


**ADDIS ABABA UNIVERSITY**

**COLLEGE OF HEALTH SCIENCE**

**SCHOOL OF MEDICINE**

**DEPARTMENT OF PSYCHIATRY**

**CLINICAL PSYCHOLOGY**

# EXPLORING THE LIVED EXPERIENCES OF SUICIDE ATTEMPT SURVIVORS: A QUALITATIVE STUDY AT TIKUR ANEBESSA SPECIALIZED HOSPITAL AND AMANUEL MENTAL SPECIALIZED HOSPITAL IN ADDIS ABABA, ETHIOPIA

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**A THESIS SUBMITTED TO THE DEPARTMENT OF PSYCHIATRY, SCHOOL OF MEDICINE, COLLEGE OF HEALTH SCIENCES, ADDIS ABABA UNIVERSITY IN PARTIAL FULFILMENT OF THE REQUIREMENTS MASTER'S DEGREE IN CLINICAL PSYCHOLOGY**

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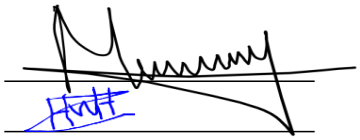
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**DEPARTMENT OF PSYCHIATRY, SCHOOL OF MEDICINE, COLLEGE OF HEALTH SCIENCES, ADDIS ABABA UNIVERSITY**

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**ACRONYMS**

| | |
|---|---|
| WHO | World Health Organization |
| LMIC | Low- and Middle-Income Countries |
| PTSD | Posttraumatic Stress Disorder |
| saPTSD | Suicide Attempt-related Posttraumatic Stress Disorder |
| APA | American Psychiatric Association |
| DSM-5 | Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition |
| FVT | Fluid Vulnerability Theory |
| 3ST | Three-Step Theory of Suicide |
| IMV | Integrated Motivational-Volitional Model |
| STS | Strain Theory of Suicide |
| SCS | Suicide Crisis Syndrome |
| STB | Suicidal Thoughts and Behaviors |
| TSMs | Threat to Self-Moderators |
| MMs | Motivational Moderators |
| VMs | Volitional Moderators |
| OPD | Outpatient Department |
| DWIs | Deep Wrist Injuries |
| GPs | General Practitioners |

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# ABSTRACT

**Background:** Suicide is a critical global public health crisis with over 727,000 annual deaths, mainly in LMICs (WHO, 2025). In Ethiopia, lifetime prevalence estimates for suicidal ideation range from 1% to 55%, while suicide attempts vary between 0.6% and 14% (Tegegne et al., 2022). Despite these high figures and the fact that a previous attempt is a critical risk factor for future suicide (Mann et al., 2005), the perspectives and subjective lived experiences of survivors remain largely unexamined (Pompili, 2010). This critical research gap directly hinders the development of culturally sensitive interventions and policies, which is the foundational justification for this study (Shaw et al., 2019).

**Objectives:** To explore the lived experiences of suicide attempt survivors to improve mental health support and guide culturally appropriate interventions.

**Methods:** To achieve these aims, a qualitative phenomenological approach was employed. Nine participants, 5 Female and 4 Male, aged from 15 years and 40, who have survived a suicide attempt was purposively recruited from Tikur Anebeesa Specialized Hospital and Amanuel Mental Specialized Hospitals in Addis Ababa. Data was collected through in-depth, semi-structured interviews conducted in Amharic, audio-recorded, transcribed verbatim, and analyzed thematically using Open Code software.

**Result:** Six major themes and twelve subthemes emerged from interviews. Participants described going through overwhelming hopelessness, emotional pain, loneliness, feeling like a burden to others, and conflict within their families before attempting suicide. Most felt misunderstood, unsupported, and unable to openly talk about their struggles because of stigma and fear of judgment. Survivors also spoke about the importance of emotional support, understanding, professional help, and spirituality in coping and recovery.

**Conclusion:** The findings suggest that suicide attempts developed within complex emotional, relational, social, and cultural contexts. Hopelessness, family conflict, emotional isolation, and feeling like a burden were central in survivors' experiences, while supportive relationships, treatment, and faith helped the majority move toward recovery.



**Key words:** Suicide attempt survivors; Lived experience; Suicide prevention; Mental health; Qualitative Research

# CHAPTER 1: INTRODUCTION

## 1.1 Background of the study

Suicide, derived from the Latin term "sui caedere," meaning to self-kill, refers to the act of purposely ending one's own life. A suicide attempt signifies non-lethal actions or preparations that were meant to result in death. Such actions may have been halted, interrupted, or ultimately failed (Jans et al., 2018).

Numerous philosophical, sociological, and clinical perspectives have been used to analyze the complicated and multifaceted phenomenon of suicide. Suicidal behavior can be viewed as a spectrum that includes suicidal thoughts, attempts, and actualizations. When there is direct or indirect proof that the person attempted suicide, an action that could result in self-harm without death is referred to as an attempt at suicide. Injuries may or may not result from this act (Ramdurg et al., 2011).

Suicide is a significant public health challenge that requires a coordinated public health response. According to World Health Organization (WHO) data, over 727,000 people kill themselves each year, with many more attempting suicide. This is equivalent to one suicide every forty seconds. According to WHO (2025), each suicide is a tragedy that affects families, communities, and nations, leaving long-term consequences for those who survive. Suicide is caused by a variety of factors, including social, cultural, biological, psychological, and environmental influences that occur throughout a person's lifetime. Suicide occurs at all ages and was the third leading cause of death among people aged 15 to 29 worldwide in 2021. In fact, nearly three-quarters (73%) of global suicides occurred in low and middle-income countries in 2021 (WHO, 2025).

For every suicide, it is estimated that there are about 20 attempts (WHO, 2019). A previous suicide attempt is also a crucial risk factor for suicide within the broader population (Mann et al., 2005; Retterstøl & Mehlum, 2001).

Suicide accounts for 1.4% of total deaths and 15% of injury-related deaths (Värnik, 2012). The true number of suicide deaths is most likely underestimated due to significant limitations in detection and reporting (WHO, 2014; AbouZahr et al., 2015). It is also worth noting that, while much suicide prevention research is conducted in high-income countries, nearly 80% of suicides occur in low- and middle-income countries (LMIC) (WHO 2018; Lopez-Castroman et al., 2015).

In Ethiopia, various studies have been conducted on lifetime suicidal thoughts (ranging from 1% to 55%), attempted suicide (from 0.6% to 14%), and suicide death rates (7.2 to 8.4 per 100,000). Suicide receives less attention than other major causes of death, such as highly infectious diseases (Tegegne et al., 2022).

According to Tiet et al. (2006), the annual suicide rate in Addis Ababa is 7.76/100000 individuals. The lifetime prevalence of suicidal thoughts and attempts among psychiatric outpatients at Gondar Comprehensive Teaching Hospital was 64.8% and 19.2%, respectively (Hooman et al., 2013), whereas in the urban community of Addis Abeba, the lifetime prevalence of suicidal ideation and attempts was 2.7% and 0.9%, respectively (Bekry, 1999).

To explain, predict, and prevent suicide, it is critical to understand what suicidal thoughts and feelings mean for those who have them (Pompili, 2010). To understand any human experience, we must first ask the phenomenological question: "What is this or that type of experience like?" (van Manen, 1997). Although early suicidologists, such as Edwin Shneidman and Erwin Stengel, asked, "What does it mean to be suicidal?" In recent decades, the phenomenology of suicidality has shifted away from the field's research focus (Pompili, 2010).

Understanding the subjective, lived experiences of those affected by suicidality can help develop culturally sensitive health services, influence public policy, and bring about meaningful societal change (Shaw et al., 2019). This paper presents a phenomenological qualitative study investigating the lived experiences of individuals who survived suicide attempts.

## 1.2 Statement of the problem

Despite significant research efforts, suicide rates continue to rise, indicating gaps in our understanding of the experiences and meanings associated with suicidal behavior. More hermeneutic and phenomenological studies are being sought to explain and understand these lived experiences (Cutcliffe, 2003).

Current approaches to suicide prevention frequently come from healthcare professionals who address the physical and psychological consequences of an attempt, rather than those who have lived through it firsthand. Individuals who have attempted suicide are often overlooked in suicide prevention literature. As a result, the most profound insights about suicide are lost by excluding the voices of people who have personally attempted suicide (Maple et al., 2019).

Suicide survivors' perspectives are frequently overlooked, and this is a significant limitation of the existing suicidology literature. From 2005 to 2007, more than 95% of studies published in peer-reviewed journals used quantitative methods. According to Hjelmeland and Knizek (2010), this trend stems from a strong emphasis on correlations and causative factors. They advocate for more qualitative research to understand the phenomenon of suicide from the perspective of individuals. Individuals who have survived suicide attempts may have the most valuable insights for shaping current intervention strategies (Webb, 2010).

Suicide attempts are the primary predictor of future lethal attempts, with those who have attempted suicide being 100 times more likely to commit suicide than the general population (Owens et al., 2002). This emphasizes the importance of improving our understanding of this phenomenon in order to better support individuals.

Survivors often experience emotional distress, social difficulties, and a desire for connection and acceptance (Shamsaei et al., 2020). Their experiences provide valuable insights into suicidal episodes and the barriers to receiving appropriate support (Maple et al., 2019). Without investigating how these individuals make sense of their experiences, why they attempted suicide, what helped them survive, and how they view their lives after the attempt, mental health interventions risk becoming disconnected from the real-life needs of those they seek to assist.

Mental health remains under-prioritized in Ethiopia, and suicide is still stigmatized (Girma et al., 2022). To the best of the researcher's knowledge, no qualitative study in Ethiopia exploring the lived experiences of suicide attempt survivors could be found. This lack of understanding leaves a significant gap in suicide prevention strategies, clinical responses, and community education.

Personal narratives are recognized as an effective way to communicate health information and meet information needs following a suicide attempt (McGill et al., 2019). Findings emphasize the importance of integrating lived experiences in suicide prevention initiatives (Shamsaei et al., 2020; Maple et al., 2019).

## 1.3 Significance of the study

The goal of this study is to look into the lived experiences of people who have been suicidal and attempted suicide, in order to determine how health care professionals can better meet, care for, and treat those who have attempted suicide, as well as help them prevent future attempts. Discussing suicide can be challenging (Mozaffor et al., 2020). Previous suicide attempts are the most significant risk factor for future suicides; thus, remaining silent can have serious consequences, whereas awareness and communication can help prevent suicide and save lives (O'Connor & Pirkis, 2016). Suicide prevention relies heavily on education and awareness, which can be achieved through timely, evidence-based, and often low-cost interventions. To better understand, respond to, and reduce the prevalence of suicide, high-quality research in this area is required. It also must be ethically sound (Fisher et al., 2002; Dereje et al., 2024).

Research into the lived experiences of suicide attempt survivors reveals several key themes. Survivors' experiences include mental pain, social challenges, and a need for love and belonging (Shamsaei et al., 2020). Survivors frequently struggle to disclose their suicidal thoughts, both before and after attempts, due to stigma and a lack of understanding (Maple et al., 2019). Studies emphasize the importance of including survivors' voices in research, as they provide critical insights into the suicidal experience and the challenges of seeking appropriate support (Maple et al., 2019). Such findings can help to shape suicide prevention strategies and provide support to survivors of attempted suicides.

David Webb (2010) describes the experiences that effectively demonstrate the impact of these insights. Webb describes his own experience with suicidal thoughts, expressing profound anger and disappointment after surviving several meticulously planned attempts, as well as feelings of hopelessness and helplessness, saying, "There is no sense of failure quite like failing at suicide" (Webb, 2010). Along with these intense emotions, many people must deal with physical injuries or disfigurements caused by their attempts. According to Webb (2010), one of the most important aspects of treatment is feeling heard and validated, which allows people to share their experiences in their own words without fear of rejection, denial, or avoidance of the topic.

In general, research involving people at risk of suicide could help scientists and clinicians gain a better understanding of suicide, its triggers, and the reasons why people consider or commit such acts. Furthermore, for service providers, it can guide the effective reduction of risk through the structure of services, methods of delivering care, and treatment options; increase overall public knowledge and awareness about suicide; and, most importantly, assist family and friends in minimizing risk and seeking help sooner (Lakeman & FitzGerald, 2009).

As a result, a thorough understanding of the experience of suicide attempts has the potential to drive significant advances in scientific knowledge on this topic, encouraging reflection, reinterpreting the subject, and improving professional training and clinical practices. As a result, the purpose of this study is to examine the personal experiences of people who have attempted suicide.

## 1.4 Review of related literature

### 1.4.1 Overview

People with firsthand experience of collaboration are rarely included in suicide prevention research. The benefits of actively including people in mental health research are becoming more widely acknowledged, and this will improve procedures, treatments, and outcomes (McCabe et al., 2022). The suicide prevention literature still demonstrates a deficiency in the inclusion of people with lived experiences, despite the fact that their participation in suicide prevention research is growing annually. This is because there are factors such as a lack of guidelines or frameworks to guide their involvement (Bailey et al., 2020), difficulties in obtaining ethics approval, and worries about the possible risks of involving people with lived experiences (Watling et al., 2020).

Suicide attempt history is associated with a number of negative consequences (e.g., Fergusson et al., 2005; Goldman-Mellor et al., 2014; Owens et al., 2002), including mental health conditions (e.g., depression; Fergusson et al., 2005), physical conditions (e.g., inflammation; Goldman-Mellor et al., 2014), and financial difficulties (Goldman-Mellor et al., 2014). Crucially, those who have survived a suicide attempt are at an increased risk of attempting suicide again and actually completing it (Bostwick et al., 2016; Owens et al., 2002).

### 1.4.2 Prevalence

Suicidal behavior is still a major public health concern on a global scale. Approximately one suicide occurs every 40 seconds, with over 727,000 people dying by suicide annually, according to the World Health Organization (WHO, 2025). Suicide was the third most common cause of death for people between the ages of 15 and 29 in 2021, and 73% of all suicides took place in low- and middle-income countries (LMICs). There are at least 20 attempts for every suicide that takes place, suggesting that non-fatal suicidal behavior is much more prevalent (WHO, 2019).

In the general population, the lifetime prevalence of suicidal thoughts varies from 3.1 to 56% worldwide. The percentages in Ethiopia and Africa are 6% to 55% and 18.6 to 20.7%, respectively. Suicide attempt rates also vary from 0.4% to 5.1% worldwide, 18.6 to 20.7% in Africa, and 1.4% to 19% in Ethiopia (Bifftu et al., 2021). The methodological flaws in local reporting systems and the variations in study populations (clinical versus community) are partially to blame for this variability.

Research conducted in hospitals shows even greater rates. According to a Gondar Teaching Hospital study, 19.2% of psychiatric outpatients attempted suicide and 64.8% had lifetime suicidal thoughts (Mekonnen & Kebede, 2011). According to Kebede and Alem (1999), a community study conducted in Addis Ababa revealed much lower rates, with 2.7% for suicidal ideation and 0.9% for attempts. According to a different study conducted among Addis Ababa high school students, the lifetime attempt rate was 14.3% (Kebede & Ketsela, 1993), suggesting that adolescents may be particularly vulnerable.

According to Ferede et al. (2025), the combined estimate of suicide attempts among Ethiopian youths and adolescents between the ages of 10 and 24 was 12.38%. Having a family history of suicide attempts, being female, not having social support, and performing poorly in school were all significant factors.

Data from 10 studies on suicide attempts and 12 studies on suicidal ideation in the Ethiopian general population were combined in a meta-analysis conducted by Bifftu et al. (2021). A 12-month pooled prevalence of 4% for attempts (ranging from 1% to 8%) and 9% for ideation (ranging from 5% to 16%) was found. According to Bifftu et al. (2021), the lifetime pooled prevalence for suicide attempts was estimated to be 4%, with a range of 3% to 6%. These

findings highlight the alarmingly high prevalence of suicidal behavior.These results emphasize that suicidal behavior is prevalent and alarmingly widespread in Ethiopia.

This concern is further supported by long-term trends. According to a 15-year retrospective study carried out in Addis Ababa (1981–1996), the average suicide rate was 7.76 per 100,000, with males consistently exhibiting higher rates than females (Abdulreshid, 1999). More recently, Kassaw and Alemayehu (2023) evaluated 10-year trends (1999–2022) and found rising rates of suicidal ideation and attempts, particularly among younger people.

Summary of Studies Illustrating 10 Year Trends (1999–2022) of Suicidal Behavior in Ethiopia

| Authors | Year of Publication | Sample | Suicidal Ideation % | Suicidal Attempt % |
|---|---|---|---|---|
| **Alem A, et al** | 1999 | 10,468 | 6.7 | 3 |
| **Kebede D, et al** | 1999 | 10,203 | 2.7 | 0.9 |
| **Fekadu A, et al** | 2007 | 68,378 | 0.003 | 0.01 |
| **Fekadu A, et al** | 2008 | 1714 | 0.06 | 0.02 |
| **Fekadu A, et al** | 2014 | 1497 | 13.5 | 1.8 |
| **Fekadu A, et al** | 2016 | 2499 | 7.9 | 4.4 |
| **Jordans M, et al** | 2018 | 2503 | 17.5 | 9.3 |
| **Nyundo A, et al** | 2019 | 2010 | 7.3 | 4.2 |
| **Melkam M, et al** | 2022 | 372 | 14.5 | 9.9 |

(Kassaw&Alemayehu, 2023)

Despite the availability of data, a sizable amount of the literature currently in publication is epidemiological in nature, focusing on trends and risk factors. The experiences of Ethiopians who have survived suicide attempts are not well understood. Suicidal behavior is strongly associated with emotional distress, social isolation, stigma, and a sense of purposelessness or lack of belonging, according to the scant qualitative research that has been done globally (Maple et al., 2019; Mok et al., 2020).

### 1.4.3 Living with suicidal ideation and survived attempt

In order to investigate how people deal with suicidal thoughts, Lakeman and Fitzgerald carried out a thorough analysis of the literature, paying special attention to "recovering a desire to live" (Lakeman & Fitzgerald, 2014). According to their findings, people frequently struggled with

suicidal thoughts and frequently expressed feelings of intense suffering and alienation from other people. According to a more recent review, people had to strike a careful balance between the hope for the future after a suicide attempt and the severe pain of ongoing suicidal thoughts (Berglund et al., 2016).

In a related study, the majority of participants expressed mostly negative emotions like sadness, depression, disappointment, emptiness, anger, embarrassment, or shame, with only 10 out of 50 reporting feelings of happiness or relief right after their suicide attempt. More than 30% of participants still felt negatively about their survival, despite the fact that many reported feeling happier, more grateful, and more hopeful by the time they entered the study (Maple et al., 2019).

