

Exploring the Underlying Causes and Contextual Determinants of Suicide Among Adolescents Under 19 Years of Age in Dezful, Iran: A Qualitative Study (2024–2025)

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Abstract

Background

Suicide is a major global public health concern and one of the leading causes of death among adolescents worldwide. Despite the increasing prevalence of suicidal behaviors among young people, limited evidence exists regarding the contextual and sociocultural factors influencing adolescent suicide in southwestern Iran. This study aimed to explore the underlying causes and contexts of suicide among individuals under 19 years of age in Dezful, Iran.

Materials and Methods

This qualitative study was conducted in 2024–2025 using purposive and convenience sampling methods. Thirty-one participants were recruited, and data were collected through in-depth semi-structured interviews. All interviews were audio-recorded, transcribed verbatim, and analyzed manually using an inductive–deductive thematic analysis approach. Data collection continued until thematic saturation was achieved. Measures to ensure rigor and trustworthiness were applied throughout the study.

Results

Nine major themes emerged from the analysis: family violence and domestic adversities, identity crises, poverty and economic hardship, psychiatric disorders and emotional distress, substance abuse, emotional trauma and maladaptive interpersonal relationships, sociocultural pressures and social harms, spiritual and religious crises, and structural and systemic challenges. The findings revealed that adolescent suicide is a complex and multidimensional phenomenon shaped by interacting psychological, familial, social, economic, and cultural factors.

Conclusions

The findings underscore the urgent need for comprehensive and culturally sensitive suicide prevention strategies targeting adolescents. Policymakers and healthcare authorities should strengthen educational, psychosocial, economic, and legal support systems to create safer and more supportive environments for young people and reduce the burden of adolescent suicide.

Introduction

The term “suicide” derives from the Latin *sui* (“self”) and *caedere* (“to kill”) and denotes a conscious, voluntary act in which an individual ends their own life through a lethal action (1). Today, suicide is recognized as one of the most pressing global public health challenges, with far-reaching consequences

at the individual, family, social, and economic levels (2). A suicide attempt refers to a deliberate act of self-harm or excessive ingestion of medication or substances carried out without the intervention of others (3). This behavior is not necessarily accompanied by a clear intent to die; rather, it may represent an attempt to express psychological distress, seek attention, or alter the way others perceive and respond to the individual (4). Nonetheless, a suicide attempt is one of the strongest risk factors for completed suicide and demands serious attention from health systems and mental health policymakers (5). The impact of suicide on societies and health systems is profound. According to global estimates, approximately 700,000 people die by suicide each year—a figure that surpasses the death toll of many wars (6). Moreover, suicide is a leading cause of death among adolescents and young adults, contributing substantially to the global burden of disease and to psychosocial harm. Adolescents are particularly vulnerable to high-risk behaviors and suicidal thoughts because they are navigating a critical period of identity formation, emotional regulation, and social development (7). Research has shown that the factors influencing suicide are multidimensional and can be broadly divided into individual and environmental categories. Environmental factors include inadequate access to mental health services, social and economic pressures, exposure to violence, peer influence, and media portrayals of suicide. Individual factors encompass predisposing, mediating, and precipitating elements, each of which can contribute to the development of suicidal ideation and behavior. In addition, psychiatric disorders, feelings of hopelessness, social rejection, bereavement, chronic physical illness, guilt, and helplessness are among the most critical risk factors for suicidal behavior (8). In recent years, the suicide rate in Iran has shown an upward trend, reaching approximately 9.4 per 100,000 population (9). Although Iran still ranks among countries with a moderate suicide rate relative to many other nations, the geographic distribution of suicide within the country is uneven. National reports indicate that provinces such as Ilam, Kermanshah, Hamedan, and Khuzestan carry a higher suicide burden, while the provinces of Tehran and Fars report the highest absolute numbers of cases. This upward trend, particularly among adolescents and young people, further underscores the need to identify the social, cultural, and psychological factors underlying suicide (10). Despite the alarming rise in suicide rates in Iran—especially in provinces such as Khuzestan—the existing evidence is derived largely from quantitative and epidemiological studies and offers limited insight into the lived experiences, family contexts, cultural factors, and social processes that shape suicidal behaviors in adolescents. Moreover, no comprehensive qualitative study focusing on adolescents under 19 years of age has been conducted in Dezful County. Because adolescence is a sensitive period for psychological, social, and identity development, and the contextual factors contributing to suicide during this period may be shaped by region-specific cultural and social characteristics, a deeper understanding of these factors is essential for designing evidence-based preventive interventions and policies. The present study was therefore conducted to explore the causes and contexts of suicide among adolescents under 19 years of age in Dezful County during 2024–2025, drawing on the experiences and perceptions of individuals with a history of suicide attempts.

