

# Characterization of adolescents with suicidal behavior and their families

Caracterização de adolescentes com comportamento suicida e suas famílias

Caracterización de adolescentes con conducta suicida y sus familias

Raysa Abreu Fonseca<sup>1</sup> <https://orcid.org/0009-0005-3869-3417>

Luísa Bottoni Corrêa<sup>1</sup> <https://orcid.org/0000-0003-1189-2473>

Sheila Cavalcante Caetano<sup>2</sup> <https://orcid.org/0000-0001-8403-7078>

Elson de Miranda Asevedo<sup>2</sup> <https://orcid.org/0000-0002-3109-2695>

Andréia Cascaes Cruz<sup>1</sup> <https://orcid.org/0000-0003-2264-0140>

Lucía Silva<sup>1</sup> <https://orcid.org/0000-0002-6353-7580>

## Abstract

**Objective:** To characterize the profile of families and adolescents with suicidal behavior.

**Methods:** This was a descriptive, quantitative study carried out in two outpatient clinics of the Department of Psychiatry at the *Universidade Federal de São Paulo*. Data was collected by consulting medical records, applying instruments developed by researchers to collect sociodemographic data, and constructing genogram and ecomap. The data was analyzed using descriptive statistics.

**Results:** Twenty-five people took part in the study (12 mothers and 13 adolescents). The mothers were aged between 30 and 59, of whom 38.46% reported having depression and 8.33% reported suicidal behavior by adolescents' fathers. With regard to adolescents, 53.85% were aged between 16 and 17 years old, 69.23% were female, 92.31% had planned to attempt their own lives and 53.85% had attempted suicide.

**Conclusion:** Half of the adolescents in this study had attempted suicide, putting their lives at risk. Half of the mothers did not have someone who was co-responsible for caring for adolescents.

## Resumo

**Objetivo:** Caracterizar o perfil de famílias e adolescentes com comportamento suicida.

**Métodos:** Estudo descritivo, quantitativo, desenvolvido em dois ambulatórios do Departamento de Psiquiatria da Universidade Federal de São Paulo. Os dados foram coletados por meio de consulta aos prontuários, aplicação de instrumentos elaborados pelos pesquisadores para coleta de dados sociodemográficos, e construção de genograma e ecomapa. A análise foi realizada por estatística descritiva.

**Resultados:** Participaram do estudo 25 pessoas (12 mães e 13 adolescentes). As mães tinham idade entre 30 e 59 anos, das quais 38,46% referiram ter depressão e 8,33% relataram comportamento suicida dos pais dos adolescentes. Em relação aos adolescentes, 53,85% tinham entre 16 e 17 anos, 69,23% eram do sexo feminino, 92,31% planejaram atentar contra a própria vida e 53,85% tentaram o suicídio.

**Conclusão:** Metade dos adolescentes deste estudo realizou uma tentativa de suicídio e colocou sua vida em risco. Metade das mães não tinha alguém que se corresponsabilizasse pelo cuidado do adolescente.

## Resumen

**Objetivo:** Caracterizar el perfil de familias y adolescentes con comportamiento suicida.

**Métodos:** Estudio descriptivo, cuantitativo, realizado en dos ambulatorios del Departamento de Psiquiatria de la *Universidade Federal de São Paulo*. Los datos fueron recolectados por medio de consulta de historias clínicas, aplicación de instrumentos desarrollados por los investigadores para recopilar datos sociodemográficos, y construcción de genograma y ecomapa. Los datos se analizaron mediante estadística descriptiva.

**Resultados:** Participaron del estudio 25 personas (12 madres y 13 adolescentes). Las madres tenían entre 30 y 59 años, de las cuales 38,46% relataron tener depresión y 8,33%, comportamiento suicida por parte de los padres de los adolescentes. En cuanto a los adolescentes, 53,85% tenían entre 16 y 17 años, 69,23% eran mujeres, 92,31% habían planeado atentar contra su vida y 53,85% habían intentado suicidarse.

**Conclusión:** La mitad de los adolescentes de este estudio había intentado suicidarse y había puesto su vida en riesgo. La mitad de las madres no tenía quien se corresponsabilizase del cuidado del adolescente.

## Keywords

Pediatric Nursing; Suicide; Suicide Attempt; Family; Adolescent; Mental Health

## Descritores

Enfermagem Pediátrica; Suicídio; Tentativa de Suicídio; Família; Adolescente; Saúde Mental

## Descriptores

Enfermería Pediátrica; Suicidio; Intento de Suicidio; Familia; Adolescente; Salud Mental

## How to cite:

Fonseca RA, Corrêa LB, Caetano SC, Asevedo EM, Cruz AC, Silva L. Characterization of adolescents with suicidal behavior and their families. *Rev Soc Bras Enferm Ped.* 2024;24:eSOBEP202416i.

