ASIA PACIFIC JOURNAL OF EDUCATION AND SOCIETY

Asia Pacific Journal of Education and Society, 2026, 14(2), Article 1
eISSN: 3177-7743

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Research paper

Reasons for Attempted Suicide in Arab Druze Society in Israel

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Citation: Bader, N. (2026). Reasons for attempted suicide in Arab Druze society in Israel. *Asia Pacific Journal of Education and Society, 14*(2), Article 1. https://doi.org/10.20897/apjes/18997

Published: July 23, 2026

ABSTRACT

Suicidal behavior is a complex clinical phenomenon driven by bio-psycho-social interactions. Although global models highlight the roles of depression, hopelessness, and family dynamics, little research explores these pathways within minority populations, such as the Arab Druze in Israel. This preliminary study investigated demographic, clinical, family, and cultural reasons for suicidality among Arab Druze; how socioeconomic status, cultural shifts, and belief in reincarnation interact with psychological distress and suicidal intent. In a mixed-methods study, a quantitative sample of 55 Arab Druze suicide attempters within the previous year (aged 12–67) completed standardized instruments measuring suicide attitudes (SUIATT), ideation severity (PSS), lethality, general psychological distress (GSI), and reasons for living (RFL), alongside a culturally specific questionnaire. Qualitative semi-structured interviews with 50 additional Arab Druze participants (aged 12–58) presented personal narratives behind their suicide attempts. Stepwise linear regressions, adjusted for demographic factors, revealed that survival and coping beliefs significantly predicted lower endorsement of the right to commit suicide, while GSI was the sole significant predictor of suicidal ideation severity. Perception of family and social difficulties—rather than a shift toward Western culture or belief in reincarnation—was strongly correlated with higher distress. Thematic content analysis identified four main drivers for suicidal behavior across all age groups: family difficulties, socioeconomic stressors, social difficulties, and severe psychological distress. Suicidality in Arab Druze society is primarily motivated by immediate socio-familial stressors and GSI rather than traditional cultural or spiritual beliefs. Interventions strengthening family support systems and enhancing psychological coping mechanisms to mitigate distress are recommended.

Keywords: Arab, Druze, suicidality, reasons for suicide, reincarnation

Suicidal behavior is a serious clinical phenomenon that has detrimental effects on individuals and their environment. It is defined in the literature by a broad range of behaviors, from suicidal thoughts, expressions, self-injury, non-fatal suicide attempts, and serious suicide attempts to complete suicide (Bursztein & Apter, 2008). Unlike *complete suicide*, in which the outcome is clear, there is less consensus among researchers regarding the definition of *suicide attempts*. In general, it involves a distinction between an act of self-injury that is unrelated to an intention to die, and suicide attempts, in which there is some degree of death wish. However, in practice, it is often difficult to differentiate between the two (Bertolote et al., 2009).

Theoretical approaches to suicidality

Many theories have been proposed to characterize, explain, and understand suicidality. The main approaches in this field are the sociological approach, the approach of stress leading to desperation, and the family approach. *The sociological approach* focuses on the social climate of the suicidal person, which is seen as the cause of suicidality. Durkheim (1897), one of the first scholars to study suicidality, focused on the social climate in which the suicidal

person lives. He believed that suicidality is one of the social phenomena that express the intensity of society's control over the individual. According to this model, it is impossible to explain suicidal behavior by what he termed non-social factors, including psychotic-organic disorders, but only by social factors, such as lack of social integration, which lead to suicidal thoughts. *The stress-diathesis hopelessness hypothesis (SDH)* approach is based on an assumption that stress situations constitute an integral part of the process of human development, and every developmental stage of life involves experiencing crisis, which demands revitalization of the person. According to this theory, developed by Schotte and Clum (1987), Arab adolescents, in general, and Arab Druze adolescents, in particular, are situated within a cycle of development, conflict, and change, and if they are unable to cope with or resolve their problems, they may tend toward suicidal thoughts. *The family approach* is based on a view of suicidal behavior as a side-effect of family stress factors and of suicidal acts as an automatization of the family problem (Fishman, 1988).

Theoretical models

In the present research, I examined several theoretical models in order to better understand the interaction of the many factors involved in suicidal behavior. In general, and taken together, the different models describe the interaction as a flow from biological factors to factors of illness, background factors, mediating factors, moderating factors, and, finally, catalysts and deterrents.

According to the model presented by Beautrais (2003), life strains appear as an independent factor, and later, as a mediating factor, as well. Roberts et al. (1998) found that depression, suicide attempts during life, and stresses of life affected suicidal behavior and were very significant among adolescents. The results of Lewinsohn et al. (1996) indicated that psychopathology, physical illness, personal history and background, or interpersonal problems were the factors that constituted a pathway to suicide. Orbach and Iohan (2005) showed that personality variables, such as negative self-regulation, perfectionism, and self-criticism had a direct impact on suicidal behavior. Their model, contrary to that of Lewinsohn et al. (1996) distinguished between personality aspects and more subjective aspects (mental suffering). However, both models suggested multiple interactions among the independent mediators. Wagner and Hustead (2002) claimed that the pathways to suicidal behavior of adolescents were built on the relationships between children and their parents. They presented three pathways: the first is driven by the child, in which suicidal behavior is encouraged by the child's problems; the second is driven by the parents, who enable the suicidal behavior of the adolescents; and in the third, the reciprocal pathway, the suicide attempts are described as interpersonal messages driven by the family (Wagner & Hustead, 2002).

Reasons for suicide attempts

A survey of the research literature suggests numerous reasons for suicide. Some are associated with the main factors that influence suicidal thoughts, and others do not provide a specific explanation of suicidal behavior. The most prominent factors are *Depression*: Wetzler et al. (1996) found that a depressive state correlated with all forms of suicide, and Spirito et al. (2003) found that the basis for a depressive state was related to suicidal ideation and attempts. *Hopelessness*: Research results have established a strong correlation between hopelessness and suicide among adults (Beck et al., 1985), as well as adolescents (Horesh et al., 2003; Thompson et al., 2005). *Anxiety*: Increased anxiety, particularly trait anxiety, is an emotional characteristic of suicidal adolescents (Fennig et al., 2005). *Anger, hostility, and rage*: It seems that suicidal adolescents experience more anger and hostility and get angry more than their peers who do not have suicidal tendencies (Penn et al., 2003). *Shame, guilt, and loneliness*: Analysis of audio-taped suicide notes of suicidal adolescents, and moment-by-moment follow-up of suicidal emotions indicated that shame may be destructive to the ego and is liable to lead to suicidal behavior (Loraas, 1997; Savarimuthu, 2003). Haliburn (2000) found that feelings of guilt also characterize suicidal adolescents. In addition, adolescents who are suicidal express intense feelings of loneliness, which increases the likelihood of self-destruction. *Emotional suffering*: Shneidman (1993) presented the concept of unbearable "psychache" as a direct cause of suicidal behavior, referring to a general emotional condition that differs from a general negative feeling. In research by Orbach & Iohan (2005), mental pain has emerged as a separate characteristic of a suicidal emotional state among adolescents. *Psychological instability*: Some suicidal adolescents shift very quickly from one mood to another. These transitions have been associated with difficulty in emotional regulation and with suicidal behavior (Miller et al., 2000).

