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Circumstances for a suicide attempt in perception of managers, health professionals and adolescents

Circunstâncias para a tentativa de suicídio na percepção dos gestores, profissionais de saúde e adolescentes

Circunstancias relacionadas con el intento de suicidio desde la perspectiva de gestores, profesionales de la salud y adolescentes

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ABSTRACT

Objective: To analyze the psychosocial circumstances surrounding adolescent suicide attempts, from the perspectives of the adolescents themselves, healthcare professionals, and CAPSij managers.

Method: A qualitative study grounded in dialectical hermeneutics, conducted through semi-structured interviews between January and December 2024 with 27 healthcare professionals, five CAPSij managers, and nine adolescents who had attempted suicide in a metropolitan area of southeastern Brazil. Bardin's content analysis identified three categories: weakened family ties, experiences of violence, and the invisibility of mental suffering.
Results: Participants indicated that female, Black and Brown adolescents were more vulnerable. Family relationships were marked by conflict and lack of affection. Adolescents reported experiencing physical, psychological, and sexual violence, bullying, racism, and xenophobia. Psychological suffering was evidenced by social isolation, body dissatisfaction, eating disorders, depressive symptoms, non-suicidal self-injury, and socio-emotional difficulties.
Final Considerations: Adolescent suicide attempts are rooted in multiple psychosocial vulnerabilities, including fragile family ties, various forms of violence, and unacknowledged mental suffering. Nursing plays a key role in providing support and developing care strategies for adolescent survivors.
Descriptors: Suicide Attempt; Adolescent; Intersectional Framework; Mental Health Services.

RESUMO

Objetivo. Analisar as circunstâncias psicossociais que envolvem tentativas de suicídio entre adolescentes, segundo a perspectiva deles próprios, profissionais de saúde e gestores de CAPSij.
Método. Estudo qualitativo, fundamentado na hermenêutica-dialética, com entrevistas semiestruturadas realizadas de janeiro a dezembro de 2024 com 27 profissionais de saúde, cinco gestores de CAPSij e nove adolescentes que tentaram suicídio em uma metrópole do Sudeste brasileiro. A Análise de Conteúdo proposta por Bardin revelou três categorias: vínculos familiares fragilizados, marcas de violência e invisibilidade do sofrimento mental.
Resultados. Os participantes destacaram maior vulnerabilidade entre adolescentes do sexo feminino, negras e pardas. Os vínculos familiares foram marcados por conflitos e carência afetiva. Os adolescentes relataram vivências de violência física, psicológica, sexual, *bullying*, racismo e xenofobia. O sofrimento psíquico manifestou-se por isolamento social, insatisfação corporal, transtornos alimentares, sintomas depressivos, autolesão não suicida e dificuldades socioemocionais.
Considerações Finais. As tentativas de suicídio entre adolescentes decorrem de múltiplas vulnerabilidades psicossociais, incluindo vínculos familiares fragilizados, distintas modalidades de violência e sofrimento mental invisibilizado. A enfermagem tem papel essencial no acolhimento e no estabelecimento de estratégias de cuidado aos adolescentes sobreviventes.
Descritores: Tentativa de Suicídio; Adolescente; Enquadramento Interseccional; Serviços de Saúde Mental.

RESUMEN

Objetivo: Analizar las circunstancias psicosociales que rodean los intentos de suicidio en adolescentes, desde las perspectivas de los propios adolescentes, profesionales de salud y gestores de CAPSij.
Método: Estudio cualitativo basado en la hermenéutica-dialéctica, mediante entrevistas semiestructuradas realizadas entre enero y diciembre de 2024 con 27 profesionales de salud, cinco gestores de CAPSij y nueve adolescentes que intentaron suicidarse en una metrópoli del

sureste de Brasil. El análisis de contenido de Bardin reveló tres categorías: vínculos familiares debilitados, experiencias de violencia e invisibilidad del sufrimiento mental.
Resultados: Los participantes señalaron una mayor vulnerabilidad entre adolescentes mujeres, negras y pardas. Los vínculos familiares estaban marcados por conflictos y ausencia de afecto. Los adolescentes relataron violencia física, psicológica y sexual, bullying, racismo y xenofobia. El sufrimiento psíquico se manifestó en aislamiento social, insatisfacción corporal, trastornos alimentarios, síntomas depresivos, autolesiones no suicidas y dificultades socioemocionales.
Consideraciones Finales: Los intentos de suicidio en adolescentes se relacionan con múltiples vulnerabilidades psicosociales, incluyendo vínculos familiares frágiles, diversas formas de violencia y sufrimiento mental invisibilizado. La enfermería desempeña un papel esencial en el acogimiento y en el desarrollo de estrategias de cuidado para adolescentes sobrevivientes.
Descriptores: Intento de suicídio; Adolescente; Marco interseccional; Servicios de salud mental.

