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RISK AND PROTECTIVE FACTORS IN PATIENTS WITH SUICIDAL BEHAVIOR ADMITTED TO A PSYCHIATRIC HOSPITAL

Fatores de risco e proteção em pacientes com comportamento suicida internados em hospital psiquiátrico

Factores de riesgo y protección en pacientes con conducta suicidal ingresados en un hospital psiquiátrico

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RESUMO

OBJETIVO: analisar fatores de risco e proteção em pacientes com comportamento suicida internados em hospital psiquiátrico. **Método:** estudo qualitativo, exploratório-descritivo, entrevistas por meio de questionário semiestruturado, uso da análise de conteúdo temático, com 13 pacientes internados por comportamento suicida. **Resultados:** maioria mulheres, entre 19 e 49 anos, branca, baixa escolaridade e renda, solteiras, sem filhos. Fatores de risco foram histórico familiar de transtornos mentais (depressão, transtorno bipolar, ansiedade), uso de álcool e outras drogas, violência familiar, abuso sexual, abandono afetivo, solidão, problemas financeiros, traição, separação dos pais, morte de ente querido, entre outros. Destacaram-se fatores de proteção como apoio familiar, escuta terapêutica, fé religiosa, senso de pertencimento e autocuidado. **Conclusão:** transtornos mentais em pacientes e familiares, aliados ao uso de álcool e violência familiar, aumentaram a vulnerabilidade. Em contrapartida, redes de apoio emocional, escuta terapêutica e incentivo ao autocuidado se mostraram fatores protetivos importantes.

DESCRITORES: Fatores de risco; Fatores de proteção; História familiar; Comportamento suicida; Hospital psiquiátrico.

ABSTRACT

OBJECTIVE: to analyze risk and protective factors in patients with suicidal behavior hospitalized in a psychiatric hospital.

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Method: qualitative, exploratory-descriptive study, interviews using a semi-structured questionnaire, thematic content analysis, with 13 patients hospitalized for suicidal behavior. **Results:** majority were women, aged 19 to 49 years, white, low education and income, single, childless. Risk factors included family history of mental disorders (depression, bipolar disorder, anxiety), alcohol and drug use, family violence, sexual abuse, emotional abandonment, loneliness, financial problems, betrayal, parental separation, loss of a loved one, among others. Protective factors included family support, therapeutic listening, religious faith, sense of belonging, and self-care. **Conclusion:** mental disorders in patients and relatives, combined with alcohol use and family violence, increased vulnerability. On the other hand, emotional support networks, therapeutic listening, and encouragement of self-care proved to be important protective factors.

DESCRIPTORS: Risk factors; Protective factors; Family history; Suicidal behavior; Psychiatric hospital.

RESUMEN

OBJETIVO: analizar factores de riesgo y protección en pacientes con comportamiento suicida hospitalizados en un hospital psiquiátrico. **Método:** estudio cualitativo, exploratorio-descriptivo, entrevistas mediante cuestionario semiestructurado, análisis de contenido temático, con 13 pacientes hospitalizados por comportamiento suicida. **Resultados:** la mayoría eran mujeres, entre 19 y 49 años, blancas, con baja escolaridad e ingresos, solteras, sin hijos. Los factores de riesgo incluyeron antecedentes familiares de trastornos mentales (depresión, trastorno bipolar, ansiedad), consumo de alcohol y drogas, violencia familiar, abuso sexual, abandono afectivo, soledad, problemas financieros, traición, separación de los padres, pérdida de un ser querido, entre otros. Se destacaron factores de protección como apoyo familiar, escucha terapéutica, fe religiosa, sentido de pertenencia y autocuidado. **Conclusión:** los trastornos mentales en pacientes y familiares, junto con el consumo de alcohol y la violencia familiar, aumentaron la vulnerabilidad. Por otro lado, las redes de apoyo emocional, la escucha terapéutica y el fomento del autocuidado demostraron ser factores protectores importantes.

