ISSN: 2663-5798 || Arab Journal for Scientific Publishing

الإصدار الثامن – العدد الثالث والثمانون
تاريخ الإصدار: 2 – ايلول – 2025م
www.ajsp.net

"Unveiling the Unseen: Lived Experiences of Suicide Attempt Survivors in Lebanon"

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https://doi.org/10.36571/ajsp837

ISSN: 2663-5798 || Arab Journal for Scientific Publishing

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Abstract:

Objective: Suicide is a significant public health concern worldwide, yet nonfatal suicide attempts remain underexplored, particularly in Lebanon. This study presents primary exploratory descriptive data from one component of a doctoral thesis, focusing on the lived experiences of individuals who attempted suicide, including pre-attempt vulnerabilities, the execution of suicidal behavior, and post-attempt states of mind.

Methods: A qualitative design was employed, collecting in-depth narratives from individuals who survived suicide attempts. Thematic analysis was used to identify patterns related to personal, interpersonal, familial, and socio-environmental factors, as well as coping mechanisms and perceptions of treatment.

Results: Findings revealed a complex trajectory preceding suicide attempt, shaped by emotional dysregulation, low self-esteem, traumatic experiences, familial and marital distress, and socio-economic stressors. Suicidal behavior emerged in response to cumulative distress, triggering events, and perceived inability to cope. Post-attempt experiences demonstrated a dual reality: participants reported growth, increased self-awareness, and proactive coping, alongside persistent negative emotions, fear of relapse, and social and emotional vulnerabilities. Treatment experiences highlighted the critical role of emergency stabilization and inpatient care, though participants noted limited post-discharge support and opportunities for continued guidance.

Conclusions: The study emphasizes the nuanced and multifaceted nature of suicidal behavior, highlighting the coexistence of resilience and ongoing vulnerability. Understanding the subjective experiences of individuals who attempt suicide provides essential insights for research, prevention, and supportive interventions, and underscores the need for continued exploration of tailored post-attempt care strategies.

Keywords: Suicide attempts, Lived experiences, Exploratory study, Post-attempt state of mind, Trajectories, Lebanon.

Introduction:

Suicide is a profound and multifaceted human tragedy that transcends age, gender, culture, and socioeconomic boundaries (Centers for Disease Control and Prevention [CDC], 2008). Globally, it accounts for approximately 1.1% of all deaths, claiming more than 720,000 lives each year, and is the third leading cause of death among individuals aged 15–29 (World Health Organization [WHO], 2025a). Despite a nearly 40% decline in the global age-standardized suicide mortality rate from 1990 to 2021, significant regional disparities persist, with some areas experiencing stagnation or rising trends (Institute for Health Metrics and Evaluation [IHME], 2025).

Nonfatal suicide attempts are considerably more frequent, with estimates suggesting that for every completed suicide, there are over 20 attempts (WHO, 2025a, 2025b). These attempts carry serious psychological and social repercussions, profoundly affecting the individuals involved as well as their families and communities (McIntosh, 2009). Survivors often face persistent negative emotions, fluctuating mental states, and ongoing vulnerabilities that extend well beyond the immediate aftermath of the attempt (Hawton et al., 2013; O'Connor & Kirtley, 2018).

This study presents primary exploratory descriptive data from one component of a doctoral thesis, focusing specifically on the lived experiences of individuals who have attempted suicide in Lebanon. Through exploring the trajectories, risk factors, and post-attempt coping mechanisms reported by these individuals, the study provides detailed insight into the multifaceted nature of suicidal behavior and its enduring psychological impact. Such exploration is critical for generating a nuanced understanding of the phenomenon and establishing a foundation for further research in this context (Joiner et al., 2005; Turecki & Brent, 2016).

1. Suicide Attempt: Specificity of Concept

A suicide attempt encompasses a wide range of non-fatal but harmful self-inflicted behaviors, accompanied by explicit or implicit evidence that the individual intended to die (Silverman, 2006). Similarly, it can be defined as an act resulting in non-

fatal injury, intoxication, or self-harm, in which the person intentionally sought to end their life (CARMHA, 2007). Commonly, suicide attempts are understood as intentional self-injury with the genuine desire to die.

However, the terminology surrounding suicide attempts remains debated. Nock and Kessler (2006) suggest that a suicide attempt may, in some cases, function as a cry for help or an effort to gain attention, reflecting the belief that underlying each attempt is a treatable problem. In alignment, the World Health Organization (WHO, 2014) includes self-harm without suicidal intent in its broader definitions, whereas the Centers for Disease Control and Prevention (CDC, 2015) emphasize the intent to die as central to the definition. Terms such as attempted suicide, para-suicide, deliberate self-harm (DSH), and non-fatal suicidal behavior are sometimes used interchangeably, though the nuances among them are important (CARMHA, 2007).