Material and Methods

Study Design and Participants

This qualitative study employed a conventional content analysis approach based on the method of Graneheim and Lundman (11) to explore the causes and contexts of suicide in adolescents under 19 years of age. Participants were selected from individuals referred to Dezful General Hospital in Dezful, Iran, following an unsuccessful suicide attempt. A purposive and convenience sampling strategy was used, and recruitment continued until data saturation was achieved. A total of 31 participants were enrolled, all of whom completed in-depth semi-structured interviews. Inclusion criteria comprised willingness to take part in the research, experience of a suicide attempt, the ability to reflect on personal experiences, the capacity to communicate and articulate those experiences, and readiness for the interview and any subsequent follow-up. Participants who became unwilling to proceed during the interview or whose mental or physical condition made continuation inappropriate were withdrawn. All participants were free to withdraw from the study at any stage without any consequence for their ongoing treatment.

Research Setting and Interview Characteristics

Data were collected between 2024 and 2025. Interviews were conducted face-to-face, according to participants' preferences, in a calm, safe environment grounded in mutual trust. The interview location was chosen based on participants' wishes and was primarily the psychiatrist's office. In some cases, and with prior consent, parents or spouses were also interviewed to enrich the data. The interviews were carried out by a research team with expertise in psychiatry and health in disasters and emergencies. All team members had prior experience in qualitative research and in-depth interviewing. A supportive, confidential, and non-judgmental atmosphere was intentionally cultivated to enable participants to express their experiences and feelings freely. Interview duration varied according to the participant's condition and the depth of information shared.

Data Collection

Before the interviews, participants received a full explanation of the study's aims, procedures, confidentiality protections, data handling, and the voluntary nature of their participation. They were assured that declining to participate would not affect their treatment or services, and that no costs would be incurred. Written informed consent was then obtained from all participants. Data were gathered through in-depth semi-structured interviews, each beginning with the open-ended question: "If you were to describe a day in your life, how would you describe it?" Probing questions were subsequently posed to gain deeper insight into participants' experiences, emotions, family relationships, social circumstances, and the contexts surrounding the suicide attempt. All interviews were audio-recorded with permission and transcribed verbatim immediately after each session. Field notes were also recorded throughout data collection to capture the interview atmosphere and participants' non-verbal reactions.

Data Analysis

Data analysis was conducted concurrently with data collection and was performed manually. Using the conventional content analysis approach of Graneheim and Lundman (11), the researchers read the transcripts repeatedly to achieve a thorough understanding of the material. Meaning units were identified, condensed, and coded. Similar codes were then grouped into subcategories and categories, from which the main themes were ultimately derived. The analysis followed an inductive–deductive logic: concepts and themes emerged from the data, while continuous reflection and constant comparison among data, codes, and categories refined the process. Data collection and analysis ceased when no new information emerged and conceptual saturation was reached.

The analytical steps were as follows:

1. Verbatim transcription of interviews immediately after each session;
2. Repeated reading of transcripts to obtain an overall sense of the data;
3. Identification of meaning units and extraction of initial codes;
4. Classification of similar codes into subcategories and categories;
5. Extraction and articulation of the main themes.