Research aims

The purpose of the present research was to conduct a preliminary study of the reasons for and hence, the factors that predict suicidality in Arab Druze society. The quantitative part of the research examined different demographic and family contexts of suicide attempts in society: level of distress, difficulties and strengths, perception of reasons to live and the reasons for the suicide attempt, as well as emotions, attitudes, and thoughts

about suicide among people who had attempted suicide. The focus was on the unique characteristics of suicidality in this particular society. In addition, the research examined social and cultural perceptions of reasons for suicide attempts in this population.

Research hypotheses

1. Low socioeconomic status of the family and family history of suicidality will be found to be associated with higher levels of distress, more numerous reasons for suicide, fewer reasons to live, and attitudes and thoughts that are more supportive of suicide.
2. Higher levels of psychological distress and greater extent of influence of the reasons for self-injury will be correlated with greater suicidal ideation severity (Paykel Suicide Scale; PSS), more permissive attitudes toward suicide (Suicide Attitude Questionnaire; SUIATT), greater severity of the suicide attempt result, and stronger endorsement of the right to commit suicide. Conversely, higher scores on reasons for living will be correlated with lower severity of the suicide attempt result.
3. The stronger the Arab Druze participants' belief in reincarnation and the stronger the belief that Arab Druze society is undergoing a social and cultural change, the higher the distress levels will be, the higher their scores will be on reasons for suicide and the lower their scores will be on reasons to live and attitudes and thoughts that support suicide.

METHODS

Research population and sampling method

This research was part of a larger study on suicide attempts across four different religious groups in Israel: Arab Druze, Arab Christian, Arab Muslim, and Jewish (manuscript in preparation). The present study focuses on the Arab Druze sample, which consisted of 55 Arab Druze male and female adolescents and adults aged 12–67, in stable clinical condition. The inclusion criterion was having attempted suicide that had required medical attention at least once in the 12 months preceding the research. All the participants met this criterion, as they had all been hospitalized, but due to confidentiality issues, no specific data was available regarding the medical intervention they received. In addition, semi-structured individual interviews were conducted with another 50 Arab Druze adolescents and adults aged 12–58, males and females, who had attempted suicide. The participants were asked about their reasons for having attempted suicide.

The Arab Druze participants who completed the research questionnaire were 22 men (40%) and 33 women (60%). Thirty (54.5%) of them were adolescents and 25 (45.5%) were adults; they were residents of different villages. Sixteen (29.1%) of them reported very low economic status, 20 (36.4%) reported middle economic status, and 19 (34.5%) reported high or very high economic status.

Research instruments

Suicide attitude questionnaire

The SUIATT examines the permissiveness of the attitudes of individuals in different stressful situations toward themselves, toward those close to them, and toward people in general (Diekstra, 1989; Diekstra & Van der Loo, 1978). It refers to different components of the attitude toward suicide: the identity of the person who commits suicide; contact between the person who commits suicide and the person who expresses the attitude; the expected outcome of the suicide for the person expressing the attitude; the close environment, in general, and society in general; the circumstances of the suicide; and moral judgement of the act of suicide. In the current research, reliability of the three components was excellent (Cronbach's α: self = .909, family: .898, general: .912) and highly correlated so it was decided to combine it into one measure (Cronbach's α: .954).

The lethality rating scale

The Lethality Rating Scale (Mann & Malone, 1997) examines the lethality of the damage resulting from a suicide attempt. It includes the Medical Damage Rating Scale (MDRS; Beck et al., 1975), which is used to evaluate physical and medical damage due to a suicide attempt. The severity of a suicide attempt is evaluated according to the method by which it is executed, divided into eight categories: (a) sedative medications or drugs, (b) non-sedative medications or substances, (c) shooting, (d) burning, (e) drowning, (f) self-laceration or stabbing, (g) jumping, and (h) hanging. Each suicide method has a specific scale of lethality, according to the different possibilities of medical damage.

Paykel suicide scale

The PSS (Paykel et al., 1974) was designed to examine suicidal ideation severity during the past 2 weeks. In the present research, the version of the questionnaire developed by Meneese and Yutrzenka (1990), which consists of five questions, was used. The fifth item on the questionnaire, which refers to carrying out a suicide attempt (yes/no) was removed, because in the present sample, the answer was positive in all cases. All the answers were based on a 6-point Likert scale, from 0 (never) to 5 (always). In the current research, reliability of the scale was excellent (Cronbach's α:.948).

Self-strengths and difficulties questionnaire

The SDQ (Goodman, 1997), which was designed to examine strengths and difficulties, includes 25 items in the five following scales: emotional difficulties, behavior problems, hyperactivity/attention disorder, problems with social relations with peers, and prosocial behavior (five items in each scale). In the current research, only the reliability of the prosocial behavior subscale was acceptable (Cronbach's α = .783) and thus this was the only subscale used. When items were grouped by response format, both were of questionable reliability (nonreversed: Cronbach's α = .651; reversed: α = .600).

Reasons for living inventory

The RFL inventory (Linehan et al., 1983) is a self-report instrument that measures the ability to contribute to refraining from suicidal behavior. The questionnaire comprises six factors, but in the present research only two of them were used: survival and coping beliefs (25 items) and fear of suicide (5 items). In the current research, reliability of the survival and coping beliefs subscale was excellent (Cronbach's α = .966), and fear of suicide factor was good (Cronbach's α = .867).

Reasons for attempted suicide questionnaire

The Reasons for Attempted Suicide Questionnaire (Holden et al., 1998) was translated into Hebrew by Levinger (Levinger & Holden, 2014). Based on an earlier questionnaire on reasons for taking overdoses (Bancroft et al., 1979), the questionnaire comprises 13 statements that represent reasons for attempted suicide attempted. Responses were on a 1–5 scale regarding the extent of the influence of each reason on the decision (1 = very weak influence to 5 = very strong influence). These statements were divided into social and personal reasons. In the current research, the six social reasons for attempted suicide had good reliability (Cronbach's α =.797) whereas the seven personal reasons for the decision had questionable reliability (Cronbach's α =.671).