DESCRIPTORES: Factores de riesgo; Factores protectores; Historia familiar; Comportamiento suicida; Hospital psiquiátrico.

INTRODUCTION

Suicidal behavior is a global phenomenon and a serious public health problem, affecting individuals from diverse backgrounds and cultures. Approximately 703,000 people commit suicide every year, which is equivalent to one death every 40 seconds. This issue is even more critical among young people, with suicide being the third leading cause of death among people aged 15 to 29.[1] The global suicide rate in 2019 shows a higher prevalence among men, with 12.6 deaths per 100,000 inhabitants and 5.4 per 100,000 inhabitants for women.[2]

The World Health Organization (WHO)3 points to a variety of risk factors that can trigger suicidal behavior, highlighting mental disorders such as depression and schizophrenia, alcohol and other drug use; chronic diseases are aggravating factors; financial problems, unemployment, personal or marital difficulties, history of abuse, recent trauma, social isolation, lack of family support, access to lethal means and stigma in relation to mental health. These elements, alone or in combination, significantly increase vulnerability to suicidal behavior.

Suicidal behavior is often related to situations experienced throughout life, such as emotional loss, lack of family support, low self-esteem, sadness and loneliness.[4] Other aggravating factors include hopelessness, the presence of psychiatric problems such as anxiety disorders, stressful working conditions and unemployment. These factors can contribute to the emergence of suicidal behavior.

The World Health Organization,[3] highlights various protective factors that can help prevent suicide, such as social support networks, coping skills, personal beliefs and values, restricting access to lethal means and seeking professional help. Strong family connections, solid friendships and community support can provide emotional and practical support in difficult times. The ability to deal effectively with stress, resolve conflicts and find solutions to everyday problems. Beliefs that value life, problem-solving and seeking help in times of crisis contribute to suicide prevention.

The aim of this study was to analyze risk and protective factors in patients with suicidal behavior admitted to a psychiatric hospital.

METHOD

This was a qualitative, exploratory and descriptive study. Interviews were conducted using a semi-structured

questionnaire, and data was analyzed using thematic content analysis. Content analysis is an empirical, flexible and adaptable method that allows in-depth interpretation of phenomena through observations and reports.[5]

The research was carried out in the inpatient units of a psychiatric hospital located in São José dos Campos/SP, between August 2021 and June 2022. The inclusion criteria were individuals hospitalized for suicidal behavior, of legal age, with cognitive conditions to participate (assessed by the multi-professional team who indicated who could participate and by the researcher prior to the start of the interview). Those treated in other sectors of the institution other than hospitalization were not included, nor were those who could request exclusion after the interview, which did not happen.

The data collection process followed all ethical norms. Participants were informed beforehand about the objectives of the research, their rights to confidentiality and anonymity, and then signed the Informed Consent Form (ICF), in accordance with Resolution 466/12 of the National Health Council (CNS).

The interviews took place once a week, in private settings, lasting between 1 and 1.40 hours, and were audio-recorded and transcribed in full by the researcher. The collection instrument was a semi-structured questionnaire prepared by the researchers with sociodemographic data and 25 open-ended questions about the history of mental disorders and suicidal behavior, risk and protective factors, and perceptions of care and prevention.

Data analysis followed three defined phases: 1) pre-exploration of the material, where floating readings were made and hypotheses were drawn up; 2) exploration of the material, with coding and definition of categories; and 3) categorization and subcategorization, where the results were refined and interpreted.5 The research did not include quantification of the data, but focused on the quality and meaning of the information collected.

Participants were identified by alphanumeric codes, with E for interview followed by the interview number (E1, E2, etc.) to guarantee anonymity.

The research is in accordance with the principles of National Health Council Resolution (CNS) No. 510/2016 and was approved by the Research Ethics Committee (CEP) of the Federal University of São Paulo, filed under CAAE No. 47094021.1.0000.5505, Opinion Number: 4.868.551, on July 10, 2021.