The term para-suicide refers to self-injurious acts that have all the characteristics of suicide but do not result in death. Notably, para-suicides often precede completed suicide, with estimates suggesting that for every suicide, there are approximately 20–30 para-suicides (Maris, 2000). Despite its historical use, the CDC does not recognize para-suicide due to its broad and ambiguous nature (CDC, 2015).

Intentional self-injury without the desire to die is distinguished as non-suicidal self-injury (NSSI), classified in the DSM-5 as a condition for further study (American Psychiatric Association [APA], 2013). NSSI is conceptually separate from suicide attempts, as it involves self-harm behaviors without suicidal intent (Kerkhof, 2000). Nevertheless, evidence indicates a strong relationship between deliberate self-harm and suicide, with prior self-harm considered a significant risk factor (Cooper, 2005; Zahl & Hawton, 2004). Some studies suggest that over half of individuals who die by suicide have a history of self-harming behaviors (Foster, Gillespie, & McLelland, 1997), though the precise nature of this link remains debated, with some viewing self-injury as a maladaptive coping strategy rather than an expression of a death wish (Adler & Adler, 2011).

Within clinical practice, terminology related to suicide attempts is further refined. An unsuccessful suicide attempt refers to potentially self-destructive behavior with evidence that the individual intended to die but stopped before serious injury occurred. Lethality of suicidal behavior describes the objective danger posed by a suicide method, which is distinct from the person's perception of medical risk (APA, 2010). These definitions are critical for guiding clinical assessment and intervention.

For the purposes of the present study, a suicide attempt is conceptualized as an act, with or without injury, performed with the intent to die. Defining these fundamental concepts and reviewing related prevalence is essential for understanding vulnerabilities, informing clinical practice, and ultimately developing effective strategies to prevent suicide relapse.

International and Lebanese Epidemiological Prevalence of Suicide Attempts

An overview of suicide mortality rates highlights the increase in suicide attempts, as it is estimated that for each suicide death, numerous suicide attempts are registered. The severity of suicide attempts is evident when reviewing the rates and estimated mortality due to suicide.

The prevalence of suicide attempts is significantly higher than that of completed suicides. Nonfatal suicidal acts are believed to occur at least 10 times more frequently than fatal suicides (Nock et al., 2008). Recent estimates indicate that for each completed suicide, there are more than 20 suicide attempts, surpassing previously reported rates (World Health Organization [WHO], 2023). For instance, in the United States, there is an average of 25 attempts for every completed suicide, with approximately 123 suicide deaths occurring per day (American Foundation for Suicide Prevention [AFSP], 2016). Both the Centers for Disease Control and Prevention (CDC) and WHO emphasize the concerning increase in suicide mortality rates (CDC, 2015; WHO, 2015), which may correspondingly elevate the ratio of suicide attempts.

Unfortunately, there is a global gap in the registration of suicidal behaviors, particularly for suicide attempt cases, as noted by WHO (WHO, 2016). Suicide attempts can be obtained from two sources: self-reports in surveys of representative populations and medical records from healthcare facilities (De Leo, 2004). However, the extent to which suicide attempts and suicides are reported to hospitals or primary care services is often compared to an iceberg: only the tip is visible, while most attempts remain hidden and unknown to health services (Conner, 2004; Gvion & Apter, 2012; Kapur et al., 2015).

Even though data regarding attempted suicide across countries and cultures is essential, there are no systematic national statistics on attempted suicide in many countries (WHO, 2005; 2014; 2016).

Vulnerable Group Prevalence

Suicide can occur at any point throughout an individual's lifespan. Certain groups, however, show a higher risk of attempting or dying by suicide.

Globally, 60% of suicides occur in Asia, affecting at least 60 million people (Beautrais, 2006), and 79% of suicides occur in low- and middle-income countries (WHO, 2018). In high-income countries, 3 out of every 1,000 individuals report at least one suicide attempt in the preceding year, while in middle-income countries, the ratio is 3 out of 1,000 males and 6 out of 1,000 females; in low-income countries, the prevalence is 4 out of 1,000 individuals for both genders (WHO, 2014).

The ratio of suicide attempts to deaths also varies by age and gender. Suicide is the second leading cause of death among individuals aged 15–29 years worldwide (WHO, 2018). Among adults above 18 years, the estimated global annual prevalence of suicide attempts is approximately 4 out of 1,000 adults (WHO, 2014). Among adolescents, there may be as many as 200 attempts for every suicide death (Patton et al., 2009). In young adults aged 15–24 years, the estimated attempt-to-completion ratio is approximately 100–200 to 1, higher than any other age group (International Association for Suicide Prevention [IASP], 2014). In the United States, 8.6% of adolescents in grades 9–12 attempted suicide in 2014, with girls attempting more than boys (11.6% vs. 5.5%) (Vermont Department of Health Division of Health Surveillance, 2015). Suicide deaths among young people each year exceed the combined deaths due to homicide and war (IASP, 2014).

