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Traumatic experiences and coping strategies from the perspective of individuals who have repeatedly attempted suicide: A phenomenological study

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ABSTRACT

Background: Suicide is a complex and multidimensional public health problem that affects hundreds of thousands of people worldwide every year.
Objectives: This study was conducted to evaluate traumatic experiences and coping strategies from the perspective of individuals with repeated suicide attempts.
Methods: Using a phenomenological design from qualitative research methods, this study was conducted with 18 individuals with repeated suicide attempts. Criterion sampling method, one of the purposeful sampling methods, was used in the study. Interviews continued until data saturation was achieved. All interviews were recorded with a voice recorder and then transcribed. The research data were analyzed using Colaizzi's phenomenological method, and the research was conducted and reported in accordance with the COREQ (Consolidated Criteria for Reporting Qualitative Research) checklist.
Results: Three main themes (traumatic life events, psychological trauma and affect, coping strategies) and nine sub-themes (abuse, neglect, family dynamics, social problems, feelings of worthlessness and emptiness, anger and inner conflict, hopelessness and burnout, functional pathways, and hopeful steps) were obtained.
Conclusion: This study highlights the multidimensional nature of suicidal behavior by revealing that repeated suicide attempts are closely related to traumatic events experienced by individuals, intense emotional processes, and the coping strategies they use.

Introduction

Repeated suicide attempts are considered not only an indication of a temporary crisis but also of deepening psychosocial difficulties, psychological distress, and inadequate coping skills (O'Connor & Kirtley, 2018). Individuals with repeated suicide attempts are treated as a distinct clinical group in the literature because they exhibit higher risks of reattempt and death, as well as more severe psychopathology and social risk factors. Indeed, research indicates that a history of previous attempts is one of the strongest predictors of a new suicide attempt and that these individuals more frequently exhibit risk factors such as psychiatric disorders, hopelessness, and low social support (Pemau et al., 2024).

According to the reports of the World Health Organization (2023a, 2023b), an individual ends their life every 40 seconds and approximately 700,000 people die every year due to suicide (WHO, 2023a). This process, which usually occurs with a reaction of hopelessness, is followed by momentary suicidal thoughts. This process can then continue with detailed plans and attempts. Each untreated thought can be repeated frequently with more serious attempts, increasing its lethality (Park et al., 2020). Repeated suicide attempts are a situation that needs to be studied sensitively. Studies emphasize that individuals who attempt suicide more than once have a high rate of mental illnesses, personality pathologies, and substance use disorders (Abascal-Peiró et al., 2023).

Recent studies reveal that coping strategies used against stressful life events can directly affect the frequency and severity of suicidal thoughts (Al-Dajani et al., 2022; Stanley et al., 2021). Traumatic situations such

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as childhood neglect and abuse, feelings of worthlessness, stigmatization, inadequate support systems, and social exclusion may cause persistence or recurrence of suicidal thoughts in individuals (Laporte et al., 2023; Pan et al., 2024). However, while alternatives such as distracting activities, seeking social support, problem-solving skills, functional coping methods, etc., provide a decrease in suicidal thoughts in the short term, avoidant, suppressive, or self-harming coping styles stand out as a risk factor that maintains suicidal behavior (Burke et al., 2016; Porras-Segovia et al., 2022).

In this context, understanding how individuals attempt suicide and which coping strategies they adopt in this process is very important in terms of improving the quality of mental health services. Studies focusing on the subjective experiences of individuals with recurrent suicide attempts are limited in number, and the need for in-depth studies with qualitative methods continues (Harmer et al., 2024).

This study sheds light on the deep psychosocial dynamics behind suicidal behavior by examining the subjective experiences and coping strategies of individuals with repeated suicide attempts with a phenomenological approach. It is believed that the limited number of qualitative studies addressing recurrent suicide attempts in Turkey may be related to factors such as social stigma surrounding suicidal behavior, difficulties in reaching these individuals within the scope of research, and the sensitivity of ethical procedures. In this context, qualitative research aims to fill the gap in the literature by providing comprehensive and contextual data to understand the experiences of individuals who have made repeated suicide attempts, the traumatic events they have experienced, and the strategies they have developed to cope with these situations.