INTRODUCTION

Attempted suicide is understood as a deliberate action with the intention of ending one's own life, even without a fatal outcome[1,2]. It represents a significant public health problem worldwide, especially among adolescents[1]. In Brazil, a significant increase of 47.34% in notifications of attempted self-harm among adolescents has been observed, with the most accelerated growth in the Southeast region, in the 2018-2021 period[2]. In these circumstances, it becomes necessary to understand the multiple dimensions involved in this phenomenon, considering the psychosocial determinants.

The National Policy for the Prevention of Self-Harm and Suicide (PNPAS) (Law No. 13.819/2019) represents a relevant normative milestone[3]. However, gaps are evident in the effectiveness of its implementation, especially regarding the absence of specific strategies for the contexts and diversity of adolescence[1,2], indicating the need for further knowledge about the applicability and influences of this policy on these groups.

Previous studies commonly identify risk factors associated with suicidal behavior in adolescents, such as depression, anxiety, eating disorders, family conflicts, and various forms of violence in home and school settings[4-10]. In recent years, research has incorporated the debate on intersectionality, broadening the understanding of vulnerabilities with support from markers of race, gender, and social class[7,11]. Thus, qualitative studies are necessary to produce and deepen knowledge about the experiences and interpretations of subjects directly involved in the care and experience of suicide attempts in adolescence. Such understanding can support care practices that are more sensitive to the specificities of the territories and

adolescents served in Child and Adolescent Psychosocial Care Centers (CAPSij), contributing to the qualification of mental health care and the strengthening of intersector practices in the field of mental health nursing and evidence for the implementation of the PNPAS. Therefore, the following question arises: - What is the perception of adolescents who attempted suicide, and of healthcare professionals and CAPSij (Psychosocial Care Centers for Children and Adolescents) managers, regarding the psychosocial circumstances involved in the act?

Considering these reflections, the study reported here aims to analyze the psychosocial circumstances surrounding suicide attempts among adolescents, from the perspective of the adolescents themselves, healthcare professionals, and CAPSij (Psychosocial Care Center for Children and Adolescents) managers.

METHOD

Qualitative research, based on the theoretical framework of hermeneutics-dialectics [12]. The methodological guidelines of the Consolidated Criteria for Reporting Qualitative Research (COREQ) instrument were followed.

The setting of the study comprised eight CAPSij (Psychosocial Care Centers for Children and Adolescents), five CAPSij II and three CAPSij III, located in areas of high social vulnerability within a Southeast Regional Health Coordination Center (CRSS) in a metropolitan area of Southeastern Brazil. This CRSS encompasses five technical health supervision units with varying profiles and territorial configurations. The existence of integrated teaching-research-service-community relationships from the researchers' involvement in these services through academic activities such as undergraduate internships, extension programs, and residency programs is also mentioned.

The inclusion criteria were health professionals and managers who had been working at the CAPSij (Psychosocial Care Center for Children and Adolescents) for at least six months and who had attended to cases of attempted suicide among adolescents in their current service. This minimum time requirement is justified by the participant's familiarity with the institution's routines, the territory's profile, and caregiving experiences. Exclusion criteria excluded participants who were on vacation, on leave, or on temporary contracts covering absences. Participant selection was based on convenience sampling, according to the subjects' availability and previously defined inclusion criteria. The fieldwork was initiated by the research coordinator during a visit to the services included in the study, when this coordinator explained the research objectives in a meeting with the team. Those who agreed noted their

contact information, and subsequently, the researchers scheduled the best day and time, without interfering with the service's routines or the participants' work schedules.

Twenty-seven professionals (27) participated out of a total of 240. Of these, 190 were excluded, considering that 70 had been in the service for less than six months, 32 were on leave, 55 were on vacation, ten had temporary contracts, and 23 refused, arguing that they were not interested in participating. Regarding the managers, five of the eight agreed to be part of the study. Among the eight service managers, three had been in the service for less than six months. Data was collected from January to December 2024.

Semi-structured interviews with professionals and managers of CAPSij, as well as with adolescents who had received care in these services after attempted suicide, were conducted in person. With the assistance of the professionals, notification forms of self-inflicted violence from the last two years and in the age range of ten to 19 years[13] were consulted to identify adolescents who had experimented with suicide and were not currently at risk to be invited to participate in the study. Those who had made new attempts in the last month or were in overnight care at CAPSij III were rejected.