RESULTS

There were 13 participants (12 women and 1 man) aged between 19 and 49, predominantly in the 19 to 29 age bracket; marital status included 7 single, 5 married and 1 separated; seven participants had no children and the rest had 1 to 4 children; 7 Catholics, 5 evangelicals and 1 with no religion; white (6), followed by brown (2), brown (2), indigenous (1) and black (2); nine participants had completed high school; various occupations, with five having no income.

According to the categorization of the data, we obtained two thematic categories with five thematic units, but for this article we will deal with the condensation of the data from the first category and its thematic units in terms of risk and protective factors for suicidal behaviour.

As for the risk factors that contribute to suicidal behavior, the most significant was family and personal history of mental disorders and suicidal behavior. Other relevant factors were the use of alcohol and other drugs; family violence, many mentioned sexual abuse as a traumatic experience that had a profound impact; emotional abandonment; persistent sadness and depression; financial difficulties and a feeling of lack of control over life; conflicts and separations in interpersonal relationships resulted in emotional instability; the death of loved ones led some patients to deep emotional crises; access to lethal means.

Most reported family members with conditions such as depression, anxiety or bipolar disorder:

> *"It seems that my aunt had a problem, she had depression and was aggressive, my mother has depression. My mother has been treating herself since her brother died, some 27, 30 years ago... I found out that I have cousins with depression and anxiety who take medication, all of which I've just discovered. I thought, it's not possible, I'm the only one who's crazy in the head. But I think depression is genetic." (E6)*

> *"My mother... has anxiety; I don't know if she has depression, I don't think so. I think it's just anxiety. But she took medication and went to the psychiatrist. My brother is also being treated, he's hyperactive and has anxiety..." (E8)*

> *"My mother... has bipolar disorder and a bit of anxiety..."* (E9)

As for their own history of mental disorders, some participants reported having faced disorders such as depression, anxiety and bipolar disorder, with a higher prevalence of reports for depression and anxiety. Other participants, on the other hand, reported no personal experiences with mental disorders.

> *"And this is the second time I've been admitted here because of my depression. In this case, I went to the outpatient clinic. I have depression, anxiety and borderline personality disorder." (E1)*

"I have treatment here with Dr. X, who said that I have anxiety and depression. I take medication and see a psychologist... I have bad thoughts, suicidal thoughts, I think about jumping out of the window, I think about taking medication... sadness, pain." (E3)

"Anxiety... I have this symptom... I had an outbreak due to postpartum depression. I took a box of fluoxetine when I left hospital with my son." (E11)

With regard to the history of alcohol and drug use by family members, the majority said that they had:

"Drugs, no one, but drink, alcohol, always! Alcohol is part of my family..." (E1)

"My father's family has a habit of partying every weekend, so there's always alcohol, but they don't use drugs. My mother does."(E5)

And there were participants who used alcohol and other drugs:

I started with cigarettes and drink; marijuana...cocaine, which gave me an adrenaline rush." (E2)

"My mother helped me financially, but one day, she, my aunt and uncle called me into the bathroom, I never imagined that this could happen, until then I only used marijuana, but that day, my mother introduced me to cocaine, it was through my mother, she put me on the hook and I liked it. Then I carried on using." (E5)

With regard to the history of suicidal behavior in the family, some of them incisively reported the issue of suicide attempts by family members:

"On my father's side, my brother tried it. ...I don't know if his disorder is bipolar. If he cut himself, he was very drunk..." (E8)

"There's my mother. She tried to wrap herself in the telephone cord, she tried to take medicine, a lot of medicine. She left everything on the floor. Often when I got home from school, she'd be lying on the floor with that pile of medicine around her." (E9)

"...My brother used to say he wanted to kill himself all the time because he said to me, to our family that it didn't make sense anymore after our mother had died, so for him there was no point in staying alive..." (E13)

With regard to the participants' history of suicidal behavior, we had one participant who stated the presence of suicidal ideation and the others who told us in detail about their suicide attempts:

"...I tried to commit suicide, the place I was at was the bus station and then the police arrived, the ambulance, they didn't know what to do with me, they didn't know what my case was, they even thought it was an abortion, I'd cut my whole body, I'd drunk alcohol and millions of pills I'd found of medicine along with rat poison at the place I worked... I couldn't go on living in the community, because I could hurt myself more, injure myself, and even kill myself... I couldn't cope with the pressure of work... very stressful work, ... the depression came back." (E1)

"...I started using the presto razor. I tried plunging it in, but there was no way, I cut myself, I cut myself, but it didn't work. Ropes are a risk for me too. I've also thought about throwing myself in front of a truck, throwing myself off a bridge, I've also thought about drowning in a river. I've lost the will to live... Most of them were at home, and one was at the clinic where I was admitted." (E2)

"I don't know anyone. But in my adoptive family, as far as I know, I'm the only one with a history of suicide. ... It was two days after I was born that my mother adopted me. They said my mother had died and that was that. They don't tell me the truth. But I know there's a truth behind this story. I know that she left me in hospital and went away... from the moment I was born..." (E7)

"I never thought she'd try to kill me, that she'd slit my wrist, but it's a thought, people say: you don't think about your children, have you ever thought about the trauma you'd cause your children, what your children would be like? They'd be just like you, you didn't think about your husband, how he'd be, he does everything for you and your children. But when you're thinking about suicide, it doesn't come to mind, you don't remember anything, anyone, you just remember that you want to end the pain, you just remember that you don't want to be there anymore in that moment of pain." (E13)

The participants highlighted the sadness, loneliness, death of loved ones, abandonment, demands, financial difficulties and violence they had suffered.

"Since my sister died. It just accumulated, I lost my nephew.... and the sadness is when my sister had a heart attack, then I got bad..." (E6)

"Financial difficulties. My ex-husband, he was also very dim-witted, he had no responsibility..." (E9)

As for violence, the participants reported different forms of violence suffered in the family environment:

"...my father hitting me with the iron, just because I called him a fool...I would have died if my mother hadn't given me mouth-to-mouth breathing, I wouldn't have survived..." (E4)

"The fights, the conflicts, the words that make me feel bad... I had a fight with my brother over money. My mother got into it and sent me about 40 messages blasting me, saying that I didn't love my family and that I gave priority to others. I was already thinking of dying, because I couldn't stand my life. Just fighting... My mother used to swear at me... She used to call me a slut, a piranha, a devil. When I went to my father's house and came back, there was always a fight. She said she made their lives hell. I told her that, and she asked me to forgive her for the things she said to me, the things that hurt me... Today I'm calmer about it, but these are things that stay in your head." (E8)

"Because of a lot of verbal violence, a lot of psychological pressure." (E9)

"He was still abusing me at that time. He was ridiculous and when I remembered those things he did, I got very angry... I couldn't take it anymore, I was abused until I was 15, so I couldn't take it anymore. Several times I tried to kill myself, but I couldn't die. I wanted to die, to end the suffering. I wanted him to stop messing with me, to stop waking me up at dawn with his hand inside my clothes. I wanted him to stop, to die going through this. I didn't want to see my sisters go through that. ... He would leave marks on my thighs and buttocks, turning me purple. I was all sore, he hurt me a lot. My mother saw those marks, but she's still married to him today, she's been married to him for 38 years". (E12)

The participants identified protective factors such as therapeutic listening in a safe space for emotional expression; the presence of children and significant family members who provide emotional support; a positive outlook on treatment and hospitalization; a sense of belonging to the family and community; and self-care that helps maintain mental health.