### 1.4.4 Attempted suicide as a risk factor for completed suicide

One important risk factor for suicide in the general population is having previously attempted suicide (Mann et al., 2005; Retterstøl & Mehlum, 2001). According to the Baltimore Epidemiologic Catchment Area Study, a community-based longitudinal study, people who had previously attempted suicide were much more likely to succeed than people who had never attempted suicide (odds ratio = 11.3, $p < 0.001$). Only gender and previous attempts were associated with subsequent suicide in a multiple logistic regression model that controlled for sociodemographic variables; men were six times more likely than women to die by suicide (odds ratio = 5.9, $p < 0.001$) (Suominen et al., 2004).

According to Pallikkathayil and McBride (1986), 60% of their sample reported that they planned their suicide attempts in less than 24 hours, demonstrating that suicidal behavior frequently happens as an impulsive act. When O'Donnell, Farmer, and Catalan (1996) studied survivors of high-lethality suicide attempts, they found similar results. A person's likelihood of engaging in suicidal behavior in the future and ultimately completing suicide is considerably increased if they have survived a prior suicide attempt (Jenkins, 2002). An 87% increase in successful suicides within four years after a previous suicide attempt was noted by Nordentoft and Rubin (1993). According to Hopkins et al. (1995), between 25% and 40% of people who died by suicide had attempted suicide at least once before. With the right interventions given following an attempt, perhaps the risk of future suicidal acts could be reduced.

### 1.4.5 Suicide and Gender

Suicide rates are higher among men (12.6 per 100,000) than among women (5.4 per 100,000) worldwide. With 18.0 suicides per 100,000, the WHO African Region has the highest rate of male suicides of any region (NCD Team, 2022).

There are notable gender differences in suicidal behavior. Women typically attempt suicide at a higher rate than men, who are more likely to commit suicide altogether. The gender paradox, which has been reported in a number of nations, is the situation where men commit suicide at higher rates while women attempt suicide at higher rates (Mendez-Bustos et al., 2013).

Research in suicidology emphasizes the gender differences in suicide methods and indicates that the more violent methods used are largely responsible for the high rates of completed suicides among young men (Hawton et al. 1982; Hassan 1995). In contrast, it is believed that the elevated figures of non-fatal attempts can be explained by the methods that young women choose. The purpose of the act has been linked to the suicide means (Hassan 1995).

Some authors provide the 'lethality of intent' (Hassan 1995) as a justification for distinguishing between attempted and completed suicides, as well as between male and female completions, and it has been linked to the choice of methods. In addition to complicated age, gender, cultural, and social norms, other researchers suggest that convenience may also play a role in the methods chosen (Hassan 1995; Ruzicka & Choi 1999; Hunter et al. 2001).

Abdulreshid's (1999) study looked at the number and percentage of male and female suicide methods in Addis Ababa over a given 15-year period. It was found that the most common technique was "hanging and strangulation," which was used by 1502 (70.2%) victims of both sexes. The second most frequent method, which accounted for 328 cases (15.3%), was drowning. Among both sexes, the third method, drinking poisonous liquids, accounted for 161 deaths (7.5%). Moreover, 150 cases (7%) were categorized as "Undetermined Deaths," meaning that the records did not elaborate on the methods used. Prior discussions have addressed the inclusion of "Undetermined Deaths" in suicide statistics (Abdulreshid, 1999).

In a similar study, it was examined how suicide methods changed every five years, the percentage of people who committed "hanging and strangulation" for both sexes has been steadily declining. In females, the drowning technique showed only minor changes, with the

exception of minor successive decreases, whereas in males, it increased dramatically over the second five-year period, almost doubling, and then leveled off in the third five-year period. While the percentage of males who consumed poison decreased significantly from 10.58% to 2.75% during the second five-year period, and then approached the previous percentage again in the third, the percentage of females who consumed poison stayed relatively constant throughout the three five-year periods. According to Abdulreshid (1999), the procedures for "Undetermined Deaths" were not specified.

Such deaths have increased dramatically in both sexes. For men, the rate, which was 0.26 during the first five years, has increased to 11.36 during the third five years. According to Abdulreshid (1999), the percentage for females increased from 0.00 in the first five-year segment to 24.38 in the third five-year period (Abdulreshid, 1999).

Throughout the 15-year period, the crude Suicide Death rates for males have consistently surpassed those for females. For males over 15, the average crude suicide death rate was 12.71, and for females, it was 2.45 (per 100,000). As a result, the average rates' male-to-female ratio is 5.19:1. When combining both sexes, the average crude Suicide rate was 7.76 (per 100,000) (Abdulreshid, 1999).

### 1.4.6 Suicide attempt and PTSD

Suicide attempts theoretically satisfy the A1 criterion for posttraumatic stress disorder because they pose a risk to one's life and physical integrity (APA, 2022). Only two empirical studies have examined this topic to date, and they discovered that 46.7% and 27.5% of people, respectively, had suicide attempt-related PTSD (saPTSD) (Bill et al., 2012; Stanley et al., 2019). Additionally, Bill et al. (2012) demonstrated that saPTSD was exclusively associated with the actual suicide attempt, exhibiting no connections to other traumatic experiences or ingrained coping mechanisms. However, the lack of a control group and a focus on specific suicide attempt methods in these earlier studies precludes comparing saPTSD rates to PTSD rates after other types of trauma.

In terms of mechanism, localization, and severity, self-inflicted deep wrist injuries (DWIs) with suicidal intent were associated with higher levels of PTSD symptoms than comparable accidental injuries. PTSD can develop as a result of deep wrist injuries that are self-inflicted with the intention of suicide. Therefore, individuals who have attempted suicide should be assessed for

PTSD symptoms in addition to safety planning and treating the mental illness that caused wrist cutting (Westermair et al., 2020).

In a 2019 study, Stanley and colleagues looked at the traits, frequency, and associated elements of PTSD related to suicide attempts in a sizable population of people who have made an attempt at suicide. According to the DSM-5 diagnostic criteria for PTSD, the findings showed that 27.5% of participants met the requirements for a probable PTSD diagnosis related to their suicide attempt. Compared to participants whose most deadly attempt occurred more than a year ago, those whose most deadly attempt occurred within the last year were more likely to fit the criteria for this probable diagnosis. These findings have significant ramifications for clinical interventions aimed at this vulnerable population as well as for comprehending the experiences of those who have attempted suicide (Stanley et al., 2019).

### 1.4.7 Reasons for attempted suicide

Previous research suggests that it is critical to investigate the reasons people give for attempting suicide (Holden et al., 1998; Johns & Holden, 1997).

According to Mok and colleagues' (2020) research, there are many interrelated and complicated factors that contribute to suicide attempts. Negative life events, like abuse during childhood, failed relationships, financial hardships, and health issues, can compound over time and leave people feeling stuck. Vulnerable people may become isolated due to stigma and discrimination, which makes it challenging for them to get assistance. People may also be discouraged from expressing their distress due to cultural and societal norms, such as the expectation that women should suffer or the pressure to hide feelings. In addition, decreased self-esteem can result in feelings of worthlessness and purposelessness, particularly in older people, those who are unemployed, or those who are socially isolated. Relationship breakdowns can also make loneliness worse, particularly when there is abuse or a lack of emotional support. Moreover, the availability of suicide methods, influenced by media portrayals or easy access to harmful substances, can increase the risk of suicide attempts, although awareness of potential consequences may sometimes deter individuals. (Mok et al., 2020).

An examination of data from fifteen qualitative studies from 1994 to 2014 showed that, even though they occasionally felt safe, people who struggled with suicidal thoughts frequently fought an internal battle to keep hope when life became too much. In addition, the difficult situations

they faced resulted in a continual search for emotional balance. According to Carnevale (2009) and Lindholm & Erik, suffering is a personal experience that carries a lasting emotional burden for the person experiencing it.

### 1.4.8 Suicide disclosure and help seeking behavior

Numerous studies on suicide have looked at help-seeking behaviors. Based on the information that was available, Tiller et al. (1997) discovered that almost 90% of people who died by suicide made no appreciable attempts to get help before passing away. Between 50% and 75% of people who had suicidal thoughts and attempts reported them to primary healthcare services prior to ending their lives, according to research on attempted suicide (Bifftu et al., 2021). According to some studies, people who attempt suicide often see social workers, psychiatrists, and general practitioners (GPs) in the month before the attempt, even though they frequently keep their suicidal thoughts to themselves (Hawton et al., 1982). Young people, on the other hand, are typically the least likely to see a general practitioner (GP), and they might instead choose to seek support from their friends and family (Kids Help Line, 1996).

In a study looking at people who had previously experienced suicidal thoughts to find out how they felt about being questioned about them, almost two-thirds of participants reported having been asked about suicidal thoughts. The majority of probes came from friends, family, and mental health providers, with 24.5%, 27.5%, and 26.8% of respondents reporting inquiries from these sources, respectively. Even though not every participant was experiencing suicidal thoughts at the time, many of these questions probably indicated opportunities for care referrals, social support, and the provision of successful treatment meant to lower the risk of suicide (Brown & Jager-Hyman, 2014). Interestingly, people were found to tell mental health professionals about their suicidal thoughts more truthfully than they did their relatives. This implies that after seeking mental health services, people might feel more at ease discussing their suicidal thoughts in the hopes of getting focused treatment. However, obstacles to truthful expression of such thoughts were still observed to impact their communication with various kinds of probers. According to Hom et al. (2017), for instance, stigma, the potential for mandatory hospitalization, and the possibility of receiving a prescription were all mentioned as barriers to candid disclosure.

Suicide attempts frequently indicate a need for assistance rather than a clear desire to end one's life. Thus, it is essential to address the person's distress in order to prevent suicide (Kebede & Alem, 1999). According to Blumenthal (1988), most patients who die by suicide have seen a doctor in the weeks or months before they passed away. Compared to people who are not suicidal, those who report having suicidal thoughts and having attempted suicide in the past are more likely to use some kind of mental health service. Suicidal ideation sufferers typically seek assistance, and the healthcare system could prevent a large percentage of suicides with the right responses (Blumenthal, 1988; Pirkis et al., 2001).

To conduct psychoeducational initiatives beyond the typical help-seeking messages, it is important to take into account the factors that influence how people express their desire to end their lives or their silence on the subject. The majority of suicide prevention messages currently in circulation are designed to encourage people who are at risk to seek help, but this data suggests that individuals who have tried suicide frequently find it difficult to express their inner experiences. An example of this struggle is when one participant talks about "confessing" their attempt to their psychiatrist years later. This reflects the growing corpus of research on the challenges of expressing suicidal thoughts and intentions (Frey & Fulginiti, 2017; Maple, Frey, et al., 2019).

### 1.4.9 Theoretical framework

#### 1.4.9.1 Interpersonal Theory of Suicide

According to the interpersonal theory of suicide, three crucial factors must come together for a person to consider suicidal ideas and actions: a sense of being excluded, a sense of being burdened, and the ability to harm oneself (Van Orden et al., 2010). Suicide risk is influenced by how easy or difficult people believe it is to change these psychological states. For example, higher levels of risk are associated with a sense of helplessness about changing one's perceived burdensomeness and capability. Suicidal thoughts occur when people feel less afraid of dying and more tolerant of pain; perceived burdensomeness is the idea that one is a burden to others; and thwarted belongingness is the feeling that one is not connected to or accepted by others (Van Orden et al., 2010; Chu et al., 2017).

This theory indicates that when individuals feel both thwarted belongingness and perceived burdensomeness, they may be more prone to suicidal thoughts. Compared to people who only

experience thwarted belongingness and perceived burdensomeness, those who experience all three factors may be more likely to experience suicidal intent or attempt suicide (Van Orden et al., 2010; Chu et al., 2017).

Numerous studies have examined the interpersonal theory of suicide in relation to Veterans and found that they are more likely to have experienced past trauma, substance use problems, and self-directed violence (Chu et al., 2020; Holliday et al., 2020). Furthermore, compared to the general population, veterans usually have easier access to firearms and are more comfortable and proficient with their use. These factors may increase Veterans' risk of suicide (Holliday et al., 2020).

#### 1.4.9.2 Fluid Vulnerability Theory

The Fluid Vulnerability Theory (FVT) views suicide risk as a dynamic and changing phenomenon in order to address changes in suicide risk over time. FVT demonstrates that suicide risk varies between a baseline state, which is made up of long-lasting, stable risk and protective factors, and acute dimensions or characteristics, which indicate changes in suicide risk in response to outside factors (Rudd, 2006; Bryan et al., 2019). According to Bryan et al. (2019), this theory helps explain how the interaction of various factors can raise the risk of suicide.

The suicidal mode, a fundamental idea in FVT, describes the interplay between acute and chronic factors that, when activated, can result in a suicidal action. While emotional upheaval, relationship problems, and unfavorable life events are acute risk factors for suicidal thoughts and behaviors (STB), chronic risk factors include gender, a history of trauma, mental health conditions, and prior suicide attempts. An individual's behavior, emotions, physiology, and thought processes are all influenced by these predispositions, triggers, and other risk factors (Rudd, 2006; Bryan et al., 2019). Contextual factors and environmental stressors are examples of triggers that can make a suicidal episode more severe (Bryan et al., 2019).

According to the FVT hypothesis, people in an activated suicidal mode may find it easier to deescalate their risk as they move from an acute to a baseline risk state if they reduce triggering risk factors (Rudd, 2006). Some aspects of this theory have been supported by research, such as the finding that suicidal thoughts and feelings of hopelessness, loneliness, and burdensomeness can change dramatically in a matter of hours (Kleiman et al., 2017).

### 1.4.9.3 Three-Step Theory of Suicide

According to the Three-Step Theory of Suicide (3ST), having pain (usually psychological) and feeling hopeless can lead to suicidal thoughts, which can then escalate into more serious suicidal thoughts when the pain exceeds one's sense of connection (Klonsky & May, 2015). If a person experiences circumstances that increase their acquired (i.e., overcoming innate urges to harm themselves), dispositional (e.g., low sensitivity to pain, decreased avoidance of harm, genetic predispositions), and practical (e.g., access to and familiarity with lethal means, expertise related to lethal methods) ability to commit suicide, suicidal thoughts may develop into an attempt (Klonsky & May, 2015; Klonsky et al., 2021). Suicidal thoughts and behaviors can become more intense due to the interaction of pain, hopelessness, and connectedness, as explained by the 3ST framework (Pachkowski et al., 2021; Anderson & Happ, 2020).

### 1.4.9.4 Integrated Motivational-Volitional Model

According to the Integrated Motivational-Volitional (IMV) model, suicidal thoughts are influenced by feelings of helplessness and entrapment, while the transition from suicidal ideation to actual suicidal actions is influenced by specific moderating factors. The premotivational, motivational, and volitional phases are the three distinct stages that are described in this model. The context or circumstances that may raise a person's risk of committing suicide are covered in the premotivational phase. These circumstances may include triggering events, personality traits, and biological, genetic, cognitive, and socioeconomic factors. Suicide risk is increased by these sudden or persistent vulnerabilities. The processes and interactions that result in the development of suicidal thoughts are the main focus of the motivational phase. In this case, the emergence of such thoughts is significantly influenced by feelings of entrapment, defeat, and/or humiliation. Whether or not feelings of defeat lead to a sense of entrapment depends on the presence or absence of threat to self-moderators (TSMs), which include coping strategies, memory biases, social problem-solving skills, and ruminative tendencies (O'Connor & Kirtley, 2018).

Motivational moderators (MMs) can also either increase or decrease the likelihood that entrapment will result in suicidal ideation. These MMs include thwarted belongingness, feelings of burdensomeness, future aspirations, social norms, resilience, social support, and attitudes. While negative MMs, such as burdensomeness and a lack of social support, may raise the risk of

suicidal ideation, positive MMs, such as reasons for living, belongingness, and connectedness, may encourage a more optimistic outlook and be protective against suicidal ideation. The Volitional Phase is the period of time when the transition from suicidal ideation to suicidal behavior is driven by volitional moderators (VMs), such as exposure to suicidal behavior, planning, impulsivity, mental imagery, past suicidal behavior, and access to lethal means (O'Connor & Kirtley, 2018).

#### 1.4.9.5 The strain theory of suicide

According to the STS, certain psychological strains are usually followed by suicide (Zhang et al., 2011).

A strain is not the same as a stress or pressure. In their daily lives, people may frequently encounter the latter without necessarily coming across the former. In everyday life, strain results from the interaction of at least two pressures or variables, whereas pressure or stress is defined by a single variable. Strain pulls or pushes a person in opposing directions, causing feelings of frustration, upset, anger, or even pain. This is similar to how cognitive dissonance forms (Festinger, 1957), but it is more severe and harmful. Conflicts between various cultural values, a disconnect between one's goals and reality, a difference in one's status compared to others, and the incapacity to handle a crisis are examples of this. Strain is a psychological frustration or even suffering that needs to be resolved in order to lessen or completely eradicate it, much like cognitive dissonance. A mental illness can arise from a very severe and substantial strain. Unresolved stress can ultimately lead to suicide.

#### 1.4.9.6 Narrative-Crisis Model

According to the narrative crisis model of suicide, people attempt suicide when they go through a specific emotional state known as the suicide crisis syndrome. According to this model, stressful life events can set off a particular series of cognitive-affective reactions (the suicidal narrative and the suicide crisis syndrome) in individuals with chronic risk factors, increasing their short-term risk of suicidal thoughts and behavior (STB). (Cohen and others, 2021). Suicidal narrative, suicidal crisis syndrome, and trait vulnerability are the three parts of the model. All static risk factors, which are not directly related to acute suicidal behavior and are comparatively stable over time, are included in trait vulnerability.

A suicidal person's view of their life story, in which the past has resulted in an unbearable present and an unthinkable future, is known as suicidal narrative. Suicidal crisis syndrome (SCS) is a unique emotional state marked by loss of cognitive control, affective dysregulation, and entrapment. The emotional desire to put an end to the unbearable mental suffering caused by SCS leads to the suicidal act. The suicidal narrative and trait vulnerability both independently contribute to the SCS intensity, which is the primary determinant of imminent suicide risk (Cohen et al., 2021; Briggs, 2017).