Methods

Type of research

Phenomenological design, a qualitative research method, was used in the study. COREQ was followed and reported throughout the study (Tong et al., 2007).

Population/sample of the study

The study sample consisted of cases of suicide attempts referred to the forensic medicine outpatient clinic of a teaching and research hospital in northern Turkey for the purpose of obtaining a forensic report. The sample consisted of individuals with repeated suicide attempts who met the inclusion criteria.

The criterion sampling method, one of the purposive sampling methods, was used to select the sample. The criterion sampling method is a sampling method in which the criteria are determined by the researcher, and all parameters that meet the criteria are considered (Yıldırım & Şimşek, 2021).

Research design

This study was conducted with 18 individuals who made repeated suicide attempts between October 2024 and March 2025. In-depth individual interviews were conducted with 18 individuals who met the inclusion criteria and agreed to participate in the study. Inclusion criteria: being over 18 years of age, agreeing to participate in the study, having made repeated suicide attempts, being mentally capable of understanding the questions asked, and not having any verbal, auditory, etc., disability that would prevent communication.

The research team and reflexivity

Two members of the research team were active faculty members (with PhDs) at a nursing school, while one member worked as a psychiatrist. Both researchers hold PhDs in psychiatric nursing, and the other researcher holds a PhD in clinical psychiatry. Both have experience working as clinical nurses in hospitals, and all three researchers have received training in qualitative research methods.

Data collection

The data form consists of three stages. In the first stage, questions to determine the socio- demographic information of the participants (age, gender, marital status, etc.), in the second stage, questions related to suicide, illness, etc. (number of suicides, method, presence of physical, mental illness, etc.), and in the third stage, six semi-structured open-ended questions to determine traumatic experiences and coping strategies. Data were obtained through face-to-face interviews in a separate room free of stimuli. In the interviews, open-ended questions were asked to determine the traumatic experiences and coping strategies of the individuals who made repeated suicide attempts, and they were asked to express their experiences on the subject. Continuous communication techniques were used, and all interviews were conducted by the first author. A voice recorder was used in the interviews, and the dialogues were transcribed verbatim after the interview.

Questions in the semi-structured interview form;

1. Can you tell us about your individual, familial, and social negative life experiences shortly before your suicide attempts?
2. Can you talk about your traumatic experiences in the past and the feelings and thoughts that these experiences created in you?
3. Can you talk about your thoughts and experiences about the meaning of life and your view of life before and after suicide?
4. Can you tell us about the psychological process you went through in relation to your suicide attempts and your experiences related to this process?
5. Can you talk about your coping experiences before and after suicide attempts?
6. What are your experiences with psychiatric support after suicide attempts?

Each interview was conducted individually in a single session and lasted approximately 35–45 min. Twenty patients referred to the forensic medicine clinic were invited to participate in interviews, and 18 were interviewed once data saturation was reached. The study was terminated when the data began to show repetition.

Data analysis

Colaizzi's seven-stage phenomenological method was used to analyze the data (Colaizzi, 1978). First, the interview dialogues were transcribed and then read and re-read independently by both the researcher and a faculty member experienced in qualitative research methodology. Important statements in the dialogues were selected and edited, and the data intended to be explained in the statements were identified and analyzed. They were discussed until the researchers reached consensus, and the meanings were formulated and approved. Subsequently, themes and sub-themes were identified, and the findings were presented to the participants to confirm the accuracy of the themes and content. Including participant statements allows readers to evaluate the interpretation and analysis of the data (Yıldırım & Şimşek, 2021).

Ethical aspects of the research

This study was approved by X University Scientific Research Ethics Committee (E53593568- 771-253100399) on 04.09.2024. Institutional permission was obtained from the relevant institution before the research. Written and verbal consent was obtained from the participants before the interview began. Recordings and transcripts are stored on a password-protected device (PC). The study was conducted in accordance with the principles of the Declaration of Helsinki. Participants were informed about the purpose and subject of the study, and that their personal information would remain confidential, that the records

obtained would not be shared, and that they would be used only for scientific purposes.