Rigor and Trustworthiness

Trustworthiness was established using the criteria of credibility, dependability, confirmability, and transferability proposed by Guba and Lincoln (12). To enhance credibility, the researchers employed prolonged engagement with participants, member checking, and peer review; sampling also continued until data saturation was achieved. Confirmability and dependability were strengthened by having the interview transcripts, initial codes, and categories reviewed by team members and a faculty expert in qualitative research, with revisions made accordingly. Transferability was supported through method triangulation (interviews and field notes) and maximum variation sampling in terms of sex, educational level, social status, and type of family relationships. Throughout analysis, the researchers consciously monitored their preconceptions and potential biases, ensuring the findings remained grounded in the participants' actual experiences. The research team comprised a psychologist, a psychiatrist, a general practitioner, and a specialist in health in disasters and emergencies, all of whom had experience in qualitative inquiry and clinical work with patients exhibiting self-harm and suicidal behavior. This clinical and contextual familiarity facilitated a deeper comprehension of participants' experiences and eased the interview process. To mitigate bias, data analysis was firmly rooted in participants' narratives, and the coding and theme development processes were continuously reviewed, compared, and discussed among team members to prevent the imposition of individual viewpoints. Member checking and peer review were employed at multiple stages to further enhance the confirmability and dependability of the findings.

Ethical Considerations

This study was conducted at Dr. Ganjavian Teaching and Research Hospital in Dezful, Iran, and was approved by the Ethics Committee of Dezful University of Medical Sciences (Ethics code: IR.DUMS.REC.1403.041). In addition to the routine general consent obtained at hospital admission, separate written informed consent for study participation was obtained from the parent or legal guardian of each participant younger than 18 years, together with the participant's assent when appropriate to their age and level of understanding. Participants and their parents or legal guardians were informed about the study objectives and procedures, confidentiality, the voluntary nature of participation, and the right to decline or withdraw without any effect on the care or services received. All data were de-identified and handled confidentially throughout the study.

Results

In this study, in-depth interviews were conducted with 31 adolescents who had a history of unsuccessful suicide attempts. Participants ranged in age from 13 to 18 years. The majority were female, single, and living in rural areas. Most had either lower or upper secondary education. Most participants were unemployed; a smaller number were engaged in manual labor, agriculture, or housekeeping. The demographic and background characteristics of the participants are presented in Table 1.

Table 1
Characteristics of demography and background information

Number	Age	Sex	Marital status	Residence status	Education level	Job
1	18	M	Single	Village	High school	Worker
2	17	F	Single	City	High school	Unemployed
3	18	F	Single	City	High school	Worker
4	18	F	Single	City	High school	Unemployed
5	18	M	Single	Village	High school	Unemployed
6	16	F	Single	Village	High school	Unemployed
7	14	F	Single	Village	Middle school	Unemployed
8	17	F	Single	City	High school	Unemployed
9	17	F	Single	City	High school	Unemployed
10	14	F	Single	City	Middle school	Unemployed
11	18	F	Married	Village	Middle school	Housewife
12	15	F	Single	Village	Elementary	Farmer
13	14	F	Single	Village	Elementary	Unemployed
14	18	F	Single	Village	Middle school	Farmer
15	17	F	Single	City	High school	Unemployed
16	15	F	Single	Village	Middle school	Unemployed
17	17	F	Single	Village	High school	Unemployed
18	18	M	Single	City	Middle school	Worker
19	14	F	Married	Village	Middle school	Unemployed
20	16	F	Single	Village	High school	Unemployed
21	13	F	Single	City	Elementary	Unemployed
22	18	M	Single	Village	High school	Unemployed
23	18	M	Single	Village	High school	Unemployed
24	17	M	Single	Village	High school	Unemployed
25	14	F	Single	Village	Middle school	Unemployed
26	18	F	Single	City	High school	Unemployed
27	13	F	Single	City	Middle school	Unemployed

Number	Age	Sex	Marital status	Residence status	Education level	Job
28	16	F	Single	City	Middle school	Unemployed
29	17	F	Single	City	High school	Unemployed
30	15	F	Single	Village	Middle school	Unemployed
31	17	M	Single	Village	Middle school	Worker

A total of 289 initial codes were extracted from the interviews. After removing duplicate and overlapping codes, 125 final codes remained. Through an inductive–deductive analytic process and constant comparison of the data, these codes were organized into 9 main themes and 19 subthemes. The findings revealed that suicidal behaviors in adolescents arise from a complex interplay of family, psychological, social, cultural, economic, and structural factors.