### 1.4.9.7 Psychodynamic Models

As a contributing factor to suicidal behavior, Freud defined "retroflexed rage" as the inward turning of aggressive feelings toward a significant other (such as a parent or partner) into self-directed hostility (Rado, 1951). Unconscious drives are thought to be the root cause of suicide. The desire to kill, particularly in relation to loved ones; the desire to be killed, associated with guilt over these aggressive thoughts; and the desire to die, resulting from feelings of depression and hopelessness fueled by self-loathing and the persistent suppression of aggressive urges, are the three fundamental motivations that Menninger theorized underlie all suicide cases (Menninger, 2007).

### 1.4.9.8 Cognitive Models

According to Beck and his colleagues, cognitive self-schemas that contain particular negative beliefs, such as dysfunctional attitudes and cognitive distortions, are what make people susceptible to depressive and suicidal symptoms. A person who makes a small error during a public speaking event, for example, could start to believe that everyone in the audience believes he is stupid. Along with the negative triad of pessimistic beliefs about oneself, other people, and the future, hopelessness is a key component of Beck's model (Beck et al., 2006). They argue that people who are suicidal misinterpret their situation negatively, just like other people who are depressed. However, the suicidal person sees suicide as the only practical solution because they feel hopeless about their circumstances.

### 1.4.9.9 Social-learning models

It suggests that exposure to people who engage in suicidal behavior, both directly and indirectly, can teach or promote suicidal behavior. A "suicide cluster," which is defined by the Centers for Disease Control and Prevention as a number of suicides or suicide attempts that occur more

frequently than would normally occur within a specific geographic area and within a brief period of time, could serve as an illustration of this model. Clusters are uncommon in people over the age of 24 and primarily impact teenagers and young adults (Gould & Irving Philips Professor of Epidemiology (in Child Psychiatry), 2020).

#### 1.4.9.10 Biopsychosocial model

George Engel recognized the interdependence and mutual influence of biological, psychological, and social factors, which led to the development of the biopsychosocial approach. The study of suicidology has made use of several variations of this methodology (Leigh, 1983). The "overlap" model, put forth by Susan Blumenthal, depicts five areas of biopsychosocial risk as circles, with the most vulnerable people being those who fall at the intersection of all five. The following are the five areas: a) Psychiatric conditions (such as schizophrenia, substance abuse, and mood disorders); b) Personality traits and disorders; c) Psychosocial and environmental factors, including exposure to suicide, recent major stressors and losses, and medical conditions; d) Genetic susceptibilities to suicidal behavior; and e) Additional biological factors, such as depression. Although protective factors (like coping skills, optimism, and social networks) can lessen the negative effects of risk factors, Blumenthal proposed that these different domains may interact to lower the threshold for suicidal actions, particularly when lethal means are available (Blumenthal & Kupfer, 1988).

### 1.4.10 Gaps in the literature

Numerous interventions and resources that identify risk factors and provide strategies to steer people away from suicidal inclinations have been developed as a result of the substantial research on suicide prevention. The main problem with current suicide research, regrettably, is that the viewpoints of suicide survivors are not taken into account. More than 95% of research published in peer-reviewed journals between 2005 and 2007 used quantitative techniques. According to Hjelmeland and Knizek (2010), this dependence results from an emphasis on causes and correlations. In order to better understand suicide from the viewpoint of people, especially those who have survived suicide attempts, they advise conducting more qualitative research. These individuals may have important insights to share that could help improve intervention strategies (Webb, 2010).

Although research suggests that there are commonalities, each person's experience of suicide is unique, so it is important to find and pay attention to their perspectives. A more thorough understanding of the experience of suicide attempts in the Ethiopian context requires more research. Giving suicide survivors a voice to describe their own experiences could help them identify the things that support or impede their road to recovery. By interviewing Ethiopians who have attempted suicide, the current study seeks to close this knowledge gap and offer suggestions for the most effective ways to assist this susceptible group.

# CHAPTER 2: RESEARCH QUESTIONS

1. How do suicide attempt survivors describe their immediate thoughts, feelings and situation they were facing leading up to and during their attempt?
2. What reasons do survivors give for their suicide attempt, and what do they believe could have prevented it?
3. What recovery processes and coping strategies have survivors used after the attempt?
4. How do survivors perceive societal attitudes, stigma, and cultural or spiritual influences related to their suicide attempt and recovery journey?
5. How do survivors make meaning of their suicide attempt over time, and in what ways do their interpretations evolve throughout their recovery process?

# CHAPTER 3: OBJECTIVE OF THE STUDY

## 3.1 General objective

To explore the lived experiences of survivors of suicide attempt at Tikur Anebessa Specialized Hospital and Amanuel Mental Specialized Hospital

## 3.2 Specific objectives

- ✓ To explore how individuals who have attempted suicide describe the situation they were facing, their thoughts and feelings before and during the decision to attempt suicide.
- ✓ To examine survivors' reflections on the reasons behind their attempt and identify perceived preventive factors for both past attempt and future ideation.
- ✓ To identify recovery processes and coping strategies used by survivors

- ✓ To examine how survivors perceive societal attitudes and stigma related to suicide and how social, cultural, and spiritual contexts influence their attempt and recovery
- ✓ To examine how survivors make meaning of their experience and how these interpretations may evolve over time throughout their recovery journey

# CHAPTER 4: METHODOLOGY

## 4.1 Research design

This study used a qualitative research design with a phenomenological approach. Phenomenology is the study of experience as seen from the viewpoint of the individual and focuses on a person's subjective view or narrative of an item or event and necessitates investigating personal experience (Lester, 1999; Smith, Flowers, & Osborn, 1997).

## 4.2 Setting

The study took place in two hospitals located in Addis Ababa, Ethiopia: Tikur Anebessa Specialized Hospital and Amanuel Mental Specialized Hospital. Tikur Anebessa is the oldest hospital in the country founded in 1964. It serves as a primary teaching hospital for both preclinical and clinical education across various disciplines in the School of Medicine at Addis Ababa University. Amanuel Mental Specialized Hospital is a public psychiatric hospital focused on mental health services and rehabilitation. This facility has been providing public specialized mental health care since 1937 E.C.

## 4.3. Study Period

The study was conducted from October 2025 to April 2026.

## 4.4 Participants

The study's participants were individuals both males and females aged 15 years and older who communicate in Amharic. Participants have a documented history of at least one suicide attempt and have been undergoing either inpatient or outpatient treatment at the aforementioned hospitals.

| Inclusion Criteria | Exclusion Criteria |
|---|---|
| Individuals aged 15 years or older | Individuals identified as emotionally unstable by their mental health providers |
| Individuals who have survived a suicide attempt and those who may or may not have a suicidal ideation | Individuals who engaged in non-suicidal self-injury or other para-suicidal behaviors (e.g., self-harm without suicidal intent) |
| Amharic speakers | Participants who can't communicate adequately due to their psychopathology that may hinder the interview process were excluded. |
| Individuals who have made at least one suicide attempt. | |
| Participants who are currently receiving or have previously received follow-up care at Tikur Anebessa Specialized Hospital and Amanuel Mental Specialized Hospital. | |

## 4.5 Sampling and Sample Size

For this study nine participants were selected through purposive sampling from Tikur Anebessa Specialized Hospital and Amanuel Mental Specialized Hospital. Participants were recruited through communication with treating physicians and nurses and those who have survived a suicide attempt were referred for inclusion in the study. The researcher outlined the inclusion criteria and requested clinicians to recommend potential participants.

## 4.6 Operational Definition of Terms

Suicide Attempt Survivors- in this study refer to individuals who have made an attempt to end their own life, regardless of the method used or the level of medical severity involved.

## 4.7 Data collection

Data was gathered through semi-structured individual face-to-face interviews. The duration of the interviews varied between 30 and 50 minutes. Before each interview participants were

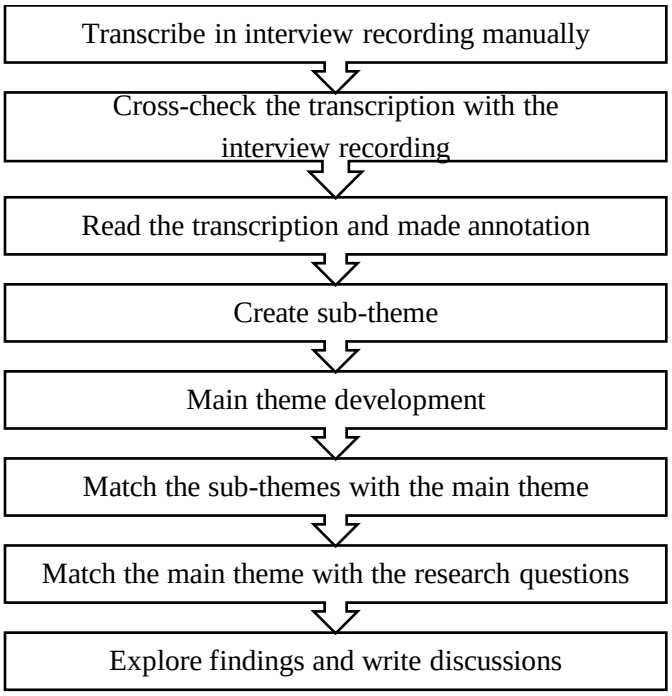
offered the informed consent form, after the study's purpose was explained, their consent was obtained. Interview took place in OPD rooms and at times when OPD rooms weren't available, an open private space provided by the hospitals were used. The interviews were audio recorded and subsequently transcribed word for word.

## 4.8 Data Analysis

This study used thematic analysis as a guide for its data analysis. Interviews were audio-recorded, transcribed verbatim in Amharic, and cross-checked against the audio recordings for accuracy.

Open code software was used for coding and data analysis. Subsequently, the respondent's words, phrases, sentences, and notes that are pertinent to the study's topic are coded and themes are developed.

The steps involved in data analysis are described in the figure below




There are two ways to go about coming up with themes: deductively, where themes come from theory and earlier study, and inductively, where themes come from unprocessed data (Boyatzis, 1998). The inductive method was used in this study to extract themes from the interview data.

The analysis of the data involved careful reading and re-reading the transcripts, taking initial notes, identifying emerging themes, exploring connections between themes, moving on to the next case, and identifying patterns across multiple cases.

## 4.9 Data Quality Assurance

Several measures were taken to ensure the data's integrity. To begin, probing techniques were employed during interviews to elicit rich and detailed data, and the collected data was immediately transcribed verbatim to reduce bias and ensure that it was not misrepresented. The themes and data analysis were discussed with supervisors to ensure that the findings were accurate and reliable.

## 4.10 Ethical Consideration

Ethical approval was sought from the Psychiatry department, College of Health Sciences of Addis Ababa University, and the Amanuel Mental Specialized Hospital. Participants received comprehensive information regarding the study's objectives, procedures, risks, and their rights including the voluntary nature of participation and the ability to withdraw at any time without penalty. Their freedom to participate was honored, and consent was obtained willingly and with full comprehension. In addition for participants under 18, assent and parental consent was obtained.

Furthermore, the informed consent document specified that participants might experience emotional discomfort during the interview and that the researcher can offer assistance in contacting professional services if immediate support is needed. To minimize potential emotional discomfort associated with discussing sensitive experiences, participants' emotional wellbeing was checked at the end of each interview. Most participants reported feeling relieved, okay, or good after sharing their experiences, suggesting that the interview process was generally experienced as supportive rather than distressing. Only one participant reported emotional discomfort; however, the participant indicated that the distress had already been present prior to the interview and was not caused by the discussion itself. In accordance with the ethical protocol of the study, the participant was referred to the treating physician for further support and follow-up care. Overall, no significant interview related psychological harm was identified during the study.

To safeguard their privacy, personal data was kept confidential and managed securely and anonymously.

When sharing the research findings, emphasis was placed on responsible and truthful reporting without misrepresentation. Proper recognition was given to all contributors.

# CHAPTER 5. RESULTS

## 5.1 Socio-demographic Characteristics of the Participants

The study involved a total of nine suicide attempt survivors aged between 15 and 40 years. Five participants were female and four were male. Five participants were recruited from Tikur Anebessa Specialized Hospital, while four participants were recruited from Amanuel Specialized Mental Hospital.

Seven of the participants were from Addis Ababa, one from Arsi, and one from Dessie. As for marital status, seven participants were single and two were married. In terms of religion, six participants identified as Orthodox Christian, one as Muslim, one as Protestant Christian, and one reported no religious affiliation. On educational status, one participant had attended college after completing high school but did not complete her university education, while one participant had no formal education. Four participants had reached high school level education, and three had attended primary school.

Regarding occupation, four participants were students, one was a housewife, one worked as a retail worker, and one worked as a maid. Two participants reported being unemployed at the time of the interview; however, they stated that they had previously worked as a shoemaker and as a laborer before stopping work several years ago.

As for diagnosis, three participants had a diagnosis of Major Depressive Disorder (MDD), one had MDD with psychotic features, two had schizophrenia, one had PTSD, one had epilepsy, and one participant had no documented psychiatric diagnosis.

Participants reported a range of suicide attempt methods. Four participants reported overdose or poisoning as a method. Other methods included throat cutting, hanging, wrist cutting, self-

stabbing, jumping from a tree, and jumping in front of a car. Three participants reported using multiple methods across different suicide attempts.

| Coded ID | Age | Sex | Address | Marital Status | Religion | Level of Education | Occupation | Diagnosis | N° of attempt | Method |
|---|---|---|---|---|---|---|---|---|---|---|
| 001 | 28 | F | A/A | Married | Muslim | 9th grade | House wife | PTSD | 1 | Overdose |
| 002 | 20 | M | Arsi | Single | Orthodox | 12 | Student | Schizophrenia | 3 | Throat cutting, hanging and poisoning |
| 003 | 20 | F | Dessie | Single | Orthodox | 9th grade | Retail worker | MDD with Psychotic features | 1 | Overdose |
| 004 | 24 | F | A/A | Single | None | Some university education | Student | MDD | Many | Overdose |
| 005 | 18 | M | A/A | Single | Protestant | 12th grade | Student | MDD | 2 | Overdose, Cutting |
| 006 | 15 | F | A/A | Single | Orthodox | 8th grade | Student | - | 1 | Overdose |
| 007 | 40 | F | A/A | Married | Orthodox | None | Maid | MDD | 1 | Poisoning |
| 008 | 40 | M | A/A | Single | Orthodox | 7th grade | None/ Shoe maker | Schizophrenia | 5-6 | Throat-cutting |
| 009 | 32 | M | A/A | Single | Orthodox | 8th grade | None/ Laborer | Epilepsy | 3 | Jumping from a tree, Throwing self in front of a car, Self-stabbing |

## 5.2 Themes

Six major themes and twelve subthemes emerged from the data analysis, as presented below:

| **Theme** | **Subtheme** |
|---|---|
| **Theme 1**: The Phenomenology of the Suicidal Crisis | **1.1** What they felt before and during: *"I couldn't take it anymore"*<br>**1.2** Post-Attempt States: Surviving, Reflecting, Changes and Meaning<br>**1.3** From survival to supporting others |

| | |
|---|---|
| **Theme 2**: Drivers and Triggers | **2.1** Perceived Burdensomeness: Feeling like a burden on the people they loved<br>**2.2** Family Conflict and Relational Distress: Breaking apart at home<br>**2.3** Lack of autonomy and agency: Losing control over one's life and choices<br>**2.4** Struggling with stress, loneliness, voices, and substance use |
| **Theme 3**: Prevention Beliefs and Unmet Needs: What could have stopped it | |
| **Theme 4**: Cultural, Societal, and Spiritual Dimensions: When Context Wounds and Comforts | **4.1** Facing stigma, invalidation, and misunderstanding: *"Being judged rather than heard"*<br>**4.2** Interpreting suicide through faith and spirituality |
| **Theme 5**: Coping Strategies: Getting through it | |
| **Theme 6**: Health Care and System Experiences: What helped and what didn't | **6.1** Negative healthcare experiences<br>**6.2** Positive professional support<br>**6.3** Survivors' recommendations for better care |

### 5.2.1 The Phenomenology of the Suicidal Crisis

This theme is about the experience of the attempt itself, the affective and psychological states in the events leading up to and during attempt as well as the post attempt experience and how survivors reflect on their experience. The theme is described with in three subthemes: What they felt before and during, post attempt states and from survival to supporting others.

#### *5.2.1.1 What they felt before and during: "I couldn't take it anymore"*

This subtheme focuses on the psychological and emotional experiences that the participants had prior to and during the attempt. Hopelessness is one of the most common emotions described by the participants. All of the participants stated that they felt hopeless in life prior to the attempt, which led to ideation, which then grew to the point where they chose to end it.

> "….I was feeling happy, really... I thought I was going to die right then. And... it was to find relief; I had completely given up hope... I didn't think about my family, I didn't feel pity for them... I didn't think about myself either, not even for my own self did I feel

pity... All I focused on was death. But, you know, I am aware that I will be held accountable before God. Still, I prayed for God to forgive me..., then I took the medication because living had become so bitter, it had defeated me, and I couldn't bear it anymore. Life has completely drained me of hope." (P3)

"….It was because I had lost hope. I just got so tired of trying over and over again, of being stuck in same situation... and then, when you add the pain on top of it... I don't know, like I said, it's hard to put into words, but the pain was just weighing on me so heavily. I mean, that was how I felt on that particular day." (P1)

"I had this feeling that I didn't want to live anymore, I then started trying to end my life. The feeling was like, 'I don't have to live' kind of thing. Even now, I don't have hope or anything; I'm just living for the sake of it. I don't know... I don't know what this thing called 'hope' even is..." (P4)

Most participants also reported feeling worthless. They believed they were a burden to the people around them. This mindset often led to the thought that others would be better off if they were gone. Some felt useless in their daily lives. They viewed their own death as a gift to their loved ones. In their minds, dying would remove the stress and weight they placed on family or friends. This belief made them feel that their absence is a way to help those they care about.