The interviews were conducted in a room at the outpatient clinic. To ensure safety during the interview, the interviewer was accompanied by a colleague. The interviews lasted 35 to 45 min. All interviews were conducted in Turkish, and audio recordings and field notes were taken. With the participant's consent, mental health professionals were informed prior to the interview. No professional expressed any reservations regarding their patients' participation in the study. To address any potential concerns during or after the interview, a clinical psychologist employed at the hospital was available to meet with the interviewers. Additionally, the interviewer called three weeks after the interview to inquire about the participants' well-being. In the event of adverse events, we consulted the corresponding author.

Results

The average age of the participants was 37.83 ± 9.83. 11 participants were female, 10 were high school graduates, and 10 had low economic status (Table 1).

The number of suicides of the participants ranged between 2 and 6 and the methods of suicide were as follows: taking drugs (15), cutting (6), jumping from a height (5), hanging (4), using a firearm (2), stabbing oneself (1), jumping under a vehicle (1), and jumping into the sea (1). However, some participants had more than one diagnosis of psychiatric illness. These were bipolar disorder (5), schizophrenia (5), alcohol and substance use disorder (6), anxiety disorder (2), depression (3), and borderline personality disorder (1). Participants were also diagnosed with physical illnesses: diabetes mellitus (5), goiter (3), hypertension (2), COPD (2), epilepsy (1) (Table 2).

As a result of the study, three main themes (traumatic life events, mental trauma and affect, coping strategies) and nine sub-themes (abuse, neglect, family dynamics, social problems, feelings of worthlessness and emptiness, anger and inner conflict, hopelessness and burnout, functional ways, hopeful steps) were obtained (Table 3).

Category 1. Traumatic life events

Within the scope of this theme, participants mentioned that they were exposed to different types of neglect and abuse during the suicide process and also mentioned problems related to family dynamics.

Theme 1. Abuse

Some of the participants reported having experienced abuse as a result of traumatic events.

> "My own uncle sexually abused me from the 1st grade. He sexually abused me by inserting his finger into my private area. This situation continued until the 4th grade. I started masturbating from a young age, and I still masturbate frequently. I cannot trust anyone. I could not kiss my father for years. Wherever I see a small child, I feel uneasy if anyone kisses or hugs them" (P4).

Theme 2. Neglect

Some participants reported experiencing neglect following traumatic events.

> "I have attempted suicide four times, and all of them were the result of traumatic events for me. Before my first suicide attempt, I was not being understood by my family, not being cared for, thinking that I was worthless, being oppressed, etc. Then I could not stand it, so I drank medicine. Later, during an argument with my brother, he used

Table 1
Socio-demographic information of the participants.

Participant number	Age	Gender	Education	Economic situation	Marital status	Place of residence	Employment status	Criminal record	Parental education level (mother/father)	
									Mother	Father
P.1.	41	Female	High School	Middle	Single	Center	Yes (worker)	No	Middle school	Primary School
P.2.	22	Female	High School	Bad	Single	Village	No	No	Primary School	Middle school
P.3.	42	Male	Primary School	Middle	Single	Center	Yes (worker)	Yes	Primary School	Middle school
P.4.	18	Female	High School	Middle	Single	Center	No	No	Primary School	Primary School
P.5.	48	Female	Primary School	Bad	Married	Village	No	Yes	Primary School	Primary School
P.6.	37	Male	High School	Bad	Married	Village	No	No	Primary School	Primary School
P.7.	31	Female	High School	Middle	Single	District	No	No	Primary School	Primary School
P.8.	35	Male	High School	Middle	Single	District	No	Yes	Middle School	Middle School
P.9.	54	Female	Middle School	Good.	Single	Center	No	No	Primary School	Primary School
P.10.	49	Female	High School	Bad	Single	Center	No	No	Primary School	Primary School
P.11.	46	Female	High School	Bad	Single	Center	No	No	Primary School	Primary School
P.12.	45	Male	High School	Bad	Single	District	No	Yes	Primary School	Primary School
P.13.	42	Male	Primary School	Bad	Single	Center	No	Yes	Primary School	Primary School
P.14.	34	Female	Middle School	Bad	Married	Village	No	Yes	Primary School	Middle School
P.15.	36	Male	Middle School	Bad	Single	District	No	No	Illiterate	Middle School
P.16.	46	Female	High School	Middle	Single	Center	No	No	High School	High School
P.17.	27	Male	University	Good	Single	Center	No	No	Primary School	Primary School
P.18	28	Female	Middle School	Bad	Single	Center	No	No	High School	Primary School

Table 2
Participants' knowledge about suicide and illness.