Initially, an invitation letter explaining the objectives of the investigation was delivered to the caregiver responsible for adolescents under 18 years of age and to those over 18 years of age. Eighteen adolescents were located, but there were difficulties in extending the invitation, as five family caregivers refused, citing the adolescent's lack of time, while two cases occurred due to incorrect phone numbers, and two adolescents did not accept participation because they did not want to remember the act. Meetings were then scheduled with the nine selected adolescents.

The semi-structured interview script was developed specifically for this investigation and validated by the research team in a study group meeting. The individual semi-structured interviews consisted of closed-ended questions to identify the sociodemographic profile, while open-ended questions were asked to understand the object of study, focusing on the circumstances the interviewer perceived as making the adolescent vulnerable to suicidal ideation. With the adolescents, the questions concerned the circumstances involved in the experience of self-destruction and their life stories. The set of questions also included sociodemographic items of the adolescents interviewed, such as sex, age, skin color, method and number of attempts, and symptoms shown. The questions were organized in a logical pattern and were not modified at any stage of data collection. Although the script included predetermined themes, there was flexibility to open up to other themes, with the aim of capturing additional insights not **initially** foreseen. There was no repetition of interviews.

Data collection was made by a team composed of undergraduate nursing students and postgraduate professionals in nursing and occupational therapy, predominantly female. The postgraduate professionals have over ten years of experience in qualitative research and mental health, while the undergraduates have one year of experience in scientific initiation, had already taken a mental health course, and had participated in a research group. The team was previously trained in a study group meeting, which included a simulation, with the intention of conducting the interviews in an ethical and non-directive manner, avoiding interference in the participants' speech.

A relationship of trust and a friendly atmosphere were established with the participants before the start of the interview, through informal conversations and introduction of the research objective. Interviews with professionals and managers were conducted in private rooms within the service itself, without the participation of third parties, guaranteeing privacy and lasting an average of 30 minutes each. Interviews with adolescents were conducted remotely, via the Google Meet platform, at their preference. For those over 18 years of age, the signing of the Informed Consent Form (ICF) was requested before the interview began. In the case of adolescents under 18 years of age, family members and the adolescents consented, signing the Informed Assent Form (IAS), and also gave permission to record the interviews on an electronic device. Data collection was concluded when the researchers identified data saturation among professionals and managers, that is, the point at which further interviews did not add substantive elements to the emerging analytical categories. It is noteworthy that, among adolescents, the recognition of data saturation occurred concomitantly with the collection of recurring and repeated themes that answered the objective of the study[14].

The interviews from the audio-recorded content were transcribed in full, excluding any potentially identifying sections to guarantee anonymity. The transcripts were sent to the participants individually; however, there was no response, or the participants indicated they did not have the 15 days required to read and return them.

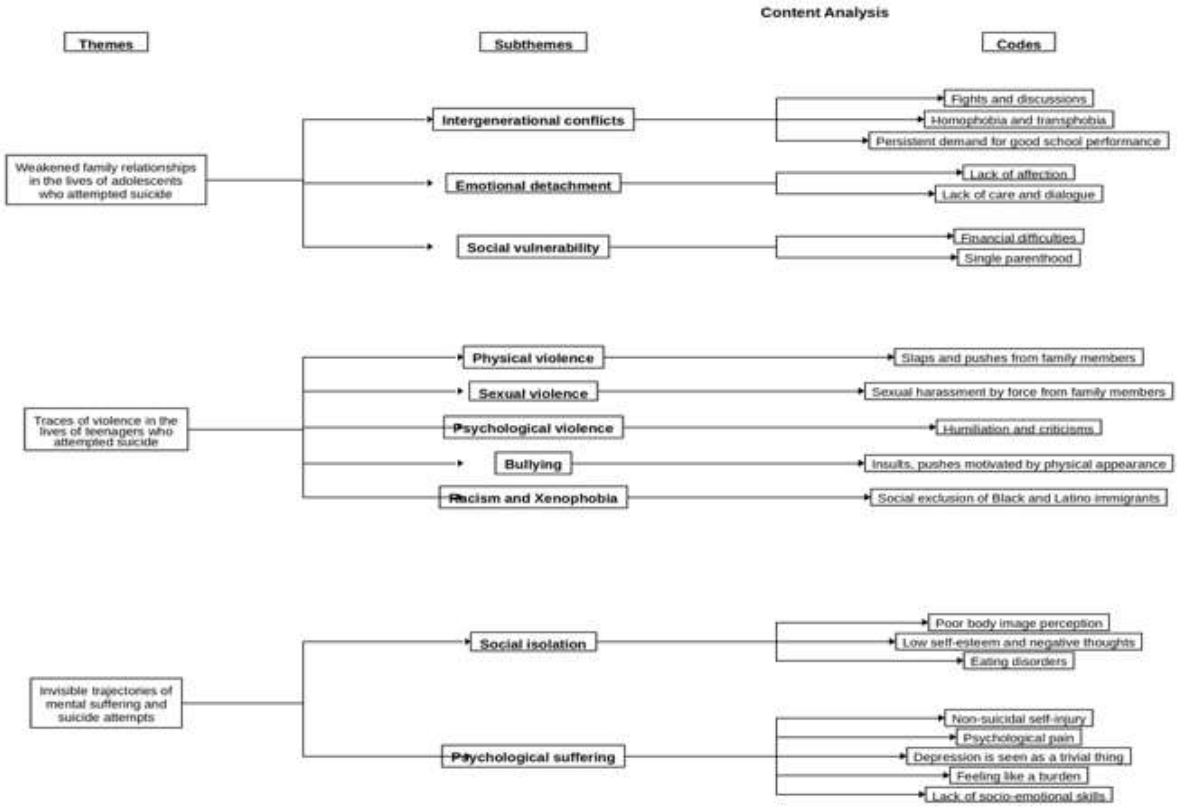
Software was not used in data analysis due to the subjectivity and complexity of the subject matter. The Content Analysis technique was adopted[15]. In the thematic modality, in accordance with the objectives outlined in the study, two researchers, jointly and without participating in data collection, conducted all stages of the examination of the indicators in weekly meetings.

