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Title: Comparison of adaptation and family cohesion among adolescents with and without suicide risk in Tlaxcala

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Introduction

Suicidal behavior can be defined as a set of complex events, which begins, in many cases, with thoughts and ideas, followed by suicidal plans and attempts without reaching death, until the consummate suicide. In such a way, it can affect people of any age or condition and is occasionally triggered by various biological, psychological or sociocultural factors (Cañón Buitrago, cited in Minsalud, 2017).

In Mexico, in 2018 there were 641 deaths due to self-inflicted injuries in the group of girls, boys and adolescents aged 10 to 17 years (INEGI, 2020). This represents a rate of 3.6 deaths per 100,000 girls, boys and adolescents, which has remained practically unchanged since 2014 where it was at 3.7. By gender, the rate for men in this age range is 4.2 per 100,000, while for women of these ages it was 2.9 per 100,000.

Introduction

Therefore, talking about suicide is not taking into account a single cause, but various events that can trigger it (INEGI, 2020). Thus, the Mexican Psychiatric Association (APM) (cited in Valadez and López, 2020) mentions that the current generations of 12 to 17 years have more mental health problems such as anxiety and affect problems; in addition, some of them abuse substances such as alcohol and drugs; have disruptive or antisocial behaviors; and eating disorders. This is mainly associated with rape, sexual abuse, followed by beatings, armed robbery, harassment, which contribute to having ideas, planning and attempting to commit suicide (Chávez, 2020).

The family plays an essential role in the development and well-being of adolescents to the changes they face by providing the necessary support in understanding and adapting to their emotional needs, otherwise, it could affect their mood, generating negative ideas and triggering mental health problems. Therefore, the family can itself be an element of health or origin and cause of problems, this will depend on whether or not it fulfills its functions adequately, which will reflect a healthy family system, or become a sick system (Araujo, 2016).

Introduction

Family functioning has been defined as a set of attributes that characterize the family as a system and that explain the way in which the family system operates, evaluates or behaves (McCubbin and Thompson, in family functioning, File Akurion, 2018). Therefore, family functioning facilitates and promotes the adaptation of the family in a situation of change, by constantly transforming their interactions and family rules that allow maintaining, on the one hand, the continuity of the family and, on the other, the growth of its members.

Olson's Circuit Complex Model (1991) studies family functioning by establishing a typology that classifies and manages different integrated profiles in two dimensions: adaptation and cohesion; meanwhile, family adaptation focuses on the degree flexibility and aptitude for the change of the family system, which implies the ability of the system to change its power structure, the dynamics between roles and the rules of family relationships in response to evolutionary (developmental) and situational stressors. Family cohesion refers to the degree of separation or connection that an individual has with respect to his family system and includes the emotional bond that family members have with each other. So, the Circumplex Model allows to adequately predict the problems that may arise in the different stages of family development.

Introduction

Objective

Analyze the differences in adaptation and family cohesion between high school adolescents with and without suicide risk in Tlaxcala.

Methodology

Participants

The design carried out for the research was quantitative of a comparative type. The sample consisted of 50 high school adolescents intentionally chosen and detected by the school with behavior problems, low school achievement, self-injurious behaviors and bullying; being 58% women and 42% men; who were in 50% first graders and 50% second graders; with ages of 13 (48%), of 12 (34%) and 14 years (18%).

Methodology

Materials

For data collection, a sociodemographic interview was conducted in which age, sex, education, number of siblings, place in the family, if they lived with both parents, as well as the age, education and occupation of the parents were asked.

The online Teen Suicide Risk Inventory (IRISA) was also used (Hernández and Lucio, 2011), with a Cronbach's alpha of .95. It consists of a Likert-type frequency scale with 50 items with three subscales and an index: a) suicidal ideation and intentionality, b) depression and hopelessness, c) absence of protective circumstances, and index of psychological distress associated with suicidal risk. In addition, it contains three critical or significant items: 1) suicidal ideation, 2) suicidal plan (s) and 3) previous suicide attempt (s). The score shows levels of high risk, tentative, ideation, alert and no risk, and the student's open responses.

