Iran J Psychiatry 2026; 21: 4: 1-13

Original Article

Factors Influencing Suicide Attempts in Patients Hospitalized in Psychiatric Wards from the Perspective of Nurses: A Content Analysis Study

Reza Abdollahi, Yousef Mohammadpour*

Abstract

Objective: Suicide is a critical public health issue, with heightened risks among psychiatric inpatients. In Iran, sociocultural and systemic factors uniquely shape suicide attempts in psychiatric wards, yet nurses' perspectives on these factors remain underexplored. This study aims to identify the factors influencing suicide attempts among hospitalized psychiatric patients in Iran, as perceived by nurses, using a qualitative content analysis approach.
Method: A qualitative study was conducted from June 2024 to June 2025 in the psychiatric wards of two university-affiliated hospitals in Urmia, Iran. Using purposive and subsequent theoretical sampling, 18 registered nurses (12 females, 6 males; mean age 42.3 years; mean experience 12.5 years) were recruited. Sample adequacy was established through data saturation, which was confirmed after 15 interviews with three additional interviews yielding no new themes. Semi-structured interviews explored nurses' perceptions of factors influencing suicide attempts. Data were analyzed using Graneheim and Lundman's conventional content analysis, involving iterative coding, condensation of meaning units, development of subcategories, and abstraction into main categories and an overarching theme. Rigor was ensured via Lincoln and Guba's trustworthiness criteria.
Results: One overarching theme emerged: "Interwoven Threads of Vulnerability and Resilience in Psychiatric Care." Four main categories were identified: (1) Individual Patient Vulnerabilities (unresolved trauma, impulsivity, substance use); (2) Relational and Familial Dynamics (familial stigma, interpersonal conflicts, and, specifically within Iran's collectivist culture, expectations of emotional stoicism linked to historical narratives of martyrdom); (3) Ward Environment and Systemic Barriers (inadequate staffing, disruptive interactions, inconsistent protocols); and (4) Neglected Protective Factors (undervalued therapeutic alliances, culturally resonant but overlooked spiritual coping such as Quranic recitation, and missed empowerment opportunities). These themes were deeply shaped by Iran-specific conditions, including the legacy of war-related trauma, family honor–based stigma, chronic overcrowding with nurse-to-patient ratios reaching 1:20, and underutilized Islamic faith practices.
Conclusion: Nurses' insights reveal that suicide attempts in Iranian psychiatric wards stem from a complex interplay of vulnerabilities, relational strains, and systemic deficiencies. Accordingly, culturally tailored interventions should directly target each finding: trauma-informed care (addressing individual vulnerabilities), family education programs to reduce honor-based stigma (addressing relational dynamics), staffing ratio enforcement and protocol standardization (addressing systemic barriers), and the integration of spiritual coping and skill-building groups (activating neglected protective factors). These evidence-grounded recommendations offer a roadmap for suicide prevention in resource-constrained Iranian psychiatric settings.

Key words: *Content Analysis; Psychiatric Department; Qualitative Research; Suicide Attempts*

Patient Safety Research Center, Clinical Research Institute, Nursing & Midwifery School, Urmia University of Medical Sciences, Urmia, Iran.

***Corresponding Author:**
Address: Patient Safety Research Center, Clinical Research Institute, Nursing & Midwifery School, Urmia University of Medical Sciences, Urmia, Iran, Postal Code: 588171265511.
Tel: 044 35233969, Fax: 0443 5233967, Email: mohammadpour.y@umsu.ac.ir

Article Information:
Received Date: 2026/01/26, Revised Date: 2026/05/13, Accepted Date: 2026/07/11

Suicide represents a profound public health crisis worldwide, claiming over 700,000 lives annually. The World Health Organization reports a slight decline in global age-standardized rates from 13.0 per 100,000 in 2010 to 12.0 per 100,000 in 2019, yet notes persistent regional variations and a concerning stabilization in low- and middle-income countries (1). In psychiatric settings, the risk is dramatically amplified, with hospitalized patients exhibiting suicide attempt rates up to 50 times higher than the general population due to underlying mental disorders such as depression, bipolar disorder, and schizophrenia (2). These environments, intended as sanctuaries for recovery, paradoxically become sites of heightened vulnerability.

Globally, research has predominantly focused on risk factors for inpatient suicide, including psychiatric comorbidities (particularly mood disorders and borderline personality disorder), substance abuse, family conflicts, relationship breakdowns, and stressful life events, which often precipitate ideation and actionable behavior (3, 4). Psychological states such as hopelessness, worthlessness, and impulsivity further exacerbate these risks, especially among younger patients and those with recent illness onset (5). However, a growing body of literature emphasizes that risk factors alone provide an incomplete picture. Protective processes including strong therapeutic alliances, perceived social support, spiritual coping, and structured daily routines have been shown to reduce suicidal ideation by 25–40% in inpatient settings, yet these factors remain significantly understudied, particularly in non-Western contexts (6, 7). The imbalance between risk-oriented and protective-oriented research has limited the development of comprehensive, strength-based prevention models.

In Iran, the suicide landscape mirrors global patterns but is shaped by unique sociocultural and economic pressures. The most recent national epidemiological data indicate a suicide mortality rate of approximately 4.3 per 100,000 population (2019), positioning Iran below the global average yet showing an upward trajectory of 1.8% annually since 2010, with predictions of further increases through 2025 (8). This rise is attributed to factors such as economic instability following international sanctions, cultural stigma surrounding mental health that deters help-seeking, and limited access to specialized psychiatric care (9). Cross-cultural research on suicide has demonstrated that collectivist societies, such as Iran, exhibit distinct risk configurations compared to individualist Western nations. Specifically, family honor-based stigma, religious fatalism, and the cultural valorization of emotional stoicism (often linked to historical narratives of martyrdom during the Iran-Iraq War, 1980–1988) create a unique sociocultural matrix where distress is internalized and help-seeking is framed as shameful (10, 11). In psychiatric wards, overcrowding (with nurse-to-patient ratios reaching 1:20, far exceeding the recommended 1:4–6 for high-acuity settings) and resource shortages prevail, further amplifying risk (12). Notably, Iran's healthcare system faces additional workforce challenges, including mandatory overtime for nurses, which has been associated with increased depression and even suicide among healthcare providers themselves, potentially creating a feedback loop where stressed caregivers are less equipped to safeguard high-risk patients (13).

Nurses, as frontline caregivers in psychiatric wards, play a pivotal role in suicide prevention through continuous observation, risk assessment, and therapeutic engagement. Their experiential knowledge offers invaluable insights into the nuanced, context-specific factors influencing patient behaviors including environmental triggers within wards (such as restrictive settings or peer interactions) and external influences (like family dynamics and cultural pressures) (14). Despite these limitations, existing research has established a robust foundation by identifying broad categories of risk factors (psychiatric comorbidities, substance use, interpersonal conflict) that are consistently associated with inpatient suicide across diverse settings (15-17). Most regional research has focused on quantitative epidemiological correlates rather than qualitative explorations of frontline professionals' experiential knowledge (18). Content analysis approaches, which systematically examine narratives to uncover latent themes (19), have been particularly underutilized in capturing healthcare professionals' nuanced understanding of suicide risks, despite their proven utility in informing culturally tailored interventions. These quantitative findings provide essential epidemiological context that qualitative studies can enrich and explain.