"I had thoughts telling me to do it. Thoughts like: 'Because of you, all of this is happening. Because of you, there is constant chaos in the house. Because of you, your friends cannot even go out and return home peacefully. Since you are the cause of all this, you should disappear.' I also felt trapped, like I could not even change countries or escape the situation in any way. So, it felt like the only thing I could do was die. I kept thinking that my death could become a kind of relief for many people." (P5)

"I kept thinking, 'What am I even doing? Life felt pointless to me. I'm useless; I'm of no use. …… It would be better if I didn't exist. There were thoughts like, 'the people around me are being hurt because I'm alive,' and things like that. ... Most of the time I think, "they are better off without me.'' (P4)

> "There was a struggle… I had the thought that maybe if I died, my family would be happy… that they would finally be at peace and rest. That is what I thought at the time." (P3)

In some participants, feelings of hopelessness and being a burden were present during the interview, where they reported plans to attempt suicide again. One participant, who was receiving inpatient treatment, stated:

> "… It is such a very horrible life. Even now, what I feel like doing is only to end my life, to kill myself. I do not think I will ever live a normal, stable life… never. I am very distressed. Even now, I have no feeling that I will get out of this, or that I will go out and do something or change. I do not have that kind of hope at all. Once I leave this hospital, I've just decided; since God has hated me as He does, my plan is to find a way to end my life that leaves no room for error, rather than hurting people by dragging them through all of this..." (P3)

The other emotional states that participants reported before trying to end their lives included feeling stressed, depressed, sad, unhappy, and experiencing masked pain or suffering. Most participants felt unhappy or carried hidden pain that they did not show to others. They stated that these feelings remained unchanged despite their efforts. This stagnation led to a sense of hopelessness. They felt helpless because they saw no way out.

> "I was extremely stressed… really stressed. Suddenly… and I did not even know where the stress was coming from. It was severe depression… just hopelessness… having no hope at all…Even when my friends were laughing and having fun, even just seeing them, I could not feel happy. There was no joy in anything." (P3)

In a number of the participants the chronic feeling of unhappiness and sadness is accompanied by masked pain/suffering they go through. They stated that their pain and suffering is invisible to others which made them go though it alone even when surrounded by people. This masked suffering meant they looked fine on the outside while struggling inside.

> "I am not happy at all. I am never happy, even now I am not happy. Inside, I feel like I am burning… I feel sad, I feel overwhelmed, I feel… I don't even know how to explain it. I am just always frustrated, constantly thinking and overthinking… I am never happy.

> Sometimes people say to me, 'Why don't you smile?' and I just say okay and force a smile. But I am never truly happy…" (P7)
>
> "I am not happy. Most of the time, especially when I go to school and things like that… people always assume that I am happy all the time. They do not really think that I might be feeling down or struggling." (P6)

Participants reported feeling hopeless and stressed, sad or depressed. Some faced a rush of overwhelming emotions that they could not name. Fear and anger were also reported.

> "I was feeling sad when I was taking the medications in an attempt to end my life. I used to judge people when I heard about friends attempting suicide or dying by suicide. I would say things like, 'No matter what happens, it should not be done like that.' But later, I found myself in that same situation I had judged others for, and I felt deep sadness about it. I had once had a lot of hope and believed I would achieve many things in life. At the same time, many people had expectations from me. So, finding myself in this situation, and becoming like this, really made me sad." (P5)
>
> "At that time, I was just crying… there was frustration… hopelessness… a feeling of inability. I was in a completely mixed and confused emotional state." (P1)
>
> "Because I was very angry at that moment, I did not feel anything else. I was so angry that I was not aware of anything else at that time. I was just in a state of anger, that's all" (P9)
>
> "Mostly sadness and fear… very intense… everything felt mixed together, as if all emotions were blended at once." (P6)

A smaller group of participants had a different experience. They felt empty or numb. One participant said she felt hollow. These individuals reported feeling nothing at all, with no fear or other emotions present.

> "Once I made the decision myself, there was no fear. When I tried to end my life, there was no panic and no fear at all. I had already made up my mind and fully decided on it. At that point, I felt nothing." (P3)

> "I felt empty. It was like there was a hole in my heart. Like… hollow. Just hollow. Even the word 'hollow' itself does not really describe it. A vacuum-like feeling… no, even that does not describe it; even that word feels too small for what I was feeling." (P4)

> "I did not want to do anything at all. And… it was darkness. My mood was very low. At that time, it was not just low; I also had a kind of numb feeling…" (P4)

Of the nine participants in the study, two had hallucinatory experiences but only one reported that the hallucinations influenced their attempt. He reported having a commanding auditory hallucination that told him the specifics of how to kill himself, including the method and location. He claimed that resisting the voice was nearly impossible, and he had attempted suicide several times by cutting his neck. He also stated that he tried to distract himself from acting on the voice by going out with friends and drinking, but the voice worsened after alcohol consumption.

> "At that time, I would hear a voice in my ears… and that is when I attempted to end my life. When I hear this voice, it tells me things like 'end your life,' 'you are not useful,' 'you are worthless,' 'you are not helpful,' and so on. So I followed those commands and tried to kill myself. The voice was giving me instructions, like telling me to cut my neck."(P8)

Some participants reported feeling pain or experiencing somatic symptoms like headache and gastric pain prior to the attempt.

> "It was pain. I did not really understand it myself. Sometimes it felt like a headache, sometimes something else, but nothing felt right for me at that time. …. When it became too overwhelming, I took a painkiller, but it still did not calm me. It all started to feel like the only possible ending was to end my life. I felt like I could not stop myself or control what was happening. It was extremely painful. I cried for a very long time, and then I took a large amount of medication. At times, I do have feelings like I should not be alive, but I usually do not act on them. However, at that moment, I could not manage it." (P1)

#### *5.2.1.2 Post-Attempt States: Surviving, Reflecting, Changes and Meaning*

This subtheme focuses on participants' reflections after the suicide attempt, how they feel about having survived, how they now understand or interpret the attempt itself, and how the experience has influenced the way they see themselves and relate to others.

When asked about how they felt after surviving the suicide attempt, a majority of participants reported experiencing sadness about having survived. For some, survival was accompanied by disappointment, as the attempt had represented an escape from overwhelming distress. In addition, some participants described feelings of anger and regret following survival, expressing frustration that the attempt had not resulted in death.

> "To be honest, I am not happy that I survived. Because on that day, I had fully made up my mind. Nothing has changed… nothing at all. Whenever those feelings come back, I still find myself wanting to attempt suicide again." (P3)

> "It was God who kept me alive… but I was not happy that I survived. I feel sadness about surviving… deep sadness. If I had died earlier, I would not have had to witness the deaths of my children. If I had died before them, they would have buried me, instead of me having to bury them." (P7)

> "When I think about that day… I feel disappointed in myself for becoming that weak. Sometimes I think, either I should not have survived, or I should never have done it in the first place." (P1)

> "Surviving has not really changed anything, everything still feels the same. Even now, I still feel it would have been better if I had not survived. Maybe if things in my life finally get resolved, I might one day feel relief. But up to now, since things still have not changed for me, I still do not know when that moment of relief will come." (P9)

A few participants, however, described feeling grateful to have survived the suicide attempt. These participants expressed appreciation for being given another chance at life and reported that survival allowed them to reflect on their experiences differently.

> "I felt very happy that I survived. Because afterward, I felt so much sadness and regret. First of all, I hurt my mother… and my father too… and I also hurt myself. I hurt them

so, so deeply… I honestly do not even know how to describe it. I am just grateful that I survived. (P6).

"I am happy that I survived. And doctors explained to me that it was an illness… and at that time, I also came to understand that it was an illness." (P8)

On the other hand, two of the nine participants reported feeling indifferent about their survival.. They described a sense of emotional numbness or detachment, suggesting that survival did not hold particular meaning or significance for them at the time of the interview.

"I do not really care that I survived. I mean, at first, not dying was somewhat a good thing. At least many things have changed, and I have been able to see many different things. But still, even now, there is nothing that feels exciting or that attracts or interests me after all these changes." (P5)

"Sometimes I ask myself, 'Why did I survive?' But most of the time, I feel nothing about surviving… just indifference. That is all." (P4)

Another aspect that was explored was how participants currently make sense of the suicide attempt itself. Most participants reported that, in retrospect, they often find themselves questioning why they engaged in the attempt and trying to understand their own actions at that time. Some explicitly described the act as "foolish" when reflecting on it now, indicating a changed perspective over time. For some, the attempt was described as feeling justified or "right" in the moment it occurred, suggesting that the decision was experienced as meaningful or necessary under the emotional and psychological distress they were facing at that time.

"I was foolish. To some extent, it was a foolish act. But still, at that time, I kind of had a point … at that moment it seemed right, but now if I face the same kind of challenge again, I would not do it. So now, if what I went through happens again, I would try as much as possible to use my mind rather than my emotions. At that time… people do blame and judge. But I was also young then. Still, there is maturity, and your perspective on life changes." (P5)

> "Basically, I keep asking myself why was I like that at that time? What was affecting me then? I mean… there is a little confusion. There is this question of, 'What was going on with me?" (P7)

> "I see it as foolishness. I mean, if I had taken my own life, I would have been the one I was hurting…. If I had ended my life, even though my family might have been saddened for a week or two, in the end I would have been the one truly harmed. I would not have hurt them or anyone else as much as I would have hurt myself." (P6)

> "What I understood before and what I understand now are not the same. Before, I used to think, 'it would be better if I died,' and I continued with that kind of thinking. But now, when I look at myself and remember how I was, compared to where I am now, I see that it is better. I have learned that when something like this happens, it is important to seek help early either go to treatment quickly, or tell a friend, someone close, or family." (P8)

Regarding how the experience has influenced their sense of self, most participants reported noticeable changes in the way they see themselves. Most participants described feeling that they are no longer the same person they were before the attempt, often expressing a reduced sense of confidence, diminished perceived potential, and feelings of weakness or incapability.

> "My family members say, 'The old you is no longer there.' … So I tell them, maybe for you it may seem that way, but for me it is different, I feel like no one can know me better than I know myself. I used to be a person who could give a lot for others and stand strong, even beyond myself. But now, I feel like I cannot even be myself anymore. I feel weakness and a sense of inability." (P1)

> "My self-regard has really declined. I don't think I still have the same potential I used to have. That is how I feel. Even when I start something, like classes, I feel as if I might stop halfway, and I don't believe I can really achieve things anymore. My confidence in myself… even my sense of 'knowing or not knowing' things has really gone down." (P4)

> "I had this feeling of being below other people… I felt like I was beneath everyone. It was as if I was not even a human being. That is how I used to feel at that time but it's getting better now." (P8)

In contrast, some of participants reported more positive shifts in self-perception, describing themselves as having renewed hope and a sense of potential despite what they had been through.

> "My perception of myself has changed. I mean, I now see more clearly how far I can go in the future. I realized that I still have hope" (P6)

It is also important to note that this aspect is somewhat complex to interpret. While participants were asked specifically how the experience has influenced their sense of self following the attempt, their responses reflected broader life experiences surrounding the crisis. In some cases, it was not solely the attempt itself, but rather the cumulative distress, suffering, and ongoing struggles that appeared to shape changes in self-view and relationships. As a result, reflections in this area may overlap with their experiences prior to the attempt, making it difficult to clearly separate pre- and post-attempt influences.

#### *5.2.1.3 From survival to supporting others*

This subtheme focuses on participants' responses when asked what message they would give to someone going through something similar. Almost all of the participants stated that the message is not to give up hope, that there is a way out of the darkness, and that they strongly advise others not to attempt suicide. Some participants stated that they would recommend disclosure even if they felt misunderstood, and others stated that they would advise similar others on self-care, self-love and to return to faith.

> "When I advise someone like that… someone who is distressed like I am, I would tell them: do not lose hope. Do not do this. I would tell them that it will pass tomorrow, it will pass. Everything passes. I would advise them that they should not attempt to end their life or harm themselves." (P3)

> "Maybe it is about trying to understand oneself. Most of the time, you neglect yourself in order to be there for others. People see you as kind, compassionate, always good to others, as if you have put yourself aside. But no one really understands you. I used to think this was selfishness, but it is not. There comes a point when you realize it, and by then you may no longer be able to go back. It is only later that you understand it, sometimes after you have paid a price or made a sacrifice. Even if I had died that day, people would have only cried and then moved on; no one could have truly done anything

to change it. You only understand it afterwards. So, we should first give space to ourselves. Self-love does not mean not caring about others. If you do not love yourself, you cannot truly be there for others, because you end up living only for them, and eventually you become exhausted and overwhelmed. That is what I would tell them, above all, to be there for themselves." (P1)

"Basically, when people start having such thoughts whether it is like what I experienced or anything similar whenever they start feeling this way, as I said before, they should tell someone close to them, like a friend or a family member. And if that is not possible, they should try as much as they can to go to a health facility and get checked. They should say, 'I am going through this, I am feeling this way,' and speak about it. I believe they will receive help and treatment. The main thing is not to stay silent." (P8)

"To that person I would say: right now, you are doing something even though you know it is wrong. And like, don't listen to your emotions. It's just that you are unable to open your eyes and look around; but there is always a way. After some time passes, you will find the way, but even in that situation you still need to search for a way. There is always a path…" (P5)

### 5.2.2 Drivers and Triggers

This theme focuses on the factors that participants identified as contributing to or precipitating their suicide attempts. It includes interpersonal, psychological, and contextual stressors that accumulated over time or acted as immediate triggers during moments of crisis. The theme is divided into 4 subthemes: Perceived burdensomeness, Family conflict and relational distress, Lack of autonomy and agency and Struggling with stress, loneliness, voices, and substance use.

#### *5.2.2.1 Perceived Burdensomeness: Feeling like a burden on the people they loved*

Perceived burdensomeness, defined by an intractable perception of burdening others, often reflects a false mental calculation that one's death is worth more than one's life and has been supported as a significant risk factor for suicide (Lieberman et al., 2022).

In this study, when exploring the reasons underlying the suicide attempt, perceived burdensomeness emerged as the most prominent and consistently reported factor. Nearly all participants described a subjective sense of being a burden to others. Within this context, some

participants also expressed the belief that their death would bring relief to others, reflecting a distorted yet powerful perception of themselves as contributing more harm than value in their social environment.

> "I started imagining the kind of life people would have after I died. Even after I had already overdosed the medication, for several minutes I kept thinking about it. I imagined my friends returning peacefully and enjoying themselves… my family finally finding peace and being able to rest. Those were the kinds of images my mind kept creating. And that actually pushed me to go further with it. I truly felt like I was the problem, that my existence was putting other people in danger and taking away their peace. That was how it felt to me." (P5)

> "Honestly… I feel like I'm becoming useless to others. I have also become a burden to my mother." (P9)

> "I had the thought that if I were gone, my family would be happy. I thought they would find relief, that they would rest, that's what I believed at the time." (P6)

> "Sometimes when I see my brother struggling like this because of me, taking me to holy water places, moving around with me, I become worried. When he gets tired, I always feel it. When I think about him sometimes I feel sad." (P3)

> "I think it's because it has been a long time … people also get tired. I start to feel like 'I am a burden… I will also put them into trouble.' That kind of feeling comes up. These days, I am afraid to be close with people… because it always becomes about me… it's always about my case. I hate that." (P4)

#### *5.2.2.2 Family Conflict and Relational Distress: Breaking apart at home*

Conflict with family members emerged as a significant contributing factor and trigger for the suicide attempt, and it was consistently reported across all participants. Most participants described long-standing relational tensions within the family that created a persistent sense of emotional distress and feeling misunderstood by those they expected to be most supportive and understanding.

> "…As life kept going on, I also started to hate living… With my mother, it became constant fighting for no reason." (P3)

> "I felt overwhelmed, and I started thinking, 'Maybe I should end my life…' At that time, instead of supporting me, my family was putting pressure on me." (P2)

> "The conflict and misunderstanding within my family… a lot of the time my mother would get angry at me and say things to me. But what she said might not seem like much to her, while for me it was very painful. And when things like that kept happening over and over again, suicidal thoughts would come to me. Still, I was afraid to actually do it. I would tell myself, 'I would never really do something like this… what if I die?' and I would pull back. But at some point, it became too overwhelming, and I did it." (P6)

The same participant subsequently reinforced these sentiments later in the interview, adding that:

> "It was all very complicated… fighting with my family, this deep sense of loneliness… The only people I felt I truly had were my mother and father. I had no one else. So when they fought with me, my life became dark… I lost hope. And when it got to that point, I felt like maybe everyone would be happier if I were gone… I remember thinking that." (P6)

All participants acknowledged that family conflict played an important role in their suicidal crisis. For some, it was described as the primary reason for the attempt itself, with accounts indicating that the suicide attempt occurred immediately following an argument or fight with a family member.

> "When I came home from school, I was late, and then it became, 'Where were you?' and 'Why are you coming home so late?'—that kind of argument. At that moment, I became very frustrated. I felt like no one really understood what I was going through or how I was feeling. After that, I started to lose hope… everything began to feel pointless." (P5)

> "That day, I had a fight with my family… I used to argue repeatedly, but usually with my mother, not my father. But that day, I fought with my father too. I love him so much, so I never wanted him to say those kinds of things to me. After that fight with him, that's when I went toward the decision." (P6)

#### *5.2.2.3 Lack of autonomy and agency: Losing control over one's life and choices*

This subtheme is mostly derived from the subtheme "family conflict and relational distress" emerged when reasons for conflict were investigated. As further clarifying questions were asked about the conflicts, participants responded that it's mainly because of lack of autonomy and agency. It describes participants' experiences of feeling powerless, controlled, or unable to influence their life circumstances, contributing to psychological distress and hopelessness.

> "What I think is… the deeper reason behind why I decided to attempt suicide was, first, not having control over my own decisions. If I had that decision-making power, I don't think I would have done it. I don't know… not being able to decide for myself what I want to do, the interference from my family, and not receiving the kind of support I needed, that was the main issue." (P9)

> "My family used to prevent me from going to places of worship. For example, if I wanted to go to a monastery area, they would stop me. That was a reason. I wanted to become a monk but they said no. Because of that, I had conflicts with my family, mainly with my mother. Even now, when those conflicts keep happening again and again, I often find myself thinking that it would be better if I just ended my life." (P9)

> "The issue that most frequently causes conflict between us is that she does not allow me to go out with my friends. And I find it difficult." (P6)

> "…Basically, the disagreements in ideas with my family increased, and I became overwhelmed and stressed. They would not allow me to go to places I wanted, and they also prevented me from working. Because they were not listening to me, that is why I attempted suicide. I kept thinking that if my family had just agreed with me and supported me. At that time, during the entire two-month summer period, I was constantly having thoughts of attempting suicide." (P1)

#### *5.2.2.4 Struggling with Stress, Loneliness, Voices, and Substance Use*

This subtheme relates to additional life stressors, health issues, and other personal challenges that participants identified as contributing to their suicide attempt. It emerged when participants were asked whether there were other difficulties they considered important, beyond those already discussed in depth during the interview. For most participants, no new factors were added

beyond what had already been described. However, a few participants did mention additional contributing circumstances captured within this subtheme.

Responses varied across participants. One is social isolation and lack of support. Some participants reported loneliness and isolation as a factor contributing to the attempt.