The main themes extracted included:

1. Family violence and domestic adversities
2. Identity crises
3. Poverty and economic hardship
4. Psychiatric disorders and emotional distress
5. Substance abuse
6. Emotional trauma and maladaptive interpersonal relationships
7. Sociocultural pressures and social harms
8. Spiritual and religious crises
9. Structural and systemic problems

The conceptual framework of the extracted themes and subthemes is illustrated in Fig. 1.

Family violence and unhealthy family structures emerged as one of the most prominent contexts associated with suicide attempts. Participants frequently reported experiences of humiliation, insults, verbal abuse, physical punishment, excessive control, emotional neglect, and chaotic family environments stemming from addiction, divorce, and chronic conflict. Psychological distress was identified as another central theme. Feelings of hopelessness, emptiness, weariness with life, social isolation, depression, self-harm, and a history of previous suicide attempts were observed among many participants. In some cases, severe psychotic symptoms—including auditory hallucinations and command hallucinations to commit suicide—were also reported, indicating an urgent need for specialized psychiatric intervention. Identity crises, particularly conflicts related to gender identity and tensions with socio-cultural norms, represented another important area linked to suicidal behaviors. Some adolescents felt rejected by their families and communities and faced blame, restrictions, and rejection because of their individual differences or lifestyle. Emotional trauma and destructive interpersonal relationships also played a significant role. Romantic failures, betrayal, interpersonal conflicts, abuse, and sexual assault were among the traumatic experiences that were accompanied by

intense feelings of shame, helplessness, and worthlessness. Additionally, economic difficulties, lack of social support, academic pressure, hopelessness regarding career prospects, substance abuse, and spiritual crises were among the other factors that heightened adolescents' psychological vulnerability. Many participants cited feelings of despair, academic stress, social stigma, and a weakening of religious and spiritual beliefs as factors that intensified their suicidal thoughts. The themes, subthemes, and codes derived from the participants' experiences are presented in supplementary file 1.

Discussion

This study is the first to explore the causes and contexts of suicide attempts among adolescents under 19 years of age in the city of Dezful using a qualitative approach. The findings revealed that suicidal behaviors in this population arise from a complex interplay of family, psychological, social, cultural, economic, and structural factors. Among these, family violence, identity crisis, psychological distress, economic deprivation, emotional trauma, and socio-cultural pressures emerged as the most significant contexts associated with suicide attempts. These results underscore that adolescent suicide cannot be reduced solely to individual or psychiatric disorders; rather, it must be understood within the broader framework of family relationships, social structures, and the cultural conditions of society.

Demographic characteristic

In the present study, the rate of suicide attempts was higher among girls than boys, a finding consistent with many national (13) and international (14) studies. In most countries, girls more frequently engage in suicide attempts, while death by suicide is more commonly reported among boys. This pattern may reflect the heightened vulnerability of adolescent girls to emotional pressures, social restrictions, gender discrimination, and family conflicts (15). In certain cultural contexts, strict social control, limitations on emotional expression, and the neglect of girls' psychological and personal needs can intensify feelings of helplessness, depression, and suicidal ideation.

A considerable proportion of the adolescents who attempted suicide in this study resided in rural areas. This finding differs from some previous studies (16–20) and may indicate social and cultural shifts in rural communities. Declining social support, limited access to mental health services (21, 22), cultural and economic pressures, and the social stigma surrounding psychological problems (23) may place adolescents living in rural areas in a particularly vulnerable position.

Family violence and domestic adversities

One of the most prominent findings was the role of family violence and unhealthy family structures in shaping suicidal behaviors. Participating adolescents repeatedly described experiences of humiliation, verbal abuse, physical punishment, emotional rejection, sibling discrimination, severe family conflicts, and instability caused by parental addiction or divorce. This finding aligns with national and international research that identifies dysfunctional families as one of the most critical risk factors for adolescent

suicide (24, 25). An unsafe family environment can heighten feelings of psychological insecurity, worthlessness, and loneliness, thereby reducing adolescents' ability to cope with life stressors.

Discrimination and economic injustice within the family were also among the factors influencing suicide. Consistent with earlier research, family conflicts have been recognized as a significant factor that increases the likelihood of suicide (26), while strong family social support has been associated with lower suicide rates (27).

