Chapter 8 Comparison of adaptation and family cohesion among adolescents with and without suicide risk in Tlaxcala

Capítulo 8 Comparación de la adaptación y cohesión familiar entre adolescentes con y sin riesgo de suicidio en Tlaxcala

QUITL-MELÉNDEZ, María Mónica Anastacia†*, NAVA-ERNULT, Alejandra and JIMÉNEZ-CANSECO, Sacnité

Universidad Autónoma de Tlaxcala, Mexico.

ID 1st Author: *María Mónica Anastacia, Quitl-Meléndez* / **ORC ID:** 0000-0002-1060-6896

ID 1st Co-author: *Alejandra, Nava-Ernult* / **ORC ID:** 0000-0002-0656-3256

ID 2nd Co-author: *Sacnité, Jiménez-Canseco* / **ORC ID:** 0000-0002-6082-4533

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M. Quitl, A. Nava and S. Jiménez

* maquitl4@hotmail.com

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Abstract

Differences in adaptation and family cohesion among high school adolescents with and without suicide risk in Tlaxcala were analyzed. The participants were 50 adolescents between 12 and 14 years old; 28 women and 22 men, who applied the Suicide Risk Inventory for Adolescents (IRISA) by Hernández and Lucio (2011), which consists of 50 items and three subscales, whose validity is .95; and the Family Cohesion and Adaptability Assessment Scale (FACES III), trusted and validated in Mexico by Ponce, Gómez, Terán, Irigoyen and Landgrave (1999-2002), with a Cronbach's Alpha of .70. The results showed that there were no statistically significant differences in Adaptation, however, significant differences were observed in Family cohesion and with suicide risk factors among adolescents with and without suicide risk (** p <.01). Significant differences were also found in sex, school grade and place in the family (* p <.05) with some suicide risk factors. It is concluded that the family is an essential emotional support for the adolescent that helps to avoid the presence of suicidal behaviors.

Suicide risk, Adaptation, Cohesion, Adolescent.

Resumen

Se analizaron las diferencias de adaptación y cohesión familiar entre adolescentes de secundaria con y sin riesgo de suicidio en Tlaxcala. Participaron 50 adolescentes de entre 12 y 14 años; 28 mujeres y 22 hombres, a quienes se les aplicó el Inventario de Riesgo Suicida para Adolescentes (IRISA) de Hernández y Lucio (2011), que consta de 50 ítems y tres subescalas, cuya validez es . 95; y la Escala de Evaluación de Cohesión y Adaptabilidad Familiar (FACES III), de confianza y validada en México por Ponce, Gómez, Terán, Irigoyen y Landgrave (1999-2002), con un Alfa de Cronbach de .70. Los resultados mostraron que no hubo diferencias estadísticamente significativas en Adaptación, sin embargo, se observaron diferencias significativas en Cohesión familiar y con factores de riesgo de suicidio entre adolescentes con y sin riesgo de suicidio (** p <.01). También se encontraron diferencias significativas en sexo, grado escolar y lugar en la familia (* p <.05) con algunos factores de riesgo de suicidio. Se concluye que la familia es un apoyo emocional esencial para el adolescente que ayuda a evitar la presencia de conductas suicidas.

Riesgo de suicidio, Adaptación, Cohesión, Adolescente.

8.1 Introduction

Suicide in adolescents is a worrying and relevant issue due to the impact it generates not only at the individual level, but also at the family and social level. Given its high incidence in recent decades, it constitutes a serious health problem that requires special attention. Only 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.

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). According to the International Classification of Diseases - ICD - of the World Health Organization (WHO), the Diagnostic and Statistical Manual (DSM-5) and the American Psychiatric Association (APA) (cited in Minsalud, 2017), the suicidal behavior is considered a symptom of an emotional or mental discomfort or disorder and does not represent a diagnosis in itself, so the presence of other emotional or behavioral symptoms that together are part of its diagnosis should be checked. 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).

This is how, as in the rest of the suicides, for adolescents this behavior does not mean a simple wish to die but is given as a final resource to escape from great discomfort. Mainly due to the fact that they become vulnerable to the changes that occur at the body, psychic, affective, family and social level, derived from hormonal changes, increased responsibilities, family crises, which can lead to an imbalance and a state of conflict, generating anguish, and leading to suicide as a solution to an existential problem, being the only possible way out. In this way, suicide has a great impact in adolescence, because most of the time it is the expression of a desire for change, a reaction to the powerlessness to solve an unbearable situation (Barón, 2000).

