suicidal notion [P].

On the basis of psychological outlook, they may be manifested in terms of poor coping strategies which are things like drug and alcohol use, cutting one's body and lack of interaction with other people. The mentioned behaviors also worsen the person's mental state and escalates the symptoms pertaining to depression. Complete alteration from suicidal behaviour occur only when a person feels laden with distress without any healthy way of handling the situation [P].

The previously mentioned poor coping patterns are labelled as negative self-talk and cognitive bias. These kinds of negativity symptoms are catastrophizing, overestimating the threat of an event, negative over- and underestimations, and personalization, which may add to the further worsening of hopelessness and helplessness [C. P].

Protective Factors

Problem solving

Delay been found to be the main protective asset of suicidal idealization in depressed patients. The causes of social injustices on the other hand were described in detail by the experts as being.

Depression occurs in life, and its handling involves solving several life concerns implying that the holder should be a good problem-solver. Effective troubleshooting fosters the capability of people to handle colossal problems in small proportionate stages, facets that define hopelessness. Therefore, improving these coping skills will assist in the prevention of suicidal ideas since they enable a person to be more engaged in handling their issues [C. P].

As the sayings in the field of psychiatric medicine suggest, problem solving assists in enhancing a person's approach to managing stress or any form of disturbance. Then, again, if some of the problems which people experience in their lives can be eliminated or at least managed, the subject in most cases should not be burdened with depressive symptoms. This offsets the intensity and duration of such episodes and hence poses a threat to the foundation of suicidal thoughts [P].

Social support

The main preventive factor of suicidal thoughts in depressed patient is social support. The positions were described by the experts as,

Persons with many contacts do not get lonely and have hope having been told that they are valued in the society.

Simple contact with friends, who do not negotiate with suicide, and relatives can become a safety and support and can interfere with the beginning of such thoughts.

Close friends and relatives should be persuaded to assist their kin to continue with treatment such as; taking the required drugs and going for the stipulated therapy. This is significant because for such a strong source of encouragement it will help push the individual to continue living regardless of the extreme conditions this will help address suicide cases.

Social support is primary in helping people cope with social and environmental demands. Clients and patient may need help in as far as the resources, groups and social networks which are within the health facility. Such relations can provide that feeling of belongingness; that sense of purpose in life that is essential to well being.

By the use of cognitive behavioural theory, companion support can help an individual replace a negative thought or belief. As cognitive content of depressive patients' thinking is mostly biased, slightest change in it is seen in stressful relations where positive feedback and ratio of reality could be received.

Combatting discrimination and stigma

Stemming discrimination and stigma is the another form of protection from suicidal ideation in patients with depression. Nonetheless, the experts described it as,

Opening the society for non-prejudicial and prejudices should be the aim since this influences the patients' depression to seek for help. Discrimination and stigma decrease self-esteem therefore depression is likely to be triggered along with shame feelings which in turn intensify the suicidal predisposition [WC 142].

Social prejudices and discrimination are the negative factors that hinder people from seeking mental health services. Stigma is amongst the reasons that

make people deny the appropriate care and treatment they need, and their health worsens considerably, and risk of suicide is part of this process. Measures in destigmatisation such as administration, publicity and training removes these barriers assuring that persons get right treatment [P].

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Promoting mental health services

Promoting mental health services is the important protective factor of suicidal ideation in patients with depression. The experts said it as,

Mental health services entails enhancing public awareness and availability of assistance from qualified personnel to persons suffering from depression [P].

Increasing the knowledge about the risk factors for depression and the services available helps the people seek the help of a doctor early enough [P].

With therapy, medication, and support groups, one can manage the depressive symptoms; thus, realizing minimal risk of suicide thoughts [C.P].

They support policies, which are aimed at increasing the funding for mental health, educational programmes for the training of health care professionals in practicing detection of patients with depressive disorders, and establishing community based interventions. Key components include the ability of people with depression to initiate and receive adequate subsequent mental health services, preferably in primary care if possible and phone or telehealth options if suicidal ideation is present [P].