> "The first time, I think it was mainly loneliness. I wasn't going out of the house, especially because it was during COVID. I just stayed at home. Then my family also put some pressure on me, school and other things. I also wanted to be with my friends, but I couldn't. So it was just the same thing over and over again. I would wake up in the morning, eat, study all day, sleep at night, like that for a whole year. And my mind couldn't get out of that cycle. I wanted to get out, but I couldn't. Everything started to feel pointless. I was getting frustrated all the time, crying for no reason, having these kinds of thoughts. Then one day my mother and I we started arguing. At that moment, I ran to the bathroom, trying to take a short break, and there was a razor there that she used for her eyebrows. With that, I tried to cut my wrist." (P5)

> "…People just start to distance themselves from you. I'm not sure if because of my attempts or because my mood didn't change, , but my boyfriend and I kind of drifted apart." (P4)

> "The biggest and main thing was loneliness. Then the thought that no one understands me, and actually, they don't. Losing hope. Thinking only about today and nothing beyond that." (P5)

Another identified influence is health issue.

> "If I had good health and were happy, I would hope that I would not die." (P3)

For only one participant auditory commanding hallucination and substance use was reported as a factor.

> "When the voice tells me like that… I think, 'No, instead of doing that, it would be better if I just go to a drinking place and play with the others.' So I go there while the voice is still there. I go and play with the others, and also drink areqe. When I drink, it actually

gets worse, it increases a lot. After that, I directly go into the act. I end up going into action." (P8)

For another one participant on the other hand, financial struggle and grief over dead child was identified as a factor.

> "… sometimes I would think, 'God, what if a car hit me? What if a car killed me and I could finally be free…? Or what if I just went into the water…?' I would think, 'What does any of this even matter? Haven't my children already died?' My flowers, my children, are gone… they have fallen away. And then… I just break down crying. Sometimes even when I look at their photos, something happens inside me… it hurts so deeply. It's like my whole body becomes impossible to control." (P7)

> "It was basically financial problems… poverty. Because of poverty, and as a result of frustration and conflict, all of these things led me to behave this way." (P7)

Although these factors were identified as important contributors or triggers, they appeared to influence the suicide attempt more indirectly compared to the other subthemes within this major theme. Rather than acting as immediate precipitants on their own, these stressors often seemed to intensify emotional suffering, hopelessness, or vulnerability over time, thereby contributing to the broader context in which the attempt occurred.

### 5.2.3 Prevention belief and unmet needs: What could have stopped it

This theme explores participants' reflections on what might have prevented the suicide attempt and what they needed the most at that time but didn't get. It includes perceived gaps in support, missed opportunities for intervention, and beliefs about protective factors that were absent during the crisis.

Nearly all participants frequently described unmet needs for understanding, emotional presence, and nonjudgmental support during their suicidal crisis. Nearly all participants expressed that what they needed most was "someone who really listens and understands," without criticism or invalidation.

> "What I wanted at that time was someone I could hold onto and cry with, someone I could open up to about my feelings, someone who would understand me and comfort me. That was what I needed most at the time, someone who would truly understand me." (P5)

> "First of all, if there had been someone by my side who truly supported me… someone who would listen to me. More than anything, I needed someone who would genuinely listen, someone who could put themselves in my shoes, understand what I was going through, and recognize what was happening inside me." (P1)

> "If there had been someone who understood me… someone who would encourage me and say, 'stay strong.' If I had even one friend by my side telling me 'you can get through this.' And another thing was my financial struggle, if I had had money…" (P7)

Conflicts with family members and a lack of peaceful relationships at home were triggering factors, and most participants expressed a desire for supportive family and friend relationships, as well as regular check-ins, to prevent the attempt.

> "If my family and friends who love me had supported me and cared for me… if I had been seen and treated like everyone else… and if my relationship with my father had been stronger." (P5)

> "Checking up on us, even when it seems like we don't need anyone that is what I needed at that time. Just simple checking in. Even from family… even if it looks like a perfect family, there can still be something broken underneath. Even without anything happening, families should first of all not be judgmental; they have to be there for you. Then friends come next. If not family, at least a close friend…" (P4)

> "Maybe if my father had been by my side… I think I could have stopped myself." (P6)

> "If my family had listened to what I was trying to tell them… if they had understood me. If only my family had been supportive." (P2)

Survivors described feelings of being misunderstood and emotionally neglected, particularly within family relationships. Some people expressed a perceived lack of understanding or reciprocity from loved ones.

> "If there had been someone who understood me the way I understand others… that was what I needed at the time. I had carried responsibilities for so long, and I wished there had been someone who would see me as their responsibility too. The truth is, I do not think I ever really lived for myself. I always say this… from childhood, I became used to taking responsibility and always having to do something. I think that is why I lived more for my family than for myself. And after struggling for so long, there came a point where I became exhausted and collapsed… but I felt that no one was there for me in the way I had been there for them. Maybe they did what they could, and maybe I also should not have given so much of myself to them… but I do not think I found anyone who stood by me in the way I had hoped for." (P1)

> "Another thing is that I often say no one understands me. Especially at night, sometimes when I come home after drinking, I cry. I fight with my family a lot at those times. But I am not really aware of it then because I am drunk, and the pain becomes even worse. I cry saying that no one understands me, neither outside nor at home. At that moment, it does not feel like anyone understands me at all."(P8)

In addition, some participants also reported the protective role of professional help.

> "If professional help had been available, at least it could have helped me." (P6)

> "At that time, I think if I had received medical or psychological help, it would have helped me. I would not have carried out the act. But I did not get help at the time…" (P8)

One participant expressed regret for initiating substance use and believed that avoiding it would have changed the course of their distress.

> "I wish that I had not started substance use. I did not enter into substance use by choice; it was due to peer pressure." (P8)

Health and overall well-being also emerged as a significant unmet need among the participants.

> "I used to really want to work hard and make a living. I wanted to help my family very much. In our household, I am the only son, and there are six girls. Because of that, I had a very strong attachment and love for my family. I did not want anything else; I only thought about my health being treated and getting better and supporting my family." (P8)

> "What I wanted was to have health. I did not want to be labeled as a sick person. I wanted to be free from whatever was troubling me, to interact with people, to laugh, and to live happily all the time. That is what I truly wanted at that time, but I did not have that." (P3)

### 5.2.4 Cultural, Societal, and Spiritual Dimensions: *When Context Wounds and Comforts*

This theme looks at the big factors that shape how people feel and act. It examines the contextual influences shaping participants' experiences, including cultural interpretations, social responses, and spiritual or religious meaning-making related to suicide and distress.

It focuses on how a person's background changes their view of suicide and mental pain. Culture plays a huge role here. For example, some groups see distress as a medical issue. Others see it as a social failure or a family matter. These views change how a person asks for help. Social responses matter too. Some people get support from their peers. Others face shame or coldness from their community. The theme also examines how faith and religion help people make sense of their pain.

This theme is described with in two subthemes: Facing stigma, invalidation, and misunderstanding and Interpreting suicide through faith and spirituality.

#### *5.2.4.1 Facing stigma, invalidation, and misunderstanding: Being judged rather than heard*

Participants' accounts shows how suicide-related distress is tied to the broader social, cultural, and spiritual contexts, particularly through pervasive silence, stigma, and limited understanding of mental health within their communities. Most participants described a consistent pattern of non-disclosure, often driven by fear of being judged, misunderstood, or perceived as weak, reflecting internalized societal expectations of emotional resilience and perfection. This concealment was reinforced by dominant cultural norms that discouraged open discussion of psychological suffering, leading individuals to mask their distress even from close friends and family.

> "People don't know. Only my close friends knew as things started getting worse. Even now, many people still don't know. The reason is that, in our society, when you are a good student, there are certain expectations. You are seen as 'perfect.' People expect you

to be flawless, and they do not want to see any weakness in you. So, even if you feel any kind of emotion or struggle, you don't speak about it." (P4)

"I don't speak up so I won't be judged. Plus, there is no one to support me. Nobody is going to understand. Even my own family wouldn't understand." (P4)

"I don't speak up because I fear being judged. Plus, there is no one who supports me. Nobody's gonna understand. Even my family still doesn't understand. When I talk, I feel like it is interpreted in a different way, so I think it is just exhausting to explain myself when there is no one who can truly understand me. I didn't tell my friends either… I didn't want to appear weak. Maybe if I had died, they would have known that I attempted suicide. But as long as it didn't succeed, I didn't want them to know." (P5)

"The main problem comes from the family. For example, if I am once labeled as having a mental illness, people will see me as mentally ill for life. My family… they think I do not understand or am not aware. They assume it is because I have an illness. This comes from a lack of knowledge." (P9)

Nearly all participants responded that there's societal misconception and misunderstanding related to suicide. They believe most people do not understand why someone chooses to end their life. This gap in knowledge leads to harmful stereotypes. Some people see it as a sign of weakness or a choice made for attention. These wrong ideas make it hard for those in pain to ask for help. Most feel judged by a public that relies on myths instead of facts. This misunderstanding keeps people silent and prevents them from finding real support.

"Among people our age, suicide is a very serious issue. When I tell her that my friend have died by suicide, she says things like 'they were just being reckless', What did she lack? It's just misbehavior.' or 'their families spoiled them.' That's how it is for our age group in their understanding. Something like that. In society, they see it as just being 'spoiled', they think it is because the person couldn't tolerate a small problem. There is a distorted understanding in society." (P5)

"Suicide, in society, is often misunderstood. People say things like 'what did she lack?' It is not something you can judge just by looking at someone's clothes or appearance. The person who truly knows what is inside is the person themselves. That is what I want to

say. People should stop thinking and saying, ‘she was just being reckless, what did she lack, everything was provided for her,’ and instead ask, ‘what happened to her? What was going on in her mind? What pushed her to do this?’ They should try to understand what was happening inside her. There is a lot about suicide in society that is not talked about and not understood.” (P6)

> “Many people do not see it as something related to illness or pain. But those who might understand usually only come after the person has already passed away. That is when they start asking, ‘what have happened?’ But at the beginning, no one asks, ‘why did this happen?’ So in the end, everyone judges instead of truly trying to understand you. No one can really understand you properly. It is mostly seen as a weakness. Everyone just gives their own opinion. No one says, ‘maybe we didn’t understand her,’ or ‘maybe something happened that led to this.’ At the time, everyone just judges and says you are weak.” (P1)

When disclosure did occur, responses were frequently described as invalidating or blaming, with some participants reporting that their experiences were attributed to moral weakness or religious interpretations such as spiritual wrongdoing.

> “Their response, when I was in that situation, was difficult. As I mentioned, their repeated question was: ‘Why did you think like this? Why did you do this?’ They did not understand that when a person thinks about something like this, it is usually because they have gone through something very difficult…” (P1)

> “They used to say things like, ‘Why are you doing this to yourself? Why are you putting yourself through this?’ and ‘Suicide is forbidden,’ and similar things. At that time, when they said this, I even found myself thinking, ‘they might as well just kill me,’ that kind of thought came to me. I had that kind of feeling.” (P2)

In certain cases, families responded through strongly religious or traditional coping practices, including church based interventions or holy water treatment, which participants experienced as both supportive and, at times, misunderstood or coercive.

> “They were there, my family. But they don’t understand. They thought it was something else, like ‘it’s not her, it’s not her doing; it’s the devil,’ that’s what they believed. I feel

misunderstood. They used to force me to go to holy water sites. They could suddenly take me to such places … I don't want to go there." (P4)

"My friends did not know about it. But my family… they asked me about my reasons and I told them. They told me not to try it again, and that if I ever had such thoughts, I should tell them. My mother also took me to church and said I should go and repent. She took me there, and that really helped me." (P6)

#### *5.2.4.2 Interpreting suicide through faith and spirituality*

Participants described religion and spirituality as playing a personal and often complicated role in how they understood their suicide attempts and emotional suffering. For most, suicide was seen as a serious sin within their religious beliefs, which led to strong feelings of guilt, shame, and fear after the attempt. Some participants spoke about feeling trapped between unbearable emotional pain and the belief that taking one's life was morally wrong.

"In our religion, suicide is not acceptable. Human beings are creations made by God, and only God has the right to take a life. So, it is considered a very serious sin. But God is also forgiving… Right now, in the condition I am in, I do not feel able to do it yet. Maybe once I recover a little more and come to terms with everything, I will take that step and repent." (P6)

Others described feeling distant from God during the time of the attempt, saying that their faith had weakened as anxiety, hopelessness, and emotional exhaustion increased.

"My previous faith and my current way of practicing faith are not the same. My earlier faith was much stronger, but now it has gradually weakened. In the past, I did not experience this level of anxiety inside me. But now, I experience overwhelming anxiety and feelings of hopelessness. I become very anxious because of these thoughts that keep coming to me. Over time, my faith has been decreasing. However, even now, I still believe that God helps me, even a little, and I still ask God for forgiveness, even in a small way. That is how I used to try to cope with it." (P9)

At the same time, religion also became a source of comfort and hope for several participants after the attempt. Some described slowly reconnecting with their faith and finding strength through prayer or support from religious communities.

> "There were some youths from the church Sunday school who would talk to me and tell me things like, 'this is a sin,' trying to stop me from harming myself. They encouraged me to become more involved in religious practices again. It helped me a little and I improved for some time, but then the thoughts would return again." (P2)

> "Suicide is something you do when you have completely lost hope… when I returned to my faith again, it gave me hope for myself, at least to some extent. It gives you something that pulls you back and makes you reconsider… it makes you stop and ask yourself why, and helps you keep going." (P1)

### 5.2.5 Coping Strategies: Getting through it

This theme explores how participants managed their recovery after the suicide attempt and how they believed they would respond if suicidal thoughts emerged again in the future. Participants often described recovery as a gradual and non-linear process, where suicidal thoughts had not always completely disappeared but became more manageable over time. Several participants described trying to calm and encourage themselves during moments of distress by holding onto hope that things could improve in the future.

> "If I ever find myself in that kind of situation again, I cope by giving myself hope. I tell myself that maybe tomorrow will be better, that I still have hope for tomorrow… that I will change one day. I try to encourage and calm myself all the time but sometimes the thoughts come suddenly, and something inside me becomes deeply disturbing." (P3)

For some, suicidal ideation had not fully disappeared, but they explained that they had learned ways to manage the thoughts when they emerged.

> "Right now the feeling of not wanting to live is still there. I came here about 17 or 18 days ago, and the feeling was still present. But as long as I am under treatment, I can cope with it. When those feelings come, I told my sisters, and my sister brought me here to this treatment service. It was suggested that I be admitted for a short period of treatment. My medication was adjusted. Now I am doing much better. I am in a very good and comfortable condition at the moment." (P8)

Others described relying on distraction and emotional regulation strategies to get through difficult moments. Participants spoke about sleeping to escape overwhelming thoughts, keeping

themselves busy through distraction, or using breathing techniques learned during treatment to reduce emotional intensity.

> "I usually go to sleep. When I wake up, I tend to forget it. Also, I was taught some techniques here at the facility, coping strategies, especially breathing techniques, which have been very helpful to me. But mainly, when these thoughts come, I try to distract my mind. I start watching TikTok or doing something to keep my mind busy." (P5)

> "When suicidal thoughts come, I don't know… I try to sleep, or I tell someone who is close to me." (P6)

Writing also emerged as a personal coping strategy. One participant responded:

> "Most of the time, when these thoughts come, I try to write them down because I like writing. I try to write as much as I can, and I often try to talk to my notebook as if it is a friend. It reduces the intensity a little. When I write, even though there is no response, it feels like I am being heard, rather than talking to a person. So after I finish writing, I feel a bit lighter." (P1)

Prayer and religious practices were also commonly mentioned, particularly during moments of emotional overwhelm, with some participants describing turning to God or going to church when suicidal thoughts resurfaced.

> "I just go to church. When I feel overwhelmed and thoughts like 'harm yourself' come to my mind, I get angry and either go out and walk around the church, or I go somewhere where no one can see me and come back. I don't really have strong suicidal intentions now. I try to distract myself so that the thoughts go away." (P9)

> "I go and pray. I just plead with God…" (P2)

For most participants, recovery was closely tied to seeking help from others and receiving professional treatment. A number of participants explained that, compared to before the attempt, they are now more willing to disclose their distress to family members, friends, or healthcare providers when suicidal thoughts arise. They described treatment, medication and therapy as central to helping them stabilize and regain a sense of comfort and safety.

> "Right now the feeling of not wanting to live is still there. I came here about 17 or 18 days ago, and the feeling was still present. But as long as I am under treatment, I can cope with it. When those feelings come, I told my sisters, and my sister brought me here to this treatment service. It was suggested that I be admitted for a short period of treatment. My medication was adjusted. Now I am doing much better. I am in a very good and comfortable condition at the moment." (P8)

> "The advice we receive here is helpful. Secondly, following the medication treatment also helps. It was the combination of medication and treatment that helped me recover." (P3)

> "After therapy, I started communicating more with my friend, and he was very supportive and present for me. Before the attempt, I had tried to tell him, asking whether he could help stop me." (P4)

Some participants also combined psychiatric treatment with spiritual or religious healing practices such as holy water rituals, experiencing both as important parts of their recovery process.

> "Treatment, holy water ritual, and medication together are what helped me." (P7)

### 5.2.6 Health Care and System Experiences: *What helped and what didn't*

This theme explores survivors' experiences with the healthcare system during the immediate aftermath of the suicide attempt and throughout their ongoing follow-up care. Participants' experiences with healthcare providers and treatment services were important in shaping how they understood their recovery and support after the attempt. Their accounts provide insight into areas where care was experienced as helpful, as well as gaps that may inform the development of more responsive, compassionate, and effective suicide prevention and post-attempt care services.

This theme is divided into 3 subthemes: Negative healthcare experiences, Positive professional support and Survivors' recommendations for better care

#### *5.2.6.1 Negative healthcare experiences*

Participants described their contact with the healthcare system after a suicide attempt as a mix of experiences during emergency care and follow-up psychiatric visits. While nearly all of them

were taken to hospital or emergency services right after the attempt and all have regular psychiatric follow-up appointments, nearly half of the participants felt that these encounters were not always emotionally supportive, and at times felt insensitive, lacking in warmth, safety, and genuine human connection.

One concern raised by a participant was the very clinical way communication was handled, which felt quite formal and distant. She described clinicians focusing on writing things down, asking structured questions, and interacting in a way that felt more like an interview than a conversation. The participant shared that even during an emergency admission after a suicide attempt, seeing the clinician with a pen and notebook made her feel uneasy and not fully understood, as if her experience was being documented rather than genuinely listened to.