The brief symptom inventory (BSI)

The BSI (Derogatis & Melisaratos, 1983) examines the level of general psychological distress of a person as expressed in a broad range of symptoms. The questionnaire is a shortened version of SCL-90-R (Derogatis, 1977); it is composed of 53 items that represent different psychological symptoms. In the current research, the reliability of the scale was excellent (Cronbach's α=.969).

Reasons for suicidality in Arab Druze society questionnaire

For the purpose of the present study, a questionnaire was developed to examine the specific reasons for suicide in the Arab Druze society. The first part of the questionnaire consists of a list of 20 reasons for suicidality. This list was developed by means of interviews with 30 religious leaders, educators, therapists, adolescents, adult men and women, and officials in Arab Druze society. The 20 items that represent attitudes regarding reasons for and causes of suicidality in Arab Druze society were derived from their answers. Three factors were defined: family and social difficulties (11 items, e.g., weak family ties, unemployment), collapsing values (three items, e.g., transition from a traditional to a modern society, the mother working outside the home), and exposure to Western culture (five items, e.g., exposure to the media, exposure to other sectors of the society during military service). In addition, belief in reincarnation was defined as a separate measure. The family and social difficulties subscale had good reliability (Cronbach's α:.862), and the collapsing values and exposure to Western culture subscales had acceptable reliability (Cronbach's α:.715, .768 respectively).

Demographic questionnaire

In the demographic questionnaire, the respondents provided information regarding their gender, age, type of place of residence (urban/rural), family economic status, past suicide attempts, number of attempts, suicidality in the family, and whether or not they had spoken with anyone after the suicide attempt.

Semi-structured individual interview

A semi-structured interview was conducted with Arab Druze participants to examine the reasons for the attempted suicide. The interviews lasted between 30 minutes and 1 hour. Participants were asked an open-ended question about the reasons for the suicide attempt. As the conversation developed, and according to the topics raised, follow-up questions were posed regarding how the suicidal thoughts had begun, how the attempt was executed, feelings regarding the suicide attempt, whether they had spoken with anyone about the suicide attempt, and they were invited to mention any other details that they thought were relevant.

Data collection

A written request was made through contacts in seven hospitals in the north of Israel, to examine the possibility of their participation in the research. Meetings were arranged with those hospitals that agreed in principle, to discuss the research, its aims, and the characteristics of the target research population. At this stage, professional staff (doctors, social workers, therapists) were approached and agreed to serve as internal researchers at the hospital, to recruit participants and help make contact with other hospital departments, such as the emergency room and different wards where potential participants might be hospitalized. After several staff at these hospitals agreed to serve as supervisory researchers for the project, applications were submitted through them to the Helsinki committees. The data were collected according to each medical center's ethical protocol. Ongoing contact was maintained with these hospital staff to inquire about new cases, to ensure full completion of the questionnaires, and to obtain signature of informed consent from the participants or their parents/guardians.

Semi-structured interviews were conducted with 50 additional participants from the Arab Druze society who had attempted suicide, recruited either through the social service departments in their communities or by personal acquaintance with the researcher. The purpose of the research was explained to the interviewees, and they were asked to agree to answer a few questions. The participants or their parents/guardians completed an informed consent form. The interview questions solicited a description of the suicide attempt, its causes and context, and the feelings that accompanied it. Demographic details were also collected. Approximately 100 people were approached; about 50 agreed to participate. However, no precise data was available regarding the number of people who were screened, found eligible, and approached by the medical staff and then either refused to participate or were included. The refusals to be interviewed arose from unwillingness to be reminded of and discuss the subject.

Data analysis

Data was analyzed using IBM SPSS (version 28). First, the internal consistency of the research variables was examined (using Cronbach's alpha), and composite scores were computed as the means of the corresponding items. For the Self-Report Strengths and Difficulties Questionnaire (SDQ), total scores were computed by summing up the relevant items. Independent samples *t*-tests were conducted to examine differences in the research variables by age group (adolescents vs. adults), gender, and family history of suicide (yes vs. no). One-way analyses of variance (ANOVAs) were used to test for differences across economic status (low, middle, high). The distribution of the items and distribution of factors from the Reasons for Suicidality in Arab Druze Society questionnaire were described.

Pearson correlations between the research variables were examined. The Benjamini-Hochberg procedure was used to correct for multiple correlations. Multivariable stepwise regression analysis for the suicide-related variables (e.g., suicidal ideation severity) was performed using the scales that were correlated with them, controlling for age, gender, family history of suicide, and the number of suicide attempts.

A content analysis was conducted on 50 semi-structured interviews, and the themes that emerged were presented by age group (adolescents, young adults, and adults) and gender.

FINDINGS

Table 1 presents the participants' demographic characteristics. Approximately half of the participants had attempted suicide previously (27; 49.1%), before the present attempt (an average of nearly two attempts). Approximately one-quarter (14; 25.5%) of the participants reported that there had been suicide attempts in their families, and close to two-thirds (34; 64.2%) of them reported that they had received medical assistance after the attempted suicide. About one-third (18; 32.7%) had spoken with members of their peer group after the suicide attempt; close to one-fifth (10; 18.2%) had spoken with relatives, and one quarter (15; 27.3%) with other adults. Almost half of the suicide attempts (24; 43.6 %) had been carried out by swallowing either sedative or non-sedative drugs. The other attempts had involved laceration, hanging, jumping from height, or shooting. The mean severity of the suicide attempt result was approximately 2 (on a scale of 0 – no injury to 8 – death), where 38% of the cases

ended with no injury, approximately 30% with mild injury, approximately 19% with medium injury, and 13% with serious injury.

Table 1

Demographic characteristics of the sample

Variable	All (N=55)
Age in years [range]	21.6±8.5 [13–49]
Age group	
<19	30 (54.5)
19–35	19 (34.5)
>35	6 (10.9)
Gender	
Male	22 (40.0)
Female	33 (60.0)
Economic status	
Poor/very poor	16 (29.1)
Middle	20 (36.4)
High/very high	19 (34.5)
Family history of suicide	14 (25.5)
Past suicide attempts	27 (49.1)
Median number of suicide attempts (IQR) [range]	1.0 (1.0-2.75) [1-8]
Spoken to someone following suicide attempt	43 (65.5)

Data is mean ± SD [range] for continuous measures and frequency (%) for categorical measures unless otherwise noted.

As noted in the Methods section, the Reasons for Suicidality in Arab Druze Society questionnaire was constructed for this research. Table 2 presents the distribution of the items on this questionnaire in descending order of frequency, indicating that "hopelessness in life" (Item 6, 80%) was the most frequently reported reason. The least frequently reported reason was "experiences in the army" (Item 4, 76% responded negatively). It is interesting that "belief in reincarnation" was not found to be a significant cause.