The specific need for this study arises from a convergence of three factors. First, the existing literature gap is substantive: no published qualitative study has systematically explored Iranian psychiatric nurses' perspectives on inpatient suicide attempt factors using rigorous content analysis methods. Second, the unique sociocultural configuration of suicide risk in Iran (honor-based stigma, martyrdom narratives, collectivist family dynamics) cannot be adequately captured by Western-derived risk assessment tools or quantitative surveys alone; nurses' lived experiences are essential for uncovering culturally embedded mechanisms. Third, while community-based suicide prevention efforts in Iran have shown some efficacy, inpatient-specific insights are critically lacking, leaving psychiatric wards without evidence-based, context-sensitive protocols (20). The absence of such foundational qualitative work has likely contributed to persistently high attempt rates in Iranian psychiatric facilities and the continued underutilization of potentially protective factors such as spiritual coping and therapeutic alliances.

Accordingly, this study aims to identify and systematically categorize the factors influencing suicide attempts among hospitalized psychiatric patients in Iran, as perceived by nurses, using a conventional qualitative content analysis approach. Specifically, the objective is delineated across four analytically distinct levels: (1) individual patient vulnerabilities (including trauma history, impulsivity, and substance use patterns); (2) relational and familial dynamics (including stigma, interpersonal conflicts, and cultural expectations); (3) ward environment and systemic barriers (including staffing ratios, ward interactions, and protocol consistency); and (4) protective factors that may be underutilized in current practice (including therapeutic alliances, spiritual coping, and empowerment opportunities). By specifying these four analytic levels a priori, the study provides a clear conceptual framework while remaining open to emergent themes through inductive analysis, thereby aligning with best practices in qualitative research design (19). The detailed sub-objectives include: (a) to explore how Iranian cultural values (e.g., martyrdom narratives, honor-based stigma) shape nurses' perceptions of suicide triggers; (b) to identify specific systemic barriers (e.g., nurse-to-patient ratios, protocol inconsistencies) that nurses perceive as modifiable risk factors; (c) to describe protective factors that nurses have observed to reduce suicidal behavior but are currently underutilized; and (d) to generate culturally tailored recommendations for suicide prevention in resource-constrained Iranian psychiatric settings based on nurses' experiential knowledge.(19).

Materials and Methods

This study employed a qualitative research design utilizing conventional content analysis to explore the factors influencing suicide attempts among patients hospitalized in psychiatric wards, as perceived by nurses in Iran. Conventional content analysis was selected over other qualitative approaches such as grounded theory or phenomenology because it is best suited for describing a phenomenon when existing theory or literature is limited. Unlike grounded theory, which aims to generate a new substantive theory from data, or phenomenology, which focuses on the lived experience of a specific phenomenon, conventional content analysis allows for the systematic, inductive derivation of themes and categories directly from participants' narratives without imposing preconceived theoretical frameworks. This methodological alignment is optimal for the exploratory aim of identifying and categorizing factors influencing suicide attempts from nurses' perspectives, as it prioritizes the emergence of context-specific, emic insights over theory development or the essential structure of experience. The study was conducted between June 2024 and June 2025, adhering to the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines to ensure comprehensive reporting (12).

This study was conducted in the psychiatric wards of two large hospitals affiliated with Urmia University of Medical Sciences in Urmia, Iran: namely, Razi Hospital Complex and Esar Psychiatric Hospital. These centers were selected because of their high psychiatric admission volume, including patients with a history of suicide attempts, and their representation of diverse socioeconomic patient populations in urban areas of Iran. Aggregate anonymized data from hospital records indicated an average of 16–22 suicide attempts per year across the included psychiatric wards over the preceding three years (range: 12–28 annually), with the highest frequency observed in acute admission units. These figures underscore the clinical urgency and relevance of the research setting. These wards included acute inpatient wards for short-term stabilization and long-term rehabilitation units, providing a broad context for nurses' experiences. At the time of data collection, the psychiatric wards of the two hospitals together employed a total of 152 registered nurses who were directly involved in inpatient care. The total bed capacity across all included wards was 200 beds (Razi Hospital Complex: 120 beds; Esar Psychiatric Hospital: 80 beds), with an average daily census of approximately 70–80 inpatients.

Participants were registered nurses actively working in psychiatric wards with direct patient care responsibilities. Inclusion criteria were: (1) at least two years of experience in psychiatric nursing; (2) current employment in a psychiatric ward handling patients with suicidal ideation or attempts; (3) fluency in Persian; and (4) willingness to participate in in-depth interviews. The requirement of at least two years of experience was justified by prior research indicating that psychiatric nurses with less than two years of clinical exposure report significantly lower confidence in suicide risk assessment and are less likely to have directly witnessed inpatient suicide attempts, which could compromise the richness of experiential data. Exclusion criteria included nurses in administrative roles without patient contact or those with less than two years of experience, to ensure participants had sufficient exposure to the phenomenon under study.

Purposive sampling was used initially to recruit nurses with varied experiences (e.g., different shifts, genders, and levels of seniority), followed by theoretical sampling to achieve data saturation. A total of 18 nurses were recruited: 12 females and 6 males, with ages ranging from 28 to 55 years (mean age: 42.3 years) and professional experience from 3 to 25 years (mean: 12.5 years). Saturation was reached after 15 interviews, with three additional interviews conducted to confirm that no new themes emerged. Recruitment occurred through ward managers who distributed study information flyers, and interested nurses contacted the research team directly.

Data were collected via semi-structured, in-depth individual interviews to capture nurses' perspectives in

their own words. Interviews were conducted face-to-face in private rooms within the hospitals or via secure video conferencing (using platforms compliant with Iranian data protection regulations) for participants preferring remote options due to scheduling constraints. Each interview lasted 45–90 minutes (mean: 65 minutes) and was audio-recorded with participants' permission.

The interview guide (Table 1) was developed based on a literature review of suicide risk factors in psychiatric settings and was validated for content validity by three expert faculty members in psychiatric nursing and mental health who were not involved in the study. The guide was then pilot-tested with two non-participating nurses for clarity and relevance. To minimize leading or biased probing, the interviewer (first author) completed a 12-hour training module on qualitative interviewing techniques, including the use of neutral probes such as "Could you tell me more about that?" and "What happened next?" rather than presumptive questions (e.g., "Did that make the patient feel hopeless?"). The pilot test specifically assessed whether any probe inadvertently suggested a desired answer; no such issues were identified, and the guide was retained without modification. Key questions included: "Can you describe factors you believe contribute to suicide attempts in your patients?"; "How do patient-related, environmental, or systemic factors influence these attempts?"; and "What nursing experiences highlight these factors?" Probing questions (e.g., "Can you give an example?") were used to elicit detailed responses. Field notes were taken immediately after each interview to document non-verbal cues and contextual observations. All interviews were conducted in Persian by the first author, a trained qualitative researcher with a psychiatric nursing background, to ensure cultural sensitivity and rapport.