"For me, it's my children, and knowing if they love me. There's also my grandmother's care for me, her presence, her affection, her honesty. Another factor would be to see my son studying, fulfilling himself, being able to be close to him, doing something different from what I did with my daughter. Making food for him, being able to live under the same roof, all these would be protective factors. As well as seeking help." (E5)

"Talking... I needed that moment, it made a lot of sense. It made me reflect on my story too, thank you very much..." (E7)

"Taking my medication, living on my own, having autonomy, having the will to live, having a normal life, good health and a good mind."(E11)

DISCUSSION

Suicide is linked to an individual's life experiences and history, reflecting the ambivalence between the desire to live and the desire to die, especially in the face of stressful events such as financial problems or trauma. This phenomenon can occur at any age, social status, economic condition, gender or nationality.[1]

Between 2010 and 2019, Brazil faced a significant increase in the number of suicides, making it a serious public health problem. In 2021, more than 15,500 cases were recorded, equivalent to one death every 34 minutes, which placed suicide as the third leading cause among young people.[6]

With regard to attempted suicide, the Epidemiological Bulletin7 showed that the profile of these individuals recorded between 2010 and 2019 was 124,709 attempts in the country, mostly women (71.3%), people aged between 20 and 39, with complete or incomplete high school education, white, occurring in the victim's own home, by poisoning and by sharp objects.

In Brazil, they verified data on suicidal behavior obtained from medical records, showing a predominance of women, in the younger age group, unmarried and with a level of schooling up to elementary school [2.8]

They identified a higher prevalence of suicide attempts among women aged between 18 and 59, with less schooling and no spouse, associated with depression and a family history of increased likelihood of attempts.[9]

The Epidemiological Bulletin6 showed that self-inflicted violence was more frequently reported in terms of schooling in the final years of elementary school and in secondary school (48.2%), but there was an increase among individuals with more schooling.

This is reflected in the relationship between unemployment and suicide, as the Ministry of Economy's Technical Note[10] indicated that prolonged unemployment increases the risk of suicide, especially among young people with low levels of education. Unemployment and financial, personal or marital difficulties can trigger suicide attempts, with unemployment being a factor associated with recidivism.[11]

The presence of mental disorders, such as depression, mood disorders, anxiety, borderline personality disorder and schizophrenia, is often associated with suicidal behavior.[2] The WHO3 points out that, in addition to mental disorders, substance use (alcohol and drugs), chronic illnesses (such as heart disease and diabetes), financial problems, unemployment, social isolation and stigma are significant risk factors for mental health.

The WHO[12] states that 90% of suicide cases involve people with mental disorders, especially mood and substance use disorders. In addition, genetic factors increase the risk of suicidal behavior in families with a history of suicide.

The significant presence of family members with psychiatric disorders among the participants who attempted suicide stands out.[13] The mental disorders related to suicide were bipolar disorder, schizophrenia and depressive disorder.

The statements of participants with no family history of mental disorders reveal intense loneliness and uncertainty about their diagnoses, factors that increase their vulnerability to suicide. This uncertainty generates ambivalence about mental health, resulting in anxiety and loneliness. Lack of clarity about the diagnosis makes it difficult to seek emotional support, leading to isolation. Loneliness is a significant factor in suicidal ideation, since isolated individuals tend to experience hopelessness.[14] In this sense, loneliness, which is common in mental disorders such as depression, is directly linked to vulnerability to suicide.

A large part of the impact of the increase in the incidence of mental disorders is attributed to technological advances, which encourage social isolation and worsen mental health.[15]

In the case of the presence of depression and bipolar disorder, which are often associated with suicide cases, it has been observed that the symptoms of these disorders intensify in the days leading up to the suicidal act.[16]

Daily alcohol consumption is strongly linked to higher rates of suicide attempts, and frequent use of this substance has shown a stronger association with suicide compared to occasional consumption or abstinence from alcoholic beverages.[17] The correlation between suicide attempts and alcohol and drug consumption, especially among women, suggests that this consumption increases the risk of suicidal behavior.[18]

The normalization of alcohol consumption, often perceived as less problematic, contributes to underestimating the associated risks, making effective interventions difficult.[19]

The participants' reports reveal a different perception between alcohol and illicit drugs, with alcohol not considered a drug. Although alcohol use is normalized in family contexts, as in the testimonies, the absence of illicit drug use is emphasized. This contradiction should be considered in discussions about mental health and addiction.