Participant number	Number of suicides for life	Suicide method	Diagnosis of mental illness	Diagnosis of physical illness
P.1.	2	Firearms, drinking, and drugs	Major depression	–
P.2.	4	Drinking drugs, jumping from heights, cutting your wrists	Alcohol substance use disorder + Borderline personality disorder	–
P.3.	3	Hanging, drugging, incision	Alcohol use disorder + Major depression	–
P.4.	3	Drinking medicine	Alcohol use disorder + Anxiety disorder	–
P.5.	2	Jumping from heights, drugs	Taking Bipolar disorder	Diabetes mellitus
P.6.	2	Hanging, drinking medicine	Alcohol use disorder	–
P.7.	3	Drinking medicine	Bipolar disorder	Goiter
P.8.	2	Incision, drinking medicine	Depression	–
P.9.	3	Drinking medicine	Schizophrenia	Goiter, diabetes mellutus, hypertension
P.10.	2	Hanging, drinking medicine	Schizophrenia	–
P.11.	5	Jumping from height, hang, cut	Schizophrenia	Goiter, diabetes mellutus, hypertension
P.12.	4	Jumping from a height, using a firearm, jumping under a vehicle, and using drugs	Alcohol use disorder	–
P.13.	5	Drinking medicine	Alcohol substance use disorder	–
P.14.	2	Jumping into the sea, cut	Anxiety disorder	–
P.15.	6	Stabbing yourself, taking drugs	Schizophrenia	Diabetes mellitus
P.16.	3	Drinking medicine	Bipolar disorder	Diabetes mellitus, goiter
P.17.	2	Do not slit your wrists	Bipolar disorder	COPD
P.18	2	Drinking medicine	Bipolar disorder	COPD, epilepsy

COPD: Chronic Obstructive Pulmonary Disease.

violence against me, but not just like that. He repeatedly kicked me in the stomach, swore at me, hit my head against the walls, then I jumped from a height " (P2).

Theme 3. Family dynamics

Some participants reported experiencing issues related to family dynamics stemming from traumatic events.

"When I think back, I remember my father used to beat my mother and then throw her out. There was constant unrest in the house. My

Table 3
Themes, sub-themes, and codes related to the subject.

Themes	Sub themes	Codes
1. Traumatic life events	A. Abuse	A.1. Physical abuse/domestic violence
		A.2. Emotional abuse
		A.3. Sexual abuse
	B. Negligence	B.1. Lack of love
		B.2. Indifference
		B.3. To be blamed
		B.4. Incompleteness
		B.5. Inadequacy
		B.6. Worthlessness
		B.7. Moral inadequacy
		B.8. Not being accepted
		B.9. Printing and control
	C. Family dynamics	C.1. Gambling
		C.2. Material losses
		C.3. Alcohol-matter
		C.4. Losses/loss of parents
		C.5. Loss of trust
		C.6. Not being understood
		C.7. Failure to meet expectations
		C.8. To deceive/be deceived
		C.9. Ingratitude
		C.10. Divorce
		C.11. Forced marriage
		C.12. Miscommunication
		C.13. Witnessing violence
	D. Social problems	D.1. Inadequate social support
		D.2. Being excluded
		D.3. Stigmatization
		D.4. Introversion
		D.5. Peer bullying
		D.6. Child labor
2. Mental trauma and affect	A. Feeling s of worthlessness and emptiness	A.1. Meaninglessness
		A.2. Internal collapse
		A.3. Being ignored
		A.4. Worthlessness
		A.5. Being unloved
		A.6. Alone
		A.7. Self-pity
	B. Anger and inner conflict	B.1. Being repressed
		B.2. Restlessness
		B.3. Skepticism
		B.4. To be under pressure
		B.5. Fear
		B.6. Anxiety
		B.7. Rebellion
	C. Hopelessness and burnout	C.1. Explosion
		C.2. Self-harm
		C.3. Insecurity
		C.4. Anxiety
		C.5. Pessimism
		C.6. Burnout
		C.7. Not being understood
		C.8. Despair
3. Coping strategies	A. Functional pathways	A.1. Art
		Painting/charcoal drawing/oil painting
		Music
		Writing poetry/composing songs
		A.2. Nature
		Meditation
		Walking
		Gardening
		A.3. Religious rituals
		Prayer
		Praying
		A.4. Professional support
	B. Promising steps	B.1. Receive training