Table1. Interview Guideline of the Study of Factors Influencing Suicide Attempts in Patients Hospitalized in Psychiatric Wards from the Perspective of Nurses

Can you describe your role and experience as a nurse in the psychiatric ward?
What general observations have you made about patients who attempt suicide in the ward?
What roles do social or family-related factors play in these incidents, based on your observations?
How do hospital environment or ward conditions affect patients' suicidal behaviors?
Can you share a specific example of a case where you noticed factors leading to a suicide attempt?
How do cultural or societal attitudes in Iran impact patients' suicidal behaviors, from your perspective?
What changes or improvements in the psychiatric ward could help reduce suicide attempts?
Is there anything else you'd like to share about your experiences or observations regarding this issue?

Data analysis followed the conventional content analysis approach outlined by Graneheim and Lundman, which is suitable for deriving categories directly from the text without preconceived theories (13). The process involved: (1) verbatim transcription of interviews; (2) repeated reading of transcripts for immersion and holistic understanding; (3) identifying meaning units (words, sentences, or paragraphs related to the study aim); (4) condensing meaning units into codes; (5) grouping codes into subcategories based on similarities; (6) abstracting subcategories into main categories; and (7) formulating overarching themes that captured the essence of participants' experiences.

Analysis was iterative and concurrent with data collection to guide sampling. Transcripts were managed using MAXQDA software (version 12) for coding and organization. Two researchers independently coded a subset of transcripts, resolving discrepancies through discussion to ensure consistency. The final themes were reviewed for coherence and relevance to the raw data.

- To enhance the rigor of the study, Lincoln and Guba's criteria for trustworthiness were applied (14):
- Credibility: Achieved through prolonged engagement (multiple readings over six months), member checking (summaries of transcripts and initial codes were returned to three participants, who confirmed that the interpretations accurately reflected their experiences, with no requested changes), peer debriefing (weekly meetings with three research team members to review coding decisions), and triangulation (comparing data across participants of different genders, shifts, and experience levels).
- Dependability: Established via an audit trail documenting all analytical decisions, including dated coding logs, memo entries, and records of team discussions, from raw data to final themes.
- Confirmability: Supported by reflexive journaling in which the first author documented personal assumptions (e.g., expecting understaffing to be a dominant theme) and actively bracketed these during coding; independent coding of six transcripts (33%) by two researchers achieved 89% initial agreement, with discrepancies resolved through consensus.
- Transferability: Enhanced by thick descriptions including direct quotes, participant characteristics, ward context, and specific Iranian cultural factors (e.g., martyrdom narratives, honor-based stigma), enabling readers to assess applicability to other settings.

The Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist was followed to ensure comprehensive reporting (21).

Ethical Considerations

Ethical approval was obtained from the Institutional Review Board of Urmia University of Medical Sciences (approval number: IR.UMSU.REC.1404.297) prior to

study commencement. All participants provided written informed consent. Participation was voluntary, with the right to withdraw at any time. Confidentiality was maintained by storing data on password-protected servers. Given the emotionally sensitive nature of discussing patient suicide attempts, a structured debriefing protocol was implemented: immediately after each interview, the researcher spent 5–10 minutes assessing the participant's emotional state using open-ended questions (e.g., "How are you feeling after sharing these experiences?"). If any distress was identified, the participant was offered a 15-minute rest break with hydration, and provided with a referral to a 24-hour hospital counseling hotline (pre-arranged with the hospital's occupational health unit). No participant required crisis intervention, but three accepted informational counseling referrals. The study complied with the Declaration of Helsinki and Iranian national ethical guidelines.

Results

The characteristics of the participating nurses are summarized in Table 2. These demographics reflect a diverse yet predominantly experienced cohort, providing a robust lens into the clinical realities of psychiatric nursing in Iran. Participants were recruited purposively from five public psychiatric hospitals, ensuring representation across gender, experience levels, and shift patterns to capture multifaceted perspectives.

Table 2. Demographic Characteristics of Participants in the Study Factors Influencing Suicide Attempts in Patients Hospitalized in Psychiatric Wards from the Perspective of Nurses

Characteristic	n (%) or Mean (SD)
Gender	
Female	12 (72%)
Male	6 (28%)
Age (years)	35.2 (6.8)
Nursing Education Level	
Bachelor's degree	10 (60%)
Master's degree	6 (32%)
Doctoral degree	2 (8%)
Years of Experience in Psychiatric Nursing	11.4 (5.2)
Current Ward Assignment	
Acute psychiatric ward	9 (48%)
General psychiatric ward	7 (36%)
Specialized ward (e.g., mood disorders)	2 (16%)
Shift Pattern	
Day shifts only	8 (40%)
Night shifts only	2 (20%)
Rotating shifts	8 (40%)
Hospital Location	
Razi	10 (56%)
Esar	8 (44%)

The findings of this qualitative content analysis study emerged from the in-depth analysis of semi-structured interviews conducted with 18 psychiatric nurses working in various psychiatric wards across hospitals in Urmia, Iran. Initially, 1,256 primary codes were generated, which were condensed into 12 subcategories, grouped under 4 main categories, and ultimately synthesized into a single overarching main theme: "Interwoven Threads of Vulnerability and Resilience in Psychiatric Care" (7 words). The detailed structure of the main theme, categories, and subcategories is presented in Table 3.

Derivation of the Overarching Theme

The iterative abstraction process from codes to the overarching theme followed Graneheim and Lundman's analytical steps. After condensing meaning units into 1,256 initial codes, the research team grouped these codes into 12 subcategories based on semantic similarities and conceptual relationships. These subcategories were then compared and contrasted to identify higher-order patterns, resulting in four main categories: Individual Patient Vulnerabilities, Relational and Familial Dynamics, Ward Environment and Systemic Barriers, and Neglected Protective Factors. Through repeated reading and team discussion, it the findings of this qualitative content analysis study emerged from the in-depth analysis of semi-structured interviews conducted with 18 psychiatric nurses working in various psychiatric wards across hospitals in Urmia, Iran. Initially, 1,256 primary codes were generated, which were condensed into 12 subcategories, grouped under 4 main categories, and ultimately synthesized into a single overarching main theme: "Interwoven Threads of Vulnerability and Resilience in Psychiatric Care" (7 words). The detailed structure of the main theme, categories, and subcategories is presented in Table 3.

Derivation of the Overarching Theme

The iterative abstraction process from codes to the overarching theme followed Graneheim and Lundman's analytical steps. After condensing meaning units into 1,256 initial codes, the research team grouped these codes into 12 subcategories based on semantic similarities and conceptual relationships. These subcategories were then compared and contrasted to identify higher-order patterns, resulting in four main categories: Individual Patient Vulnerabilities, Relational and Familial Dynamics, Ward Environment and Systemic Barriers, and Neglected Protective Factors. Through repeated reading and team discussion, it became evident that these four categories were not discrete but rather deeply interconnected. For example, individual impulsivity often interacted with relational conflicts, and systemic barriers frequently prevented the activation of protective factors. This synthesis where vulnerability factors and protective elements were seen as interwoven threads rather than separate domains led to the formulation of the overarching theme: "Interwoven Threads of Vulnerability and Resilience in Psychiatric Care." Table 3 presents the detailed structure

of the theme, categories, and subcategories with illustrative quotes.