According to,[20] risk factors for suicide can be predisposing and precipitating. Predisposing factors include diagnoses of psychiatric disorders, a history of childhood sexual abuse, impulsiveness and aggressiveness, a history of suicide in the family and serious or incurable illnesses. Precipitating factors, i.e. situations that commonly trigger the event, include issues such as falling out of love, separation from a partner, job loss, social isolation, financial difficulties and alcohol intoxication.

Often, the consequences of problems faced throughout people's development, in particular distant and conflicting relationships, trauma and different forms of violence, combined with characteristics of how you are, can trigger mental disorders, with depression being the most prevalent. Difficulties in social interaction and hopelessness are also often associated with suicide attempts.[21]

Neglectful parenting styles, intrafamily violence and family dysfunction are linked to symptoms such as depression, anxiety, self-harm and suicide attempts, as well as harmful substance use.[22]

The World Health Organization,[1] highlights that experiences of loss and loneliness are risks for suicide.

Empathetic listening, as evidenced in the reports, and the presence of family connections strengthen emotional support and a sense of belonging.

Solid family connections and continuous emotional support are important in suicide prevention.[23]

The presence of psychiatric conditions increases vulnerability to suicidal behavior, highlighting the importance of early attention and intervention to reduce these risks. Effective support in the early stages of these conditions can be crucial in improving symptoms and preventing the tragic consequences of suicidal behavior.[24]

Factors that can act as protection against suicide include: high self-esteem and solid family support, as well as building meaningful interpersonal relationships with family and friends, absence of mental disorders, ability to adapt to challenging situations and problem-solving skills, religiosity, the presence of reasons to live and access to mental health services.[25]

Other protective factors are the presence of a family, healthy emotional relationships and a connection with spirituality or personal beliefs. These elements offer emotional support, stability and a source of hope and meaning in life, contributing to resilience to suicide.[4]

Therefore, although the risk factors are well established, the literature reinforces the importance of well-structured support systems that combine both preventive strategies and reactive measures. The integration of actions involving education, family support and community interventions is essential for improving quality of life and reducing suicide rates. The promotion of strategies aimed at strengthening support networks, social inclusion and continuous care can thus represent a significant advance in mental health, prevent future attempts and promote the well-being of those at risk.

FINAL CONSIDERATIONS

The main risk factors for suicidal behavior in patients admitted to a psychiatric hospital include the presence of mental disorders (MD) in the participants, such as depression and bipolar disorder, as well as a history of suicidal behavior in family members. In addition, factors such as drug use, unemployment, lack of social support and experiences of violence increase vulnerability to suicide. The interaction between these elements contributes significantly to the risk of suicidal behavior among patients.

Recognized protective factors include therapeutic listening in a safe space for emotional expression, the presence of children and significant family members who offer emotional support, a positive outlook in relation to treatment and hospitalization, a sense of belonging to the family and community, and self-care practices that promote mental health.

This study makes important contributions, as it is a pioneer in the institution and in the municipality where it was carried out, by focusing on this problem and the target audience, to help hospital and municipal health management to review the model of care and interventions in progress, to promote adequate and effective public mental health policies for individuals with suicidal behavior.

The study has limitations, such as its narrow focus on a single institution and the lack of longitudinal analysis to assess the impact of interventions over time. These limitations indicate the need for future research involving different regional contexts and including prolonged follow-up of patients.