Verbal and psychological violence, as well as humiliation, further contributed to suicide attempts among adolescents. Anvar Sadath et al. similarly demonstrated that humiliation and shame pose a potential risk for suicidal ideation and self-harm in adolescents (28). Adolescence is a sensitive period for identity formation and self-concept; verbal abuse and humiliation can disrupt this process, leading to feelings of worthlessness and failure. A study on emotional maltreatment found that humiliation during childhood and adolescence is a strong predictor of suicidal thoughts (29).

Physical violence and neglect were also identified as important factors. Nazarzadeh et al. showed that family conflicts (including physical violence) and socioeconomic problems (financial neglect) play a prominent role in unsuccessful suicides (30). In Iran, familial and economic pressures can amplify the effects of physical violence and neglect. For example, in families experiencing financial hardship, neglect of adolescents' basic needs—such as education and healthcare—is more common and can deepen feelings of hopelessness. Moreover, physical violence is sometimes accepted as a disciplinary method, which may lead to lasting psychological harm (31).

Traumatic and unhealthy family structures, patterns, and conditions emerged as further influences. A study by Izadi et al. (2025) found that an unhealthy family environment—including parental conflict, separation, and lack of emotional support—serves as a primary factor in adolescent suicide attempts. Traumatic family conditions, such as domestic violence or persistent instability, can function as psychological trauma with long-term effects on mental health (32). One study demonstrated that family conflicts and unhealthy environments are linked to an increased risk of suicide through the generation of chronic stress (33).

Excessive parental control and unreasonable restrictions were also significantly associated with suicide attempts. Severe limitations on social relationships, choice of friends, educational pursuits, and personal autonomy were accompanied in many participants by feelings of suffocation, rejection, and a lack of psychological freedom (32, 34). Previous research has similarly shown that controlling and authoritarian parenting styles are associated with increased anxiety, depression, and suicidal ideation in adolescents. Within the framework of the interpersonal theory of suicide, such restrictions may undermine the sense of social belonging and reinforce feelings of rejection (35).

Identity crises

Gender identity conflict and lack of social acceptance were identified as additional significant contexts. Adolescents experiencing gender identity conflicts felt rejected by family, peers, and society (31).

International studies have shown that adolescents with non-conforming gender identities, when faced with social stigma, discrimination, and family rejection, are at heightened risk for depression, anxiety, and suicidal behaviors (36). This can be explained through the lens of minority stress theory, whereby the pressures arising from discrimination and non-acceptance severely impact an adolescent's mental health (37).

Conflict with socio-cultural norms and expectations also played an important role in the development of suicidal behaviors. Pressure to conform to cultural values, concern about social judgment, honor-related prejudices, and social restrictions placed many adolescents in a state of psychological conflict (32). In some cases, adolescents felt unable to freely express their emotions, needs, and personal choices. Such chronic social pressures can intensify feelings of hopelessness, anxiety, and social isolation (30, 38).

Poverty and economic hardship

Economic deprivation and social disadvantage were also key contexts. Adolescents facing financial problems, lack of basic amenities, or economic discrimination within the family experienced greater feelings of injustice, helplessness, and hopelessness (30). Previous studies have similarly demonstrated that economic deprivation increases the risk of suicidal behaviors by elevating chronic stress, reducing social opportunities, and limiting access to psychosocial support (39).

Psychiatric disorders and emotional distress

Psychological distress emerged as another main theme. Depression, feelings of emptiness, hopelessness, weariness of life, and emotional isolation were observed among many participants. This finding aligns with numerous studies that identify depression and hopelessness as the strongest predictors of suicidal thoughts and behaviors in adolescents (31, 40). Additionally, some adolescents reported severe psychotic symptoms, including auditory hallucinations commanding suicide, indicating an urgent need for specialized psychiatric intervention (41).

Self-harm and a history of previous suicide attempts were also noted among many participants. Self-injurious behaviors may serve as a maladaptive strategy for reducing psychological tension and regulating negative emotions (42). At the same time, a prior suicide attempt is one of the most important risk factors for repeated suicidal behavior and may reflect the consolidation of this behavior as a perceived solution to crises (43).