<sup>1</sup>Escola Paulista de Enfermagem, Universidade Federal de São Paulo, São Paulo, SP, Brazil.

<sup>2</sup>Escola Paulista de Medicina, Universidade Federal de São Paulo, São Paulo, SP, Brazil.

Conflicts of interest: nothing to declare.

Submitted: November 12, 2024 | Accepted: December 18, 2024

Corresponding author: Lucía Silva | E-mail: silva.lucia@unifesp.br

DOI: 10.31508/1676-3793202416i

## Introduction

Suicidal behavior encompasses suicidal ideation, attempted suicide and suicide itself. Ideation refers to the thought of taking one's own life; attempt refers to the practice of self-inflicted violence with the same intention, but without causing one's own death. Suicide itself is suicidal behavior with a fatal outcome.<sup>(1)</sup> However, these phenomena that make up suicidal behavior are not characterized by definitive phases, i.e., an adolescent who has attempted suicide may, for instance, after a period of improvement or stability, return to suicidal ideation later on.

Suicide is one of the main public health problems: every forty seconds there is a death by suicide and every year it affects more than 800,000 people worldwide.<sup>(2)</sup> It is also estimated that for every death there are between ten and twenty times as many attempts; however, these figures are underestimated. There are barriers related to only reporting cases that have reached a healthcare service, the difficulty in distinguishing between an accident and an intentional event, and misinformation about the subject among healthcare professionals and family members.<sup>(3)</sup>

In relation to young people, suicide is the second most frequent cause of death among people aged 15 to 29 of both sexes and the third leading cause of death among 15 to 19 year olds in the world.<sup>(2)</sup> In Brazil, there were 21,790 deaths by suicide, between 2011 and 2017, and a 24% increase in rates, between 2004 and 2015, in the 10-19 age group in six major state capitals.<sup>(4,5)</sup> As for suicide attempts, 48,204 occurrences were recorded between 2011 and 2016 in the Notifiable Diseases Information System (in Portuguese, *Sistema de Informação de Agravos de Notificação - Sinan*).<sup>(6)</sup>

During adolescence, individuals face internal and external changes, and are learning to understand their role in their relationships as well as how to deal with their emotions. This whole process can be intense, causing adolescents to adopt impetuous attitudes.<sup>(1,7)</sup>

The family is a space where individuals can fully develop, establishing their first relationships and personality traits. Family dynamics and structure, as well as the health-disease process, can influence behavior. In addition, individual and socioeconomic factors, and the presence or absence of social ties can be risk or protective factors for suicidal behavior.<sup>(1,5,8-12)</sup>

Risk factors for suicidal behavior include mental disorders, personality traits, family violence, a family history of suicide, and family, socioeconomic, psychosocial, and school-related stressors, among others.<sup>(1,9,10,12,13)</sup>

This study focuses on suicidal behavior in adolescents, and it is also necessary to consider the family in which these individuals live. Characterizing adolescents with suicidal behavior and their families and understanding the environment in which they live enables better knowledge of this population and planning to target public policies for prevention and intervention. At the same time, it is understood that early recognition of risk factors and elements of negative or protective influence can prevent late diagnosis and intervention.

This study aimed, therefore, to characterize the profile of families and adolescents with suicidal behavior.

## Methods

This is a descriptive, quantitative study. The research was initially conducted at the Child and Adolescent Comprehensive Development Outpatient Clinic, linked to the Department of Psychiatry at the *Escola Paulista de Medicina, Universidade Federal de São Paulo (UNIFESP)*. This outpatient clinic is located in the Vila Mariana Integrated Mental Healthcare Center (in Portuguese, *Centro de Atenção Integrada à Saúde Mental - CAISM*), which provides care to users of the Brazilian Healthcare system (in Portuguese, *Sistema Único de Saúde - SUS*), and is part of the Psychosocial Care Network. As of September 2020, the adolescents eligible for the study began to be monitored by the outpatient clinic *Conversas de Vida: centro de promoção de esperança e prevenção de suicídio*.

There were 25 participants in the study, including family members and adolescents. Eligible family members had to be a family member or guardian who had disclosed suicidal behavior (ideation, planning or attempted suicide) and had been diagnosed and treated by the psychiatrist linked to the study site, be aged 18 or over and agree to take part in the study by giving written consent.

Eligible adolescents had to have previous or current suicidal behavior identified by the psychiatrist responsible for monitoring them, agree to take part and have their guardians' authorization to do so.