Thus, the subject of the campaign in support of mental health service can be outlined in a cognitive-behavioral perspective of informing people on the available solutions for depression such as CBT or antidepressants [P. C].

Religious activities

Religious activities is the most protective cultural factor of suicidal ideation in the depressed group of patients. The overall pacing was also questioned by the experts and they said it as:

The religious activities such as praying, meditating, and the ones specified in the description may help in turning to the planned activities in life, as well as in finding help within the communities of the same faith. To MOST of the population faith is a Hermaneutic in times of hardship and a prescription for handling stresses in life. It also makes possible the cultivation of the spiritual feeling that can aid in eradicating depressive ideas and lessen suicide probability [C. P].

With regard to the psychiatric perspective of evaluation, it may be stated that these religious activities could have the following effects: availability of a community, presentation of a learned source based on one's religion, and participation in activities that may make changes in the situation of their /emotional/ state [P].

In the case of some young people, the religious beliefs serve as hope givers and therefore negate hopelessness and other related feeling like despair. The successful treatment of depression and the desire to reduce the risk factor associated with suicide may be enhanced through the consideration of the spiritual dimension in the patient [P].

Laity and clergy know the role that religious activities have in satisfying psychological and social needs

of the depressed persons. Such services they offer include: support groups, counselling, and other religious based programmes offering mental health. Therefore, it is this possible increase in religious activity and accessibility of supportive assets will foster the improvement of social-working capacities to change individuals' weak social relations and reduce suicidal inclinations [C. P].

The concept religious activities in the context of education means acknowledging people's beliefs and

Involvement in religious activities may be useful in improving people's skills when it comes to handling their feelings in organizations. OTs have rationally defined spirituality as pressure release and work meaning as well as hope for the best during a difficult situation. This means that in respecting and valuing employee's faith practice and faith identity, organizational culture preserves currents of mental health other than emotions and cognitions that contribute to the vulnerability of suicidal tendencies of the employee [C. P].

In consequence, religious practices stay a method by which a person can get structure, meaningful occupation, and support in a fight against depression according to the cognition-behaviors perspective. CBT might incorporate aspects of spirituality and religious practice into the CBT because it helps build protective factors against suicidal ideas and hence thinking negatively, which is part of religious practice, might help curb suicidal ideas. Thus, therapists are able to help the clients integrate spiritual practices into it in cases where from such a belief clients are able to draw strength and in turn enhance the quality of therapy [C. P].

Risk factors of suicide ideation in patients with OCD

Cognitive impulsivity

Among the patients of OCD, cognitive impulsivity leads to a significantly higher risk of suicidal thoughts. Poor impulse control creates situations where some people make decisions with no regard for the consequences – that could be lethal.

It was established that patients with OCD with high cognitive impulsivity are likely to have suicidal thoughts. This impulse can further worsen the outlook they have and enhance the possibility of jumping to commit suicide [P] .

In my practice, I have realized that evidencing cognitive impulsivity is one of the biggest causes of suicidal thoughts in OCD patients. It becomes difficult to control one's mind thus increasing the risk of suicide in individuals with this disorder [C.P.].

This particular type of impulsivity, the cognitive one, makes the patients to have an increased rate of processing of distressing thoughts, which makes them prone to suicidal thoughts. They also noted that the feature suggesting the lack of impulse control leaves one at a higher risk of making an attempt to commit suicide [P].

High cognitive impulsivity correlates to a great extent with higher symptoms severity in patients with OCD and higher risk of suicidal intentions and attempts registered in my clinical practice. Reducing the possibility of this risk is anchored on managing impulsiveness [C.P.].

Impaired daily life

Clinicians from the field of Obsessive-Compulsive Disorder (OCD) have continually stressed that the presence of cognitive impulsivity poses high risks towards suicidal thinking in OCD patient. Most experts highlighted that.

Cognitive impulsivity implies that a person makes a decision without taking time to think of the likely consequences and this will lead to bad consequences [P].