(*continued on next page*)

Table 3 (*continued*)

Themes	Sub themes	Codes
		B.2. Focus on parenting
		B.3. Awareness
		B.4. Watching a movie
		B.5. Computer game
		B.6. Focus on cleanliness
		B.7. Handicraft/sewing
		B.8. Feeding stray animals

father did not trust my mother; he was jealous and suspicious. We also had economic problems. When I look back, I see unhappiness, worthlessness, a lost life " (P7).

"Not everything happens all at once, of course.... Experiences, losses, defeats, sometimes thoughts, maybe everything comes on top of each other, and you realize that you have hit rock bottom. My parents divorced when I was young, and my mother raised me. However, my father was never in my life. Some things were always missing.... Maybe life. I searched for meaning in lonely, incomplete, half-assed lives all my life. Family is so important that maybe this is what was missing in my life. "(P10).

Theme 4. Social problems

Some of the participants reported experiencing social difficulties as a result of traumatic events.

"When I was 10 years old, my family sent my sister and me to another city to weave carpets. My family was not at all interested. Until I was 16, I stayed in that city with my sister. I could not live my childhood. I got married when I was 16. At that time, our hands would hurt and even bleed from carpet weaving. I stayed there with my sister for years. We used to think that my family did not love us or did not want us. We used to get up very early in the morning and weave carpets until late at night. When I look back, I feel unloved and worthless, and I still feel very sad when I think about it" (P5).

Category 2. Mental trauma and affect

Participants talked about the emotional states they felt on the way to suicide and made various analogies in this context.

Theme 1. Feeling of worthlessness and emptiness

Some participants reported feeling worthless and empty.

"This process is like a long and thorny forest. The more you fight, the more you walk, the deeper you drown. It hurts you. Inner restlessness haunts you. Doubt swirls in your brain, and the thorns of life sting. Then you cannot cope, and you want to leave yourself in a dark void." (P11).

Theme 2. Anger and inner conflict

Some participants reported experiencing anger and inner conflict.

"I feel like a walking corpse. Actually, we are dying bye-bye. After this incident, life has no importance anymore. At that moment, I think, why didn't I kill them both? I wish I had." (P3).

Theme 3. Hopelessness and burnout

Some participants reported feeling hopeless and burned out.

The meaning of life for me has always been like a colorless balloon, a bird that cannot fly, a monochrome rainbow, ordinary and meaningless …. When I think about life before suicide, life was at rock bottom, and a depleted life is like the end of everything.

(P10)

Category 3. Coping strategies

Participants exemplified the alternative and functional coping methods they used to manage the suicide process healthily.

Theme 1. Functional ways

Some participants reported using functional coping strategies to manage their situation.

"I meditate. I listen to calming music, water sounds, forest sounds, etc. My father is a painter; he paints and sells very beautiful paintings, and I have a talent for painting. Spending time with myself and cultivating calmness and serenity are good for me."

(P18)

I received support. It progressed with medication for many years. I had occasional psychologist meetings. Apart from that, there were times when I was hospitalized during my previous suicide attempts. Intensive treatment processes helped me to get my head together after a while. However, loneliness hurts after a while. (K12).

Theme 2. Promising steps

Some participants have noted that they have taken encouraging steps to cope with their situation.

"I feed stray animals; for example, it does me a lot of good, it makes me happy. My father bought me a sewing machine. I sew sometimes. I work with charcoal and paint; I have an artistic side. I also write poems and compose songs." (P4).