According to the Ministry of Health, adolescence comprises the second decade of life (from 10 to 19 years),<sup>(14)</sup> and this criterion was used in this study.

Data collection regarding family characterization began in January 2020. It was interrupted from March to August 2020 due to the COVID-19 pandemic and was resumed between September 2020 and June 2021. Data collection on adolescents took place between August 2019 and June 2020.

The data collection stage was carried out by two undergraduate students and the researcher in charge. Eligible participants were invited to take part in the study on the day of their scheduled appointment.

After being given information about the research procedures, those who accepted signed the Informed Consent Form. The adolescents signed their names on the consent form.

The data to characterize participants was obtained from medical records and information collected from the adolescents and their families, using as a guide an instrument pre-designed by the researchers to collect sociodemographic data and construct a genogram and an ecomap. The genogram and the ecomap were drawn up in accordance with the Calgary Family Assessment Model, with the aim of understanding the family structure and relationships, their interaction with the community in which they live, their support network and how their ties with other groups are arranged, characterizing them as very strong, strong, moderate, weak, conflicting or severed, with close friends, religious institutions and healthcare services.<sup>(15)</sup>

Once collected, the data was entered into the Excel program and explored using descriptive statistics. The absolute and relative frequencies of each variable were calculated and presented.

The research has received a favorable opinion from the Research Ethics Committee of the proponent institution under number 3,165,699 (Certificate of Presentation for Ethical Consideration 04289218.0.0000.5505), and the ethical precepts contained in Resolution 466 of 2012 were followed.

## Results

Thirteen adolescents of both sexes, aged between 10 and 18, took part in the study. The mean age was 14.38

years, and the median was 16 years old. The sample of family members was made up of 12 mothers of adolescents. They were aged between 30 and 59, with a mean age of 42.58 and a median age of 42. This group was smaller because one of the participants was the mother of two adolescents (twins). Table 1 shows the sociodemographic characteristics of the group of adolescents and family members taking part in the study.

**Table 1.** Sociodemographic characteristics of the group of adolescents and their families

Variables	Adolescents n(%)	Mothers n(%)
Age		
10-11 years	3(23.08)	0
12-13 years	1(7.69)	0
14-15 years	2(15.38)	0
16-17 years	7(53.85)	0
30-59 years	0	12(100)
Sex		
Female	9(69.23)	12(100)
Male	4(30.77)	0
Marital status		
Single	13(100)	0
Married	0	3(25)
In a stable union	0	1(8.33)
Divorced	0	6(50)
Widowed	0	2(16.67)
Education		
5 <sup>th</sup> -6 <sup>th</sup> grade	3(23.08)	0
7 <sup>th</sup> -8 <sup>th</sup> grade	2(15.38)	0
9 <sup>th</sup> grade-1 <sup>st</sup> grade	5(38.46)	0
2 <sup>nd</sup> -3 <sup>rd</sup> grade	3(23.08)	0
Complete elementary school I	0	1(8.33)
Complete elementary school II	0	1(8.33)
Incomplete high school	0	2(16.67)
Complete high school	0	4(33.33)
Incomplete higher education	0	1(8.33)
Complete higher education	0	3(25)
Occupation		
Student	13(100)	0
Science and arts professional	0	5(41.67)
Service worker, retail salesperson in stores and markets	0	3(25)
Medium-level technician	0	2(16.67)
Housewife	0	2(16.67)
Family income		
Up to two minimum wages	0	7(58.34)
Between two and four minimum wages	0	4(33.33)
Between five and eight minimum wages	0	1(8.33)
Participation in government benefits	0	2(16.67)
Religion		
Evangelical	6(46.15)	4(33.33)
Catholic	4(30.77)	5(41.67)
Christian	1(7.69)	1(8.33)
Rosicrucian Order	1(7.69)	1(8.33)
Umbanda	0	1(8.33)
No religion	1(7.69)	0
Religious practice		
Practicing	8(61.54)	9(75)
Non-practicing	5(38.46)	3(25)

Table 2 shows data on the characterization of adolescents' mental healthcare profile.