> "When I came to the emergency room, I had come in a very critical condition. I had overdosed. I think it was around three years ago, if I remember correctly. Then the doctor came and started asking me questions, like what my intention had been and things like that. But still, she was holding a pen and notebook. I kept thinking, 'What is this?' Writing things down and recording them did not feel right to me… this is not like ordering laboratory tests or something medical like that. Of course, there may be medical procedures or medications that need to be ordered afterward, but when you come in after a suicide attempt and someone sits there with a notebook and pen, honestly, it makes me feel very uncomfortable and irritated." (P4).

The same participant also mentioned that despite regular weekly visits, there was "no progress," and that a lack of emotional connection with therapists made it difficult to engage in the process of care.

> "They mostly conduct therapy like an interview. They sit there with a notebook and a pen. Honestly, one of the things I disliked most was meeting doctors who immediately pulled out a notebook and pen. I don't know… maybe it is just part of the training or the system they work in. I used to go every week, but there was no progress. The therapists never really formed a connection with me." (P4)

> "When I go into the therapy room now, especially with the residents, there are things that really make me uncomfortable. Sometimes they keep checking or tapping on their

> phones, and it makes you feel like the space is not secure or safe. Even recently, maybe about two weeks ago, I asked them whether they were recording me. In those moments, you feel a kind of insecurity. More than anything, you want to feel safe. It becomes very difficult to trust. The things you talk about are deeply vulnerable, but if you do not have a connection with that new person, as I mentioned earlier, it is hard to trust them and allow yourself to be that vulnerable. When you cannot build that trust, it becomes very difficult." (P4)

Some participants also described experiences where they felt misunderstood or judged during care. One participant recalled being asked whether "something was wrong" after admission, which she experienced as dismissive given the seriousness of a suicide attempt, and she felt that some healthcare providers lacked adequate training in responding to such situations.

> "While I was admitted in emergency here, a doctor asked me, 'Is something wrong?' If something wasn't wrong, I wouldn't have attempted suicide. At that moment, I felt that sometimes, in situations like this, people need to understand you. I did not believe the questions being asked were appropriate or fully meaningful at the time. In such treatment settings, I also feel that healthcare providers who do not have mental health training should not be the ones engaging in these conversations." (P1)

In more distressing accounts, another participant described being met with harsh and stigmatizing responses from healthcare providers, and even experiencing physical punishment during care.

> "Some of the doctors said to me, 'You are malicious, why are you drinking poison to try to kill yourself? You are wicked,' and similar things…When I said I didn't want to drink the milk, they slapped me." (P7)

Frequent changes in doctors and therapists also disrupted continuity of care, making it challenging for some participants to repeatedly rebuild trust and therapeutic rapport.

> "Therapists and doctors used to change quite frequently, and every time I had to start over, learning to trust someone new, opening up again, and going through the process of building that connection from the beginning is a challenge." (P5)

Additionally, another participant described feeling that his own perspectives were sometimes overshadowed by family reports, with clinical decisions perceived as relying more heavily on parental accounts.

> "From my perspective, what I needed most was for the doctors to truly listen to me as a patient. Instead, I felt that they often gave more weight to what my parents were saying. If my parents reported something, it was immediately taken as the main truth. But I believe it should be balanced. Trusting only the parents' account is not enough; the patient's own experience should be taken just as seriously. Both sources of information need to be considered and weighed equally. I did not feel that my own reality was fully understood. Because of that, decisions were sometimes made, like increasing medication or giving injections that felt automatic, without fully capturing what I was actually going through. (P9)

#### *5.2.6.2 Positive professional support*

Most participants described their psychiatric follow-up appointments as an important and helpful part of their recovery process. As also discussed under the fifth theme, most participants spoke positively about the role of treatment, particularly therapy and medication, in helping them manage distress and gradually regain stability. They shared that these services gave them structure, emotional support, and a sense that things could improve over time.

At the same time, when reflecting on their broader healthcare experiences after the attempt, especially during hospital and emergency room admissions, participants' accounts were mixed. While nearly half of the participants of described difficult or uncomfortable experiences in the ER, some also recalled receiving compassionate care, where they felt supported, taken seriously, and treated with kindness during a very vulnerable moment.

> "They gave me advice that was helpful to me… they really helped me a lot. At least after I came here, they helped me cope with my anxiety and my anger, and manage them better." (P3)

> "After I came out of the ICU, the treatment I received… and the advice given to me really helped me a lot." (P6)

> "After an overdose, when I was hospitalized, they gave me a lot of care and compassion, and showed me kindness." (P5)

#### *5.2.6.3 Survivors' recommendations for better care*

Participants spoke about the need for care that feels more understanding and compassionate when someone is going through suicidal distress. A number of participants felt that supporting people in these situations should not fall only on mental health professionals. Instead, they described it as something that requires everyone's involvement, families, schools, religious leaders, social workers, and policymakers all playing a part and working together to respond in a more coordinated and caring way.

> "Everyone has to be involved. Religion should also be included. People working in the social sphere should be involved as well. This is something that needs to be addressed collectively, with everyone included. It is not like a physical illness where you simply give medication and that is all. There are many different factors involved." (P4)

Participants often returned to the idea that what mattered most was simply being listened to and understood, rather than being judged, ignored, or pushed away. One participant shared memories of feeling misunderstood in school or within their communities, where her quietness or withdrawal was noticed, but no one took the time to ask what was really going on or to show genuine concern. Because of this, she felt their struggles stayed hidden for too long. She also felt that if there were earlier opportunities for emotional support, places where young people could speak openly about what they are going through without fear, it might help prevent situations from becoming more serious later on.

> "I think that in any position of responsibility even at the school level, instead of excluding a child or treating them differently, it would be much better if people tried to listen and understand why that person is struggling. In my case, at school, people used to think, 'She does not interact with others' and things like that. But as I told you, no one really understood me. They would simply say, 'She is quiet,' and move on. No one tries to understand what is behind your silence. Maybe if there were programs like this in schools or other places, even once a week or at certain times, it could really help. At least some people could be saved." (P1)

Participants also reported wanting care that feels safe on an emotional level, where they are treated with respect and where their vulnerability is taken seriously, especially during suicidal crises. Some also talked about difficult experiences with certain healthcare staff, describing situations where they felt shouted at, ignored, or dismissed before they even had the chance to explain what they were going through.

> "No one comes here because they wanted to. So, as much as possible… not on a personal level, but from what I have seen and understood from many of the people being treated here… no one chooses this willingly. The people here have come through very different and difficult life experiences. They did not come because they are comfortable and just wanted to relax at a café or have fun. They came because they are struggling. So they come to find help and solutions for their problems, not to argue with you or be treated harshly… so I feel things should be handled with more understanding and responsiveness." (P6)

> "The treatment is very good. But there are some nurses… when you go to ask for help or consultation, there is arguing, shouting, and dismissing you, saying things like, 'Go away, get out of here.' I think that should be improved a little. When you go to the office, they should first ask why you came and what you need… it should be handled collaboratively and respectfully. Sometimes they push you away. Before they even listen to you, before you even get the chance to speak, they close the door on you… they dismiss you. If that could be improved, it would be very good." (P8)

Some participants spoke about the need for emergency mental health cases to be handled by trained mental health professionals rather than by providers without adequate psychological training.

> "In emergency treatment settings like this, when a person presents with these kinds of cases, it would be better if mental health professionals were involved and handled the situation. Healthcare providers who do not have mental health training should not be the ones engaging in those conversations." (P1)

Participants additionally described systemic barriers such as shortages of psychologists, inconsistent medication availability, and difficulties accessing free treatment.

> "The medication is supposed to be supplied by the government, but they tell us the medication is unavailable. Even when we go outside to look for it ourselves, they still say the medication is out of stock. I kept going from place to place searching for it. One Monday, after struggling all day trying to find the medication, I did not get home until eleven at night. There is simply no consistent medication supply." (P7)

One participant in addition mentioned that even small changes in the treatment environment, such as calmer therapy spaces, respectful communication, and more compassionate engagement, could make a meaningful difference.

> "I think the environment needs to be something that helps people feel calm. More attention should be given to the therapy rooms… not just a chair and a table. Things like plants and similar touches that naturally create a calming atmosphere would be good. Even subtle things, no matter how small, make a difference. We may not consciously notice it, but the environment definitely has an effect." (P4)

# CHAPTER 6: DISCUSSION

This study explored the lived experiences of suicide attempt survivors receiving follow-up care at Tikur Anebessa Specialized Hospital and Amanuel Mental Specialized Hospital. Using a phenomenological study design, the study examined how survivors experienced the suicidal crisis, how they understood the factors contributing to their attempts, the meanings they attached to survival, and the ways social, cultural, spiritual, and relational contexts shaped both suicidality and recovery. The findings suggest that suicide attempts emerged within prolonged experiences of emotional suffering, hopelessness, perceived burdensomeness, relational rupture, loneliness, invalidation, and unmet needs for emotional understanding. At the same time, participants' accounts also reflected survival, self-reflection, shifting meanings over time, and efforts toward healing.

The findings contribute to the growing body of phenomenological suicidology literature arguing that suicidal experiences cannot be adequately understood only through risk-factor models or diagnostic categories (Hjelmeland & Knizek, 2010). Instead, understanding suicidality requires close attention to subjective experience, meaning-making, interpersonal suffering, and cultural context. The present study is particularly important within Ethiopia, where, as far as the researcher's knowledge, there were no qualitative research exploring the lived experiences of suicide attempt survivors.

The six major themes that emerged, the phenomenology of the suicidal crisis, drivers and triggers, prevention beliefs and unmet needs, cultural, societal, and spiritual dimensions, coping strategies, and healthcare system experiences are discussed below.

### *6.1 The Phenomenology of the Suicidal Crisis*

One of the central findings of this study was the profound psychological pain participants described before and during the suicide attempt. Survivors repeatedly spoke about hopelessness, emotional exhaustion, sadness, internal chaos, numbness, worthlessness, and a feeling of being unable to continue living. Most participants described reaching a point where life no longer felt emotionally survivable. Their accounts strongly support Shneidman's (1993) theory of "psychache", which conceptualizes suicide as an attempt to escape unbearable psychological pain. Shneidman argued that it is not death that the suicidal person seeks, but the cessation of pain. Participants did not simply describe a desire for death itself; rather, they described wanting relief from suffering that felt endless, overwhelming, and impossible to communicate.

This finding is consistent with qualitative studies conducted in other settings. Webb (2010), drawing from personal and survivor narratives, described suicidality as a state in which psychological pain narrows perception until death appears to be the only escape. Orbach et al. (2003) also found that suicidal individuals often experience intense mental pain characterized by shame, loneliness, helplessness, and emotional flooding.

Hopelessness stood out as the single most consistently described pre-attempt state across all nine participants. According to Aaron Beck's cognitive model of depression and suicidality, hopelessness is defined as a stable, negative expectation about the future, functions as the primary cognitive mediator between depression and suicidal intent (Beck et al., 1990; Beck, 1986). Decades of research have affirmed hopelessness as one of the strongest predictors of

suicide attempts, often outperforming depression severity alone (Abramson et al., 2000; Brown et al., 2000).

Participants also described emotional numbness, emptiness, and detachment during the attempt. Some reported feeling “nothing,” while others described hollow or vacuum-like internal states. Suicide literatures also describe dissociation, emotional shutdown, and psychic numbing during acute suicidal crises (Pompili, 2010).

A particularly significant finding was the persistence of suicidal ideation even after survival. Some participants openly described continuing hopelessness and future suicide plans despite receiving treatment. This result is consistent with longitudinal evidence showing that previous suicide attempts remain one of the strongest predictors of future suicide risk (Owens et al., 2002).

The emotional responses that participants described after surviving their attempts were remarkably heterogeneous, ranging from relief and gratitude, through indifference and numbness, to active regret and disappointment that they had not died. This spectrum of post-attempt emotional states has not been widely examined in the quantitative suicide literature, which tends to focus on risk factors for reattempt rather than the phenomenological texture of survival.

These post-attempt reactions are consistent with previous qualitative findings. Vatne and Naden (2014) found that most survivors experience complex emotional responses after survival, including regret, shame, relief, confusion, and disappointment. Similar patterns emerged in the present study. Several participants expressed grief about surviving, what might be understood as a mourning for the death they had sought and not found. . Clinically, such post-attempt states signal ongoing acute risk that cannot be adequately captured by a focus on the attempt itself alone; what happens in a person's interior world after survival is equally important.

The findings also revealed important changes in identity and self-perception following the attempt. Most participants described feeling weaker, less capable, less confident, or fundamentally changed as people. Suicide attempts appeared to disrupt participants’ sense of self. This is supported by trauma literature suggesting that overwhelming psychological crises can profoundly alter self-concept and agency (Herman, 1992). At the same time, a smaller

number of participants described increased resilience, renewed hope, or a clearer understanding of themselves after survival.

When asked what they would say to someone going through a similar experience, nearly all participants responded with warmth, urgency, and moral concern. They advised hope, self-love, disclosure, and help-seeking. Findings have been reported by Lakeman and FitzGerald (2009), who found that survivors often develop heightened empathy and a desire to protect others from similar suffering. This seemingly simple finding carries significant weight. Participants who, in one part of the interview, described ongoing suicidal ideation and despair, were simultaneously able to articulate to a hypothetical other that "everything passes" and that "there is always a path."

### *6.2 Drivers and Triggers of the Suicide Attempt*

Participants described cumulative distress involving perceived burdensomeness, family conflict, emotional invalidation, loneliness, loss of autonomy, mental illness, poverty, grief, and social isolation.

Perceived burdensomeness emerged as one of the strongest themes across participants' narratives. Most survivors believed they were causing suffering for others and that their absence would bring peace to loved ones. These findings strongly support Joiner's Interpersonal Theory of Suicide (2005) and later work by Van Orden et al. (2010), which identifies perceived burdensomeness as a major driver of suicidal desire. Participants frequently described themselves as useless, exhausting, or harmful to others. Some imagined their death as a "gift" or relief for family members.

What adds particular depth to these accounts is how perceived burdensomeness interacted with family relationships. For most participants, the people they feared burdening were not strangers or acquaintances but parents, siblings, and close family members. This intensified the cognitive distortion: love itself became a pathway to the belief that death was the caring thing to do. Understanding this dynamic is critical for clinicians working with suicidal individuals; addressing perceived burdensomeness may require not only individual cognitive work but also relational and family-level interventions that help individuals experience their value to others in concrete, felt ways.

Family conflict and relational distress were also central contributors to suicidal crises and was consistently reported as trigger across all participants. Participants described criticism, misunderstanding, pressure, emotional neglect, repeated conflict, and feeling unheard within family relationships. For several participants, the crisis point, the moment of crossing from ideation to action, was precipitated directly by an argument or confrontation with a parent. This finding is highly consistent with existing suicidology literature. Miller et al. (2017) found that family conflict significantly predicts suicidal ideation and attempts, particularly when combined with emotional invalidation and loneliness. Other findings also indicate family conflict, particularly parent-child relational distress, as a proximal trigger for suicidal behavior (Brent et al., 1993; Joiner et al., 2009).

Participants repeatedly described feeling emotionally misunderstood or dismissed when expressing distress. Some explained that their emotions were minimized, criticized, or interpreted as weakness. Chronic invalidation may increase emotional dysregulation, self-blame, and hopelessness over time (Linehan., 1993).

Several participants described intense longing for emotional understanding, safety, and reassurance from caregivers while simultaneously experiencing conflict and emotional disconnection within those same relationships. Previous research has linked insecure attachment, emotional neglect, and disrupted belonging to increased suicide risk (Sheftall et al., 2013). In this study, family relationships appeared both protective and deeply painful at the same time.

Another significant finding involved participants' experiences of lacking autonomy and agency. Some participants described feeling controlled by family members or unable to make decisions regarding work, religion, friendships, movement, or future plans. These experiences contributed to feelings of entrapment and emotional suffocation. This finding is consistent with Williams' Cry of Pain model and O'Connor's Integrated Motivational-Volitional Model (O'Connor & Kirtley, 2018), both of which emphasize defeat and entrapment as key drivers of suicidal ideation. Participants repeatedly described feeling trapped in situations they could neither tolerate nor escape.

The relationship between loss of autonomy and suicide has been theorized within several frameworks. Self-Determination Theory (Deci & Ryan, 2000) posits that autonomy, competence, and relatedness are fundamental psychological needs, and that their thwarting produces negative

affect, alienation, and motivational collapse, states that can contribute to suicidal despair. More specifically, research on adolescent and young adult suicidality has pointed to the importance of autonomy development and the damaging effects of controlling parenting on mental health outcomes (Barber, 1996; Soenens & Vansteenkiste, 2010). When family systems constrain rather than support this process, the collision between developmental needs and relational constraints can reach breaking point.

Loneliness and emotional isolation also emerged as powerful contributors to suicidality. Several participants described feeling emotionally alone even when surrounded by people. Others concealed their suffering because they believed no one would understand them. These findings support research showing that thwarted belongingness is strongly associated with suicidal desire (Van Orden et al., 2010).

For some participants, additional stressors included psychosis, grief, poverty, substance use, and chronic illness. A participant described command auditory hallucinations instructing him to kill himself. Previous research consistently demonstrates elevated suicide risk among individuals experiencing psychosis, particularly when hallucinations involve self-harm commands (Hawton et al., 2005). Another participant linked her suicidality to grief following the deaths of her children and severe financial hardship. Bereavement by suicide or the death of a child is among the most severe precipitants of suicidal crisis (Jordan & McIntosh, 2011) and financial strain has been consistently linked to suicidal behavior, particularly in low-resource settings (Iemmi et al., 2016; Qin et al., 2003).

The role of substance use is consistent with previous evidence that alcohol and substances may intensify impulsivity, emotional dysregulation, and suicidal behavior (Sher, 2006). Importantly, participants often described these stressors as interacting with relational pain and hopelessness rather than functioning independently. The co-occurrence of multiple stressors of this magnitude points to the importance of assessing cumulative risk rather than searching for a single precipitant.

### *6.3 Prevention Beliefs and Unmet Needs*

When participants reflected on what they needed but didn't get, their answers were remarkably consistent. They described needing someone who would genuinely listen, who would sit with them in their pain without judgment, and who would make them feel that they were not invisible

or alone. The language they used was: "someone I could hold onto and cry with," "someone who could put themselves in my shoes," "someone who would truly understand me." This finding is in line with literatures supporting the protective role of connectedness, validation, and empathic engagement (Jobes, 2016). Describing what might be called the relational dimension of suicide prevention, Cutcliffe and Barker (2002) found that the experience of feeling heard and genuinely seen by another person can function as a powerful stabilizing force during suicidal crisis.