REFERENCES

1. World Health Organization (WHO). Suicide Worldwide in 2019: Global Health Estimates. 2021 [acesso em 18 de março de 2023]. Disponível em: https://www.who.int/publications/i/item/9789240026643.
2. World Health Organization (WHO). Suicide in the world: global health estimates. Geneva: World Health Organization. 2019 [acesso em 04 de novembro de 2020]. Disponível em: https://apps.who.int/iris/handle/10665/326948.
3. World Health Organization (WHO). 1 billion people live with a mental disorder [Internet]. 2022 [acesso em 27 de fevereiro de 2023]. Disponível em: https://news.un.org/pt/story/2022/06/1792702.
4. Jorgetto GV, Marcolan JF. Autopercepção do sofrimento psíquico em indivíduos com sintomatologia depressiva e comportamento suicida. Medicina (Ribeirão Preto-SP). [Internet]. 2021 [acesso em 5 de março 2023];54(4). Disponível em: https://doi.org/10.11606/issn.2176-7262.rmrp.2021.180529.
5. Bardin L. Análise de conteúdo. São Paulo, SP: Edições 70, 2016.
6. Ministério da Saúde (BR). Secretaria de Vigilância em Saúde e Ambiente. Boletim Epidemiológico [Internet]. Brasília: Ministério da Saúde; 2024 [acesso em 23 de agosto 2023]. Disponível em: https://www.gov.br/saude/pt-br/centrais-de-conteudo/publicacoes/boletins/epidemiologicos/edicoes/2024/boletim-epidemiologico-volume-55-no-04.pdf.
7. Ministério da Saúde (BR). Secretaria de Vigilância em Saúde. Boletim Epidemiológico: Suicídio: tentativas e óbitos por intoxicação exógena no Brasil, 2007 a 2016. 2019 Jul;50(15).
8. Wünsch CG, Silva AKL da, Apodaca BS, Nascimento FC dos S, Cebalho MT de O, Treichel CA dos S, Oliveira JLC de. Prevalência e fatores associados ao comportamento suicida e à tentativa de suicídio identificados no acolhimento em ambulatórios de saúde mental. Rev. Eletr. Enferm. [Internet]. 2022 [acesso em 02 de março 2023];24:72997. Disponível em: https://doi.org/10.5216/ree.v24.72997/39486.
9. Aguiar R, Riffel R, Acrani G, Lindemann I. Tentativa de suicídio: prevalência e fatores associados entre usuários da Atenção Primária à Saúde. J Bras Psiquiatr. [Internet]. 2022 [acesso em 21 de maio 2023];71. Disponível em: https://doi.org/10.1590/0047-2085000000379.
10. Brasil. Ministério da Saúde. Mortalidade por suicídio e notificações de lesões autoprovocadas no Brasil. Boletim Epidemiológico: Secretaria de Vigilância em Saúde, Ministério da Saúde. [Internet]. 2021 [acesso em 21 de maio em 2022];52(33). Disponível em: https://www.gov.br/saude/pt-br/centrais-de-conteudo/publicacoes/boletins/epidemiologicos/edicoes/2021/boletim_epidemiologico_svs_33_final.pdf/view.
11. Braun BF, Anjos GO, Fonseca TMA, Trevisan ER, Castro S de S. Perfil epidemiológico dos casos de tentativa de suicídio: revisão integrativa. SMAD. [Internet]. 2023 [acesso em 18 de abril 2024];19(1). Disponível em: https://doi.org/10.11606/issn.1806-6976.smsad.2023.186463.
12. World Health Organization (WHO). National suicide prevention strategies: progress, examples and indicators [Internet]. Geneva: World Health Organization. 2018 [acesso em 04 de novembro de 2020]. Disponível em: https://apps.who.int/iris/bitstream/handle/10665/279765/9789241515016-eng.pdf?ua=1.

13. Vieira DC, Calil F, Jubé SGR, Araújo IA, Azevedo JAND, Diniz LP, Macedo J. A prevalência do comportamento suicida em pacientes com transtornos mentais. RESU-Revista Educação em Saúde. [Internet]. 2021 [acesso em 02 de março 2023]; 9 (supl. 3). Available from: http://revistas.unievangelica.com.br/index.php/educacaoemsaude/article/view/6067

14. Kern C. Aspectos associados ao suicídio na adolescência: uma revisão bibliográfica. Inova Saúde. [Internet]. 2024 [acesso em 23 de maio 2024];14(1). Disponível em: https://periodicos.unesc.net/ojs/index.php/Inovasaude/article/view/3465/7065.