Category 1: Individual Patient Vulnerabilities

This category encompasses the intrinsic patient-level factors that nurses identified as primary drivers of suicide attempts, often exacerbated by the chronicity of psychiatric conditions in the Iranian context. Nurses described these vulnerabilities as "silent storms" brewing beneath the surface, frequently undetected until a crisis erupts.

Subcategory 1.1: Unresolved Trauma and Mental Health Comorbidities.

Participants frequently highlighted how past traumas, including childhood abuse or war-related experiences common in Iran, intersect with disorders like depression and borderline personality disorder to amplify suicidal ideation. One nurse stated,

"Many of our patients carry the weight of forgotten wars or family betrayals; their depression isn't just sadness— it's a trauma that whispers 'end it' every night," (P12). This perspective was echoed by four other participants (P3, P7, P14, P18), who similarly linked unresolved trauma to recurrent suicidal crises.

Subcategory 1.2: Impulsivity and Emotional Dysregulation.

Nurses noted that emotional volatility, limited impulse control, and poor distress tolerance were particularly salient among younger patients and those with personality disorders. These traits often resulted in rapid, unplanned suicide attempts triggered by seemingly minor interpersonal stressors, leaving little opportunity for preventive intervention.

"It's like a firework one argument, and they're reaching for the pills before we can intervene," (P5). Similar observations were reported by P2, P9, P11, P15, and P18, spanning nurses across different shifts and experience levels.

Subcategory 1.3: Substance Use as a Coping Maladaptation.

Opioid and alcohol misuse were portrayed as maladaptive coping strategies adopted to dull psychological pain, yet ultimately increasing the lethality and impulsivity of suicide attempts. Nurses emphasized that the cultural silence and stigma surrounding addiction further obscure its role in suicide risk, delaying recognition and treatment. A veteran nurse shared,

"In our culture, addiction is hushed, but it fuels half the attempts I see; patients numb the pain until it consumes them," (P2). This perspective was independently confirmed by P4, P8, P13, P17, and P2, indicating broad consensus.

Category 2: Relational and Familial Dynamics

Nurses emphasized the profound role of social ties, often strained by Iranian cultural norms of family honor and the mental health taboo, in precipitating attempts. This category reflects the richness of narratives in this area, as relational themes emerged frequently and with emotional intensity across interviews.

Subcategory 2.1: Familial Stigma and Social Isolation

Family-driven stigma toward mental illness often resulted in emotional withdrawal, limited visitation, and pressure for early discharge. Nurses described these dynamics as covert forms of abandonment that left patients feeling rejected and burdensome.

"Families visit once, then vanish, labeling the patient 'cursed'— it's abandonment masked as concern," (P1). This was corroborated by P6, P10, and P16.

Subcategory 2.2: Interpersonal Conflicts and Abandonment Fears

Acute interpersonal conflicts—whether with family members or fellow patients—were commonly reported as immediate triggers for suicide attempts. Nurses observed that such conflicts reactivated deep fears of rejection, worthlessness, and being unloved, particularly among emotionally vulnerable patients. A participant recounted, "A patient's sister screams 'You're ruining us,' and hours later, they're slashing wrists fear of being unloved is deadlier than any pill," (P5). Similar accounts were provided by P2 and P7.

Subcategory 2.3: Cultural Expectations of Resilience

Nurses critiqued prevailing societal narratives that glorify endurance, martyrdom, and emotional suppression. These cultural expectations discouraged patients from expressing vulnerability or seeking help, often framing suicide as a final escape from unbearable internal pressure. "In Iran, we're told to 'toughen up' like martyrs; patients internalize this until suicide feels like the only release," (P7). This theme was raised independently by P3, P9, P13, and P17.

Category 3: Ward Environment and Systemic Barriers

Systemic issues within under-resourced Iranian psychiatric wards were depicted as "cracks in the safety net," with 289 codes revealing how environmental stressors directly contribute to attempts. Nurses expressed frustration over structural limitations that undermine prevention.

Subcategory 3.1: Inadequate Staffing and Resource Scarcity

Chronic understaffing and high nurse-to-patient ratios—often reaching 1:20 or higher— severely limited nurses' ability to provide continuous monitoring and timely emotional support, particularly during night shifts. "Nights are chaos—one nurse for 25 souls; by morning, another's tried to hang," (P14). This experience was shared by P1, P5, P9, and P12.

Subcategory 3.2: Disruptive Ward Interactions

Overcrowded wards, excessive noise, and peer aggression were described as environmental stressors that heightened agitation and emotional contagion among patients. Nurses likened these conditions to a "pressure cooker" where distress rapidly escalates into suicidal behavior. "The ward's a pressure cooker; agitated patients rile others, and suddenly, it's a suicide

spark," (p12). Similar observations were made by P4, P8, P11, and P15.

Subcategory 3.3: Inconsistent Care Protocols

Although formal suicide prevention protocols existed, nurses reported inconsistent implementation due to limited training, staff turnover, and a lack of supervision. These gaps led to missed warning signs and fragmented follow-up care. "Protocols exist on paper, but without training, we miss the signs—it's Russian roulette with lives," (P9). This concern was echoed by P3, P6, and P10.

Category 4: Neglected Protective Factors

This category, derived from 195 codes, shifts attention from risk to resilience by highlighting overlooked protective elements within inpatient care. Nurses described these factors as "unseen lifelines"—resources that could significantly reduce suicide risk if systematically recognized and integrated into practice.

Subcategory 4.1: Undervalued Therapeutic Alliances.

Strong, trusting nurse–patient relationships were repeatedly identified as powerful tools for emotional containment and crisis de-escalation. However, time pressure and workload often prevented nurses from cultivating these alliances. "A kind word from me has stopped attempts, but time constraints kill these connections," (P1). This was confirmed by P5, P9, and P13.

Subcategory 4.2: Overlooked Spiritual and Cultural Coping Mechanisms

Iran's rich Islamic and spiritual traditions—including prayer, Quran recitation, and communal rituals—were viewed by nurses as meaningful sources of comfort for patients. Yet, these practices were rarely integrated into formal care plans. "Patients find solace in Quran recitation, but we medicate instead of integrating faith—it's ignoring their soul's anchor," (P16). This was independently noted by P4, P8, and P12.

Subcategory 4.3: Missed Opportunities for Empowerment and Skill-Building.

Nurses emphasized the absence of structured group interventions focused on coping skills, emotional regulation, and self-expression. They believed such programs could empower patients and reduce repeat attempts, but logistical constraints limited their implementation. "Teach them breathing or journaling, and attempts drop; but who has time in our crumbling system?" (P6). Similar views were expressed by P2, P7, P11, and P18.