**Table 2.** Characterization of adolescents' mental health aspects\*

Variables	Adolescents n(%)
Diagnosis	
Depression	8(61.54)
Bipolar disorder	4(30.77)
Generalized anxiety disorder	3(23.08)
Attention deficit disorder	1(7.69)
Borderline personality disorder	1(7.69)
Post-traumatic stress disorder	1(7.69)
Oppositional defiant disorder	1(7.69)
Age at diagnosis	
6-8 years	2(15.38)
9-12 years	4(30.77)
13-15 years	4(30.77)
16-17 years	3(23.08)
Drug treatment	
Antidepressants	9(69.23)
Antipsychotics	7(53.85)
Mood stabilizers	3(23.08)
Benzodiazepines	2(15.38)
Melatoninergic	1(7.69)
Non-pharmacological measures	
Individual psychotherapy	6(46.15)
Therapeutic groups	2(15.38)
Acupuncture and homeopathy	1(7.69)
Suicidal behavior	
Ideation	13(100)
Planning	12(92.31)
Attempt	7(53.85)
Number of attempts	
Once	2(28.57)
Twice	1(14.29)
Three times	4(57.14)
Sex of attempters	
Female	6(85.71)
Male	1(14.29)
History of violence	
Self-mutilation	5(38.46)
Heteroaggression	5(38.46)
Sexual abuse	2(15.38)
Bullying	4(30.77)
Physical aggression at school	2(15.38)
Exposure to domestic violence	1(7.69)
History of recent death/impact on adolescents	
Yes	6(46.2)
No	7(53.8)
Use of licit and illicit substances	
Yes	3(23.08)
Alcohol	1(7.69)
Alcohol and tobacco	1(7.69)
Marijuana	1(7.69)
No	10(76.92)
Psychiatric hospitalizations	
Yes	2(15.38)
No	11(84.62)

\*The adolescent could fit into more than one category.

Based on the genogram, the paternal presence in the family's life was mapped: seven (58.33%) were ab-

sent. Of these, two (16.67%) were cut off by a relative's death and another two (16.67%) have no contact, with one of the fathers (8.33%) having sexually abused the adolescent.

The number of psychiatric diagnoses was higher than the total number of participants: some adolescents had more than one diagnosis. Table 3 shows relational aspects and information on adolescents' family history.

**Table 3.** Relational and mental health aspects of adolescents' maternal and paternal family history

Relational aspects	Maternal n(%)	Paternal n(%)
Presence in the adolescent's life		
Yes	12(100)	5(41.67)
No	0	7(58.33)
Bond with the adolescent		
Very strong	7(58.33)	2(16.67)
Weak	2(16.67)	2(16.67)
Weak and conflicted	0	1(8.33)
Severed	3(25)	7(58.33)
Personal history of psychiatric illness		
Depression	4(33.33)	1(8.33)
Generalized anxiety disorder	3(25)	1(8.33)
Bipolar disorder	1(8.33)	3(25)
Postpartum depression	1(8.33)	0
Schizophrenia	0	1(8.33)
Abuse of multiple licit and illicit drugs	1(8.33)	1(8.33)
None	5(41.67)	5(41.67)
Unknown	1(8.33)	3(25)
Use of licit and illicit substances		
No	5(41.67)	0
Marijuana	1(8.33)	0
Unknown	6(50)	12(100)
Suicidal behavior		
Yes	2(16.67)	1(8.33)
Unknown	10(83.33)	11(91.67)
Family history of psychiatric illness		
Depression	2(16.67)	3(25)
Bipolar disorder	0	1(8.33)
Schizophrenia	1(8.33)	1(8.33)
Generalized anxiety disorder	1(8.33)	0
Postpartum depression	1(8.33)	0
Suicidal behavior in the family		
Present	1(8.33)	0
Unknown or absent	11(91.67)	12(100)

Based on the genogram, the paternal presence in the family's life was mapped: seven (58.33%) denied it. Of these, two (16.67%) were interrupted by paternal death and another two (16.67%) had no contact at all, with one of the fathers (8.33%) having sexually abused the adolescent. The ecomap showed that six (46.15%) participants reported ties with the school, with four (30.77%) having weak ties and two (15.38%) having strong ties. Six (46.15%) participants reported friends

and eight (61.54%) mentioned leisure. Of these eight, three (37.5%) used electronics, three (37.5%) went out with friends, two (25%) played ball, one (12.5%) played instruments and one (12.5%) went to the park. With regard to the support network, four (33.33%) mothers said they relied on family members. Nine (75%) of participants reported religious institutions, two (16.67%) said they had close friends and one (8.33%) reported healthcare services. Nine (75%) of participants reported having no means of leisure. Only one (8.33%) reported having them, which was listening to music. Two of participants did not mention them. It is important to note that four (33.33%) participants said they had pets, while two (16.67%) said they did not have pets and six (50%) did not mention them.

## Discussion

The adolescents who made up the sample in this study wanted to die, with the majority planning it and at least half attempting to take their own lives. This reality may shock family members, healthcare and education professionals, since the “natural” thing would be for children and adolescents to be playing, discovering and planning for the future. However, admitting that mental distress and suicidal behavior can occur during adolescence is fundamental for outlining prevention strategies.<sup>(7)</sup>

In this regard, although family, socioeconomic, cultural and individual factors that can predict risk for suicidal behavior, suicide should always be considered preventable.