Obsessive-compulsive disorder patients with increased levels of cognitive impulsivity reported significantly higher rates of suicidal thoughts, as this impulsivity worsens the patients' feeling of hopelessness [C.P.].

Among the OCD patients, the exacerbation of impulsive thoughts and the inability to control them increases the probability of suicide attempts [P].

Another scholar also submits that,

Such DOI is close linked with cognitive impulsivity and its usual leads to a quick increase of distressing thoughts making these patients at a higher risk of suicidal ideas [C.P.].

Heterogeneity results from the subgroups analysis of the OCD patients with high cognitive impulsivity have a lower ability to manage their symptoms, which is related to the increased risk of suicide [P].

Negative thoughts

Cognitive risk factors that have been identified to predispose patients with OCD to develop suicidal thoughts include negative thoughts. Such patients generally endure the exhausting, disturbing thoughts that are hard to control.

> *Obsessive thoughts in OCD can often turn into a full blown negativity and one begins to feel very inferior to accomplish anything [P].*

> *Ideas of worthlessness and self-negativity, accompanying the constant negative thoughts, increase suicidal tendencies [C.P.].*

> *Such is the nature of OCD, where the patient exercises repetitive negative thinking patterns that they cannot break easily thus contributing to the incidence of suicide [P].*

The expert emphasizes,

> *It is essential to help the patients of OCD work through these negative thoughts with therapeutic intercessions in order to get rid of suicidal thoughts [P].*

> *Using cognitive restructuring technique to encourage the patients to replace negative thoughts with positive emotions to reduce the patient's risk of experiencing thoughts of suicide [C.P.].*

Past trauma

Traumatic history is one of the predictors of suicidal guilt in patients with Obsessive-Compulsive Disorder (OCD). Most of the OCD patients have histories of traumatic events that worsen the intensity of the symptoms, as well as the likelihood of the patient developing suicidal thoughts. The experts explained that:

> *Previous trauma has an influence on increasing the severity of OCD symptoms and thus has a higher risk of developing suicidal thoughts [P].*

> *Posttraumatic stress leads to the accumulation of the emotional discomfort and personal unresolved problems which become the source of obsessive thinking and compulsive behaviors [C.P.].*

> *Forced, patient's obsession-contamination and trauma reciprocally intensify distress and hopelessness, making it almost impossible for the patient to extricate him from suicidal ideation [P].*

> *Placing efforts to heal one's past actual physical or sexual child abuse, adulthood physical and/or sexual assault, and other traumatization through designed techniques in preventing suicide in people with OCD [C.P.].*

Another expert notes that

> *Proper implementation of trauma sensitive therapy into a patient's treatment plan could assist in coping with such events hence affecting the severity of OCD in patients [P].*

Perfectionism

Perfectionism poses a critical threat of suicidal thoughts in OCD patients. Leaving high standards for themselves, obsessive-compulsive disorder is inherent in the patients, and constant striving for an ideal, often brings severe emotional suffering.

> *They found that perfectionism can worsens OCD by making undue pressure on the person and increases the level of anxiety when perfection cannot be accomplished [P].*

> *Perfectionism means that a person always tries to reach the level that is beyond his capabilities, and such a person feels a failure and worthlessness, which leads to suicidal thoughts [C.P.].*

> *Due to the negative and rigid patterns of thoughts related with perfectionism, the patients have great problems when it comes to learning from set backs and this enhances hopelessness and despair [P].*

> *Stresses the need to target perfectionism in therapeutic process as it might be useful to decrease self-suggestions of suicide [P].*

Another also noted that,

> *CBT methods can help the patient get through the obstacles of perfectionism, making the process less tense and changing self-critical attitudes for the healthier one [C.P.].*

Perceived burden

Benazzi and regarding perceived burden, the starting point in this study indicates that perceived burden constitutes a risk factor for suicidal ideation in the OCD patients. Thus, the case of OCD is considered by many patients to be a burden to close ones and care takers as well.