Elderly populations also exhibit higher suicide mortality rates. Rates are highest among individuals aged 70 years or older (WHO, 2014). Although older adults may have fewer attempts (approximately 4 attempts per completed suicide), one in four attempts is successful, compared to one in 100–200 attempts in other age groups (American Association of Suicidology [AAS], 2014). Older adults are three times more likely to die by suicide than any other age group (Aging Today, 2016).

In Lebanon, the prevalence of suicide attempts is a growing public health concern. A national study reported that 9.7% of adolescents aged 13–17 years had attempted suicide at least once (Ministry of Public Health, 2020). According to the Lebanese Internal Security Forces, 168 suicide deaths were reported in 2023, representing a 21.7% increase from the previous year (Embrace Lebanon, 2024). These statistics underscore the urgency of implementing targeted mental health interventions and suicide prevention initiatives within the country.

2. The Importance of Examining Suicide Attempts for Prevention

Suicide prevention has emerged as a major global public health priority. Recognizing the profound human, social, and economic consequences of suicidal behavior, the World Health Organization (WHO) launched a worldwide initiative in 1999 aimed at reducing suicide-related mortality and morbidity (WHO, 1999). To raise awareness, September 10th is observed as International Suicide Prevention Day**,** emphasizing the collective responsibility of societies worldwide to mitigate the harmful impact of suicide.

Effective suicide prevention requires a multisectoral approach**,** involving governments, communities, social service organizations, policymakers, and healthcare providers (WHO, 1999). Even in countries with advanced healthcare systems, proactive and coordinated action is essential to reduce suicide rates (WHO, 2013).

Within the framework of prevention, suicide attempters represent a high-risk population**,** making interventions targeted at this group a cornerstone of reducing suicide mortality (WHO, 2014). Empirical evidence consistently indicates that a history of suicide attempts is the strongest predictor of future suicide death (WHO, 2014; Yoshimasu et al., 2008). Suicide attempts are widely regarded as the most significant indicator of subsequent suicide risk (Kataoka et al., 2007; Yoshimasu et al., 2008) and constitute the greatest known risk factor for completed suicide (Brovelli et al., 2017).

Recent global data underscores the urgency of focusing on suicide attempters. In 2021, an estimated 727,000 people died by suicide, with suicide being the third leading cause of death among individuals aged 15–29 years (WHO, 2021). For each

suicide death, there are approximately 20 suicide attempts, highlighting the critical need for targeted interventions (WHO, 2021).

Given this elevated risk, interventions for individuals who have attempted suicide require specialized preventive measures, including extended hospitalization when needed, structured supportive care, and tailored clinical management (Daigle et al., 2011; Qin & Nordentoft, 2005). In such cases, policies must prioritize risk assessment, safety planning, and individualized treatment, rather than relying solely on generalized surveillance (Morgan, 1992; Qin & Nordentoft, 2005). Evidence-based strategies include systematic assessment of suicide risk factors, access to psychological and pharmacological treatments, and referrals to appropriate mental health and social services (Furuno et al., 2017; Kawanishi et al., 2014; Rose & Molina, 2017; WHO, 2014).

Examining the experiences of suicide attempters is therefore not only clinically essential but also critical for understanding the contextual and personal factors that contribute to suicidal behavior. Such insights allow for the design of targeted interventions that address the unique needs of this vulnerable population, ultimately strengthening the effectiveness of suicide prevention initiatives.

Considering the pivotal role of suicide attempters in both predicting and preventing future suicide deaths, a focused examination of their experiences is essential. Understanding the lived experiences of individuals who have attempted suicide provides critical insights for developing effective and targeted prevention strategies. To capture this complexity, the present study employed a structured methodology aimed at systematically gathering data from individuals who have attempted suicide, alongside input from their caregivers and the healthcare professionals directly involved in their care. This approach ensures a comprehensive understanding of the phenomenon, bridging the gap between theoretical knowledge and practical intervention.

3. Research Methodology

This article presents a focused component of a larger doctoral thesis investigating the management of suicide attempts across Lebanese healthcare settings. While the broader thesis explores multiple stakeholders involved in suicide case management, this study specifically examines the lived experiences of individuals who have attempted suicide, providing in-depth insight into their perspectives, needs, and interactions with healthcare services. By concentrating on this population, the study aims to generate evidence that can inform effective, targeted prevention strategies and enhance the quality of care for high-risk individuals.

Research Design and Rationale

A qualitative research design with a descriptive and exploratory orientation, grounded in a phenomenological perspective, was adopted. Phenomenology emphasizes the immediacy of lived experience and captures subjective dimensions of phenomena as directly experienced (Husserl, 1969). This approach is particularly appropriate for suicidology, as it enables a deep understanding of the lived experiences of individuals who have attempted suicide, an essential foundation for effective prevention and care strategies (Pompili, 2010).