Given these data, Cárdenas-Rodríguez, Santillana-Saucedo and Rodríguez-Verdugo (2019), recorded explanations from different perspectives of the multiple factors of suicidal processes in adolescents in Argentina, through the registration and analysis of the bibliographical compilation, where real suicide cases and statistics were recognized, as a sign of risk within the suicidal process, showing the influence of certain factors that provoke in adolescents feelings of stress, confusion, pressure, fear, leading them to a distressing situation and without resources or alternatives of coping, where they can go through a suicidal process.

In the same way, Vázquez et al (2021) analyzed the differences between adolescents with and without suicidal risk related to stressful life events; as well as, identified which of these events most predict suicide risk. Significant differences were observed between adolescents at risk and without suicidal risk in the perception of stressful life events, and higher averages in the areas of family, health, personal and behavior problems, showed higher averages in adolescents at risk. In turn, Riverón, Velázquez, Borrero and Fonseca (2016) identified, through a bibliographic review, risk factors, symptoms and behavior in adolescents with suicide attempts, finding that suicidal behavior is related to multiple biopsychosocial and cultural factors, such as : the resolution of tasks that allow them to successfully complete the step towards the stage of youth, the confrontation with significant people such as parents, family problems and as a couple, social pressure due to gender issues, conflicts in the school environment, abuse, loneliness and misunderstanding; which may be associated with the influence of alcohol, family structure and self-esteem; in addition to depression, dysthymia, hopelessness and others, as symptoms that are associated with adolescents before accessing the suicidal act.

This is how suicide in adolescents has been studied from the point of view of recent social, cultural, economic and technological changes. Therefore, Chávez (cited in Valadez and López, 2020) said that there is a link between minors and social networks that incite them, through games, to carry out self-harm. In addition, he pointed out that these cybernetic encounters impact their self-esteem, by offering unrealistic standards, they also become the prey of harassment that could affect their mental health. What can be said that suicide is sometimes pushed by social networks.

On their side, García and Mosquera (2020), through the documentary method, reviewed studies that have recovered information on the perceptions of suicide in adolescents, which showed that adolescents give meaning to the different risk and protective factors based on their construction and social context. Faced with protective environments, it is found that the family becomes a pillar of protection through the values that have been used in the accompaniment at this age, influencing prevention and adequate development of the adolescent; concluding that suicide is a problem that increasingly affects adolescents in their immediate surroundings.

In the presence of such situations, Machado (2017) detected adolescents with significant suicidal risk between 12 and 15 years old, whom he compared with the rest of the adolescent population, regarding their family functioning and level of psychological well-being; finding that adolescents with significant suicidal risk present a profile with fewer goals and projects, as well as difficulties to find a clear meaning in their lives and to deal appropriately with everyday situations, in addition to a level of mild family dysfunction with specific difficulties to adapt and resolve conflicts at the family level. Also, for their part, Loyola-Cabrera, et al. (2020) found in adolescents between 10 and 18 years old through a descriptive and cross-sectional study, that depression and dysfunctional family were the most frequent risk factors.

From this perspective, 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).

In this sense, Medellín, Rivera, López, Kanan and Rodríguez, (2012) found a relationship between family functioning and social support networks, with family and friend support networks being the ones that provided the most social support to most types of family proposed by Olson; type of family functioning connected-chaotic (close-knit families with a disorganized and confused change management style), clustered-chaotic (extremely close-knit families with a disorganized and confused change-management style) and flexible-connected (close-knit families with a moderate to highly adaptable shift management style). In turn, Estrada (as cited in Araujo, 2016) mentions that the perception of family functioning in the variables of family cohesion and adaptability, integrates the communication one, and proposes that the greater the adaptation and cohesion that exists in a family the better the communication and the better the performance.

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.

For this reason, 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.

In this way, the family plays an essential role in the physical, emotional and social well-being, becoming a risk or protective factor for the appearance of suicidal behavior, thus, studying family functioning from the Olson Circumplex Model through its dimensions of cohesion and adaptation in adolescents with and without suicidal risk, will allow the creation of timely intervention programs that support adolescents and their family members to find and implement new and better ways of relating and supporting themselves in adverse circumstances and reducing risk that the adolescent thinks or plans some form of suicide. Faced with such a situation, the present research aims to analyze the differences in adaptation and family cohesion between high school adolescents with and without suicide risk in Tlaxcala.