Substance abuse

The findings further revealed that addiction within the family and substance abuse among adolescents are significant factors associated with suicide attempts. Parental substance abuse can increase adolescents' psychological vulnerability by fostering family instability, escalating interpersonal conflicts, and diminishing emotional support (44). Moreover, substance use in adolescents is linked to reduced impulse control, exacerbated depressive and anxiety symptoms, and engagement in high-risk behaviors (45). These findings are consistent with prior research: Zamani et al. reported that 10.5% of adolescents who attempted suicide had a history of substance abuse (46), and Ghelbash et al. showed that

substance abuse in vulnerable children and adolescents is associated with an elevated risk of suicide and high-risk behaviors (47). Existing evidence indicates that adolescents with substance use disorders are several times more likely than their peers to experience suicidal ideation and behaviors (48).

Emotional trauma and maladaptive interpersonal relationships

Emotional trauma and destructive interpersonal relationships also played a substantial role. Romantic failures, betrayal, rejection, and the dissolution of intimate relationships were associated in many adolescents with intense feelings of shame, worthlessness, and hopelessness. During adolescence, when personal and emotional identity is still forming, failures in interpersonal relationships can profoundly affect self-esteem and mental health (49–51). Experiences of sexual assault (30) and abuse (52) were reported as some of the most severe traumatic factors, accompanied by feelings of insecurity, trauma, and severe psychological disorders.

Sociocultural pressures and social harms

Another important finding was the role of social pressures, social stigma, and concerns about reputation and the judgment of others. In some cases, adolescents experienced intense isolation and a lack of support due to fear of social judgment or rejection by family and community. This finding suggests that in certain cultural contexts, maintaining social appearance and honor may take precedence over adolescents' mental health, preventing them from receiving effective psychological support (40).

The present findings indicate that family factors do not operate in isolation but interact with other psychological and social factors. Many adolescents exposed to violence, rejection, or family restrictions simultaneously experienced higher levels of hopelessness, social isolation, and emotional vulnerability—underscoring the role of the family as a context that activates other risk factors.

Educational pressures and hopelessness about future careers also played a significant role. Academic stress, concern about university entrance examinations, fear of failure, and the sense of lacking a bright future were themes repeatedly mentioned by participants. Studies conducted in Asian countries have similarly shown that intense academic pressures and educational competition can increase the risk of depression and suicidal behaviors in adolescents (53, 54).

Spiritual and religious crises

In addition, spiritual crises and a distancing from religious beliefs were observed in some adolescents. Some participants felt that their religious and spiritual beliefs had been weakened by continuous suffering and life failures. Previous studies have shown that spiritual well-being and religious affiliation can serve a protective function against suicide, while religious conflicts and a sense of spiritual disconnection may increase psychological vulnerability (55–57).

Structural and systemic problems

Finally, the findings revealed that a lack of social and legal support, along with inadequate mental health services, further exacerbates adolescents' vulnerability. Limited access to support services, the inefficiency of some protective mechanisms, and the absence of coherent multidisciplinary interventions can impede the identification and support of at-risk adolescents (58, 59). These findings underscore the need to develop community-based mental health services, strengthen family and social support, teach parenting skills, and design multilevel preventive programs for adolescents.

A strength of this study was its qualitative approach, which allowed for an in-depth exploration of the experiences of adolescents who had attempted suicide in a less-studied cultural context. However, the study also had limitations. The findings were derived from the experiences of adolescents referred to a medical center in the city of Dezful; therefore, generalizability to other regions should be undertaken with caution. Moreover, the sensitive nature of the topic may have influenced how some participants expressed their experiences.

Overall, the findings indicate that adolescent suicide is a multidimensional phenomenon shaped by the interaction of individual, family, social, cultural, and structural factors. Effective suicide prevention therefore requires comprehensive, multidisciplinary interventions anchored in the family, school, community, and mental health system. Based on these findings, a multilevel conceptual model for explaining suicidal behaviors in adolescents can be proposed. In this model, structural and social factors—including poverty, limited access to social support, cultural pressures, and social stigma—create a context for family tensions and interpersonal traumas. In interaction with family violence, emotional rejection, identity conflicts, and emotional failures, these conditions give rise to psychological distress, hopelessness, social isolation, and self-harm. Ultimately, these processes heighten the risk of a suicide attempt by weakening the individual's supportive resources and diminishing psychological resilience.