The study sought to explore how suicide attempters experience their attempts, interactions with healthcare systems, and ongoing psychological and social needs. By foregrounding their perspectives, the research provides critical insights into factors contributing to suicide risk and identifies areas for responsive intervention.

Population and Sampling Strategy

The study focused exclusively on individuals who had attempted suicide and received care in Lebanese healthcare settings. Participants were recruited from eight hospitals, including emergency departments, inpatient psychiatric units, and mental health services, providing a diverse, multi-site sample.

A purposive sampling strategy was employed to select participants most relevant to understanding suicide attempters' experiences (Patton, 2002). Inclusion criteria required participants to have a history of at least one suicide attempt, be

medically stable, and consent to participate. Exclusion criteria included individuals with only suicidal ideation or severe cognitive impairment.

A total of 14 suicide attempters participated (8 males, 6 females), aged 19 to 60 years. For ten participants, this was their first attempt, while four had a history of previous attempts. Participants represented a wide range of socioeconomic and educational backgrounds, enhancing the depth and contextual richness of the findings.

Data Collection

Data were collected through in-depth, semi-structured interviews with each participant. Interviews were conducted privately, in a confidential setting, to ensure participants felt secure sharing their experiences (Rubin & Rubin, 2005). The interview guide explored participants' experiences leading up to their suicide attempt, perceptions of care received, coping strategies, and ongoing psychological and social needs.

Initial interviews often yielded brief responses; however, as trust was established, participants became more open, sharing detailed personal narratives and reflections. The qualitative approach allowed participants to articulate their experiences in their own words, providing rich, nuanced data essential for understanding the phenomenon (Bloom & Crabtree, 2006; Ohman, 2005).

Ethical Considerations

The study adhered to rigorous ethical standards, prioritizing participant welfare in accordance with the Declaration of Helsinki (2008) and Belmont Report principles (1978). Participation was voluntary, with informed consent obtained after a thorough explanation of the study's aims and procedures. Confidentiality was strictly maintained, and participants were provided with information on available mental health support if distress arose during or after the interviews.

Data Analysis

Data were analyzed using descriptive and interpretive thematic analysis, consistent with the study's phenomenological approach (Elliott & Timulak, 2005). Analysis focused exclusively on the suicide attempters' experiences, identifying key themes related to:

- Suicidal Vulnerability, Pre-Attempt Factors, and Acting Out
- **The Treatment Trajectory**
- Current State of Mind Following a Suicide Attempt

The analysis provided an integrated understanding of suicide attempters' experiences, encompassing vulnerability factors, treatment pathways, and post-attempt mental states.

Ensuring Scientific Rigor

Maintaining scientific rigor was a core consideration throughout the study to ensure the credibility, reliability, and trustworthiness of the findings. Initially, a purposive, multi-site sampling strategy was employed to include diverse participants from eight different hospitals, capturing context-rich perspectives from individuals who had attempted suicide (Patton, 2002; Yin, 2003). This approach enhanced the depth and transferability of the findings by representing variations across clinical settings and demographic backgrounds.

Second, data were collected from multiple sources across hospitals representing all regions of Lebanon, enhancing credibility by comparing diverse perspectives and minimizing bias (Denzin, 1978, 1988; O'Reilly & Parker, 2012)

Finally, transparency in data analysis was maintained through meticulous documentation of coding procedures, thematic development, and decision-making throughout the analytic process (Elliott & Timulak, 2005; Fusch, 2013). Such

transparency ensures that interpretations are traceable and replicable, supporting the overall trustworthiness and scientific rigor of the study.

Building on the methodological approach and the measures taken to ensure rigor, the focus now shifts to the direct experiences of individuals who have attempted suicide. This section emphasizes the perspectives of the attempters themselves, shedding light on the circumstances leading to their attempts, their interactions with healthcare services, and their personal reflections on the support they received. By presenting these firsthand accounts, the study moves from abstract concepts of suicide prevention to the concrete realities faced by at-risk individuals, providing actionable insights for improving intervention strategies and tailoring care to the needs of those most affected.

This paper is particularly relevant as it captures the lived experiences of suicide attempters, a perspective often underrepresented in research, providing critical insights that can guide evidence-based interventions, improve clinical care, and strengthen suicide prevention efforts in the Lebanese context and beyond.

4. Results Overview

The analysis of narratives from individuals who attempted suicide revealed a complex and multifaceted trajectory leading to suicidal behavior, encompassing pre-attempt vulnerabilities, the immediate progression from ideation to action, and subsequent interactions with treatment and recovery processes. The findings are presented across three interconnected domains:

Suicidal Vulnerability, Pre-Attempt Factors, and Acting Out

Analysis of the data revealed a complex trajectory leading up to suicide attempts, influenced by intertwined personal, familial, and environmental factors. Several key domains contributed to individuals' vulnerability, as well as factors that facilitated the progression from ideation to action.