Such conditions may make patients think they are an imposition on families' generosity and patience, thus needing constant support and attentiveness [P].

Such feelings as guilt and shame in care recipient can worsen by perception of being burden hence promoting suicidal behaviors [C.P.].

Since the symptoms of OCD are relatively long-enduring, the patient feels incompetent and regrets their inade

quacies, which increases suicidal thoughts [P].

Specifically, such feelings are reported to be important to address within therapy to help the patients change their perspectives on their effects on other people [C.P.].

Involving the family in the treatment process will complement the efforts of lessening burden perceived by the patient as this contributes to overall well-being of the client [P].

Psychological distress

Therefore, in the sample of patients with OCD, psychological distress emerged as a significant mediator of suicidal ideation. Primary symptoms of OCD are typically most prominent in the patient's life and interfere with daily functioning, causing significant emotional and psychological strain.

The kind of anxiety and fear that OCD patients' experience results in a continuous mental state that is nearly unbearable, which is compounded by the likelihood of suicide attempts [C.P.].

Living in a constant struggle with obsessions and compulsions tends to exhaust the patients' emotions, and the conditions can result in severe depression and hopelessness [P].

The accumulative result of this distress makes the patients feel trapped and desperate, which is usually preceded by suicidal thoughts [C.P.].

Among methods can prevent suicide, it is crucial to state psychological distress and the corresponding interventions like exposure and response prevention (ERP) [P].

Ensuring patients have appropriate management tools and/or an empathetic listening ear can considerably reduce the patient's suffering and moderate state of mental health [C.P.].

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Another also noted that,

CBT methods can help the patient get through the obstacles of perfectionism, making the process less tense and changing self-critical attitudes for the healthier one [C.P.].

Social isolation

All categories of social contacts showed a significant relationship between suicidal ideation in OCD patients and social isolation. The distressing nature of symptoms is suffered by many people with OCD, which is why they often isolate themselves from social interactions and relationships.

Withdrawal increases the intensity of loneliness and leads to the level of social isolation among people [P].

That is, patients do not have friends and family with whom they can share their experiences and who would encourage them in their struggle, thus, the feelings of hopelessness can be enhanced [C.P.].

OCD patients can experience the loss of insight due to social isolation that results in an increased degree of functional impairment and increases the risk of presence of suicidal thinking [P].

Supporting patient's roles in supportive communities and including patients to make friends as a way of eradicating social isolation [C.P.].

Stigma

This paper has established that patients suffering from Obsessive-Compulsive Disorder (OCD) can develop suicidal thoughts due to shame.

People have some misconceptions about OCD as they think it is just a personality disorder or a cleanliness obsession that results in misunderstanding and discriminating people with OCD. This means that OCD is viewed as an embarrassing condition that separates the affected individuals from the rest of society, which worsens the shame that is felt by the affected persons.

Self denial due to the stigma associated with the symptoms of the condition ensures that the patients do not seek help and support hence the risk of developing suicidal intentions.

Advocacy by explaining and informing people what OCD really is so as to reduce the stigma.

Protective factors

Coping skills

The ability to manage stress is a major protective factor while dealing with suicidal thoughts in Obsessive-Compulsive Disorder patients. Healthy coping strategies enable patients to face the problems arising from OCD symptoms with more strength.

> *Instructing patients on how to manage stress results in improved skills that threshold patient's stress and anxiety [P].*

> *Learning coping skills to deal with IT and compulsions, reduces the susceptibility to developing suicidal ideas [C.P.].*

> *Promoting problem solving and positive thinking abilities about combating hopelessness and desperation in patients helps in building patients' coping mechanisms [P].*

> *Issues concerning the use of coping skills training and discussion of OCD-related distress in therapy to enhance patient's ability to cope with the condition [C.P.].*

Family accommodation

Family accommodation is also important in relation to the maintenance of OCD where the family provides or offers help in cases of obsessive-compulsive disorder.