Supporting, listening and welcoming these adolescents makes all the difference so that they can create the means to deal with adversity and gain access to professional help in good time. Judgments, belittling and taboo on others’ suffering should not be tolerated.

These results show that adolescents who think about and verbalize their desire to die make attempts. Previous attempts are a major risk factor for suicide and future attempts may be more lethal, increasing the chance of future effectiveness.<sup>(9)</sup>

The prevalence of females in this study is also observed in the literature, as in a study which associated the predominance of suicidal ideation in adolescents in Piauí with females.<sup>(16)</sup> The 85.71% prevalence rate

among those who made attempts in this study can be checked against other studies, which show a higher frequency among female adolescents, but also in other age groups.<sup>(17)</sup> Gender issues have numerous factors which can trigger suffering. In a study that gathered data from 87 countries from 2006 to 2016, increased gender equality was associated with a significant reduction in suicide rates among women.<sup>(18)</sup>

Having a previous psychiatric diagnosis is strongly associated with suicidal behavior in childhood and adolescence.<sup>(9)</sup> It is important to note that having a diagnosis gives people the opportunity to name the disorder and have the possibility of treatment for their suffering.

This investigation revealed that more than half of the sample had depression, which is one of the main factors associated with the phenomenon of suicide and a five times greater risk of attempts in this population.<sup>(9)</sup>

In this study, two adolescents had suffered sexual abuse, which is one of the risk factors for suicidal behavior.<sup>(10)</sup> It is already known that, in most cases, the perpetrator of the violence is someone known to the victim, including family members.<sup>(19)</sup> In this sense, it is important to reinforce the support of sex education in the school environment so that more adolescents have the resources to report the violence they have suffered and, consequently, prevent suicidal behavior.

With regard to family members, participants in this study were women, mothers of adolescents with suicidal behavior. They were the ones who accompanied their children to appointments as well as being the main carers for the family. In general, this social role of caregiver is assigned to mothers, and the care of the whole family is seen as the women’s responsibility. This division of roles is culturally widespread and socially present as well as being described in the literature.<sup>(20)</sup>

It should be noted that two of the participants were housewives and only one reported having leisure time; it is assumed that most of them are subjected to an exhausting routine. In a sample of five mothers of adolescents with mental distress, it was observed that physical and psychological stress became inherent in their routine, and this was greater when compared to fathers. The study also highlights how leisure can reduce the damage related to overload.<sup>(21)</sup>

During the genogram and ecomap construction, four participants said they had family members in

their support network, and that they were predominantly female. Half of participants were separated or divorced and, for most of them, the father was not present. These women are the heads of their families and experience emotional overload due to all their duties. This predisposes them to family illness so that female single-parent families are more susceptible to developing anxiety and depression.<sup>(22)</sup>

Specifically with regard to the bond with parents, a study of 604 individuals aged between 15 and 18 years revealed that adolescents whose parental emotional ties are of inadequate quality are predisposed to suicidal ideation. Secure emotional ties are protective factors, making adolescents feel more supported.<sup>(23)</sup>

Parental absence is related to negative emotional states as well as a greater propensity to suicidal ideation.<sup>(11)</sup> This is related to greater children's emotional instability, representing a loss in what should be their support network.<sup>(24)</sup>

The presence of psychiatric illnesses in the family history has been noted, and the most relevant were depression, anxiety disorder, and bipolar disorder. A study carried out in Minas Gerais with data from 2,319 patients aged up to 21 years revealed that 79% of those who attempted suicide had a family psychiatric history, which is a risk factor for the development of suicidal behavior.<sup>(25)</sup>

This study revealed the existence of suicidal behavior in parental histories. This history has a great influence on children, especially when considering caregivers' mental illness and its consequences in the family environment. Family influence has been observed in the literature, although it is unclear how much of this relationship is due to genetic, social and/or environmental factors. Considering that the illness of one of the family members can have an impact on the whole family's health, it is extremely important to trace the family's psychiatric history.

A study conducted in South Korea revealed a significant relationship between parental depressive symptoms and suicidal ideation in children. Stress and depressive symptoms were the main risk factors so that when one of the parents had suicidal ideation, their children were twice as likely to develop it.<sup>(26)</sup>

Moreover, 46.2% of participants reported a history of recent or relevant death in the family, which is a stressful event not only for adolescents, but for all

family members. Loss is a commonly considered negative factor for suicidal behavior by adolescents.<sup>(12)</sup>

It is believed that school plays an important role in adolescents' daily lives, often being the only place for social interaction. All participants were students, and of those who mentioned school as one of the systems that make up their routine, the majority cited a weak bond, which is worrying, given that it can be represented as an opportune place for friendships, physical activities, and personal, cognitive and pedagogical development.