Pre-Attempt Vulnerabilities

Analysis of participants' narratives revealed several pre-attempt vulnerabilities, including personal and interpersonal challenges, mental and physical health factors, family and parenting dynamics, and socio-economic and environmental stressors

Personal and Interpersonal Challenges
Challenges in romantic relationships, low self-esteem, feelings of worthlessness, and unresolved personal regrets were commonly reported as critical stressors. Intrapersonal factors, such as self-criticism, emotional dysregulation, and limited self-compassion, intensified psychological distress and facilitated suicidal thoughts. Previous traumatic experiences—including bullying, sexual abuse, and exposure to war or violence—further increased vulnerability.

Mental and Physical Health Factors
Mental health conditions, including depression, bipolar disorder, borderline personality traits, and other psychiatric illnesses, were frequently present. Physical health concerns, such as chronic pain or somatic symptoms, also contributed to overall distress. Gaps in treatment, misdiagnoses, and inconsistent adherence to prescribed medications were associated with elevated risk, highlighting the importance of coordinated and continuous mental health care.

Family Dynamics and Parenting
Authoritarian or highly controlling parenting, lack of privacy, intergenerational conflicts, and exposure to domestic violence emerged as recurring contributors. Marital difficulties, including neglect, infidelity, and abuse, further increased vulnerability. Dysfunctional family environments often limited access to private support or emotional care, exacerbating feelings of isolation and helplessness.

Socio-Economic and Environmental Stressors
Financial instability, unemployment, debt, and work-related stress in demanding occupations were significant sources of pressure. These socio-economic challenges often interacted with personal vulnerabilities, amplifying emotional strain and increasing the likelihood of suicidal behavior.

From Suicidal Ideation to Acting Out

Suicidal thoughts often developed gradually as individuals struggled to manage persistent suffering and distress. Triggering events—including family disputes, marital conflict, financial crises, and societal pressures—frequently precipitated the transition from thoughts to actions. Discontinuation of treatment or inadequate management of psychiatric conditions also represented critical triggers.

In some instances, exposure to suicide in the social environment or imitation of suicidal behavior served as additional precipitating factors. Individuals often viewed suicide as a way to escape pain, seeking temporary relief or a sense of peace, while simultaneously expressing ambivalence and a desire for help.

Execution and Help-Seeking Behaviors

The methods employed in suicide attempts varied, commonly including ingestion of medications or toxic substances, hanging, and self-injury. After attempting suicide, many individuals displayed ambivalence and sought assistance, reflecting a continued desire to survive and receive care. These behaviors underscore the complex interaction between suicidal intent, coping strategies, and help-seeking tendencies.

The Treatment Trajectory

Analysis of individuals' narratives revealed a multi-stage treatment process encompassing emergency stabilization, inpatient care, and post-discharge follow-up, each influencing recovery and coping differently.

Emergency Intervention and Stabilization
Following suicide attempts, individuals frequently reported immediate hospitalization, often involuntarily due to unconsciousness or critical risk. Emergency care focused on life-saving procedures, intensive monitoring, and stabilization specific to the method of attempt. Many individuals described this stage as essential for preventing further physical harm and creating a sense of temporary safety, though some noted that the urgency of medical interventions often left little opportunity to address emotional distress in the moment.

Inpatient Psychiatric and Psychological Care
Hospital stays varied from brief observation to extended periods, depending on the severity of the attempt and available resources. During inpatient care, individuals received pharmacological treatment—commonly including antidepressants, mood stabilizers, or anxiolytics—combined with structured psychological interventions. Therapy focused on enhancing self-awareness, identifying maladaptive cognitive patterns, improving emotional regulation, and developing adaptive coping strategies. Several individuals reflected that this stage helped them recognize the factors leading to their attempt, yet some expressed that the intensity of treatment felt overwhelming, and emotional support was not always tailored to their personal needs.

Individuals emphasized that inpatient care provided a temporary sense of containment from external stressors, which allowed them to pause and reflect on their thoughts. Some shared that participating in therapy sessions enabled them to articulate feelings they had long suppressed and to understand the connection between their distress and their attempts. However, a recurring concern was the short duration of meaningful psychological support, which left some individuals feeling unprepared for life after discharge.

Discharge Planning and Post-Hospital Follow-Up

Post-discharge support was often perceived as insufficient or fragmented. Where follow-up existed, it included outpatient psychiatric or psychological consultations, but consistency and continuity varied widely. Individuals highlighted that the lack of structured monitoring, guidance for daily coping, or regular check-ins sometimes triggered feelings of uncertainty, anxiety, and vulnerability to relapse. Many indicated that more frequent or personalized follow-up could have provided reassurance, strengthened coping skills, and reduced the sense of isolation following discharge.