Discussion

This study provides an in-depth examination of the life experiences of individuals who have made repeated suicide attempts, revealing the multidimensional nature and complexity of suicidal behavior. The findings indicate that suicide is not merely an individual psychiatric symptom, but rather a complex process shaped by traumatic life events, family dynamics, and the influence of the social environment. According to data from the World Health Organization (2021), while women attempt suicide more frequently than men, the rate of fatal cases is higher among men. Studies specific to Turkey also show similar results (Karaman, 2021).

The fact that most participants have a low socioeconomic status, low educational attainment, and lack job security supports the notion that suicidal behavior is linked to socioeconomic conditions. The literature indicates that among individuals with low income, reduced life satisfaction, limited coping strategies, and difficulty accessing social support increase the risk of suicide (García & Unger, 2021; Øien-Ødegaard et al., 2021). Low educational attainment also increases suicide risk, as it is associated with limited access to information and health literacy, as well as reduced life control, future expectations, and individual self-efficacy (Isaac et al., 2018; Montes-Hidalgo & Tomás-Sábado, 2016). The fact that most participants had been diagnosed with a psychiatric disorder is consistent with previous studies in the literature indicating that the vast majority of suicidal behaviors occur alongside a psychiatric diagnosis (Cavanagh et al., 2003; Franklin et al., 2017; Nock et al., 2021; Walker et al., 2020). Additionally, the participants' physical illnesses (hyperthyroidism, diabetes, COPD) suggest that comorbidity reinforces both the psychological burden and the perception of helplessness.

Traumatic life events

Traumatic life events, the first theme identified in the study, encompass multifaceted stressors such as physical, emotional, and sexual abuse; domestic neglect; issues related to family dynamics; and social exclusion. Participants' statements indicate that abuse and neglect experienced during childhood, in particular, have long-term effects on self-perception, a sense of trust, and interpersonal relationships. For example, P4's experience of sexual abuse was not limited to that period alone. However, it led to a diminished sense of trust, the development of emotional distance in social relationships, and intense anxiety reactions.

The literature indicates that exposure to physical, emotional, or sexual abuse during childhood significantly increases the risk of suicidal ideation and attempts in adulthood and is associated with a higher prevalence of trauma-related psychopathology and interpersonal trust issues (Angelakis et al., 2019).

Findings related to the theme of neglect include experiences of unmet emotional needs, feeling misunderstood, and feeling worthless. As P2 described, the individual's sense of not being understood within the family and being constantly criticized eventually led to intense feelings of hopelessness and helplessness. Research indicates that emotional neglect experienced in childhood undermines an individual's self-esteem, creating lifelong psychological vulnerability and serving as a significant risk factor for suicidal thoughts and behavior (Norman et al., 2012). Within the context of family dynamics, P7's constant exposure to an environment of violence and insecurity, and P10's feelings of emptiness, loss, and a search for meaning stemming from parental separation and the absence of a father figure, indicate that family conflict and low family functioning are associated with difficulties in emotional regulation in individuals (Picou et al., 2024). In terms of social issues, P5's child labor, lack of education, and early marriage experiences have led to a lack of social support and reduced life satisfaction. The literature indicates that social exclusion, poverty, and child labor have negative effects on mental health and serve as risk factors for suicide (World Health Organization, 2023b).

In general, traumatic experiences in the life histories of individuals who have made repeated suicide attempts often begin at an early age and accumulate across various areas of life, thereby increasing psychological vulnerability. This underscores the importance of adopting a holistic perspective when examining an individual's life history to understand suicide attempts.

Psychological trauma and emotional state

The second theme, psychological trauma and emotional state, reflects the participants' intense sense of loss, internal conflicts, and feelings of burnout. These emotions align with hopelessness, meaninglessness, and inner collapse—factors widely recognized as primary motivators of suicidal thoughts (Allen, 2022; Qiu et al., 2017).

The feelings of worthlessness and emptiness, as illustrated by P11's metaphor of a “long and thorny path,” indicate that the individual experiences life as an increasingly challenging, inevitable process of suffering. The literature indicates that feelings of worthlessness and emptiness are closely associated with suicidal ideation and behavior (O'Connor, 2016).

The theme of anger and inner conflict suggests that repressed anger and intense internal conflicts play a significant role in the suicide process (P3's statement, “feeling like a walking corpse”). The literature reports that suppressed anger and difficulties with emotional regulation reinforce suicidal ideation (Thomas Joiner, 2005).