In this investigation, bullying was reported by 30.77% of pediatric participants and 15.38% suffered physical aggression at school. School should be a community where everyone feels a sense of belonging and safety, a feeling that also protects people against suicidal behavior.<sup>(27)</sup> In a sample of 674 students in Teresina/Piauí, suicidal ideation was reported more frequently among students who had suffered physical violence and was three times more prevalent among students who had suffered sexual violence.<sup>(16)</sup> Religiousness may be a protective factor for suicidal behavior among adolescents, and 61.6% of participants in the present study reported bullying.

Religiosity can be a protective factor for suicidal behavior among adolescents, and 61.54% of this sample practiced some form of religion. Involvement in religious practice can offer support, the adoption of healthy lifestyles, motivation and guidance in difficult times.<sup>(1,28)</sup> In another Brazilian sample, which was part of a study aimed at analyzing the prevalence and associated factors of suicidal ideation among adolescents, it was found that the highest prevalence of suicidal behavior was among students with no religion.<sup>(16)</sup>

There were a number of participants who owned pets. Pets can play an important role in individuals' mental health, and the well-being they provide is evidenced in the literature. Although they are not directly responsible for any healing process, their presence in the family environment has a positive influence on suicidal behavior and is associated with a reduction in self-injurious actions.<sup>(29)</sup>

It is extremely important to note that 8.33% of the sample said they had healthcare services as part of their support network, which is a major challenge for health teams, especially in primary healthcare (PHC). The literature points to the need for comprehensive

care for individuals with suicidal behavior, with attention to biopsychosocial aspects, understanding them as part of a social group.<sup>(30)</sup>

Within this framework, we can also highlight the Patient and Family Centered Care (PFCC) model, where care provides support for the family and includes them as a comprehensive part of decision-making and healthcare. Involvement helps to understand the family's needs and context, establishing a relationship of trust, respect, and partnership.

As a study limitation, we would like to highlight the need for additional meetings to make the genogram and ecomap more complete, providing more data on the relational and mental health aspects of adolescents' parents. As the genogram and ecomap are not part of the routine care provided to these families and were drawn up strictly for the purpose of the research, they were constructed in a single meeting, and sometimes new opportunities are needed so that families can open up and report more information about their dynamics. As a result, some data was characterized as "unknown" for this reason or because the mother was unable to report some information at the time. In addition to this, both the genogram and the ecomap were constructed manually, which, although effective for care, took time and resources in terms of people and physical space in the clinic. The adoption of specific software could optimize their preparation for research, facilitating their use in publications and academic activities.

Based on the profile found, we highlighted some points for suicide prevention strategies in this population: access to healthcare services in the event of suspected mental illness or suicidal behavior; gender equality promotion; guidance on alcohol and drug use; encouragement of non-violence, good relationships in schools and sex education. In general, multi-professional teams' potential and responsibility, including PHC, to properly report self-harm is highlighted. More reliable data will help us to qualify our actions and put pressure on public authorities to invest in public policies related to the issue.

It should be noted that, during data collection, a space was established for adolescents and their families to receive and listen to therapy, and various multisectoral and multidisciplinary demands arose which could be referred to other services.

## Conclusion

The sociodemographic profile of families of adolescents with suicidal behavior was characterized by mothers, half of whom did not have a partner or someone who was co-responsible for looking after their children. The church was indicated as the only source of social support, and this support network, with limited resources, is a challenge for professional care teams, especially in PHC. The healthcare profile of family members indicated the presence of mental disorders and suicidal behavior in family history. Most of mothers had health problems. The profile of adolescents indicated that half of them had attempted suicide and put their lives at risk.

## Acknowledgements

This work was carried out with the support of the Brazilian National Council for Scientific and Technological Development (in Portuguese, *Conselho Nacional de Desenvolvimento Científico e Tecnológico - CNPq*), through the UNIFESP Institutional Program for Scientific Initiation Scholarships (in Portuguese, *Programa Institucional de Bolsas de Iniciação Científica - PIBIC*) (Processes nº 126814/2019-8 and nº144116/2020-0).

## Contributions

Fonseca RA, Corrêa LB, Caetano SC, Asevedo EM, Cruz AC and Silva L contributed to study conception, data collection, analysis and interpretation, article writing, relevant critical review of intellectual content and approval of the final version to be published.