Several individuals expressed a desire for proactive support in managing triggers, maintaining medication adherence, and integrating therapy into their daily routines. They suggested that post-discharge interventions, such as regular counseling sessions, peer support groups, or structured guidance for handling stressors, could significantly improve long-term recovery and resilience.

Overall Perceptions of the Treatment Trajectory

The treatment trajectory, as perceived by individuals themselves, revealed that emergency and inpatient care addressed immediate crises and physical stabilization, while post-discharge interventions were crucial for sustaining recovery and reinforcing adaptive strategies. Experiences suggest that continuous, individualized support—both psychological and practical—plays a central role in preventing reattempts and fostering long-term emotional stability.

Current State of Mind Following a Suicide Attempt

Analysis of participants' narratives revealed that individuals who attempted suicide experience a dynamic and multifaceted state of mind following their attempts, reflecting both recovery and ongoing vulnerability.

Positive Mindset and Recovery

Several individuals described the development of a more positive and constructive perspective after their suicide attempts. They reported increased self-awareness**,** recognizing personal strengths and the capacity to manage challenges independently. Many emphasized that they no longer view suicide as a solution, and that confronting life's difficulties can be approached through problem-solving and proactive coping strategies.

Participants indicated improvements in decision-making**,** including making changes in work, education, and daily routines to enhance well-being. They stressed the importance of personal initiative, self-help, and maintaining hope, often reflecting on past experiences as lessons that strengthened their resilience. Individuals also highlighted the value of setting goals and pursuing ambitions, considering such steps as central to regaining control over their lives.

Persistent Negative Feelings and Vulnerabilities

Despite positive shifts, many individuals continue to experience negative emotions**,** such as boredom, frustration, lack of motivation, and persistent life dissatisfaction. Feelings of self-hatred and emotional distress were reported, along with difficulty in social and intimate relationships. Emotional expression remains limited for some, hindering their ability to communicate needs or seek help effectively.

Participants acknowledged ongoing anxiety and fear of relapse, with some describing recurrent suicidal thoughts or planning potential reattempts. These persistent vulnerabilities illustrate that, although recovery processes can foster hope and resilience, the risk of suicide remains present, and ongoing coping efforts are necessary.

Reflections on Recovery and Empowerment

Individuals emphasized that learning from their experiences strengthened their sense of agency. They reported greater confidence in handling daily challenges, making informed choices, and pursuing personal development. Many expressed the belief that actively addressing problems, rather than avoiding them, is key to sustaining mental health.

Overall, the findings underscore a dual reality: post-attempt, individuals may demonstrate growth, resilience, and positive coping, yet residual distress and vulnerability continue to shape their mental state, highlighting the need for ongoing self-awareness and adaptive coping strategies.
The current section has presented the findings based solely on the experiences and narratives of individuals who attempted suicide. The results highlight key domains of vulnerability, pre-attempt factors, suicidal ideation and triggers, acting-out behaviors, and perceptions of the treatment trajectory. A discussion section will follow, providing interpretation of these findings, connecting them with existing literature, and exploring their broader implications for suicide prevention and intervention strategies.

5. Discussion and Interpretation

Understanding the experiences of individuals who survive suicide attempts requires examining the multiple processes that shape the emergence of suicidal behavior, the treatment journey, and post-attempt adaptation. This discussion interprets the study findings in relation to established theories and empirical research, providing a comprehensive perspective on the psychological, relational, and clinical dimensions involved in both risk and recovery.

Pathways of Suicidal Vulnerability and Progression to Attempts

The narratives of individuals who attempted suicide in this study reveal a complex interplay of personal, interpersonal, familial, and socio-environmental factors that shaped their vulnerability and progression toward suicidal behavior. These findings are consistent with the Integrated Motivational-Volitional (IMV) model, which emphasizes the role of defeat and entrapment in the development of suicidal ideation and attempts (O'Connor, 2011). Participants frequently reported enduring psychological distress, including depression, anxiety, and feelings of hopelessness, which correspond with established evidence identifying such states as major risk factors for suicidal behavior (O'Connor, 2011). Interpersonal difficulties, such as strained family and peer relationships, were also prevalent, echoing previous research showing that conflict and a lack of social support significantly contribute to suicidal ideation and attempts (Joiner, 2005).

Family-related stressors emerged as particularly influential. Accounts of familial conflict, neglect, and abuse were common among participants, aligning with research demonstrating that adverse childhood experiences and familial dysfunction elevate the risk of suicidal behavior (Hawton et al., 2013). Socio-economic challenges, including unemployment, financial instability, and academic pressure, were also frequently described, consistent with findings linking socio-economic adversity to higher suicide risk (O'Connor, 2011). Gender- and age-related differences were observed, with female participants tending to emphasize interpersonal and emotional distress, while male participants more often reported external pressures such as academic and financial demands. This pattern reflects broader evidence of gender differences in the expression of suicidal vulnerability (Nock et al., 2013).