Table 2

Distribution of items, Reasons for Suicidality in Arab Druze Society Questionnaire (N = 55)

Item	Not at all *N* (%)	To a slight extent *N* (%)	To a medium extent *N* (%)	To a great extent *N* (%)	*M* (*SD*)
Hopelessness in life	7 (12.7)	4 (7.3)	17 (30.9)	27 (49.4)	3.16 (1.03)
Weak family ties	14 (25.5)	8 (14.5)	15 (27.3)	18 (32.7)	2.67 (1.19)
Collapsing values	19 (35.2)	10 (18.5)	19 (35.2)	6 (11.1)	2.22 (1.06)
Difficult financial condition, unemployment	21 (38.2)	10 (18.2)	9 (16.3)	15 (27.3)	2.33 (1.25)
Lack of supportive framework for adolescents	22 (40.7)	9 (16.7)	10 (18.5)	13 (24.1)	2.26 (1.23)
Rapid social and cultural changes in society	23 (41.8)	9 (16.4)	13 (23.6)	10 (18.2)	2.18 (1.17)
Father's absence from home	25 (45.5)	11 (20.0)	10 (18.1)	9 (16.4)	2.05 (1.14)
Learning difficulties	25 (47.2)	11 (20.8)	13 (24.5)	4 (7.5)	1.92 (1.02)
Poor education in family	23 (43.4)	17 (32.1)	4 (7.5)	9 (17.0)	1.98 (1.10)
Conflict among age groups	22 (40.0)	17 (30.9)	7 (12.7)	9 (16.4)	2.05 (1.10)
Transition from traditional to modern society	28 (50.9)	14 (25.5)	10 (18.1)	3 (5.5)	1.78 (0.94)
Exposure to Internet (Facebook, YouTube)	30 (54.5)	8 (14.6)	11 (20.0)	6 (10.9)	1.87 (1.18)
Distancing from Druze values	30 (54.5)	12 (21.9)	8 (14.5)	5 (9.1)	1.78 (1.01)
Lack of occupation	31 (56.4)	9 (16.3)	5 (9.1)	10 (18.2)	1.89 (1.18)
Exposure to media (television, film)	32 (58.2)	11 (20.0)	8 (14.5)	4 (7.3)	1.71 (0.97)
Lack of possibility of becoming religious	31 (58.5)	7 (13.2)	9 (17.0)	6 (11.3)	1.81 (1.09)
Belief in reincarnation	32 (59.3)	8 (14.8)	4 (7.4)	10 (18.5)	1.85 (1.19)
Exposure to use of drugs, alcohol, nargilas	35 (63.6)	8 (14.6)	1 (1.8)	11 (20.0)	1.78 (1.20)
Mother going out to work	33 (62.3)	11 (20.8)	5 (9.4)	4 (7.5)	1.62 (0.95)
Experiences in the army	41 75.9)	4 (7.4)	4 (7.4)	5 (9.3)	1.50 (0.99)

Table 3 presents the research variables. Most of the research variables were located in the center of the scale. The only measure for which the mean was low was severity of the suicide attempt result. Gender was not

significantly associated with any of the research variables although males tended to rank collapsing values as higher than females (p=.097) as a reason for the suicide attempt. There were no statistically significant differences between adolescents and adults on any research variable, with the exception of SDQ strengths, for which adolescents scored significantly higher than adults (mean difference = 2.20, SE = 0.60, 95% CI [0.90, 3.40], p = .001). Permissive attitudes toward suicide (SUIATT) tended to be higher in adults as compared to adolescents but this did not quite reach statistical significance (mean difference =-0.39, SE: .19; 95% CI: -0.77-0.00; p=.051).

Table 3

Scales by gender and age group

		Gender				Age			
	All (N=55)	Males (N=22)	Females (N=33)	p	Effect size	<19 (N=30)	>19 (N=25)	pp	Effect size
SUIATT[1] (1–5)	3.80±0.73 (1.94-5.00)	3.91±0.77 (2.19-5.00)	3.76±0.71 (1.94-5.00)	.46	.208	3.63±0.81 (1.94-5.00)	4.02±0.58 (2.89-4.89)	.051	-.542
The right to commit suicide (1–5)	2.71±1.30 (1-5)	2.98±1.31 (1-5)	2.45±1.23 (1-5)	.14	.415	2.72±1.42 (1-5)	2.70±1.18 (1-5)	.96	.013
Severity of suicide attempt (0–8)	2.87±2.52 (1-8)	3.27±3.07 (1-8)	2.66±2.22 (1-7)	.35	.259	3.07±2.53 (1-8)	2.72±2.77 (1-8)	.55	.163
PSS[2] (0–5)	2.10±1.73 (0-5)	2.44±1.97 (0-5)	1.81±1.52 (0-5)	.19	.367	2.17±1.75 (0-5)	2.01±1.74 (0-5)	.73	.095
Reasons for attempted suicide – personal (1–5)	3.75±0.70 (1.57-5.00)	3.62±0.91 (1.57-5.00)	3.82±0.51 (2.86-5.00)	.31	-.285	3.65±0.68 (2.14-5.00)	3.86±0.73 (1.57-5)	.26	-.308
Reasons for attempted suicide – social (1–5)	3.02±1.04 (1.00-4.83)	2.87±1.00 (1.33-4.83)	3.11±1.08 (1.00-4.83)	.40	-.236	3.22±0.91 (1.83-4.83)	2.78±1.15 (1-4.83)	.12	.425
GSI[3] (1–5)	2.96±0.73 (1.32-4.45)	2.92±0.89 (1.32-4.45)	2.95±0.61 (1.45-4.1)	.90	-.036	2.99±0.67 (1.62-4.45)	2.92±0.81 (1.32-4.06)	.73	.093
SDQ[4] -Difficulties (0–40)	21.38±5.80 (9-35)	22.36±6.18 (12-35)	20.72±5.62 (9-31)	.81	.281	21.13±6.07 (9-35)	21.68±5.59 (12-33)	.73	-.093
SDQ -Strengths (0–10)	5.65±3.22 (1-10)	5.54±2.67 (2-10)	5.72±2.54 (1-10)	.32	-.067	6.63±2.44 (3-10)	4.48±2.18 (1-8)	.001	,925
SDQ -prosocial subscale (0-10)	5.20±3.23 (0-10)	5.27±3.25 (0-10)	5.09±3.30 (0-10)	.84	.055	5.73±2.97 (0-10)	4.56±3.47 (0-10)	.18	.366
RFL[5] - coping (1–6)	3.92±1.15 (1.16-5.88)	3.86±1.26 (1.16-5.88)	3.98±1.11 (1.71-5.84)	.72	-.099	3.85±1.19 (1.71-5.88)	4.01±1.13 (1.16-5.84)	.60	-.142
RFL – fear (1–6)	3.68±1.29 (1-6)	3.72±1.38 (1-6)	3.69±1.25 (1.2-6)	.94	.020	3.46±1.30 (1.2-6)	3.95±1.26 (1-6)	.16	-.382
Causes of suicidality									
Family and social difficulties	2.25±0.74 (1-4)	2.16±0.72 (1-3.55)	2.29±0.76 (1-3.55)	.53	-.176	2.33±0.81 (1-3.55)	2.16±0.63 (1-3.45)	.40	.231
Collapsing values	1.90±0.78 (1-4)	2.03±0.85 (1-3.67)	1.66±0.76 (1-3.67)	.097	.468	1.89±0.93 (1-3.67)	1.68±0.64 (1-3)	.33	,257
Exposure to Western culture	1.79±0.93 (1-4)	1.85±0.73 (1-3.6)	1.57±0.76 (1-4)	.19	.366	1.74±0.80 (1-4)	1.64±0.70 (1-3.2)	.65	.125
Belief in reincar-nation	1.85±1.19 (1-4)	2.18±1.30 (1-4)	1.65±1.08 (1-4)	.11	.457	1.83±1.17 (1-4)	1.88±1.24 (1-4)	.87	-.044