## References

1. Cardoso AS, Ceconello AM. Fatores de risco e proteção para o suicídio na adolescência: uma revisão de literatura. *Revista Perspectiva: Ciência e Saúde*. 2019; 4(2):101-17.
2. World Health Organization. Suicide in the world: Global health estimates. World Health Organization. 2019. Available at: <https://www.who.int/publications/i/item/suicide-in-the-world>
3. Marcolan JF, Silva DA. O comportamento suicida na realidade brasileira: aspectos epidemiológicos e da política de prevenção. *Revista M Estudos sobre a morte, os mortos e o morrer*. 2019; 4(7): 31-44. Available at: <https://doi.org/10.9789/2525-3050.2019.v4i7.31-44>
4. Comitê Estadual de Promoção da Vida e Prevenção do Suicídio do Estado do Rio Grande do Sul. Comissão da Criança e do/a Adolescente. Guia Intersetorial de Prevenção do Comportamento Suicida em Crianças e Adolescentes. 2019. Available at: <https://saude.rs.gov.br/upload/arquivos/201911/13155144-guia-intersetorial-de-prevencao-do-comportamento-suicida-em-criancas-e-adolescentes-2019.pdf>

5. Jaen-Varas D, Mari JJ, Asevedo E, Borschmann R, Diniz E, Ziebold C, et al. The association between adolescent suicide rates and socioeconomic indicators in Brazil: a 10-year retrospective ecological study. *Braz J Psychiatry* [Internet]. 2019; 41(5):389-95. Available at: <https://doi.org/10.1590/1516-4446-2018-0223>
6. Ministério da Saúde; Secretaria de Vigilância em Saúde. Perfil epidemiológico das tentativas e óbitos por suicídio no Brasil e a rede de atenção à saúde. *Boletim Epidemiológico*. 2017. Available at: <http://portalarquivos2.saude.gov.br/images/pdf/2017/setembro/21/2017-025-Perfil-epidemiologico-das-tentativas-e-obitos-por-suicidio-no-Brasil-e-a-rede-de-atencao-a-saude.pdf>
7. Silva L. Suicídio entre crianças e adolescentes: um alerta para o cumprimento do imperativo global. *Acta Paulista de Enfermagem*. 2019; 32(3):III-IV. Available at: <https://doi.org/10.1590/1982-0194201900033>
8. Tabares MM, Villa SR, Rendón SV. Relaciones parentofiliales en la infancia. *Prevención del comportamiento suicida*. Poiesis. 2019; 36:147-63. Available at: <https://doi.org/10.21501/16920945.3195>
9. Carballo JJ, Llorente C, Kehrmann L, Flamarique I, Zuddas A, Purper-Ouakil D, et al. Psychosocial risk factors for suicidality in children and adolescents. *European Child & Adolescent Psychiatry*. 2019; 29(6). Available at: <https://doi.org/10.1007/s00787-018-01270-9>
10. Bhering NBV, Aquino MLA, Duarte AM, Vilela BP, Chiuso D, Lopes FM de M, et al. Análise dos fatores de risco relacionados ao comportamento suicida em crianças e adolescentes. *Brazilian Journal of Health Review*. 2020; 3(4):10861-75. Available at: <https://doi.org/10.34119/bjhrv3n4-343>
11. Fu M, Xue Y, Zhou W, Yuan TF. Parental absence predicts suicide ideation through emotional disorders. *PLOS ONE*. 2017; 12(12):e0188823. Available at: <https://doi.org/10.1371/journal.pone.0188823>
12. Kennebeck S, Bonin L. Suicidal behavior in children and adolescents: epidemiology and risk factors. *UpToDate*. 2017. Available at: <https://www.uptodate.com/contents/suicidal-behavior-in-children-and-adolescents-epidemiology-and-risk-factors>
13. Ministério da Saúde. Secretaria de Vigilância em Saúde. Perfil epidemiológico dos casos notificados de violência autoprovocada e óbitos por suicídio entre jovens de 15 a 29 anos no Brasil, 2011 a 2018. *Boletim Epidemiológico*. 2019; 50(24): 1-14. Available at: <https://www.ifen.com.br/site/files/198/Nucleo-Especifico--Atuacao-Clinica-Situacoes-Suicidio/247/BE-suic-dio-24-final.pdf>
14. World Health Organization. Adolescent health. Genebra. 2009. Available at: [https://www.who.int/health-topics/adolescent-health#tab=tab\\_1](https://www.who.int/health-topics/adolescent-health#tab=tab_1)
15. Wright LM, Leahey M. *Enfermeiras e famílias: um guia para avaliação e intervenção na família*. 4.ed. São Paulo: Roca, 2008.