The transition from suicidal ideation to acting out appeared to follow a gradual process influenced by accumulated distress, adverse life experiences, and limited coping resources, aligning with the ideation-to-action framework, which distinguishes between the emergence of ideation and the mechanisms that enable action (Klonsky & May, 2015). Acute life events such as family disputes, financial crises, interpersonal losses, and broader societal pressures were often described as immediate triggers, consistent with prior studies identifying stressful events as precipitating factors for attempts (Beautrais, 2000; Franklin et al., 2017). Suicide was frequently framed as a means of temporary escape from overwhelming distress, accompanied by ambivalence between wanting relief and maintaining a desire to live, a theme widely documented in previous research (O'Connor & Kirtley, 2018).

Treatment discontinuation, including non-adherence to medication and lapses in follow-up care, was also noted as an element that increased vulnerability to acting on suicidal thoughts. This observation corresponds with evidence that inconsistent treatment adherence significantly heightens the risk of attempts among psychiatric populations (Zhou et al., 2020). Furthermore, exposure to suicide through peers or media was reported by some participants, reflecting the phenomenon of suicide contagion described in the literature, where knowledge of suicidal behaviors in others can influence vulnerable individuals (Gould et al., 2003).

Overall, the findings of this study align with theoretical frameworks and empirical research, illustrating that suicidal behavior results from the interaction of enduring vulnerabilities, acute stressors, ambivalent motivations, treatment-related challenges, and social influences.

Treatment Trajectories Following Suicide Attempts

The findings of this study indicate that recovery following a suicide attempt unfolds through a staged process encompassing emergency stabilization, inpatient psychiatric and psychological care, and post-discharge follow-up. Participants' narratives align with clinical evidence emphasizing the critical role of timely emergency intervention in preventing further harm and establishing a foundation for subsequent psychological recovery (Boudreaux et al., 2016). Immediate hospitalization and medical stabilization were consistently described as essential for addressing life-threatening injuries and assessing ongoing suicide risk.

During inpatient care, participants reported engagement in both pharmacological treatment and structured psychological interventions. Psychotherapy, as described by participants, focused on enhancing self-awareness, regulating emotions, and developing adaptive coping strategies—approaches that have been empirically supported in reducing suicide risk (Mann et al., 2005; Stanley & Brown, 2012). Hospitalization appeared to facilitate reflective processing of distress while enabling initial skill-building, suggesting that the integration of medication and therapy contributes to stabilizing mental health post-attempt.

Although participants noted variability in the availability and intensity of post-discharge follow-up, the findings correspond with existing literature emphasizing the importance of continuity of care in preventing reattempts (Zhou et al., 2020). The narratives highlight that coordinated care across all stages—emergency, inpatient, and follow-up—plays a role in the stabilization process and the ongoing management of suicide risk.

Overall, these results support a multi-stage understanding of treatment trajectories, consistent with prior research on post-attempt recovery. The evidence underscores that emergency stabilization addresses immediate safety needs, while inpatient psychiatric and psychological interventions provide structured opportunities for reflection, skill development, and the regulation of acute psychological distress. Post-discharge care, when present, complements these earlier stages by sustaining mental health stabilization and reinforcing adaptive coping strategies.

Post-Attempt Mental States: Growth and Persistent Vulnerabilities

The findings indicate that individuals' mental states following a suicide attempt encompass a complex interplay of adaptive growth and persistent vulnerabilities. Several participants reported increased self-awareness, recognition of personal strengths, and enhanced capacity to manage challenges, reflecting a more constructive perspective on life. These observations correspond with literature on post-traumatic growth, which highlights the potential for positive psychological change after crisis experiences (Tedeschi & Calhoun, 2004; Bryant et al., 2017). Improvements in decision-making, including changes in work, education, and daily routines, were also noted, consistent with evidence that structured personal initiatives support autonomy, resilience, and adaptive functioning (Johnson et al., 2020; Slade et al., 2019).

Despite these positive developments, participants continued to report negative emotions such as boredom, frustration, low motivation, and life dissatisfaction. Persistent feelings of self-hatred, emotional distress, and difficulties in social and intimate relationships were common, mirroring findings that limited emotional expression and ineffective help-seeking are linked to sustained suicidal risk (Hom et al., 2015; Kleiman & Liu, 2013). Ongoing anxiety and fear of relapse, including recurring suicidal thoughts or planning of potential reattempts, were described, reflecting longitudinal research showing that post-attempt recovery is often non-linear and marked by coexistence of growth and residual vulnerability (Nock et al., 2019; Mars et al., 2020).