Data is mean ± SD (range). Effect size is Cohen's d.

[1] Suicide Attitude Questionnaire

[2] Paykel Suicide Scale – suicidal ideation severity

[3] General Psychological Distress

[4] Self-Strengths and Difficulties Questionnaire

[5] Reasons for Living Inventory

Statistically significant differences across the three economic status groups (data not shown) were found for SUIATT (p = .046), SDQ prosocial behavior (p = .033), and family and social difficulties as the perceived reason for suicide in Arab Druze society (p=.016). Post hoc analyses for SUIATT revealed a significant difference between the poor/very poor group ($Mean$ = 3.54) and the middle group ($Mean$ = 4.11, p = .023), but not between the poor/very poor and high/very high groups ($Mean$ = 3.69, p = .58). For prosocial behavior, a significant difference was found between the poor/very poor and high/very high groups ($Mean$ = 6.81 vs. $Mean$ = 4.00, p = .007), but not between the poor/very poor and middle groups ($Mean$ = 5.05, p = .07). For family and social difficulties cause of suicide, a significant difference was found between the poor/very poor and high/very high groups ($Mean$ = 2.68 vs. $Mean$ = 2.01, p = .019), but not between the poor/very poor and middle groups ($Mean$ = 2.13, p = .064). No other statistically significant economic status differences were found for the remaining research variables. A family history of suicides was associated with the severity of the suicide attempt result ($Mean$ = 4.33 vs. $Mean$ = 2.37, p=.04; mean difference: 1.96, SE: 0.87, 95% CI: 0.–3.80).

Table 4 presents the correlations between the research variables. SUIATT and severity of the suicide attempt were not significantly correlated with any other research variable. The two suicidality measures—right to commit

suicide and PSS—displayed a consistent and conceptually coherent pattern. Both were positively associated with general psychological distress (GSI; right to commit: $r = .38$, $p = .004$; PSS: $r = .41$, $p = .002$). Both were negatively associated with reasons for living: with the coping beliefs subscale (right to commit: $r = -.56$, $p < .001$; PSS: $r = -.42$, $p = .001$) and with fear of suicide (right to commit: $r = -.50$, $p < .001$; PSS: $r = -.35$, $p = .010$). The two RFL subscales were themselves strongly intercorrelated ($r = .88$, $p < .001$).

GSI was positively associated with both personal ($r = .46$, $p < .001$) and social ($r = .41$, $p = .002$) reasons for self-injury, and with prosocial behavior on the SDQ ($r = .36$, $p = .006$). GSI was negatively associated with both RFL subscales (coping: $r = -.43$, $p = .001$; fear: $r = -.43$, $p = .001$), indicating that lower reasons for living corresponded to greater general distress.

Table 4

Correlations among the research variables (N = 55)

		1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13.	14.	15.	16.
1. SUATT[1]	r	1	-.322	-.079	-.241	-.015	-.164	-.237	.039	-.180	-.185	.202	.151	.110	-.342	-.025	-.058
	p		.017	.564	.076	.911	.231	.081	.777	.188	.177	.139	.272	.429	.011	.858	.676
2. The right to commit suicide	r		1	.159	.394	.030	.061	.384	.251	.086	.093	-.564	-.497	.010	.066	-.078	-.091
	p			.245	.003	.826	.659	.004	.064	.531	.498	<.001	,001	.941	.634	.571	.509
3. Severity of suicide attempt	r			1	-.104	-.104	.092	-.153	-.194	-.070	-.109	-.084	-.158	-.153	-.191	-.288	-.175
	p				.451	.448	.503	.263	.155	.614	.427	.541	.250	.269	.163	.033	.201
4. PSS[2]	r				1	.215	.003	.407	-.151	-.036	.001	-.418	-.346	.107	.309	.048	.145
	p					.116	.981	.002	.271	.793	.992	.001	.010	.441	.022	.729	.291
5. Reasons for attempted suicide - personal	r					1	.158	.459	.010	-.089	.178	.076	.111	.334	.283	.106	.140
	p						.249	<.001	.942	.520	.192	.580	.419	.014	.037	.441	.308
6. Reasons for attempted suicide - social	r						1	.406	-.037	.321	.130	-.029	-.067	-.209	.060	.011	-.024
	p							.002	.789	.017	.343	.831	.627	.130	.661	.939	.861
7. GSI[3]	r							1	.156	.242	.363	-.430	-.426	.172	.358	.082	.096
	p								.257	.076	.006	.001	.001	.213	.007	.550	.487
8. SDQ[4]- difficulties	r								1	.473	.657	-.292	-.230	.113	-.003	.243	.073
	p									<.001	<.001	.031	.091	.416	.982	.073	.596
9. SDQ - strengths	r									1	.517	-.111	-.207	-.024	.096	.147	.065
	p										<.001	.422	.130	.866	.488	.285	.637
10. SDQ – prosocial behaviors subscale	r										1	-.302	-.278	.224	.186	.178	.124
	p											.025	.040	.103	.174	.193	.366
11. RFL[5] - coping	r											1	.875	.052	-.062	.070	.173
	p												<.001	.709	.655	.612	.208
12. RFL - fear	r												1	.086	-.070	.014	.109
	p													.535	.610	.919	.427
13. Reincar-nation	r													1	.336	.393	.467
	p														.013	.003	<.001
14. Family and social difficulties	r														1	.600	.673
	p															<.001	<.001
15. Collaps-ing values	r															1	.783
	p																<.001
16. Exposure to Western culture	r																1
	p																

[1] Suicide Attitude Questionnaire
[2] Paykel Suicide Scale – suicidal ideation severity
[3] General Psychological Distress
[4] Self-Strengths and Difficulties Questionnaire
[5] Reasons for Living Inventory

The four subscales of the Reasons for Suicidality in Arab Druze Society questionnaire were positively intercorrelated. Collapsing values were particularly strongly associated with exposure to Western culture and was positively correlated with belief in reincarnation as a causal factor. All significant correlations remained significant after Benjamini-Hochberg false discovery rate correction for multiple comparisons.