Conclusions

The findings of this study demonstrate that adolescent suicide is a multidimensional and complex phenomenon shaped by the interaction of family, psychological, social, cultural, economic, and structural factors. Among the most significant determinants of suicidal behaviors in adolescents from Dezful were family violence and trauma, identity crises, psychological distress, economic deprivation, substance abuse, emotional trauma, socio-cultural pressures, spiritual crises, and inadequate social and legal support.

The results further revealed that many adolescents who attempted suicide had grown up in environments marked by emotional insecurity, chronic conflict, social restrictions, cultural stigma, and a lack of effective support. These findings underscore that adolescent suicide prevention must move beyond the treatment of psychiatric disorders alone. Instead, a comprehensive, multilevel, and interdisciplinary approach is required—one that simultaneously engages families, schools, communities, the mental health system, and social policymakers.

Accordingly, reducing suicidal behaviors will depend on developing community-based preventive programs, enhancing mental health literacy, teaching parenting skills, diminishing the social stigma attached to psychological problems, strengthening social support, and improving adolescents' access to specialized mental health services. Particular attention should be directed toward at-risk adolescents—especially girls, those living in deprived areas, and those exposed to family violence or social rejection.

By offering an in-depth understanding of the social and psychological contexts of adolescent suicide, this study provides a foundation for designing culturally informed interventions and preventive policies at both the regional and national levels. These findings can guide the development of culturally tailored prevention programs, the establishment of early warning systems in schools, and the strengthening of collaboration among families, the education system, and mental health services at local and national scales.

Limitations

Several limitations should be considered when interpreting the findings of this study. First, due to the sensitive nature of suicide and suicide attempts, some participants were reluctant to fully disclose their experiences, emotions, and the underlying circumstances surrounding their suicidal behavior. In particular, certain adolescents expressed concerns about the potential consequences of discussing sensitive issues such as family conflicts, violence, substance use, identity-related concerns, or other personal experiences. Consequently, the possibility of self-censorship and underreporting cannot be completely excluded. Second, family members and close relatives were occasionally hesitant to discuss the actual causes and contextual factors associated with the suicide attempts. Concerns related to social stigma, family reputation, fear of judgment by others, and cultural sensitivities surrounding suicide may have limited the extent to which some experiences and contributing factors were openly disclosed. Third, the study was conducted among adolescents with a history of suicide attempts who were recruited from a healthcare setting in Dezful, Iran. Therefore, the transferability of the findings to adolescents from other geographical regions, cultural contexts, or healthcare settings should be approached with caution. Despite these limitations, several strategies were employed to enhance the trustworthiness of the findings, including prolonged engagement with participants, conducting in-depth interviews in a supportive and confidential environment, involving experienced qualitative researchers and mental health professionals, and continuing data collection until data saturation was achieved.

Declarations

Ethics approval and consent to participate

All ethical considerations in human research, including informed consent, data confidentiality, and the right to withdraw from the study were observed in accordance with the Declaration of Helsinki. The authors would like to thank the Student Research Committee of Dezful University of Medical Sciences,

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Consent for publication

All authors declare their consent to publish the article

Availability of data and materials

The datasets generated and/or analyzed during the current study are not publicly available due to confidentiality and ethical restrictions, but are available from the corresponding author on reasonable request.

Competing interests

The authors declare that there is no competing of interest.

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Authors' contributions

Conceptualization: HE & HA; Data curation: HA & MN; Formal analysis: MN & HA; Funding acquisition: HE & SNG; Investigation: MN; Methodology: HA & AK; Project administration: HA; Resources: MN; Software: SNG; Supervision: HA & MSD; Validation: SE; Visualization: MSD; Writing–original draft: HE & SNG

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AI declaration

In the preparation of this article, the author employed artificial intelligence technologies to support specific aspects of the work. DeepSeek AI was utilized for native language translation tasks, and ChatGPT AI was employed in the design of photographic and graphic elements. The author wishes to formally acknowledge the contribution of these tools in facilitating the production of the present manuscript.