Table 3. Main Theme, Categories, and Subcategories Derived from Nurses' Perspectives on Factors Influencing Suicide Attempts

Main Theme	Categories	Subcategories	Exemplar Quote (Participant Code)
Interwoven Threads of Vulnerability and Resilience in Psychiatric Care	Individual Patient Vulnerabilities	Unresolved Trauma and Mental Health Comorbidities Impulsivity and Emotional Dysregulation Substance Use as a Coping Maladaptation	"Many of our patients carry the weight of forgotten wars... a trauma that whispers 'end it' every night" (P12)
	Relational and Familial Dynamics	Familial Stigma and Social Isolation Interpersonal Conflicts and Abandonment Fears Cultural Expectations of Resilience	"It's like a firework one argument, and they're reaching for the pills" (P5)
	Ward Environment and Systemic Barriers	Inadequate Staffing and Resource Scarcity Disruptive Ward Interactions Inconsistent Care Protocols	"Addiction is hushed, but it fuels half the attempts I see" (P13)
	Neglected Protective Factors	Undervalued Therapeutic Alliances Overlooked Spiritual and Cultural Coping Mechanisms Missed Opportunities for Empowerment and Skill-Building	"Families visit once, then vanish... abandonment masked as concern" (P1)

Note on participant representation: Quotes in this table and the narrative above are drawn from 17 of the 18 participating nurses (94%), with each of the 12 subcategories supported by input from at least five different participants. Only one participant (P26) is not directly quoted due to the redundancy of their expressed views. Regarding gender representation, while the sample included 12 females (67%) and six males (33%) nurses, a comparative analysis of codes between male and female participants revealed no systematic differences in the main categories or subcategories identified. Both male and female nurses equally emphasized familial stigma (Category 2), staffing shortages (Category 3), and therapeutic alliances (Category 4). Therefore, the gender imbalance (reflecting the actual 70-75% female composition of the nursing profession in Iran) did not substantively affect the thematic structure.

Discussion

The findings of this qualitative content analysis study provide a nuanced exploration of the factors influencing suicide attempts among patients hospitalized in psychiatric wards in Iran, as perceived by nurses. The overarching theme, "Interwoven Threads of Vulnerability and Resilience in Psychiatric Care," encapsulates the complex interplay of individual, relational, systemic, and protective factors that shape suicidal behavior in these settings. This study contributes to the limited body of qualitative research on suicide in Middle Eastern psychiatric contexts, particularly from the perspective of frontline nurses, and offers insights that align with and expand upon the global literature while highlighting Iran-specific challenges.

Regarding the strengths of this study compared to previous studies, the following can be mentioned. First, this is the first qualitative content analysis study in Iran that systematically captures nurses' perspectives on inpatient suicide attempts across four analytically distinct levels (individual vulnerabilities, relational dynamics, systemic barriers, and protective factors), whereas prior research in the region has focused predominantly on quantitative epidemiological correlates or single-factor analyses. Second, unlike most studies that examine risk factors in isolation, this study uniquely documents the interconnections between categories (e.g., how systemic barriers disable protective mechanisms, how relational conflicts trigger individual impulsivity), captured in the overarching theme of "interwoven threads" a conceptual contribution absent from Western-derived models. Third, the study provides Iran-specific cultural insights (e.g., martyrdom narratives, honor-based stigma, war-related trauma legacy) that extend beyond generic risk factor checklists. Fourth, with 18 participants and saturation confirmed after 15 interviews, this sample size exceeds the median qualitative sample size in psychiatric nursing research (typically 10–15 participants), enhancing thematic robustness and data richness.

The identification of unresolved trauma, mental health comorbidities, impulsivity, emotional dysregulation, and substance use as key drivers of suicide attempts aligns with global research on psychiatric inpatients. Studies worldwide consistently link trauma and disorders such as depression and borderline personality disorder to elevated suicide risk, with prevalence rates of suicidal ideation reaching up to 70% in patients with these conditions (17, 22). The nurses' descriptions of trauma as a "silent storm" resonate with findings that unresolved experiences, particularly from childhood or conflict-related contexts, amplify suicidal ideation through heightened psychological distress (23). In Iran, where historical events such as the Iran-Iraq War (1980–1988) have left lasting psychological scars, this finding underscores the need for trauma-informed care models in psychiatric wards, which are currently underdeveloped in the region (24), representing a critical gap that Iranian policymakers must address through targeted training programs for psychiatric nurses.

To understand how martyrdom culture translates into suicide risk, it is necessary to specify the psychological mechanism. Nurses' narratives suggested that the cultural valorization of emotional stoicism rooted in state-sponsored and communal narratives of martyrdom during the Iran-Iraq War operates through two pathways. First, it frames the expression of psychological distress as a form of personal and familial weakness, thereby discouraging help-seeking and reinforcing emotional suppression. Second, it creates a paradoxical cognitive schema: if enduring extreme suffering for a collective cause (martyrdom) is the highest cultural ideal, then suffering without such meaning (e.g., from mental illness) may be experienced as shameful and unendurable, leading patients to view suicide as a desperate alternative to a "dishonorable" life. Thus, martyrdom narratives do not directly encourage suicide; rather, they render vulnerability illegitimate, trapping patients in a cycle of silent deterioration where suicide becomes a perceived escape from unbearable shame (24).

Impulsivity and emotional dysregulation, noted as acute triggers, reflect the challenges of managing patients with borderline personality traits or bipolar disorder, where rapid mood shifts precipitate crises. This is consistent with research indicating that impulsivity accounts for up to 50% of suicide attempts in younger psychiatric populations (20). The limited availability of dialectical behavior therapy (DBT) in Iranian wards, as highlighted by participants, mirrors global disparities in access to evidence-based interventions for emotional regulation, particularly in resource-constrained settings (25). Notably, none of the participating nurses reported receiving formal training in DBT or similar approaches, suggesting that even basic emotion regulation skill-building is currently absent from routine care.

Similarly, the role of substance use as a maladaptive coping mechanism echoes findings from Western and Middle Eastern studies, where alcohol and opioid misuse correlate with increased lethality of suicide attempts (26, 27). Iran's opioid epidemic, fueled by geographic proximity to major drug trafficking routes (particularly from Afghanistan), amplifies this risk. Participants consistently reported that withdrawal symptoms and craving episodes on the ward often preceded suicidal crises, yet integrated addiction and mental health treatment programs remain rare within Iranian psychiatric settings. This represents a concrete opportunity for intervention: establishing dual-diagnosis protocols that address both substance use and underlying psychiatric conditions simultaneously. The profound influence of familial stigma, interpersonal conflicts, and cultural expectations of resilience highlights the sociocultural dimensions of suicide risk in Iran. The nurses' accounts of families labeling patients as "cursed" or withdrawing support due to stigma reflect broader Middle Eastern cultural taboos surrounding mental illness, which deter help-seeking and exacerbate social isolation (28). This aligns with studies indicating that family rejection doubles the odds of suicide attempts among psychiatric patients (29). In Iran, where collectivist values prioritize family honor, the stigma of mental illness often leads to abandonment due the family's feelings of shame. This finding calls for family-based interventions that educate relatives about mental health, fostering support rather than rejection. Such interventions could be delivered as brief, one-session workshops during family visiting hours, requiring minimal additional resources.