As well as the Family Cohesion and Adaptability Assessment Scale (FACES III), whose reliability and validity were carried out in Mexico by Ponce, Gómez, Terán, Irigoyen and Landgrave in 1999 and 2002, obtaining a Cronbach's Alpha of .70. This scale is of the Likert type that contains 20 questions, 10 to assess family cohesion and 10 to assess family adaptability, alternated numerically as odd and even; and whose score is from 1 to 5: “never” 1; almost never 2; sometimes 3; almost always 4; always 5.

Results

Table 1.1 Differences between adolescents with and without suicide risk in cohesion, adaptation and family functioning.

	With suicide risk n = 28			Without suicide risk n = 22			
Variable	M	DE	p	M	DE	p	F
Adaptation	25.68	7.538	.104	29.59	8.770	,096	.013
Cohesion	31.54	9.252	.000	40.95	6.114	.000	2.063
Familiar functioning	1.71	.743	.054	2.14	.774	.051	.021

Results

Table 1.2 Differences between adolescents with and without suicide risk with suicide risk factors.

	With suicide risk n = 28			Without suicide risk n = 22			
Variable	M	DE	p	M	DE	p	F
Ideation and Intentionality	58.07	9.447	.000	45.32	9.447	.000	4.820
Depression and hopelessness	61.29	7.226	.000	46.05	6.268	.000	.559
Absence of protective circumstances	56.07	8.927	.002	49.27	5.531	.003	3.096
Psychological distress associated with suicidal risk	65.61	7.983	.000	48.41	7.353	.000	.146
Suicide risk	3.25	1.076	.000	1.000	.000	.000	71.744

Results

To determine the differences between cohesion, adaptation, family functioning and suicide risk factors with the sociodemographic data, the one-way analysis (ANOVA) was used, the results of which are shown below:

For the gender variable, statistically significant differences were found (* p <.05) with Emotional distress (F (6.300) p = .015), Adaptation F (8.345) p = .006) and Suicide risk (F (6.248) p = .016). Taking into account the previous data and the means in both groups, it could be observed that women presented greater emotional distress (M = 61.34) and greater suicide risk (M = 2.66) compared to men (M = 53.48) (M = 1.71), while men resulted with greater adaptation (M = 31.10) than women (M = 24.72).

Concerning school grade, the data showed statistically significant differences (* p <.05) with adaptation (F (4.053) p = .050), which indicates that adolescents from the first grade of junior high school showed greater family adaptation (M = 29.68) compared to second grade students (M = 25.12).

In the same way, it was observed that the place occupied in the family showed statistically significant differences (* p <.05) with Family Functioning (F (2.919) p = .031), which can be realized that the adolescents who ranked third (M = 3.00) presented higher functioning, followed by those who ranked first (M = 1.72), then those who were in second place (M = 1.62) and those who presented less family functioning ranked fourth or less (M = 1.50).

Conclusions

The WHO (2019) has defined suicide as a serious public health problem, and to which a specific cause cannot be attributed, but rather to various factors that can affect the emotional stability of the adolescent, understanding this, as psychological, social and personal well-being (Cárdenas-Rodríguez, et. al, 2019).

Suicide in adolescence can be preventable if it is detected early and associated risk factors are identified, which can be addressed by promoting mental health and interest in mental problems and disorders. However, many of the causes are defined by poverty, unemployment, humiliation, loss of loved ones, breakdown of love relationships, abuse during childhood, in addition to certain mental disorders such as depression and schizophrenia. Given these effects, it is shown that the early identification of suicide behavior and adequate treatment for people with mental disorders constitutes an important preventive strategy (Hernández and Villareal, 2015; Cárdenas-Rodríguez, et. Al, 2019).

Conclusions

Cabra, Infante and Sossa (2010) showed that suicide in adolescents is one of the problems that societies increasingly face and it is a multifactorial phenomenon, which includes biological, psychological and social factors, which must be addressed immediately from different levels such as the family, school and public health authorities to emphasize the risk factors that may lead minors to make this decision.

For this, it is necessary not only to attend to cases of depression or suicide attempts, but also to implement strategies for the early detection of possible suicide risks (WHO, 2019).

For the prevention of these factors, adolescents have tools that strengthen their problem-solving capacities, this group of tools are known as protective factors, where the family plays an important role as support that promotes their emotional well-being. Therefore, it is concluded that the timely detection of risk factors could greatly contribute to the design and implementation of more comprehensive and efficient prevention programs against adolescent suicide.

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