Participants also emphasized learning from their experiences and cultivating agency as central to their adaptive processes, aligning with studies that highlight empowerment and skill development as integral to sustaining coping and mental well-being following crises (Czyz et al., 2019; O'Connor et al., 2018). Overall, the findings illustrate that post-attempt recovery

is multifaceted, characterized simultaneously by adaptive growth and ongoing susceptibility to emotional and social stressors, corroborating prior research on the complex, dynamic nature of recovery following suicidal behavior.

Conclusion

Suicide remains a critical public health issue, and understanding the lived experiences of individuals who attempt suicide is essential for effective prevention. This study highlights a dual reality: while many develop resilience, self-awareness, and adaptive coping strategies, persistent negative emotions, anxiety, and recurrent suicidal thoughts continue to affect their well-being, emphasizing ongoing vulnerability.

The findings underscore the urgent need for sustained, culturally sensitive interventions that extend beyond emergency care to include psychosocial support, empowerment, and skill-building. By centering the voices of those affected, Lebanon can strengthen suicide prevention strategies, reduce morbidity and mortality, and foster a society that supports resilience, hope, and dignity for individuals at risk.

Moving forward, the implementation of evidence-based, context-specific programs addressing both immediate and long-term needs is crucial. Continued research, policy development, and integration of community-based support systems can enhance prevention efforts and ensure comprehensive, tailored care.

Ultimately, understanding and addressing the persistent vulnerabilities of individuals who attempt suicide is not only a clinical imperative but a societal responsibility—transforming knowledge into action can save lives and restore hope.

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ISSN: 2663-5798 || Arab Journal for Scientific Publishing

الإصدار الثامن – العدد الثالث والثمانون
تاريخ الإصدار: 2 – ايلول – 2025م
www.ajsp.net

"كشف المكنون: الخبرات الشخصية المعاشة للأفراد الذين نجوا من محاولات الانتحار في لبنان"

الملخص:

الهدف :يُعد الانتحار قضية صحة عامة بالغة الأهمية عالميًا. ومع ذلك، لم تُدرس الخبرات الشخصية للأفراد الذين نجوا من محاولات الانتحار بشكل كافٍ، لا سيما في لبنان. تهدف هذه الدراسة، كأحد مكونات أطروحة الدكتوراه، إلى استكشاف هذه الخبرات المعاشة، مع التركيز على العوامل السابقة للمحاولة، والسلوك الانتحاري نفسه، والوضع النفسي بعد المحاولة.

المنهجية :اعتمدت الدراسة تصميمًا نوعيًا لجمع سرد مفصل من الأفراد الذين نجوا من محاولات الانتحار. وتم استخدام التحليل الموضوعي لاستخراج الأنماط المتعلقة بالعوامل الشخصية والاجتماعية والأسرية، بالإضافة إلى ضعف التحكم العاطفي، وآليات التكيف، وتجارب التدخل العلاجي. وقد أتاح هذا النهج فهماً معمقًا للخبرات الذاتية، وللتفاعلات المعقدة بين العوامل النفسية والاجتماعية.

النتائج :أشارت النتائج إلى أن مسار محاولة الانتحار معقد ومتعدد الأبعاد، ويتأثر بتراكم الضغوط النفسية والاجتماعية. وتشمل هذه العوامل ضعف التحكم العاطفي، وانخفاض تقدير الذات، والتجارب الصادمة، والضغوط الأسرية والزوجية، والمحددات الاقتصادية والاجتماعية. كما بينت الدراسة أن السلوك الانتحاري غالبًا ما ينشأ استجابةً للأحداث المحفزة والشعور بعدم القدرة على المواجهة. بعد المحاولة، كشف المشاركون عن واقع مزدوج؛ إذ أبلغوا عن نمو شخصي، وزيادة الوعي الذاتي، واستخدام استراتيجيات تكيفية نشطة، إلى جانب استمرار المشاعر السلبية، والخوف من الانتكاس، والهشاشة الاجتماعية والعاطفية. كما أبرزت تجارب التدخل العلاجي الدور الحيوي للرعاية بالمستشفى، مع الإشارة إلى محدودية الدعم والمتابعة بعد الخروج، والحاجة إلى التدخلات اللاحقة للمحاولة.

الاستنتاجات: تؤكد الدراسة على الطبيعة الدقيقة والمعقدة للسلوك الانتحاري، موضحة التعايش بين الصلابة والهشاشة المستمرة لدى الأفراد. ويبرز فحص خبرات الناجين من محاولات الانتحار أهمية تعزيز البحث العلمي، وتطوير برامج الوقاية، وتقديم التدخلات الداعمة، مع التأكيد على الحاجة إلى استراتيجيات رعاية مخصصة بعد المحاولة.

الكلمات المفتاحية: محاولات الانتحار، الخبرات الشخصية المعاشة، دراسة استكشافية، الوضع النفسي بعد المحاولة، المسارات، لبنان.