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Figures

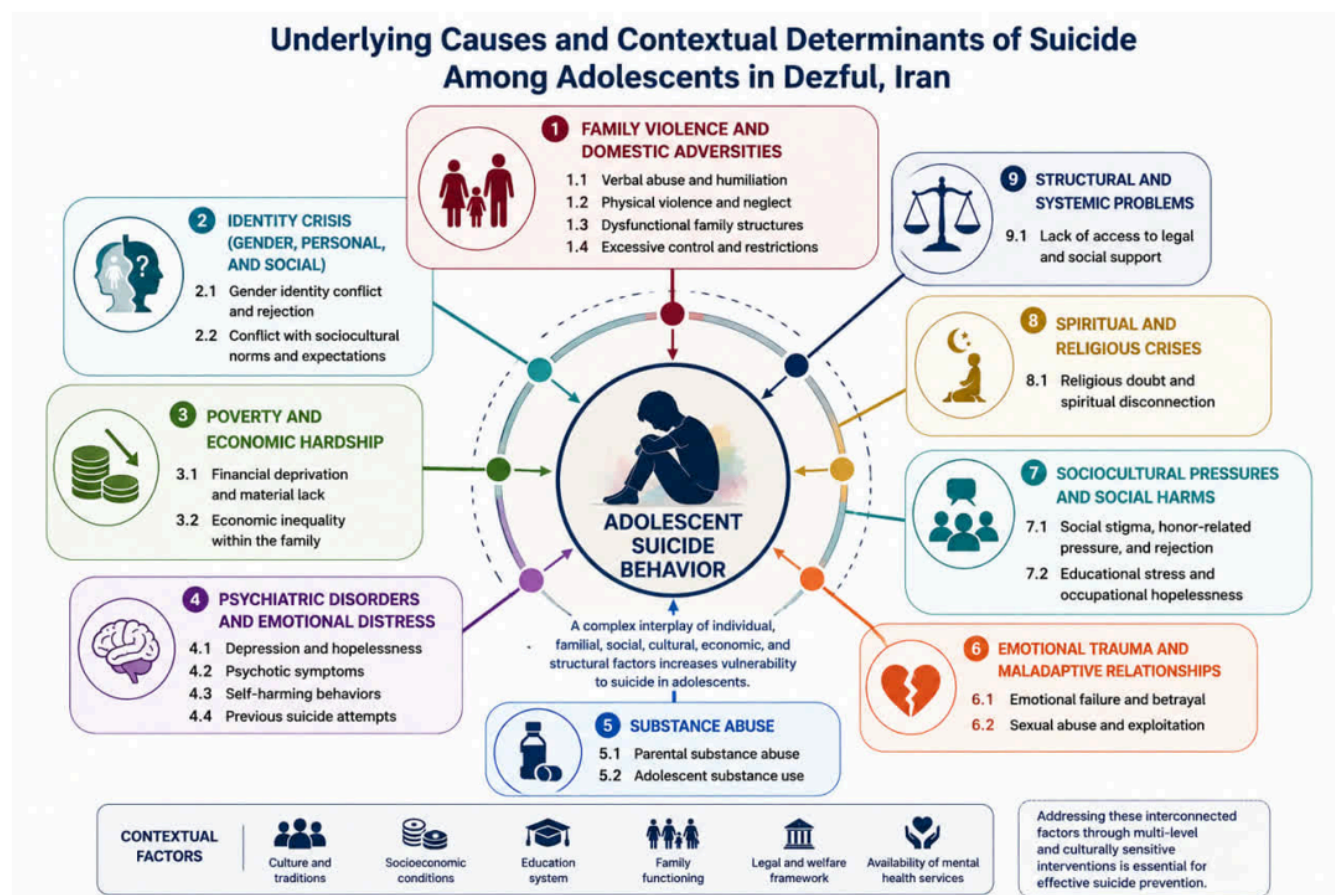


Figure 1

Conceptual framework of the causes and contexts of suicide among adolescents in Dezful

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