8.2 Methodology

8.2.1 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%). And whose sociodemographic characteristics were: adolescents who live with both parents (48%), only with the mother (26%), with the mother and other relatives (10%), with the father (6%), with both parents and other relatives (6%), with other relatives (2%) and with a rebuilt family (2%). Regarding the number of siblings, 50% had one sibling, 18% with two siblings, 14% with three, 11% no siblings, and 7% with four or more siblings.

In relation to the place they occupy in the family, 46% the first place, 21% the last place, 18% the second place, 11% is an only child and 4% the third place. Also, 54% live with both parents, 43% only with the mother, and 4% only with the father. According the mother's age: 57% were between 30 and 39 years old, 25% between 40 and 49 years old, 11% between 20 and 29 years old, 4% between 50 and 59 years old and 4% 60 years or more. About the father's age, 39% were between 40 and 49 years old, 32% between 30 and 39 years old, 18% do not know, 7% between 20 and 29 years old and 4% between 50 and 59 years old. The mother's schooling was 43% undergraduate, 25% high school, 14% junior high school, 7% postgraduate, 7% other, and 4% elementary. Respecting the father's education, 36% attended high school, 25% undergraduate, 25% other studies, 11% junior high school and 4% postgraduate. As regards the mother's occupation, 32% professionals, 21% had another occupation, 21% housewives, 11% employees, 11% merchants, 4% workers; while the father, 54% had another profession, 18% professionals, 14% employees, 7% merchants, 4% workers and 4% bricklayers.

8.2.2 Materials and procedure

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.

8.2.3 Procedure

The research was carried out with the consent and voluntary participation of the school authorities and the adolescents involved in the study, to whom the importance of participating in the research and the confidentiality of the information provided was explained. The interview and the scales were applied collectively in groups of 25 according to their school grade. The detection of suicide risk in junior high school adolescents was done in a previously published study (Quitl, Nava and Jiménez, 2019). The Suicide Risk Inventory for Adolescents was scored on the IRISA website database and the Family Cohesion and Adaptability Assessment Scale (FACES) manually. For data processing, the statistical program SPSS version 25 was used.

8.3 Results

To carry out the analysis of the results, frequencies were performed to obtain descriptive measures of mean and standard deviation, Student's t was also used for independent samples in order to determine the differences between cohesion and family adaptation, family functioning and the factors of Suicidal Risk Among Junior High School Adolescents with and Without Suicidal Risk. One-way analysis of variance (ANOVA) was also used to determine the difference in cohesion, adaptation, family functioning, and suicide risk factors with sociodemographic data.

The results of the data analysis are shown below:

Table 8.1 Differences between adolescents with and without suicide risk in cohesion, adaptation and family functioning

Variable	With suicide risk *n* = 28 *M*	*DE*	*p*	Without suicide risk *n* = 22 *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
**$p < .01$							

Source: (Self elaboration)

As can be seen in Table 8.1, the groups of adolescents with and without suicide risk did not show statistically significant differences with Family Adaptation and Functioning, but they did show statistically significant differences (** p < .01) with Cohesion. These data indicate that, according to adaptation and family functioning, both groups showed similarities in the capacity for flexibility in the face of family changes in each adolescent, as well as the facilitation and promotion of the family's adaptation in a situation of change.

However, regarding Cohesion, the results indicate greater cohesion in adolescents without suicidal risk, compared to adolescents with suicidal risk, as can be seen in the means and standard deviations, which indicates a higher degree of connection in the family of adolescents without suicidal risk and lower in adolescents with suicidal risk.

Table 8.2 Differences between adolescents with and without suicide risk with suicide risk factors

Variable	With suicide risk *n* = 28 *M*	*DE*	*p*	Without suicide risk *n* = 22 *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
**p < .01							

Source: (Self elaboration)

In Table 8.2 it can be seen that in adolescents with and without suicide risk statistically significant differences were found in Ideation and Intentionality, Depression and Hopelessness, Absence of protective circumstances, Psychological discomfort associated with suicide risk and Suicide risk (** p < .01) as shown in the means and standard deviations respectively. These results indicate that adolescents with suicide risk present greater psychological distress associated with suicide risk, depression and hopelessness, ideation and intentionality, and the absence of protective circumstances compared to adolescents without suicide risk.