The participants' narratives suggest that emotional neglect and lack of attuned support may have intensified suicidal despair. Findings have been reported in qualitative studies where survivors describe feeling invisible, emotionally unsupported, or chronically misunderstood before attempting suicide (Shamsaei et al., 2020).

Another major issue was non-disclosure. Most participants concealed suicidal thoughts due to fear of judgment, shame, or being misunderstood. This reflects broader literature showing that suicide stigma significantly reduces help-seeking and increases isolation (Corrigan et al., 2014). In collectivist contexts, disclosure may become even more difficult when emotional suffering risks bringing shame or disappointment to family systems.

The family was identified both as a source of the crisis and as a potential site of prevention. Nearly all participants expressed that if their family had been supportive, non-judgmental, and present, if parents had asked rather than accused, listened rather than condemned, things might have unfolded differently. This dual role of the family as both risk factor and protective resource is a recurring theme in the suicidology literature (Joiner et al., 2009) and underscores the importance of family-inclusive approaches to both prevention and post-attempt care

Professional support was similarly identified as potentially life-saving. Several participants believed earlier access to psychological or psychiatric care could have prevented the attempt.

Mental health services remain severely under-resourced in the country, with the treatment gap for mental disorders estimated at over 90% (Fekadu et al., 2014). In a context where the infrastructure of professional support is thin, the relational and community-level protective factors that participants described, the listening friend, the engaged family member, the understanding elder, become even more critical as practical, accessible, and culturally appropriate forms of prevention.

### *6.4 Cultural, Societal, and Spiritual Dimensions*

The study found that cultural stigma, social expectations, and spiritual beliefs all had a significant impact on suicidal behavior. Most participants hid their pain for fear of being judged, labeled weak, or misunderstood. Several people described feeling pressured to appear emotionally strong, successful, or "normal" despite experiencing severe internal distress.

According to Corrigan and colleagues, stigmatizing attitudes toward mental illness and suicide increase shame, secrecy, and emotional isolation. In many African and non-Western settings, suicide is often interpreted through moral, spiritual, or character-based explanations rather than psychological frameworks (Mars et al., 2014). Participants in this study repeatedly described suicide being viewed as weakness, recklessness, irresponsibility, or lack of gratitude.

Participants also described widespread misunderstanding of mental illness and suicidality within their communities. This stigma appears to be particularly potent and socially embedded. Participants described community attitudes toward suicide that were dismissive and moralistic, framing it as "misbehavior," as something only "spoiled" people do, or as a failure to tolerate minor problems. Similar findings have been documented in Ethiopian mental health research showing low mental health literacy and strong stigma surrounding psychiatric conditions (Girma et al., 2014). Such misunderstandings may discourage emotional disclosure and delay help-seeking.

Survivors who disclosed their experiences reported receiving invalidating rather than supportive responses. Being told "why did you do this?" or "suicide is forbidden", without any curiosity about the suffering that preceded the act, communicated to these individuals that their inner world was not a legitimate subject of concern. This kind of response confirms the survivor's worst fear that they cannot be understood, reinforces isolation, and may contribute to the decision not to disclose in the future.

Religion and spirituality emerged as both protective and distressing. Majority of the participants described suicide as a serious sin within their faith, which often produced guilt, fear, and shame after survival. Similar findings have been reported in religious suicide literature, where individuals experience conflict between unbearable suffering and religious prohibitions against suicide (Colucci & Martin, 2008).

At the same time, spirituality also functioned as an important source of hope, meaning, and coping. Prayer, church involvement, repentance, and reconnecting with faith helped several participants manage distress and reconsider suicidal action. Previous research has similarly found that spirituality may reduce suicide risk by fostering hope, meaning, belonging, and moral resistance against self-harm (Koenig, 2009).

Interestingly, some participants experienced religious interventions as coercive or invalidating, especially when their distress was interpreted solely as spiritual attack or demonic influence. Faith-based responses may become harmful when psychological suffering is dismissed or misunderstood. Clinicians therefore need culturally sensitive approaches that respect spiritual beliefs while still recognizing the importance of psychological care.

### *6.5 Coping Strategies and Recovery*

Participants described recovery as gradual, unstable, and deeply relational. More than half of the participants continued experiencing suicidal thoughts after the attempt but reported learning ways to manage distress more safely. Recovery often involved emotional regulation, distraction, disclosure, prayer, writing, treatment engagement, and rebuilding hope. Consistent with the literature on coping and resilience after suicidal crises (Stallman, 2018) participants drew on a combination of behavioral, cognitive, social, and spiritual resources ,and most indicated that no single strategy was sufficient on its own.

Distraction, through sleep, social media, physical movement, was among the most commonly reported strategies. While this might appear superficial from a clinical standpoint, research on emotion regulation has shown that behavioral distraction can serve as an effective short-term buffer against acute suicidal urges, buying time for the crisis to pass and for more deliberate coping to become available (Linehan, 1993).

Treatment, including both medication and therapy, was named by most participants as central to their recovery, particularly those who had been in psychiatric follow-up for some time. This finding support the evidence base for pharmacological and psychotherapeutic treatment of depression, schizophrenia, and PTSD as conditions associated with suicide risk (Hawton et al., 2016). Several participants also described the way that treatment had improved their willingness to disclose, that they now told family members or clinicians when suicidal thoughts arose, rather than hiding them. This represents a meaningful shift in the behavioral indicators of safety, and it

is in line with researches suggesting that effective treatment not only reduces symptoms but builds the kind of trust and self-awareness that supports safer help-seeking behavior (Jobes, 2016).

Still, recovery remained fragile for more than half of the participants, particularly when social difficulties, loneliness, or hopelessness persisted. This reflects broader literature emphasizing that suicide recovery is rarely linear and often involves recurring vulnerability (Owens et al., 2002).

### *6.6 Healthcare System Experiences*

The healthcare experiences described by participants revealed a system that, at its best, was capable of providing genuine compassion, stabilizing treatment, and life-changing support, and, at its worst, was capable of causing additional harm to people already at their most vulnerable. Both realities were present in this sample.

The negative experiences were particularly significant and deserve clinical attention. Several participants described emergency and inpatient encounters characterized by clinical detachment, intrusive documentation practices, inappropriate questioning, and in one deeply troubling account, physical mistreatment, being slapped during a medical procedure after a suicide attempt. Stigmatizing language from healthcare providers compounds the shame and self-blame that survivors already carry and directly contradicts the foundational ethical obligation of clinical care. Research has consistently shown that negative healthcare interactions after a suicide attempt are associated with reduced help-seeking in the future, treatment disengagement, and elevated risk for reattempt (Ougrin et al., 2015).

Research also shows that when one feel stigmatized, dismissed, or "judged" by emergency room staff or clinicians after an attempt, they are significantly less likely to engage in follow-up care, which increases their long-term risk (Gaily-Luoma, 2023).

A concern raised by participant in the study about clinicians conducting sessions with a notebook and pen, rather than engaging in what felt like genuine dialogue, points to a more subtle but equally important issue: the quality of the therapeutic relationship. Therapeutic alliance, the relational bond between clinician and patient, has been consistently identified as one of the most powerful predictors of treatment outcome across all psychotherapeutic modalities (Wampold &

Imel, 2015). When survivors feel that they are being interviewed rather than heard, that their distress is being catalogued rather than understood, the conditions necessary for genuine therapeutic work are undermined. The frequent rotation of residents and therapists exacerbated this problem by requiring survivors to repeatedly rebuild trust from scratch.

In addition, patients' perspectives being systematically underweighted relative to parents' reports by clinicians, is an important issue in epistemic justice in mental health care, as is the degree to which patients' own accounts of their experiences are given authority in clinical decision-making. In the context of a young person with a mental health diagnosis, there may be a clinical temptation to privilege the more apparently stable informant. But this carries real risks: it can leave the patient feeling unheard, inaccurate clinical pictures can be formed, and the therapeutic relationship is weakened.

Against these difficulties, participants also described genuinely positive healthcare experiences, moments of warmth, compassion, and skilled care that helped them stabilize. These accounts confirm that the same system that can harm can also heal, and that the difference often lies in individual clinician attitudes, training, and the quality of the therapeutic environment, factors that are modifiable through policy, training, and institutional culture change.

Participants also identified systemic barriers that lie beyond the individual clinician: medication shortages, insufficient numbers of trained mental health professionals, and absence of mental health specialists in emergency settings. These are structural problems that require structural responses.

## CHAPER 7: STRENGTHS AND LIMITATION

The study included participants with different backgrounds in terms of age, gender, diagnosis, and method of attempt, which increased the richness of the data and allowed different perspectives to emerge.

The study also addressed an important research gap in Ethiopia. Most previous suicide studies in the country focused mainly on prevalence rates, associated factors, or psychiatric diagnoses. Very little attention has been given to the lived experiences of survivors themselves. Because of this, the findings have practical value for mental health professionals, policymakers, and hospitals. The participants' recommendations regarding emotional support, compassionate care,

family understanding, and reducing stigma provide realistic insights that can improve suicide prevention and mental health services in Ethiopia.

Despite these strengths, the study also has several limitations. First, participants were recruited from clinical settings, meaning the study only included individuals who had access to mental health or medical services. Survivors who avoid treatment, lack access to care, or remain hidden due to stigma may have different experiences that were not captured in this study.

The clinical setting in which interviews took place may have introduced social desirability bias, with participants potentially tempering accounts of ongoing suicidality or dissatisfaction with care in the presence of a researcher affiliated with the clinical environment. The retrospective nature of the accounts also introduces the possibility of recall bias and narrative reconstruction, as participants described experiences that in some cases occurred months or years prior to the interview.

# CHAPTER 8: CONCLUSION

This study explored the lived experiences of suicide attempt survivors. The findings showed that suicide attempts developed within complex emotional, relational, social, and cultural contexts. Participants described intense hopelessness, emotional pain, loneliness, family conflict, feelings of burdensomeness, and struggles with being understood by others. Most survivors felt trapped in situations they believed would never improve, which contributed to their decision to attempt suicide. At the same time, the findings revealed the importance of emotional support, compassionate care, spirituality, and meaningful human connection in recovery.

The study also demonstrated that survivors' experiences extend far beyond the suicide attempt itself. Several participants continued to struggle emotionally even after surviving, while others gradually found meaning, hope, and motivation.

All in all, the findings show the importance of listening to survivors' voices when developing suicide prevention strategies and mental health interventions. Understanding the lived experiences of survivors can help healthcare professionals, families, and communities respond in more compassionate, culturally sensitive, and effective ways.

# CHAPTER 9: RECOMMENDATIONS

Health professionals should place greater emphasis on listening to and validating the emotional experiences of suicide attempt survivors. Most participants described feeling misunderstood, ignored, judged, or emotionally neglected before and after their attempts. This shows the importance of compassionate, non-judgmental, and empathetic communication during assessment and treatment. Survivors need to feel heard rather than criticized. Health professionals especially in emergency settings should therefore receive additional training on suicide-sensitive care, emotional validation, and trauma-informed approaches.

Hospitals and mental health institutions should strengthen follow-up care and psychosocial support for suicide attempt survivors. Dedicated post-attempt care pathways in hospitals need to established, starting at the point of emergency admission. This should include a psychological assessment before discharge, counseling, family support interventions, safety planning, and accessible a clear plan for ongoing community-based mental health support. Peer support programs involving individuals with lived experience may also help survivors feel less isolated and more understood.

The findings also show the need to address stigma surrounding suicide and mental illness in the society. Community awareness programs should focus on improving public understanding of emotional distress, suicidal behavior, and help-seeking. Families, schools, religious institutions, and communities should be educated about the importance of emotional support and open communication. Since majority of the participants discussed spirituality and faith as important parts of recovery, collaboration with religious leaders may also help reduce stigma and encourage compassionate responses toward survivors.

Policymakers should give greater attention to suicide prevention within the national mental health agenda. Suicide prevention strategies should include social, relational, and cultural factors such as family conflict, emotional isolation, unemployment, stigma, and lack of support. Mental health services should also become more accessible and affordable, particularly for vulnerable groups such as adolescents, unemployed individuals, and people living with severe psychological distress.

Future researchers should conduct larger qualitative studies involving participants from different regions and backgrounds. Research involving rural communities, individuals who do not seek treatment, and families of survivors could provide a broader understanding of suicidal experiences. Longitudinal studies may also help explore how survivors' thoughts, coping strategies, and meaning-making processes change over time. In addition, future studies can examine culturally appropriate intervention approaches that integrate psychological care, family involvement, and spiritual support.

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# APPENDIXES

## Annex A: Informed Consent

**Research Title**: Lived Experience of Suicide Attempt Survivors

**Researcher Information**: My name is Eman Seid, a second-year clinical psychology trainee at Tikur Anebessa Specialized Hospital, Addis Ababa University. I am conducting a research study for the partial fulfillment of my Master's degree in Clinical Psychology and this study has received ethical clearance from the Addis Ababa University and Amanuel Mental Specialized Hospital Institutional Review Board.

**Purpose of the Study**: The aim of this study is to explore the lived experiences of individuals who have attempted suicide. The research hopes to gain a deeper and more human understanding of your journey, including the psychological, emotional, and social factors involved, and to learn from your personal experiences. The findings may help inform support systems and future care strategies for others facing similar challenges in Ethiopia.

**Procedures**: If you agree to participate, you will be invited to take part in an individual interview, which will last approximately 50 to 60 minutes. The interview will include questions about your experience before, during, and after the suicide attempt and your reflections now. You will be encouraged to share your story in your own words. The interview will be conducted in a private and safe setting, and will be handled with great sensitivity and care. With your consent, the interview may be audio-recorded.

**Voluntary Participation and Right to Withdraw**: Your participation is entirely voluntary. You have the right to refuse to participate or to withdraw from the study at any time, without any penalty, explanation, or impact on any current or future services or care you may receive. You may also refuse to answer any question that you are not comfortable with.

**Potential Risks and Discomforts**: Participating in this study may lead to emotional discomfort or distress as the questions may touch on painful or sensitive memories. However, you are free to stop the interview at any point, skip any question, or take a break. A contingency plan is in place to handle emotional distress or risk. If you become distressed, you will be supported, and if needed, referred to mental health professionals for appropriate care and follow-up.

**Confidentiality and Data Protection:** All the information you provide will be kept strictly confidential. Your name or identifying details will not be used in any written report, thesis, or publication. Instead, your responses will be coded and anonymized. Audio recordings and transcripts will be stored securely and accessed only by the principal investigator. Confidentiality will only be breached if there is a risk of imminent harm to yourself or others, in which case safety will be prioritized in line with ethical standards.

**Benefits of Participation**: There are no direct financial or material benefits to you for participating. However, your contribution will help others better understand the lived experiences of suicide attempt survivors. This may influence how services are designed and how care is offered to others in similar situations. Some participants may also find emotional relief or validation in sharing their story.

**Support and Safety Measures**: After the interview, a short debriefing will be offered. Resources and referrals will be provided at the end of the interview in case you wish to talk to a mental health professional or need support.

**Consent Statement**

I confirm that the purpose, procedures, risks, benefits, confidentiality measures, and my right to withdraw at any time have been explained to me clearly and in a language I understand. I have been given enough time to consider my decision. I have had the opportunity to ask questions, and all of them have been answered. I voluntarily agree to participate in this research.

Participant Name: _____ Date_____ Signature _____

**Contact Information**

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## Amharic Version of the Informed Consent

**የትምህርት ምርምር ርዕስ፡** ራሳቸውን ለማጥፋት ሞክረው የተረፉ ሰዎች የሕይወት ተሞክሮ

**የምርምር አድራጊው መረጃ፡** ስሜ ኢማን ሰይድ ሲሆን፣ በአዲስ አበባ ዩኒቨርሲቲ በጥቁር አንበሳ ሆስፒታል የሁለተኛ ዓመት የክሊኒካል ሳይኮሎጂ ተማሪ ነኝ። ይህንን ጥናት የማካሂደው በክሊኒካል ሳይኮሎጂ የማስተርስ ዲግሪዬን ለመጨረስ ከሚያስፈልጉኝ መስፈርቶች አንዱን ለማሟላት ነው። ይህ ጥናት ከአዲስ አበባ ዩኒቨርሲቲ እና ከአማኑኤል የአእምሮ ስፔሻላይዝድ ሆስፒታል የኢንስቲትዩሽናል ግምገማ ቦርድ የሥነ-ምግባር ፈቃድ አግኝቷል።

**የጥናቱ ዓላማ፡** የዚህ ጥናት ዋና ዓላማ ራሳቸውን ለማጥፋት ሞክረው የተረፉ ግለሰቦች የኖሩበትን ልምድ መመርመር ነው። ምርምሩ የእርሰዎን የስነ-ልቦናዊ፣ ስሜታዊ እና ማህበራዊ ሁኔታዎችን ጨምሮ ጉዞዎትን በጥልቀት እና በስብዓዊነት ለመረዳት እንዲሁም ከእርሰዎ የግል ተሞክሮዎች ለመማር ያለመ ነው። የጥናቱ ግኝቶች በኢትዮጵያ ውስጥ ተመሳሳይ ችግር ለገጠማቸው ሌሎች ሰዎች የድጋፍ ስርዓቶችና የወደፊት የእንክብካቤ ስልቶችን ለማሻሻል ይረዳሉ።

**የአፈጻጸም ሂደት (ሂደቶች)፡** በጥናቱ ለመካፈል ፈቃደኛ ከሆኑ፣ ለብቻ በሚደረግ ቃለ-መጠይቅ ላይ እንዲሳተፉ ይጋበዛሉ። ቃለ-መጠይቁ ከ50 እስከ 60 ደቂቃዎች ያህል ሊወስድ ይችላል። ቃለ-መጠይቁ ከራስ የማጥፋት ሙከራው በፊት፣ በወቅት እና በኋላ ስላጋጠመዎት እንዲሁም አሁን ስላሉዎት ሃሳቦች ጥያቄዎችን ያካትታል። ታሪክዎን በራስዎ ቃል እንዲያካፍሉ ይበረታታሉ።