> *When families are aware of their relative's OCD signs and do not encourage the behaviors/compulsions it benefits the patient. This stance helps decrease the level of the patient's anxiety and strengthens the therapeutic process [P].*

> *In the therapy sessions, family members can explain to them what OCD is, develop an understanding of the illness, and increase the family's bond which is vital in the improvement of the patient [C.P.].*

> *Family involvement in treatment can also assist with providing directed behavioural therapy at home and exposure with response prevention drills .*

Hope for future

Talking to the patients and helping them find hope, especially for the future, with be a key reasoning for the reduction of suicidal thoughts in patients with OCD.

> *Hope enables the patient to develop the positive aspects and constructive thinking that may exist beyond the daily fighting of Obsessive Compulsive Disorder manifestations [P].*

> *Promoting hope enables the patients to build a sense of hope by overcoming the bad experience that comes with significant disease, thereby reducing the feeling of hopelessness and helplessness [C.P.].*

> *A need to or to use patient's psychology and suggest them to set goals and aspirations that should serve as a motivation and drive them to live [P].*

> *There is therefore a need for intervention to self-care models which aim at helping the patient increase hope and optimism to reduce the likelihood of suicidal thoughts [C.P.].*

> *We found that developing a therapeutic alliance and enhancing the hope of the patient will make it easier for the patient to manage the disorder [P].*

Impulse control

In patients with OCD, impulse control can be seen as a protective factor which helps prevent the occurrence of SI.

> *This is because patients of OCD need to learn how to deal with the programs, the thoughts, the prompts and urges that are typical of the disorder that cause them a lot of distress [P].*

> *People who have impulse control are more likely to manage the complications stemming from obsessive thinking and compulsive behaviors to avoid the detriment of despondency [C.P.].*

> *Informing patients on ways in which they can exercise self-control and learn proper ways of handling themselves when the impulse takes them [C.P.].*

> *The supporting therapy and importance of maintaining and enhancing the healthy and adaptive ways of dealing with the situation, and increasing the essential ability to control own impulsive behavior [P].*

Religious Support

Religious support has a very strong and significant positive influence in protecting patients with Obsessive-Compulsive Disorder (OCD) against suicidal ideas. There is a general perception that religious practices offer comfort to several people, thus enabling them to come to terms with these disturbing manifestations.

Religious involvement helps in creating meaning and purpose in people's lives, and that such patients would find solace during difficult times [P].

Religious groups come in handy, because they help to encourage someone, and make the person feel they are not alone [C.P.].

The use of prayer and meditation as part of the managed care approach in OCD because of the healthy effects of religion and spirituality in the restoration of the human mind [P].

Any patient should include the spiritual aspect to exert an overall positive effect on a patient's healthcare atmosphere and mental wellness [P].

Resilience

Hope is one of the most significant variables exerting a buffering effect on suicidal thoughts in patients with OCD. The characteristics of resilience enable the person to cope with the pressure caused by the manifestations of OCD.

Recovery oriented people from OCD work through inherently defended styles that assists them to confront and handling distressing thoughts and compulsory behaviors.

Resilience helps one retain positivity and a fighting spirit hence giving up on life is the last thing one can consider [P].

Resiliency, therefore, encompasses understanding the self, acquiring personal and interpersonal coping skills, and utilizing comprehensible relationships.

Psychotherapeutic approaches which target the patient's ability to cope with adversity include cognitive restructuring and practicing mindfulness, which help the OCD patient manage the disorder and improve his or her life [C.P.].

Social Skills

Effective social relations should be considered a powerful mediator against suicidal thoughts in patients diagnosed with OCD.

A better social adaptability seems to be present in those persons that have enhanced parameters of the social competence, which in its turn seems to point at the fact that such individuals tend to have a richer social context and healthier social contacts. Such a support allows patients to feel more encouraged and facilitates them in their pursuit of overcoming OCD symptoms [P].

Social relations can improve the patients' integration into society and decrease their rates of loneliness, which is a well-known factor for suicidal processes [C.P].