Two separate stepwise linear regression analyses were conducted, each adjusting for age group (adolescent/adult), gender, family history of suicide, and number of previous suicide attempts.

For the right to commit suicide, the RFL coping beliefs subscale was the only variable that entered the model ($\beta = -0.63$, SE = 0.14, 95% CI [−0.91, −0.35], $p < .001$), explaining 28.0% of the variance. For every one-point increase in coping, the right to commit suicide decreased by 0.6 points. For suicidal ideation severity (PSS), GSI was the only variable that entered the model ($\beta = 0.82$, SE = 0.31, 95% CI [0.20, 1.45], $p = .011$), explaining 11.2% of the variance. For every one-point increase in general distress, suicidal ideation severity increased by 0.8 points.

Summary of examination of hypotheses

1. Hypothesis 1 was partially supported by the results. Low socioeconomic status of the family was associated with permissive attitudes toward suicide, SDQ prosocial behavior, and the perception that family and social difficulties were the cause of suicide. A family history of suicidality was not found to be associated with the research variables except for the severity of the suicide attempt result.
2. Hypothesis 2 was supported partially by the results. Two of the four suicidal measures—suicidal ideation severity (PSS) and endorsement of the right to commit suicide—were positively associated with GSI and negatively associated with both reasons for living subscales (survival and coping beliefs; fear of suicide). The remaining two measures—SUIATT and severity of the suicide attempt result—were not significantly associated with any of the predictor variables examined: extent of influence of reasons for self-injury, personal strengths and difficulties, or the Arab Druze-specific reasons for suicidality.
3. Hypothesis 3 was largely not supported by the results. Belief in reincarnation did not correlate with reasons for suicide or reasons to live. Only the perception of family and social difficulties within Arab Druze society was correlated with the level of distress.

Interviews: Qualitative analysis

As noted, qualitative interviews were conducted with 50 Arab Druze participants who were purposefully sampled either through the social services, through personal acquaintance of the researcher, or through acquaintance with people in the community who referred her to potential participants. The interviewees were 19 adolescents (nine boys and 10 girls aged 12–18), 15 young adults (eight men and seven women aged 19–35), and 16 adults (eight men and eight women aged 36–58). First, the researcher contacted potential participants by telephone, explained the study, and invited them to participate. The researcher arranged an interview with those who agreed to participate at a time and place that was convenient for each participant, e.g., at school, their place of work, or at the researcher's home. Before the interview they all signed an informed consent form. The researcher assured the participants that their anonymity would be maintained and that they were entitled to stop the interview at any point without consequence. The interview was based on an initial open question: Why did you attempt to commit suicide? The participants' answers led to follow-up questions according to the topics discussed. If the researcher identified psychological distress in the participants during the interview, she referred them to professional assistance, such as the social services, the family physician for a referral to psychological help, or telephone hotlines, according to their own preference. This occurred mainly with female interviewees. The researcher sent the interview transcripts to a statistics expert for thematic content analysis. First, the interview transcripts were read and reread to gain familiarity with the data. Then, common phrases and connections across the interviews were coded as units of meaning, leading to the identification of patterns and the emergence of four main themes: Family difficulties; Social difficulties; Religion-related difficulties, and psychological distress.

Theme 1: Family difficulties

Participants from all age groups and both genders reported family-related reasons for the suicide attempt. Adolescents reported receiving inadequate attention:

> I don't feel good at home. My mom is always busy with her work. My dad works till late. I feel neglected and don't receive warmth and love. (Male adolescent)
>
> Schoolwork is difficult for me. My parents' expectations of me are too high. (Male adolescent)
>
> Our situation at home is very hard. I feel unloved, neglected, they don't care for me; violence and anger. So, I don't want to live and I jumped off the roof. I had severe fractures all over my body. (Female adolescent)

From these quotes it is apparent that the parents' lack of availability drove these adolescents to feel isolated and neglected, which contributed to the reasons for their suicide attempt.

Socioeconomic difficulties were noted particularly in the female adolescent group:

> Our financial situation at home is very hard. I feel as though they don't love me. Neglected. They don't care for me. (Female adolescent)
>
> I am a weak student in school. Our economic situation at home is very difficult. (Female adolescent)

Adult males also mentioned socioeconomic difficulties:

> My wife is sick, I am sick; it is very hard financially and socially. I can't rely on anyone, and the medications are expensive, our young children are in school and it's hard for me to provide for all their needs. Stress, depression, not good to continue living, so I shot myself. (Male 36-58 group)
>
> After the army it wasn't easy to carry on with life. I did not study, I had no means of earning a living, no profession. I want to get married but have no money to build a house or to rent an apartment. I didn't

> know what to do. I was disappointed and was in a very bad way mentally. Stressors; I didn't know how to cope. (Male young adult)

These descriptions convey the sense of being alone and trapped in a situation with no prospects, which drove the men to the suicide attempt.

The adult females' reasons related mainly to the marital relationship:

> My husband was always unfaithful to me, would talk to other women and not treat me with respect. (Female 36–58 group)

In this group too, economic problems were mentioned:

> There is no money, the children are uncared for. No food. Sometimes the house is empty of everything: food, love, respect, and money. (Female young adult)

This emptiness, the absence of life's most basic needs leaves the woman with the feeling that she has no place or reason to live.

Women reported different types of abuse:

> An unsuccessful marriage. Violence at home. No money. No one cares about me. My husband beats me. (Female young adult)
>
> I am a woman who works hard, outside the home, and my husband takes all the money. He exploits me. I have nothing to my name. The children don't respect me, and I am ashamed of what is happening to me. (Female young adult)

The issue of shame recurred in several interviews with women. It seems that, notwithstanding the pain of violence and poverty, shame was the final breaking point.

Theme 2: Social difficulties

Social difficulties also were mentioned by all age groups and both genders. The adolescents' hardships largely revolved around romantic and peer group relationships.