ቃለ-መጠይቁ ደህንነቱ በተጠበቀ ስፍራ የሚካሄድ ሲሆን፣ በእርሰዎ ፈቃድ፣ ቃለ-መጠይቁ በድምፅ ሊቀረጽ ይችላል።

**ፈቃደኝነት ላይ የተመሠረተ ተሳትፎ እና የመውጣት መብት፡** ተሳትፎዎ ሙሉ በሙሉ በፈቃደኝነት ላይ የተመሠረተ ነው። በማንኛውም ጊዜ ያለ ምንም ቅጣት፣ ማብራሪያ፣ ወይም በአሁኑ ወይም በወደፊት በሚያገኙት አገልግሎት ላይ ምንም ተጽዕኖ ሳይደርስብዎ በጥናቱ ውስጥ መካፈልን የመቃወም ወይም ለመውጣት ሙሉ መብት አልዎት። ምቾት የማይሰጥዎትን ማንኛውንም ጥያቄ ለመመለስም እምቢ ማለት ይችላሉ።

**ሊደርሱ የሚችሉ ጉዳቶች እና ምቾት ማጣት፡** በዚህ ጥናት መካፈል ጥያቄዎቹ ስሜታዊ የሆኑ ትዝታዎችን የሚነኩ ሊሆኑ ስለሚችሉ የስሜት ምቾት ማጣት ወይም ጭንቀት ሊያስከትል ይችላል። ሆኖም፣ በማንኛውም ጊዜ ቃለ-መጠይቁን የማቆም፣ ማንኛውንም ጥያቄ የመዝለል ወይም እረፍት የመውሰድ መብት አልዎት።

ጭንቀት ከተሰማዎ ድጋፍ ያገኛሉ፣ አስፈላጊ ከሆነም ለትክክለኛ እንክብካቤ እና ክትትል ወደ አእምሮ ጤና ባለሙያዎች ይላካሉ።

**ምስጢራዊነት እና የውሂብ ጥበቃ (የመረጃ ደህንነት)፡** የሚያቀርቡት መረጃ ሁሉ በጥብቅ ሚስጥራዊ ሆኖ ይቀመጣል። ስምዎ ወይም ማንነትዎን የሚገልጹ ዝርዝሮች በምንም ዓይነት የጽሑፍ ሪፖርት፣ የጥናት ወረቀት ወይም ህትመት ውስጥ

ጥቅም ላይ አይውሉም። በምትኩ፣ ምላሾችዎ በኮድ ተይዘው ስም-አልባ ይሆናሉ። የድምጽ ቅጂዎች እና ጽሑፎች በአስተማማኝ ሁኔታ ተቀምጠው በዋናው ተመራማሪ ብቻ ተደራሽ ይሆናሉ።

ሚስጢራዊነት የሚቋረጠው በእርሰዎ ላይ ወይም በሌሎች ላይ ጉዳት የመድረስ አደጋ ካለ ብቻ ሲሆን፣ እንዲህ ያለ ሁኔታ ሲያጋጥም ደግሞ በሥነ-ምግባር ደንቦች መሠረት ደህንነትዎ ቀዳሚ ይሆናል።"

**በጥናቱ የመሳተፍ ጥቅሞች፡** በጥናቱ ለመካፈል የሚያገኙት ቀጥተኛ የገንዘብ ወይም የቁሳቁስ ጥቅም የለም። ሆኖም፣ የእርሰዎ አስተዋጽዖ ሌሎች በራስ የማጥፋት ሙከራ የተረፉ ሰዎችን የኖሩበትን ልምድ በተሻለ ሁኔታ እንዲረዱ ይረዳል። ይህም አገልግሎቶች በሚሰጡበት መንገድ እና ተመሳሳይ ሁኔታ ውስጥ ላሉ ሌሎች የሚሰጠው እንክብካቤ ላይ ተጽዕኖ ሊያሳድር ይችላል። አንዳንድ ተሳታፊዎች ደግሞ ታሪካቸውን በማካፈል ስሜታዊ እፎይታ ወይም ማረጋገጫ ሊያገኙ ይችላሉ።

**የድጋፍ እና የደህንነት እርምጃዎች፡** ከቃለ-መጠይቁ በኋላ አጭር የሆነ የማጠቃለያ ውይይት ይቀርባል። ከቃለ-መጠይቁ መጨረሻ ላይ ከአእምሮ ጤና ባለሙያ ጋር መነጋገር ከፈለጉ ወይም ድጋፍ ከፈለጉ አስፈላጊ መረጃ ይሰጣሉ።

**የፈቃድ መግለጫ** (Consent Statement)

የጥናቱ ዓላማ፣ የአፈጻጸም ሂደት፣ አደጋዎች፣ ጥቅሞች፣ ምስጢራዊነትን ለመጠበቅ የተወሰዱ እርምጃዎች እና በማንኛውም ጊዜ ለመውጣት ያለኝ መብት በግልጽ እና በሚገባ በምረዳው ቋንቋ እንደተብራራልኝ አረጋግጣለሁ። ውሳኔዬን ለመወሰን በቂ ጊዜ ተሰጥቶኛል። ጥያቄዎችን የመጠየቅ ዕድል አግኝቻለሁ፣ እና ሁሉም ተመልሰዋል። በዚህ የምርምር ጥናት ውስጥ በፈቃደኝነት ለመካፈል ተስማምቻለሁ።

የተሳታፊው ስም፡ _____ ቀን፡ _____ ፊርማ፡ _____

የምስክሩ ስም፡ _____ ቀን፡ _____ ፊርማ፡ _____

## Annex B: Semi structured interview guide

**Section 1: Personal Background**

Date: _____ Identification Number: _____

**Demographic Information**

Age: _____ Sex: _____

Residence: _____ Religion: _____

Marital Status: _____ Educational Status: _____

Occupation: _____

**Clinical Information**

Diagnosis: _____ Duration after a Diagnosis was given: _____

Site of Treatment: _____ Treatment Duration: _____

Number of suicide attempt _____ When _____

Current State _____ (In remission/Partial remission)

**1. Before and During the Attempt**

1. Can you tell me about your experience of trying to end your life?
   *(Prompt: What happened, which method did you use, and how did you feel at that moment?)*
2. How would you describe your life before your attempt?
   *(Prompt: How were your relationships, work, daily life, or health at that time? Were there changes or stresses you remember?)*
3. What thoughts were on your mind leading up to the attempt?
4. How did you feel emotionally during the attempt?
   *(Prompt: Fear, sadness, anger, emptiness, relief, or something else?)*
5. Were there specific events or challenges that influenced your decision?
   *(Prompt: Loss, conflict, failure, financial struggles, illness, or other life challenges?)*
6. Did you tell anyone about your thoughts or feelings before the attempt? Why or why not?
7. What did you need most during that time that you didn't have?
8. If you've had more than one attempt, how would you describe each experience? Were there any differences or similarities between them?

**For Individuals with Psychosis**

- Have you ever experienced hearing voices or unusual beliefs?
  *(Prompt: How did these experiences affect your decisions? Did voices ever tell you to hurt yourself? Did you try to resist? How did that feel?)*

## 2. Reflections and Coping

1. Looking back, what do you feel were the deeper reasons behind your attempt?
   *(Prompt: Personal struggles, relationships, cultural or societal influences?)*
2. How did you feel about surviving?
3. What might have helped prevent your attempt at that time?
   *(Prompt: Emotional support, professional help, changes in circumstances?)*
4. What do you think could help prevent similar situations for yourself or others in the future?
   *(Prompt: Community resources, counseling, stronger relationships, awareness campaigns?)*
5. Since your attempt, what has been most helpful for your recovery?
   *(Prompt: Therapy, family or friends, faith, routines, medication, self-help strategies?)*
6. What challenges have been hardest to overcome?
   *(Prompt: Emotional struggles, stigma, financial issues, access to help?)*
7. How do you cope now when you experience thoughts or feelings similar to those before your attempt?
   *(Prompt: Talking to someone, distraction, spiritual/religious practices, self-care?)*

## 3. Social, Cultural, and Spiritual Contexts

1. How did people around you respond after your attempt?
   *(Prompt: Family, friends, health professionals—what felt supportive or unhelpful?)*
2. How did these responses affect you?
   *(Prompt: Did you feel supported, judged, misunderstood, or accepted?)*
3. How do you think your community or society understands or responds to suicide?
   *(Prompt: Acceptance, stigma, silence, misinformation?)*
4. Have you experienced stigma or misunderstanding related to your attempt?
   *(Prompt: From whom, and in what ways?)*
5. How do your cultural, religious, or spiritual beliefs shape how you understand your experience and recovery?
   *(Prompt: Have these beliefs changed over time? How important are they to your healing?)*

## 4. Meaning-Making and Closing Reflections

1. How do you make sense of your suicide attempt now?
   *(Prompt: Has your interpretation and understanding of the experience changed over time?)*

2. Has your sense of self or your relationships changed since the attempt?
   *(Prompt: How have these changes influenced your life and recovery?)*
3. What message would you give to someone going through something similar?
4. What would you like mental health professionals, communities, or policymakers to understand about suicide and recovery?
5. Is there anything else about your experience that you would like to share?

**5. Post-Interview Debriefing**

1. How are you feeling after this discussion?
2. Was anything in the interview difficult or upsetting?
3. Would you like to speak to a support person or mental health professional now?

## Amharic Version of the Topic Guide

**1. Before and During the Attempt**

1. ሕይወትዎን ለማጥፋት ስለሞከሩበት ተሞክሮ ሊነግሩኝ ይችላሉ? (ተጨማሪ ጥያቄ፡ ምን ተከሰተ፣ ምን ዓይነት ዘዴ ተጠቀሙ፣ እና በዚያ ቅጽበት ምን ተሰማዎት?)
2. ከሙከራዎ በፊት የነበረውን ሕይወትዎን እንዴት ይገልጹታል? (ተጨማሪ ጥያቄ፡ በዚያን ጊዜ ግንኙነቶችዎ፣ ሥራዎ፣ የዕለት ተዕለት ሕይወትዎ ወይም ጤንነትዎ እንዴት ነበር? የሚያስታውሷቸው ለውጦች ወይም ጭንቀቶች ነበሩ?)
3. ሙከራውን ለማድረግ ከመወሰንዎ በፊት በአእምሮዎ ውስጥ ምን ዓይነት ሀሳቦች ነበሩ?
4. በሙከራው ወቅት ምን አይነት ስሜት ነበር የተሰማዎት ? (ተጨማሪ ጥያቄ፡ ፍርሃት፣ ሀዘን፣ ቁጣ፣ ባዶነት፣ እፎይታ፣ ወይስ ሌላ ነገር?)
5. ውሳኔዎ ላይ ተፅዕኖ ያሳደሩ ክስተቶች ወይም ችግሮች ነበሩ? (ተጨማሪ ጥያቄ፡ ኪሳራ፣ ግጭት፣ ውድቀት፣ የገንዘብ ችግር፣ ሕመም፣ ወይም ሌሎች የሕይወት ፈተናዎች?)
6. ከሙከራው በፊት ስለ ሃሳቦችዎን ወይም ስሜቶችዎን ለሰው ነግረው ነበር? ከሆነ/ካልሆነ ምክንያቱ ምንድን ነው?
7. በዚያን ጊዜ በዚያ ሰዓት እንዲኖርዎት በጣም የፈለጉት ግን ያልነበረዎት ነገር ምን ነበር?
8. ከአንድ በላይ ሙከራ አድርገው ከሆነ፣ እያንዳንዱን ተሞክሮ እንዴት ይገልጹታል? በመካከላቸው ልዩነቶች ወይም ተመሳሳይነቶች ነበሩ?

### For Individuals with Psychosis

- ለሌሎች ሰዎች የማይሰማ ለእርስዎ ብቻ የሚሰማ ድምፅ ኖሮ ያወቃል? (ተጨማሪ ጥያቄ፡ ድምፅ መስማት በውሳኔ አሰጣጥዎ ላይ ተጽዕኖ ያሳደሩት እንዴት ነው? ድምጾቹ እራስዎን እንዲጎዱ ነግረውዎት ያውቃሉ? ለመቃወም የሞከሩባቸው ጊዜያት ነበሩ? ያ ምን እንዲሰማዎት አረገ?)

## 2. Reflections and Coping

9. ወደ ኋላ መለስ ብለው ሲመለከቱ፣ ከሙከራዎ በስተጀርባ የነበሩት ጥልቅ ምክንያቶች ምን ይመስልዎታል? (ተጨማሪ ጥያቄ፡ የግል ትግል፣ ግንኙነቶች፣ ባህላዊ ወይም ማኅበራዊ ተጽዕኖዎች?)
10. በሕይወት በመትረፍዎ ምን ተሰማዎት?
11. በዚያን ጊዜ ሙከራውን እንዳይፈጠር ለመከላከል ቢኖር ይረዳ/ ያግዝ ነበር ብለው ያስባሉ? (ተጨማሪ ጥያቄ፡ ድጋፍ፣ የባለሙያ እርዳታ፣ የሁኔታዎች ለውጥ?)
12. ለወደፊቱ እርስዎ ላይ ወይም ለሌሎች ላይ ተመሳሳይ ሁኔታዎች እንዳይከሰቱ ለመከላከል ሊረዳ ይችላል ብለው የሚያስቡት ነገር ምንድነው? (ተጨማሪ ጥያቄ፡ የማኅበረሰብ ምንጮች፣ የምክር አገልግሎት፣ ጠንካራ ግንኙነቶች፣ የግንዛቤ ማስጨበጫ ዘመቻዎች?)
13. ከሙከራዎ በኋላ፣ በማገገም ሂደት ውስጥ የረዳዎት ነገር ምንድን ነው? (ተጨማሪ ጥያቄ፡ ሕክምና፣ ቤተሰብ ወይም ጓደኞች፣ እምነት፣ የዕለት ተዕለት ተግባራት፣ መድኃኒት፣ ራስን የመርዳት ስልቶች?)
14. ለማሸነፍ በጣም አስቸጋሪ የሆኑት ፈተናዎች ምን ነበሩ? (ተጨማሪ ጥያቄ፡ ስሜታዊ ችግሮች፣ መገለል ፣ የገንዘብ ችግሮች፣ የእርዳታ ማግኘት?)
15. አሁን ከሙከራዎ በፊት ከነበሩት ጋር የሚመሳሰሉ ሃሳቦች ወይም ስሜቶች ሲያጋጥሙዎት እንዴት ይቋቋማሉ? (ተጨማሪ ጥያቄ፡ ለሰው መናገር፣ ትኩረትን ማዘናጋት፣ ሃይማኖታዊ ክንውኖች፣ ራስን መንከባከብ?)

## 3. Social, Cultural, and Spiritual Contexts

16. ከሙከራዎ በኋላ በዙሪያዎ ያሉ ሰዎች ምን አይነት ምላሽ ሰጡ? (ተጨማሪ ጥያቄ፡ ቤተሰብ፣ ጓደኞች፣ የጤና ባለሙያዎች? ያገዝዎት ነገር ምን ነበር? አጋዥ ያልነበረው ምንድን ነው?)
17. ምላሻቸው ምን ዓይነት ተጽዕኖ አሳደረ? (ተጨማሪ ጥያቄ፡ ድጋፍ ተሰምቶዎታል፣ ተፈርዶብዎታል፣ አልተረዱዎትም፣ ወይስ ተረድተዎታል?)
18. ማኅበረሰብዎ ራስን ማጥፋትን እንዴት ይረዳል ወይም ይመለከታል ብለው ያስባሉ? (ተጨማሪ ጥያቄ፡ ተቀባይነት፣ መገለል፣ ዝምታ፣ ተሳሳተ ግንዛቤ?)
19. ከሙከራዎ ጋር በተያያዘ መገለል ወይም በተለየ እይታ የመታየት ነገር አጋጥሞዎት ያውቃል? (ተጨማሪ ጥያቄ፡ ከማን፣ እና በምን መንገዶች?)
20. ባህላዊ፣ ሃይማኖታዊ ወይም መንፈሳዊ እምነቶችዎ የእርስዎን ተሞክሮ እና ለመዳን የሄዱበትን መንገድ በምን አይነት መልኩ ቀርጸውታል ብለው ያሰባሉ? (ተጨማሪ ጥያቄ፡ እነዚህ እምነቶች ከጊዜ ወደ ጊዜ ተለውጠዋል? ለፈውስዎ ምን ያህል አስፈላጊ ናቸው?)

## 4. Meaning-Making and Closing Reflections

21. አሁን ወደኋላ መለስ ብለው ሰተመለከቱ የራስ ማጥፋት ሙከራውን እንዴት ያዩታል? (ተጨማሪ ጥያቄ፡ የርስዎ ትርጓሜ እና መረዳት ከጊዜ ወደ ጊዜ ተለውጧል?)
22. ከሙከራው በኋላ ስለራስዎ የነበረዎት አመለካከት ወይም ግንኙነቶችዎ ተለውጠዋል? (ተጨማሪ ጥያቄ፡ እነዚህ ለውጦች ሕይወትዎ ላይ እና የማገገም ሂደትዎ ላይ ምን አይነት ተፅዕኖ አላቸው?)
23. ተመሳሳይ ነገር/ሁኔታ ውስጥ ላለፈ ሰው ምን መልእክት ይሰጣሉ?
24. የአእምሮ ጤና ባለሙያዎች፣ ማኅበረሰቦች ወይም የፖሊሲ አውጪዎች ስለ ራስ ማጥፋት እና የማገገም ሂደት ምን እንዲረዱ ይፈልጋሉ?
25. ስለ ተሞክሮዎ ማጋራት የሚፈልጉት ሌላ ነገር አለ?

## 5. Post-Interview Debriefing

26. በዚህ ቃለ መጠይቅ ተሞክሮዎትን ካካፈሉ በኋላ አሁን ምን እየተሰማዎት ነው?
27. በቃለ-መጠይቁ ውስጥ ከባድ የነበረ፤ የሚያስጨንቅ ወይም የሚረብሽ ነገር ነበር?
28. አሁን ከአንድ ድጋፍ ሰጪ አካል ወይም የአእምሮ ጤና ባለሙያ ጋር ማውራት ይፈልጋሉ?

# DECLARATION OF ORIGINAL WORK (THESIS)

I, the undersigned, declare that this thesis is my original work, where my work is indebted to the work of others, it has not been accepted or presented for a degree in this or any other university and that all sources of materials used for the thesis have been fully acknowledged.

If proven otherwise, I understand that appropriate actions will be taken based on the Senate Legislation of Addis Ababa University and the Guidelines provided by the Ministry of Education.

Name of Investigator: Eman Seid

Signature: _____

Date of submission: May 2026 GC

This thesis has been submitted to DOP with my approval as a supervisor

- Name and Signature of the first supervisor _____
- Name and Signature of the second supervisor _____