It could also be observed that there is a higher prevalence of psychological distress and depression and hopelessness in the sample of adolescents with suicide risk.

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).

8.4 Conclusions

Suicidal behavior is a sequence of events that appear in many cases progressively with ideas or thoughts, followed by suicidal plans, until reaching the consummate suicide, and that can be triggered by various biological and psychological risk factors or sociocultural. 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).

Thus, the results showed that among the adolescents with and without suicide risk, there were no significant differences with adaptation, which would indicate that in both groups of the sample the flexibility capacity is presented in a similar way to the changes that are manifested in the family. On the contrary, it was possible to observe significant differences with cohesion, being greater for adolescents without suicide risk compared to those who presented suicide risk, taking into account that cohesion implies the degree of separation or emotional connection of the individual towards their families. Hence, Muñoz, Pinto, Callata, Napa and Perales (2006) showed that low levels of family cohesion are associated with a greater risk of suicidal ideation, although they did not indicate that belonging to a family with high levels of cohesion implies less risk of intent, they did emphasize that family problems are more precipitating for suicidal behavior. As well as, Santillán and Pereyra (2020) analyzed the effect of risk and protective factors in students between 13 and 15 years, finding that exposure to protective factors reduces the risk of experiencing a suicide attempt, while risk factors decrease it.

It was also observed that there were no significant differences with family functioning between adolescents with and without suicide risk, which would indicate that in both groups the adaptation of the family is facilitated and promoted in a similar way in a situation of change. Regarding this, Marco-Sánchez, Mayoral-Aragón, Valencia-Agudo, Roldán-Díaz, EspliegoFelipe, Delgado-Lacosta & Hervás-Torres (2020) mention that the family environment is a variable involved in the suicide risk of adolescents, acting as both a risk factor and a protector. Therefore, they demonstrate the importance of modifying the family environment to influence the suicide risk of adolescents.

Respecting the differences between the adolescents with and without suicide risk with the suicide risk factors, it could be observed that there are significant differences between both groups with Ideation and Attempt, Depression and Hopelessness, Absence of protective circumstances and psychological distress associated with risk suicide; showing that adolescents with suicide risk present greater psychological distress associated with suicide risk, Depression and Hopelessness, Ideation and Intentionality and Absence of protective circumstances compared to adolescents without suicide risk. It was also observed that there is a higher prevalence of psychological distress associated with suicide risk and depression and hopelessness in the sample of adolescents with suicide risk. This is how Alvarino (2019) found that adolescents who have carried out previous suicidal behaviors score higher in the dimensions of suicide risk of depression-hopelessness, family dysfunction or lack of family support, self-harm-suicidal ideation and social isolation, than those with no suicidal history.

Concerning the differences between cohesion, adaptation, family functioning and suicide risk factors with the sociodemographic data, it was observed that gender differed significantly with Emotional discomfort, Adaptation and Suicidal risk; and in which, it could be observed that women presented greater emotional distress and greater suicide risk compared to men, while men resulted with greater family adaptation than women.

Regarding school grade, significant differences were found with family adaptation, indicating with this, that first-grade junior high school adolescents showed greater family adaptation than second-grade adolescents. About the place they occupy in their family, significant differences were shown with Family Functioning, with adolescents who ranked third being those who presented the highest functioning, followed by those who ranked first, then those who were in second place and finally those who were in fourth place or more presented less family functioning. Regarding this, 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.

Given the above, the WHO (2019) points out that, to prevent suicide, it is necessary to monitor and follow up the number of cases, and improve the integrity, quality and timeliness of the data. As long as suicide is one of the main causes of death among the adolescent population, it will be necessary to know not only how it occurs, but also the related factors, which allow adequate responses to be offered to the population groups at higher risk. Through knowledge and understanding of the phenomenon, appropriate prevention and care strategies will be designed. It is a fact that suicidal behavior in adolescents has increased in recent decades, which causes great concern in health professionals, teachers, parents and other social groups. Recognizing the risk factors associated with this problem and their prevalence can serve as the basis for the design of timely and effective interventions.

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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