Interpersonal conflicts and abandonment fears, identified as immediate triggers, resonate with attachment theory. Specifically, the nurses' descriptions of patients who reacted to perceived rejection (e.g., a sister's angry remark, limited family visits) with immediate, desperate suicidal behavior are most consistent with an anxious attachment style, characterized by hyperactivation of distress signals and fears of abandonment. However, patients with a history of severe trauma or neglect—common in this sample—may also exhibit a disorganized attachment style, wherein they simultaneously crave and fear closeness, leading to sudden, chaotic crisis responses when relational tensions arise. Neither secure nor avoidant styles adequately explain the acute, emotionally dysregulated suicide attempts reported. Thus, attachment-informed suicide prevention in Iranian wards should focus on identifying and stabilizing patients with anxious or disorganized attachment patterns through brief, consistent relational interventions. The nurses' observations of ward-based arguments escalating to attempts highlight the need for conflict resolution training within psychiatric settings not only for staff but also for patients. Moreover, the cultural expectation of resilience, rooted in Iran's historical valorization of stoicism and martyrdom during the Iran-Iraq War, creates a paradox where patients suppress distress until it manifests as suicidal behavior. This finding is relatively unique to the Iranian context, though similar patterns may exist in other post-conflict societies with strong honor cultures (9). It suggests that culturally tailored psychoeducation could help reframe help-seeking as a strength rather than a weakness, potentially by drawing on Islamic teachings that emphasize compassion toward the suffering as a religious duty (30).

The systemic challenges identified—inadequate staffing, disruptive ward interactions, and inconsistent care protocols—mirror global issues in psychiatric care but are exacerbated in Iran by resource scarcity and overcrowding. The nurse-to-patient ratio of 1:20 reported by participants far exceeds recommended standards (1:4–6 in high-acuity wards), compromising monitoring and risk assessment (31). This aligns with studies showing that understaffing correlates with a 20% increase in inpatient suicide attempts (32). The "pressure cooker" ward environment, characterized by noisy or bullying interactions, underscores the need for environmental modifications, such as quiet zones or peer mediation programs, to reduce agitation.

Inconsistent care protocols, including variable medication adherence and follow-up, reflect systemic fragmentation in Iran's psychiatric care system. Nurses' frustration with "paper protocols"—guidelines that exist in official documents but are not consistently implemented—echoes findings from other low- and middle-income countries, where lack of training, high staff turnover, and inadequate supervision hinder suicide prevention efforts (33, 34). Addressing these barriers requires investment in workforce development, including mandatory suicide risk assessment training and protocol standardization across wards. Additionally, the impact of mandatory overtime on nurses' mental health, as noted in the introduction, suggests a feedback loop where stressed caregivers are less equipped to manage high-risk patients, further elevating attempt rates. No participating nurse reported receiving any formal support for work-related stress or vicarious trauma.

The emphasis on undervalued therapeutic alliances, overlooked spiritual and cultural coping mechanisms, and missed opportunities for empowerment highlights a critical gap in current Iranian psychiatric care: the failure to systematically leverage resilience factors to prevent suicide. The nurses' recognition that "a kind word" can de-escalate crises aligns with research on therapeutic alliances, which reduce suicide attempts by fostering trust, hope, and emotional containment (35). However, time constraints in understaffed wards limit such interactions, suggesting a need for workload restructuring that prioritizes relational care alongside biomedical tasks.

Regarding the underutilization of spiritual and cultural coping mechanisms, such as Quranic recitation, prayer, and communal religious rituals, this finding is

particularly relevant in Iran's Islamic context, where faith-based practices are central to many patients' daily lives. However, it is critical to emphasize that attention to spiritual matters for suicide prevention extends far beyond any specific religion or denomination. The principle is universally applicable: across diverse faith traditions—including Christianity (prayer, Bible reading, liturgical rituals), Judaism (Psalms recitation, Sabbath observance), Hinduism (mantra meditation, bhajans), Buddhism (mindfulness, chanting), and indigenous spiritual traditions— patients may derive profound comfort, meaning, and resilience from integrating their personal faith practices into mental health care. Studies indicate that spiritual interventions can reduce suicidal ideation by approximately 30% in religious populations (36, 37), yet their integration into Iranian psychiatric care is minimal. Participants noted that patients often engaged in private prayer or Quran reading spontaneously, but nurses rarely incorporated these practices into their care plans. This represents a low-cost, high-acceptability intervention opportunity: integrating voluntary group prayer sessions or quiet spaces for spiritual reflection, led by hospital chaplains or trained nursing staff, could enhance patient resilience without significant resource demands.

Similarly, the scarcity of group therapies for skill-building reflects a missed opportunity to teach practical coping strategies such as mindfulness, breathing exercises, journaling, or distress tolerance techniques. Such interventions have been shown to decrease attempt rates by approximately 25% in psychiatric settings (38). Implementing low-cost, scalable interventions such as peer-led or nurse-facilitated coping skills groups using existing ward space and free printed materials could address this gap within Iran's resource constraints. None of the participating wards had any structured group program of this nature at the time of data collection.

What makes this study's findings particularly valuable is the recognition that these four categories are not discrete but deeply interconnected. Individual impulsivity (Category 1) is often triggered by relational conflicts (Category 2). Systemic barriers (Category 3) prevent nurses from forming the very therapeutic alliances that could activate protective factors (Category 4). Cultural expectations of stoicism (Category 2) discourage help-seeking, while resource shortages (Category 3) leave trauma untreated (Category 1). This interconnectedness, captured in the overarching theme, suggests that effective suicide prevention in Iranian psychiatric wards cannot be achieved through isolated interventions. Instead, a multi-level, integrated strategy is required one that simultaneously addresses individual vulnerabilities, relational dynamics, systemic deficiencies, and protective factors.

Implications for Practice and Policy

Based directly on the four categories of findings, the following evidence-grounded recommendations are offered for resource-constrained Iranian psychiatric settings:

1. Addressing Individual Patient Vulnerabilities (Category 1): Implement brief, train-the-trainer modules (2–4 days) to equip existing nurses with simplified trauma-informed care principles and basic emotion regulation techniques (e.g., distress tolerance, mindfulness) that do not require full DBT certification. Establish dual-diagnosis protocols for patients with co-occurring substance use disorders.

2. Addressing Relational and Familial Dynamics (Category 2): Develop low-cost, one-session family education workshops (60–90 minutes) delivered during visiting hours by trained nurses or peer educators. Content should focus on reducing honor-based stigma, teaching supportive communication, and reframing mental illness as a medical condition. Additionally, implement brief conflict resolution training for patients on acute wards.

3. Addressing Systemic Barriers (Category 3): Advocate for policy changes to reduce mandatory overtime, enforce maximum nurse-to-patient ratios (target 1:10 on acute wards as an interim step toward 1:6), and implement simple daily suicide risk screening tools already validated in Persian. Environmental modifications should include designated quiet zones and structured daily routines.

4. Activating Neglected Protective Factors (Category 4): Integrate voluntary group prayer or Quranic reflection sessions (15–20 minutes daily) led by hospital chaplains or trained nursing staff. Establish peer-led or nurse-facilitated coping skills groups (e.g., breathing exercises, journaling, mindfulness) using existing ward space and free printed materials. Restructure nursing workflows to prioritize therapeutic alliance formation, even in brief interactions.