16. Sousa CM de S, Mascarenhas MDM, Gomes KRO, Rodrigues MTP, Miranda CES, Frota K de MG. Suicidal ideation and associated factors among high school adolescents. *Rev saúde pública*. 2020. Available at: <https://doi.org/10.11606/s1518-8787.2020054001637>
17. Sousa GS de, Santos MSP dos, Silva ATP da, Perrelli JGA, Sougey EB. Revisão de literatura sobre suicídio na infância. *Ciência & Saúde Coletiva*. 2017; 22(9):3099-110. Available at: <https://doi.org/10.1590/1413-81232017229.14582017>
18. Milner A, Scovelle AJ, Hewitt B, Maheen H, Ruppanner L, King TL. Shifts in gender equality and suicide: a panel study of changes over time in 87 countries. *Journal of Affective Disorders*. 2020; 276:495-500. Available at: <https://doi.org/10.1016/j.jad.2020.07.105>
19. Araujo G de, Ramos M, Zaleski T, Rozin L, Sanches L da C. Determinantes da violência sexual infantil no estado do Paraná - Brasil. *Espac. Saude*. 2021; 20(2):42-54. Available at: <https://doi.org/10.22421/15177130-2019v20n2p42>
20. Borsa JC, Nunes MLT. Aspectos psicossociais da parentalidade: o papel de homens e mulheres na família nuclear. *Psicologia Argumento*. 2017; 29(64). Available at: <https://doi.org/10.7213/rpa.v29i64.19835>
21. Silva JB, Soares CCD, Silva PM de C, Azevedo EB de, Saraiva AM, Filha M de OF. "Padecendo no paraíso": as dificuldades encontradas pelas mães no cuidado à criança com sofrimento mental. *Revista Eletrônica de Enfermagem*. 2015; 17(3). Available at: <https://doi.org/10.5216/ree.v17i3.25362>
22. Basoni A, Siqueira AC, Silva AL de A. As famílias monoparentais femininas: um estudo sobre o nível de ansiedade e depressão. *Revista FAROL*. 2021; 12(12):117-31. Available at: <https://revista.farol.edu.br/index.php/farol/article/view/327/217>
23. Nunes F, Mota CP. Vinculação aos pais, competências sociais e ideação suicida em adolescentes. *Arquivos Brasileiros de Psicologia*. 2017; 69(3):52-65. Available at: [http://pepsic.bvsalud.org/scielo.php?script=sci\\_arttext&pid=S1809-52672017000300005&lng=pt](http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1809-52672017000300005&lng=pt)
24. Santos D da S, Angonese AS. O impacto da figura paterna no desenvolvimento emocional e da personalidade dos filhos. *Unoesc & Ciência - ACBS*. 2016; 7(1):97-104. Available at: <https://periodicos.unoesc.edu.br/acbs/article/view/10066>
25. Tostes JP, Cunha LR da, Chaves ACM, Gandra ALS, Campos AMFS, Machado MCL. Perfil clínico-epidemiológico de pacientes atendidos por comportamento suicida em um serviço de urgência em psiquiatria da infância e adolescência de Belo Horizonte. *Revista Interdisciplinar Ciências Médicas*. 2019; 3(2):23-9. Available at: <https://revista.fcmmg.br/index.php/RICM/article/view/82>
26. Chae W, Park E-C, Jang S-I. Suicidal ideation from parents to their children: An association between parent's suicidal ideation and their children's suicidal ideation in South Korea. *Comprehensive Psychiatry*. 2020; 101:152181. Available at: <https://doi.org/10.1016/j.comppsy.2020.152181>
27. Olco K, Kim Y, Gulbas LE. Sense of Belonging and Youth Suicidal Behaviors: What Do Communities and Schools Have to Do with It? *Social Work in Public Health*. 2017; 32(7):432-42. Available at: <https://doi.org/10.1080/19371918.2017.1344602>
28. Gomes CFM, Silva DA da. Aspectos epidemiológicos do comportamento suicida em estudantes universitários. *Research, Society and Development*. 2020; 9(5):e38953106. Available at: <https://doi.org/10.33448/rsd-v9i5.3106>
29. Love HA. Best Friends Come in All Breeds: The Role of Pets in Suicidality. *Anthrozoös*. 2021; 34(2):175-86. Available at: <https://doi.org/10.1080/08927936.2021.1885144>
30. Motta CCL da, Moré CLOO, Nunes CHS da S. O atendimento psicológico ao paciente com diagnóstico de depressão na Atenção Básica. *Ciênc saúde coletiva*. 2017; 22:911-20. Available at: <https://doi.org/10.1590/1413-81232017223.27982015>