The theme of hopelessness and burnout is supported by P10's description of life as a “colorless balloon and a bird that cannot fly.” The literature indicates that hopelessness is one of the strong psychological predictors of suicidal behavior and that the loss of positive expectations for the future significantly increases the risk of suicide (Ribeiro et al., 2018).

Coping strategies

The third theme, coping strategies, highlights the functional methods participants have developed to cope with challenging life conditions. Activities such as art, interaction with nature, and religious rituals enhance psychological resilience and reduce depressive mood (Mosqueiro et al., 2015; Roberts et al., 2019).

Seeking professional help and gaining awareness assists individuals in coping with themselves and their problems. Given that cultural and religious practices play a significant role in coping strategies in Turkey, interventions must be designed with cultural sensitivity in mind (Çinici, 2024; Ediz et al., 2024). In a study conducted with individuals who had made repeated suicide attempts, it was reported that while they preferred healthy coping methods such as communication with healthcare professionals and family support, they also resorted to dysfunctional methods such as substance use and social withdrawal (Hicks et al., 2025).

Participant P18's use of meditation, calming music, and artistic activities, along with K12's participation in professional support and long-term treatment processes, demonstrates that functional coping strategies are effective in psychological recovery. The literature indicates that performing arts interventions in suicide prevention programs support mindfulness, self-efficacy, and coping skills, and enhance psychological well-being (Davico et al., 2022). These findings highlight the critical importance of healthy coping with traumatic experiences and reducing suicide risk.

Conclusion

In conclusion, both socio-demographic disadvantages and clinical characteristics reveal the multifactorial nature of recurrent suicide attempts. The data of this study clearly demonstrate that mental health services should be planned by taking into account not only individual but also social, economic, and structural factors. In this context, it is necessary to facilitate access to mental health services, expand early intervention programs, and strengthen social support mechanisms.

Additionally, the findings highlight the importance of psychiatric nursing practices that include trauma-informed assessment, supporting coping strategies based on individuals' lived experiences, and ensuring continuity of care and follow-up.

Limitations

This study has certain limitations. The fact that the sample was selected from a forensic medicine clinic has both strengthened and limited the study's findings. Forensic medicine clinics typically include individuals who have undergone medical or legal procedures following suicide attempts. While this allows the sample to represent traumatic and high-risk cases, it may not include suicide attempts occurring outside the clinic, such as those with milder symptoms or in different sociocultural contexts. Participants may also have been cautious about sharing certain experiences due to concerns related to medical and legal contexts. However, individuals selected through the forensic medicine clinic provide reliable data in terms of case validity and the documentability of traumatic experiences. Therefore, the findings are valid for individuals experiencing recurrent suicide attempts but have limitations regarding generalizability to the general population.

The limited number of participants in the study and the use of qualitative methods restrict the statistical generalizability of the results. However, in-depth interviews have enabled a detailed, comprehensive understanding of participants' experiences. The prominence of subjective narratives may lead participants' accounts to be shaped by personal interpretations; particularly traumatic and emotionally intense experiences may result in exaggerations or omissions in the narrative. The influence of the social and cultural context on the study's findings constitutes another limitation; Turkey's sociocultural structure and family dynamics may limit the direct applicability of the results in different cultural contexts. Since the data obtained in the study are cross-sectional, it is not possible to track changes in long-term psychological processes and coping strategies.

Ethical aspects of the study

This study was approved by the Scientific Research Ethics Committee of X University (E53593568-771-253100399) on September 4, 2024.

CRediT authorship contribution statement

Nurten Gülsüm Bayrak: Writing – review & editing, Writing – original draft, Visualization, Validation, Resources, Methodology, Formal analysis, Data curation, Conceptualization. **Sevda Uzun:** Writing – review & editing, Supervision, Methodology, Formal analysis, Data curation, Conceptualization. **Halil İlhan Aydoğdu:** Writing – review & editing, Writing – original draft, Resources, Methodology, Conceptualization.

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Declaration of competing interest

The authors declare that they have no known conflicts of interest or personal relationships that could influence the work reported in this article.

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