> A one-sided breakup, infidelity. My girlfriend betrayed me and went off with my friend. My friend betrayed me and went off with my girlfriend. I felt terrible, frustrated, depressed; felt my life was no good, and decided to commit suicide, and shot myself. (Male adolescent)
>
> He played around with me and then chucked me. We were always arguing, but I love him. (Female adolescent)

An issue confronting male adolescents and young male adults was enlistment in the Israel Defense Forces (IDF), which has been mandatory in the Arab Druze community since 1956. However, some young men's personal wishes were incompatible with the society's expectations, reflecting a shift in values in the family and in society:

> I don't want to enlist in the IDF. After I went for all the tests and the basic training, I didn't feel good. I was frustrated; it was hard for me. I didn't feel good. I felt very conflicted. I couldn't cope with the idea. So, I decided to end my life. I took pills. (Male adolescent)
>
> I am not interested in enlisting in the army. They [the family] put a lot of pressure on me, and I feel it's not for me. I don't believe in it. (Male adolescent)

Another indication of collapsing values was the mention of involvement with criminality:

> I got mixed up with drugs. I stole. (Male young adult)
>
> I became involved with the underworld, and it was hard for me. I lost my family, and there were a lot of threats, thefts. (Male young adult)

Other interviewees spoke about becoming involved in socially unacceptable romantic relationships:

> I fell in love with my son's wife, and I found out. It was hard for me to accept, because of the social pressure. (Male 36–58 group)

Female adults spoke about the social pressure to raise a family:

> I got married and, so far, have no children. There is social pressure, they want me to have children. I feel embittered, the family is putting pressure on me; my husband is putting pressure on me. (Female young adult)

Refusal to enlist in the army, degeneration to criminal activity, forbidden romantic relationships, and reluctance to have children in a traditionally familial society are all symptoms of the gradual collapse in values occurring in the Arab Druze society.

Theme 3: Religion-related difficulties

Both male and female adolescents described situations in which their marital preferences contradicted Druze religious values:

> In high school, I fell in love with a girl from a different religion and it was very hard for me to accept that I wouldn’t be able to live with her because in our ethnic group it is unacceptable to marry someone from

> a different faith. So, it was very difficult for me; I felt angry, disappointed, hopeless, and empty. I didn't want to go on living and thought of ending my life. I took a large dose of pills. (Male adolescent)
>
> They want to marry me off to someone I don't love, and I'm not satisfied. Because of that, I didn't want to stay alive. (Female adolescent)

The belief in reincarnation is a foundational tenet of the Druze religion, and it was mentioned in all age groups and by both genders in the context of the suicide attempt.

> In a previous life, I was killed in the army, and I had very difficult thoughts in the army in that life, and I don't want to go through that again. (Male adolescent)
>
> My brother committed suicide and I could not live without him. (Male adolescent)
>
> I wanted to end my life and get a new life. Maybe that will comfort me after all the bad feelings. (Male young adult)
>
> Maybe in my next life things will be better for me. (Male 36-58 group)
>
> I decided to commit suicide. Perhaps I will end this difficult period of my life and will move into a new life in the next generation. (Female adolescent)

This perception of death, not as an ending but as the opening to a new beginning, was shown to serve as a catalyst to taking action.

Theme 4: Psychological distress

The fourth theme, psychological distress, ties the other three main themes together.

> No work, no home, financial debts. I do not want to live. (Male young adult)
>
> I am in a chronic state of depression. I feel frustrated and alone. I can't sleep at night and live on medication. I wanted to punish my husband and those around him. I wanted to hurt them because they have been hurting me my whole life. (Female 36–58 group)
>
> I do so much for everyone and no one respects me or gives me love or affection. I give everything and receive nothing. (Female 36–58 group)
>
> Difficult financial situation, violence at home, my husband is an alcoholic, lots of children at home, the house is neglected, hopelessness, no future, no money. We are barely alive, so I don't want to live. I tried to end my life. I took tablets. (Female 36–58 group)
>
> My husband died. I'm left alone at home and I am very frightened. My children have abandoned me and I can't sleep alone. I feel isolated. (Female 36–58 group)

It is clear from these quotes that family difficulties, social difficulties, and difficulties related to the Druze religion and the shifting values in society, for example "my children have abandoned me," all lead to a sense of psychological distress. This sense of hopelessness for the future was what drove the participants in all age groups to the suicide attempt.

DISCUSSION

This preliminary study set out to examine the reasons for suicidality in the Arab Druze society in Israel. The quantitative results indicate that suicidality among Arab Druze adolescents and adults is driven primarily by general psychological distress and less by the belief in reincarnation and the perception of collapsing traditional values, despite the hypothesis that the latter would play a major role. This aligns with Shneidman's (1993) conceptualization of "psychache," where unbearable emotional suffering acts as the direct catalyst for self-harm. Moreover, as general psychological distress (GSI) was the sole variable to enter the regression model for suicidal ideation severity, regardless of cultural background, internal emotional turmoil can be seen to be the primary driver of suicidal thoughts.

Hypotheses 1 and 2 were partially supported. Hypothesis 1 revealed a complex relationship between socioeconomic status, family history of suicidality, and suicidal behavior. Participants from lower socioeconomic backgrounds were more likely to view family and social difficulties as primary causes of suicide and held more permissive attitudes toward the act. In Hypothesis 2, a family history of suicidality did not correlate with cognitive or attitudinal measures but were positively associated with the physical severity of the suicide attempt result. This suggests a behavioral modeling in which individuals with a family history may not necessarily think about suicide more permissively, but their attempts utilize more lethal or severe means.

Hypothesis 3 was largely unsupported. Contrary to expectations, the Druze belief in reincarnation did not significantly correlate with suicidal ideation, attitudes, or reasons for living. Theoretically, a firm belief in reincarnation could be hypothesized to either deter suicide—due to spiritual accountability—or facilitate it—by reducing the fear of the finality of death. However, these results suggest that, during acute psychological crisis, individuals' immediate situational distress overrides their abstract theological beliefs.

In understanding the pathways away from suicide, the Reasons for Living (RFL) inventory (Linehan et al., 1983) provided the most robust insights. In the stepwise regression, survival and coping beliefs emerged as the sole significant buffer against endorsing the right to commit suicide, accounting for 28% of the variance. This highlights a critical clinical insight that suicide prevention in this population may rely less on reducing external stressors and more on actively building internal cognitive coping mechanisms and resilience strategies.