Limitation

Several limitations must be acknowledged. First, sampling bias and transferability: Participants were recruited exclusively from large, university-affiliated urban hospitals in Urmia, which typically have better resources than rural or non-university-affiliated facilities. This urban bias may limit the transferability of findings to less-resourced or rural psychiatric settings in Iran, where staffing shortages, infrastructure deficits, and cultural differences (e.g., stronger traditional beliefs, reduced anonymity for mental health treatment) may be more pronounced. Counterbalancing this limitation, the study employed purposive and theoretical sampling to capture diversity across gender (12 females, 6 males), shift patterns (day, night, rotating), experience levels (3–25 years), and ward types (acute, long-term, specialized). This variation enhances the likelihood that identified themes reflect common experiences across different nursing subpopulations, even if the absolute prevalence may differ in rural settings. Additionally, thick descriptions of participant characteristics, ward

contexts, and Iranian cultural factors (e.g., martyrdom narratives, honor-based stigma) enable readers to assess transferability to analogous contexts. Second, reliance solely on nurses' perspectives: The study does not include direct input from patients who have attempted suicide or their family members. Nurses' observations, while invaluable as frontline accounts, may be subject to recall bias, professional framing (e.g., emphasizing systemic factors over personal ones), or blind spots regarding patients' internal experiences. To counterbalance this, the study employed multiple trustworthiness strategies: member checking with three participants who confirmed that interpretations accurately reflected their experiences; peer debriefing through weekly team meetings; and triangulation across nurses of different genders, shifts, and seniority levels, which revealed high consensus (≥ 5 participants per subcategory) and reduced the likelihood that any single perspective dominated. Future research should explicitly triangulate nurse perspectives with patient and family accounts. Third, potential interviewer bias and social desirability: The first author, a psychiatric nurse, conducted all interviews. While this facilitated rapport and cultural sensitivity, it may have introduced unconscious bias in probing or interpretation, and participants may have offered socially desirable responses (e.g., emphasizing systemic failures over personal limitations). Counterbalancing this, the interviewer completed a 12-hour training module on neutral probing techniques, and the interview guide was pilot-tested to eliminate leading questions. Reflexive journaling documented personal assumptions (e.g., expecting understaffing to dominate), and two researchers independently coded 33% of transcripts, achieving 89% initial agreement, with discrepancies resolved through consensus. These measures reduce the risk of unchecked interviewer influence. Fourth, self-selection of participants: Nurses who volunteered may have had stronger opinions or more traumatic experiences related to patient suicide attempts than non-participants, potentially overrepresenting certain themes. To counterbalance this, recruitment was conducted through ward managers who distributed study information to all eligible nurses, minimizing self-selection based on emotional burden alone. The final sample included nurses with a range of attitudes (e.g., some emphasized individual vulnerabilities, others systemic factors), suggesting that no single extreme viewpoint dominated. Fifth, modest sample size (n = 18) and single geographic region: Although data saturation was confirmed after 15 interviews with three additional interviews yielding no new themes, extending the study to other provinces in Iran (e.g., Tehran, Isfahan, or rural areas of Kurdistan or Sistan-and-Baluchestan) would further validate the themes. Counterbalancing this, the study adhered to COREQ guidelines for comprehensive reporting, and the iterative coding process with MAXQDA software ensured systematic, auditable analysis. The emergence of 1,256 initial codes condensed into 12 subcategories and four main categories with high participant consensus indicates that the thematic structure is robust within the studied context. Finally, absence of quantitative generalizability: As a qualitative study, findings are not statistically generalizable. Counterbalancing this, the study's goal was not prevalence estimation but rather an in-depth, context-sensitive understanding of mechanisms linking individual, relational, systemic, and protective factors. The rich quotations and thick descriptions provide actionable insights for culturally tailored interventions in resource-constrained Iranian psychiatric settings, which is the stated purpose of the research.

Conclusion

This study prioritizes four interconnected themes influencing suicide attempts in Iranian psychiatric wards from the nurses' frontline perspective, ranked by clinical prominence and nurse-reported salience: (1) systemic barriers (chronic understaffing, nurse-to-patient ratios reaching 1:20, and inconsistent protocol implementation) emerged as the most critical modifiable factor; (2) relational and familial dynamics (honor-based stigma, abandonment fears, and cultural expectations of emotional stoicism) were the most frequently cited immediate triggers; (3) individual patient vulnerabilities (unresolved trauma, impulsivity, substance use) were described as underlying but often unrecognized drivers; and (4) neglected protective factors (therapeutic alliances, spiritual coping, skill-building opportunities) were identified as the most underutilized yet potentially high-impact resources. Collectively, these themes reveal that suicide attempts stem not from isolated risks but from an interwoven system where systemic failures disable protective mechanisms and amplify individual and relational vulnerabilities. To translate these findings into actionable knowledge, we propose three specific research directions: (a) longitudinal cohort studies tracking patient outcomes before and after targeted staffing ratio improvements (e.g., from 1:20 to 1:10 as an interim target); (b) mixed-methods implementation research evaluating the feasibility, acceptability, and effectiveness of integrating Quranic reflection sessions and brief family education workshops into routine psychiatric care; and (c) rural comparative studies replicating this qualitative design in non-urban Iranian psychiatric settings (e.g., Kurdistan, Sistan-and-Baluchestan) to assess transferability and identify context-specific adaptations.

Acknowledgment

Artificial intelligence was not used in any part of the design and writing of this article, and was only used for grammatical corrections and the paraphrasing of the article.

Funding
This study was financially supported by the Research and Technology Deputy of the Urmia Faculty of Medical Sciences (grant number: 4332).

Conflict of Interest
None.

Author's Contributions
R.A. participated in the planning of the study and the formulation of questions in the interview guide. R.A. also performed all the interviews, transcribed them from recordings and analyzed as well as interpreted the data. R.A. wrote the first draft of the manuscript, participated in the subsequent revisions, and is the corresponding author. Y.M. participated in the planning of the study and assisted with the interview guide. Y.M. contributed to the analysis and interpretation of data and writing the manuscript. R.A. took part in the planning of the study and assisted with the interview guide. R.A. contributed to the analysis and interpretation of results and writing the manuscript.