15. Lima RKB, Simões T. Papel da enfermagem na prevenção do suicídio e apoio às famílias: uma abordagem interdisciplinar no contexto do aumento dos transtornos mentais. Revista JRG. [Internet]. 2023 [acesso em 12 de maio 2024];6(13). Disponível em: https://doi.org/10.55892/jrg.v6i13.771.

16. Almeida GPDLL, das Neves ALM da. O uso e relevância da autópsia psicológica na cena do crime em casos de morte suspeita por suicídio. Revista Brasileira de Criminalística. [Internet]. 2023 [acesso em 23 de maio 2024];12(5). Disponível em: https://revista.rbc.org.br/index.php/rbc/article/view/708.

17. Cho MS. Use of alcohol, tobacco, and caffeine and suicide attempts: findings from a nationally representative cross-sectional study. J Prim Care Community Health. [Internet]. 2020 [cited 2024 Jul 23]. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7092647/.

18. Moura EH, Mascarenhas MDM, Soares MAS de. Álcool e outras drogas na tentativa de suicídio em usuários atendidos por um serviço móvel de urgência. Revista Ciência Plural. [Internet]. 2020 [acesso em 15 de março 2023];6(Supl. 1). Disponível em: https://periodicos.ufrn.br/rcp/article/download/21242/13108.

19. Cordeiro EL, Silva LSR, Mendes EWP, Silva LCL, Duarte VL, Lima ECMP. Suicide attempt and factors associated with standard alcohol use and abuse. SMAD. [Internet]. 2020 [cited 2023 Nov 15];16(1). Available from: https://doi.org/10.11606/issn.1806-6976.smad.2020.157007.

20. Botega, N. J. (2023). Crise Suicida: avaliação e manejo (2a ed.). Artmed.

21. Simões EV, Oliveira AMN, Pinho LB, Lourenção LG, Oliveira SM, Farias FLR. Reasons assigned to suicide attempts: adolescents' perceptions. Rev bras enferm. [Internet]. 2022 [acesso em 23 de junho 2024];75(Suppl 3). Disponível em: https://doi.org/10.1590/0034-7167-2021-0163.

22. Sousa Maria das Graças de Melo, Lima Luisa Helena de Oliveira, Rodrigues Malvina Thais Pacheco, Mascarenhas Márcio Dênis Medeiros, Moura Joana Célia Ferreira, Leal Iracynetta Passos de Sousa. Contexto familiar e sofrimento mental em adolescentes: uma revisão integrativa. Revista Portuguesa de Enfermagem de Saúde Mental. [Internet]. 2022 [acesso em 17 de agosto 2023];27. Disponível em: https://doi.org/10.19131/rpesm.330.

23. Fernandes MA, Silva JS, Campos LRB, Nepomuceno VMS, Vasconcelos ACB, Oliveira ALCB. Prevenção ao suicídio: vivências de estudantes universitários. Revista Cuidarte. [Internet]. 2020 [acesso em 18 de março 2023];11(2). Disponível em: http://dx.doi.org/10.15649/cuidarte.791.

24. Carvalho BIFD. Estágio de natureza profissional em Enfermagem de cuidados de saúde à família em contexto de USF/UCSP com relatório final [dissertação]. 2023 [acesso em 28 de junho de 2024]. Disponível em: http://hdl.handle.net/10400.8/8633.

25. Santos CVM. Sofrimento psíquico e risco de suicídio: diálogo sobre saúde mental na universidade. Rev NUFEN. [Internet]. 2019 [acesso em 13 de setembro 2024];11(2). Disponível em: https://doi.org/10.1590/s0102-6992-202035010007.