The qualitative interviews shed light on the quantitative lack of correlation between a belief in reincarnation and suicidal ideation or reasons for living. When interviewed about the immediate moments leading up to their attempt, participants did not generally mention theological concepts. Instead, their narratives were dominated by acute interpersonal pain, overwhelming shame, or family conflict. This qualitative finding strongly indicates that during a state of severe emotional crisis, abstract religious doctrines were shunted aside. The immediate, agonizing reality of emotional suffering appeared to overpower longstanding metaphysical beliefs about the cycle of life and death, explaining why reincarnation failed to emerge as either a protective buffer or a facilitator in the statistical models. However, the qualitative interviews revealed another perspective; that rather than being a reason for suicidality, reincarnation provided a framework for interpreting the crisis. Individuals in deep distress due to an insufferable life situation perceived reincarnation as a comforting idea: "Maybe in my next life things will be better for me." Individuals with ill health and facing financial difficulties did not attempt suicide *because of* the belief in reincarnation, but the idea served to soften the terminal nature of death and was hence a catalyst for performing the act. This is in line with a study by Prazak et al., (2023), which found that the commonly repeated notion that reincarnation beliefs are conducive to suicidal behavior was scarcely supported; instead, social and pragmatic factors shaped the meaning and interpretation of religious beliefs, which then buffered or facilitated suicidal behavior. There is a fine distinction between reincarnation as a reason and as a framework, but it has theoretical importance as it offers an additional explanation for why the hypothesis was not fully supported. In practical terms, belief does not change the approach to intervention. There is no need to fight against religious belief, but to focus on concrete distress. Once that is solved, the belief in reincarnation will once again be a spiritual perception rather than a concrete escape route.

In the quantitative model, GSI emerged as the single variable entering the stepwise regression for suicidal ideation severity. The qualitative interviews complement this finding by showing that distress in Arab Druze society is rooted largely in relational and cultural transitions (Walter & Siwar, 2021). For adolescents, the qualitative content analysis highlighted issues of intense stress regarding family honor, restrictive social codes, and the friction of navigating modern aspirations within the traditional community structure. For adults, distress was more frequently voiced through economic displacement and the shame of failing to meet collective family expectations. Thus, what registers quantitatively as general psychological distress is, in reality, a deeply sociocultural experience of feeling trapped between shifting generational values.

Limitations of the study

The first limitation is the small sample size. Recruiting participants was very challenging. Many refusals to participate were due to the difficulty of dealing with the subject and to the Arab Druze society perception that suicidality violates family honor. Thus, despite the anonymity of the research, potential participants were unwilling to disclose themselves. Refusal was not only individual, but institutional as well. The Ministry of Education refused the researcher's request to distribute questionnaires to adolescents in schools, and not all hospitals that were approached agreed to take part. Thus, as the findings might not be representative of the entire Arab Druze population, potential selection bias is indicated and limits generalization. Future research is recommended to address this recruitment difficulty, with emphasis on the characteristics of suicide attempters who refuse to participate. Another key institutional body that was not included in the study was the IDF. According mainly to the qualitative findings, a relationship was apparent in the Arab Druze society between suicide and military service. Further research in which Druze soldiers are interviewed during their military service is recommended. Quantitatively, the small sample limits the ability to detect small-to-medium effects. However, the regression findings (particularly the RFL coping explaining 28% of the variance in the right to commit suicide) are robust despite the sample size. The second limitation is the wide age range, which introduces developmental heterogeneity that the adolescent/adult split only partially addresses. Replication with larger samples disaggregated by tighter age bands is warranted. The third limitation is the cross-sectional design. As it is impossible to establish temporal precedence or to predict outcomes, the regressions/predictions reported should be interpreted with caution. Prospective longitudinal studies are needed to clarify the directionality of these relationships.

Clinical and practical implications

In light of the research findings, clinicians working with the Arab Druze community must screen individuals presenting high psychological distress as this was directly associated with suicidal ideation. Nationwide prevention programs are recommended for parents, teachers, school counselors, and religious leaders to provide professional and community gatekeeper training to identify individuals at high risk, for referral to immediate intervention. In the Arab Israeli society, in general, and in the Arab Druze society, in particular, there is a paucity of standards and budgets for intervention programs, in the Education and Health Ministries and in the community. The Arab society in Israel is coping with myriad problems, including multidimensional discrimination derived, inter alia, from the Basic Law: The Nation State of the Jewish People,[1] enacted in June 2018, which does not include commitment to equality for all the citizens of Israel alongside the values of a Jewish and democratic state.

CONCLUSION

This study offers important insights into the complex, under-researched phenomenon of suicidal behavior within Arab Druze society in Israel. Through a mixed-methods approach, the research reveals that although suicidality is statistically driven by immediate psychological distress (GSI) and is buffered by internal coping beliefs (RFL), the qualitative findings reveal this distress to be deeply sociocultural. What registers clinically as general psychological distress is, in fact, the painful lived experience of individuals caught within shifting generational values, rigid social expectations, and economic scarcity.

Furthermore, this study clarifies the role of cultural and religious doctrines during an acute crisis. Although the foundational Druze belief in reincarnation does not function as a statistical cause of suicidal ideation, the qualitative findings show that it operates as a profound psychological framework—an escape route that softens the finality of death when immediate pain becomes unbearable. Ultimately, these findings underscore that suicide prevention and clinical intervention within this population should not focus on challenging deeply held metaphysical beliefs, but must prioritize alleviating immediate, concrete relational and socioeconomic distress while actively fostering internal cognitive resilience strategies.

Acknowledgement

The article is based on the author's doctoral dissertation, Department of Special Education, Faculty of Education, University of Haifa. Special thanks to my supervisors, Professor Alan Apter and Professor Salim Abu Rabia.

Funding

The research received no external funding.

Ethical statement

This study was conducted in accordance with ethical guidelines for research on human subjects and received Helsinki Committee approval from the following medical centers in the north of Israel: Tzafon Medical Center, Baruch Padeh, Tiberias; Emek Medical Center, Afula; Carmel Medical Center, Haifa; Galilee Medical Center, Nahariya; Mazra Mental Health Center, Acre; The Nazareth Hospital EMMS; Ziv Medical Center, Safed.

Competing interests

The author has no competing interest in declaring.

Author contributions

The author was responsible for all aspects of the research and manuscript preparation.

Data availability

Data is available on request.

[1] The full wording of the law can be found in the Book of Laws, 24 Av, 5778/July 19, 2018, Basic Law: Israel: State of the Jewish People, page 898. An unofficial translation to English appears on the Knesset website, https://m.knesset.gov.il/EN/activity/documents/BasicLawsPDF/BasicLawNationState.pdf

AI disclosure

The statistical analysis and data interpretation were independently performed and verified by a human researcher. AI was used solely to generate and insert data into the tables and to improve readability of parts of the manuscript. The author takes full responsibility for all content.

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