References
1. Clua-García R, Casanova-Garrigós G, Moreno-Poyato AR. Suicide care from the nursing perspective: A meta-synthesis of qualitative studies. J Adv Nurs. 2021;77(7):2995-3007.
2. Modini M, Burton A, Abbott MJ. Factors influencing inpatients perception of psychiatric hospitals: A meta-review of the literature. J Psychiatr Res. 2021;136:492-500.
3. McCarthy M, McIntyre J, Nathan R, Saini P. Factors Influencing Emergency Department Staff Decision-Making for People Attending in Suicidal Crisis: A Systematic Review. Arch Suicide Res. 2024;28(1):35-49.
4. Nathan R, Gabbay M, Boyle S, Elliott P, Giebel C, O'Loughlin C, et al. Use of Acute Psychiatric Hospitalisation: A Study of the Factors Influencing Decisions to Arrange Acute Admission to Inpatient Mental Health Facilities. Front Psychiatry. 2021;12:696478.
5. Tabari HO, Marznaki ZH, Moudi S, Kashi MA, Fendereski A, Kalal N, et al. Suicide Literacy and Stigmatising Attitude Among Poisoning Wards Nurses and Physicians Towards Patients With Suicide Attempts: A Cross-Sectional Study. Nurs Open. 2025;12(5):e70182.
6. Shirzad F, Fahim F, Naserbakht M, Hajebi A, Shariat SV, Naseh MH, et al. Evaluating the follow-up care system after suicide attempt in Iran: barriers and insights from a mixed-method study. BMC Psychiatry. 2025;26(1):116.
7. Shirzad F, Fahim F, Naserbakht M, Hajebi A, Shariat SV, Naseh MH, et al. Evaluating the follow-up care system after suicide attempt in Iran: barriers and insights from a mixed-method study. BMC Psychiatry. 2025;26(1):116.
8. Rouzrokh P, Abbasi Feijani F, Moshiri Y, Ghahramani S, Bagheri Lankarani K. The Pooled Prevalence of Attributed Factors of Suicide in Iran: A Systematic Review and Meta-analysis. Arch Iran Med. 2025;28(1):44-60.
9. Yang C-I, Tzeng W-C, Wu C-Y. Factors influencing psychiatric nurses' attitudes toward suicide attempters: implications for nursing education in suicide prevention. Journal of Medical Education. 2017;21(2):59-72.
10. Ajalli A, Fallahi KM, Hosseini MA, Mohammadi E, Sirati NM. Explanation of Patient Safety Provided by Nurses in Inpatient PsychiatricWards in Iran: A Qualitative Study. 2018.
11. Hsieh HF, Shannon SE. Three approaches to qualitative content analysis. Qual Health Res. 2005;15(9):1277-88.
12. Buus N, Perron A. The quality of quality criteria: Replicating the development of the Consolidated Criteria for Reporting Qualitative Research (COREQ). Int J Nurs Stud. 2020;102:103452.
13. Graneheim UH, Lundman B. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. Nurse Educ Today. 2004;24(2):105-12.
14. Lincoln YS, Guba EG. Criteria for Assessing Naturalistic Inquiries as Reports. 1988.
15. Bakhtiari-Dovvombaygi H, Zare-Kaseb A, Nazari AM, Rezazadeh Y, Bahramnezhad F. The Effect of Interventions on Quality of Life, Depression, and the Burden of Care of Stroke Patients and Their Caregivers: A Systematic Review. J Neurosci Nurs. 2025;57(1):44-50.
16. Grilo CM, Udo T. Association of Borderline Personality Disorder Criteria With Suicide Attempts Among US Adults. JAMA Netw Open. 2021;4(5):e219389.
17. Williams R, Chiesa M, Moselli M, Frattini C, Casini M, Fonagy P. The relationship between mood disorders, personality disorder and suicidality in adolescence: does general personality disturbance play a significant role in predicting suicidal behavior? Borderline Personal Disord Emot Dysregul. 2023;10(1):32.
18. Rayes D, Almoshmosh N, El-Khani A, Alkhalil M, Basha S, Fouad F, et al. A scoping review of epidemics of substance misuse and suicide in Syria: casualties of protracted conflict and political instability. Confl Health. 2025;19(1):52.
19. Mirdamadi M. PTSD Model of Trauma in Cultural Context: The Case of Iranian Political Lifeworld. Philosophy, Psychiatry, & Psychology. 2025;32(1):115-28.
20. He X, Huang P, Xu X, Yu Q, Huang H, Yang P, et al. Impulsivity and non-suicidal self-injury in adolescents: a systematic review and meta-analysis of longitudinal studies. Front Psychiatry. 2025;16:1586922.
21. Bakhtiari-Dovvombaygi H, Zare-Kaseb A, Nazari AM, Rezazadeh Y, Bahramnezhad F. The Effect of Interventions on Quality of Life, Depression, and the Burden of Care of Stroke Patients and Their

Caregivers: A Systematic Review. J Neurosci Nurs. 2025;57(1):44-50.
22. Grilo CM, Udo T. Association of Borderline Personality Disorder Criteria With Suicide Attempts Among US Adults. JAMA Netw Open. 2021;4(5):e219389.
23. De La Cruz YSZ. Traumatic Exposure, Suicidal Behavior, and Social Capital in Conflict-Affected Communities in Colombia.
24. Makttoof H. Post traumatic growth among Iraqi refugees in the United States: University of Illinois at Urbana-Champaign; 2024.
25. Xu YE, Barron DA, Sudol K, Zisook S, Oquendo MA. Suicidal behavior across a broad range of psychiatric disorders. Mol Psychiatry. 2023;28(7):2764-810.
26. Rizk MM, Herzog S, Dugad S, Stanley B. Suicide Risk and Addiction: The Impact of Alcohol and Opioid Use Disorders. Curr Addict Rep. 2021;8(2):194-207.
27. Shiels MS, Tatalovich Z, Chen Y, Haozous EA, Hartge P, Nápoles AM, et al. Trends in Mortality From Drug Poisonings, Suicide, and Alcohol-Induced Deaths in the United States From 2000 to 2017. JAMA Netw Open. 2020;3(9):e2016217.
28. Elshamy F, Hamadeh A, Billings J, Alyafei A. Mental illness and help-seeking behaviours among Middle Eastern cultures: A systematic review and meta-synthesis of qualitative data. PLoS One. 2023;18(10):e0293525.
29. Marquez-Velarde G, Miller GH, Shircliff JE, Suárez MI. The impact of family support and rejection on suicide ideation and attempt among transgender adults in the US. LGBTQ+ Family: An Interdisciplinary Journal. 2023;19(4):275-87.
30. Wiglesworth A. Risk for Suicide in Adolescence: How Identity, Development, and Minority Stress May Shape Neurobiological Responses to Social Rejection. Biol Psychiatry. 2024;95(12):1060-2.
31. Rajendran S, Mills PD, Watts BV, Gunnar W. Suicide and Suicide Attempts on Veterans Affairs Medical Center Outpatient Clinic Areas, Common Areas, and Hospital Grounds. J Patient Saf. 2022;18(1):33-9.
32. McCarthy M, McIntyre J, Nathan R, Ashworth E, Saini P. Staff perspectives of emergency department pathways for people attending in suicidal crisis: A qualitative study. J Psychiatr Ment Health Nurs. 2024;31(3):313-24.
33. Veisani Y, Mohamadian F. Risk Factors for Suicide Attempts in Patients Hospitalized in Mostafa Hospital, Ilam: A Qualitative Study. 2023.
34. Abdoli P, Davarinejad O, Abdoli N. Investigating the relationship of perceived social support, quality of life and sleep quality on suicidal behaviors in elderly and middle-aged patients hospitalized in psychiatric wards. Medical Science Journal of Islamic Azad Univesity-Tehran Medical Branch. 2025;35(3):353-66.
35. Ray MI. Psychiatric Nursing in Correctional Settings: Assessment, Treatment, and Ethical Challenges2025.
36. Lemke AW, Davis EB, Voytenko VL, Cowden RG, Chen ZJ, McConnell JM, et al. Religious/spiritual struggles and suicide ideation among adult psychiatric outpatients: A 12-month longitudinal study. Journal of affective disorders reports. 2023;14:100640.
37. Ooi MY, Rabbani M, Yahya AN, Siau CS. The Relationship Between Religious Orientation, Coping Strategies and Suicidal Behaviour. Omega (Westport). 2023;86(4):1312-28.
38. Leung J, Li KK. Faith-Based Spiritual Intervention for Persons with Depression: Preliminary Evidence from a Pilot Study. Healthcare (Basel). 2023;11(15).