Another therapeutic modality that may be useful in combating suicidal ideation includes social skills training as well as group therapy that enables the patients to be made to develop healthy ways of handling their conditions [P].

Analysis of the family and peer support as the factors that help people develop the social skills and encourage other people to participate in the process of recovery [C.P.].

Strong self-esteem

High self-esteem act as a buffering effect on suicidal ideation amongst patients suffering from Obsessive-Compulsive Disorder.

It is also crucial to note that the receptor or the potential OCD sufferer, who has a positive image about 'self' is in a better position to manage with the sets back the of OCD. They have a positive outlook of events meaning that they are able to see that events that are perceived as negative could be temporary hence they do not get despondent [P].

Psychological coping and high levels of positivity that helps people avoid thoughts of suicide during phases of poor health [C.P.].

Cognitive restructuring and self-affirmations are among the promising approaches to increase the level of self-esteem that can be beneficial in trying to prevent patients' suicidal contemplation and promote their overall health [C.P.].

In addition to the economic impacts of OCD and related disorders, additional efforts like improving patients' self-esteem while creating a supportive and validating atmosphere would help enhance patients' ability to confront the obstacles of OCD [P].

Implications

The implications of the research are manifold and extend to various stakeholders involved in the treatment and management of individuals with depression and OCD. Mental health professionals, including psychologists and psychiatrists, can benefit from a deeper understanding of the risk and protective factors associated with suicidal ideation in patients with depression and OCD. This knowledge can inform assessment procedures, treatment planning, and intervention strategies tailored to address the specific needs of this population. Clinicians may integrate targeted interventions aimed at addressing identified risk factors while bolstering protective factors to mitigate the risk of suicidal behaviour. Individuals diagnosed with depression and OCD stand to gain from improved clinical care informed by the findings of this research. Enhanced understanding of the complex interplay between psychological, social, and environmental factors contributing to suicidal ideation can facilitate more comprehensive and individualized treatment approaches. Patients may receive interventions that not only target symptom reduction but also address underlying risk factors, promote resilience, and foster adaptive coping strategies to manage suicidal thoughts effectively. Insights gleaned from this research can inform the development and implementation of public health initiatives aimed at suicide prevention. By identifying key risk factors prevalent in individuals with depression and OCD, public health campaigns can target at-risk populations with tailored interventions, awareness programs, and support services. Efforts to reduce stigma, increase access to mental health resources, and promote early intervention may be particularly beneficial in mitigating suicide risk among vulnerable individuals. Education and training programs for mental health professionals may incorporate findings from this research to enhance clinical competencies in suicide risk assessment and management. By familiarizing practitioners with the nuanced presentation of suicidal ideation in patients with depression and OCD, training curricula can equip clinicians with the knowledge and skills necessary to provide evidence-based care. This may include training in suicide risk assessment, crisis intervention, and collaborative treatment planning to ensure comprehensive care delivery. The findings of this research contribute to the growing body of literature on suicide risk assessment and management, particularly in the context of comorbid psychiatric conditions. Policymakers and funding agencies may use this evidence to prioritize research funding, develop guidelines, and shape policies aimed at addressing suicide prevention efforts. By highlighting the specific risk and protective factors relevant to individuals with depression and OCD, policymakers can advocate for targeted interventions and resource allocation to support suicide prevention initiatives.

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Authors' contributions
R.S was responsible for concept formation, search strategy design, data extraction and synthesis, and manuscript composition. A.A was the supervisors for R.S who conducted this work as part of a research higher degree PhD program.

Data availability
The datasets used and analysed during the current study available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate
This study was conducted in accordance with the principles of the Declaration of Helsinki (1964) and its subsequent amendments. Ethical approval was obtained from Institutional Review Board of the University of Central Punjab, Lahore, Pakistan, and informed consent was provided by all participants prior to inclusion in the study. Participants were informed about the study's purpose, procedures, and any potential risks, and they provided written informed consent to participate.

Competing interests
The authors declare no competing interests.

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