The preliminary analysis was conducted through exhaustive and in-depth reviews of the transcribed material. Then, the transcripts were read and reread, and a global synthesis of the initial ideas identified was carried out. Furthermore, discursive similarities and differences

were observed, considering the criteria of exhaustiveness (considering all responses related to the investigated object); homogeneity (ensuring that the analyzed transcripts followed the selection criteria, allowing for comparability and analytical consistency); relevance (maintaining the epistemological focus with the selected material being appropriate and relevant to the research problem and the study's objectives); objectivity (referring to the clarity and explicitness of the categorization criteria); and fidelity (ensuring the consistency of the coding throughout the analytical process).

The exploration with manual coding of the most relevant excerpts from each interview and treatment of the *corpus* produced, due to the repetition of content; the inference and interpretation based on the elaboration of the registration units that derived the central thematic categories and related subcategories[15]. The themes underwent careful review and rigorous refinement to ensure that they accurately and consistently reflected the information. The final review involved reading the codes, participant reports, and themes to ensure that the subthemes captured the complexity of the data. Additionally, one of the researchers, who did not participate in the data collection and analysis phase, acted as an external observer and verified the conformity of the results by reviewing and confirming the extracted themes and subthemes, as reported in Figure 1.

Figure 1 – Categorization of themes and subthemes, São Paulo, 2026



The results section includes the main topics, with verbatim quotes from the participants. The interpretation of the thematic categories followed data triangulation through the researcher's interpretation, articulation with local characteristics, hermeneutics-dialectics [12] and national and international scientific evidence regarding the substance of the researched knowledge.

Researcher bias was minimized with the use of multiple approaches, such as, for example, being involved at different stages of the study. This collaborative approach allowed for the incorporation of various perspectives and reduced the risk of individual biases that could affect the collection and analysis of indicators.

In order to comply with ethical requirements, this research was approved by the Research Ethics Committees (CAAE) of Universidade Federal de São Paulo and Secretaria Municipal de São Paulo: 16435819.1.0000.5240 and 63307322.0.3001.0086. To preserve the anonymity and confidentiality of the participants, coding was established according to the function performed, following the numerical order of the interview transcription sequence.

RESULTS

The interview included professionals from the following fields: occupational therapy, psychology, social work, pharmacy, nursing (higher and technical level), medicine – pediatrics, speech therapy, social education, and nursing technician, aged 25 to 64 years. Some participants (20) had experience at CAPSi prior to the team they belonged to at the time of the interviews. The length of time working on the team ranged from one to 13 years. The period of experience ranged from one to 31 years, with an average of 14.58 years. The managers reported as their first experience in management what is described in Table 1.

Table 1. Characterization of the sociodemographic data of the participants, São Paulo, SP, 2025

Interview	Age	Sex	Race/Color	Profession	Time in service	Experience
Professional 1	37 years old	Feminine	White	Occupational Therapist	02 years	10 years
Professional 2	42 years old	Masculine	White	Psychologist	06 years	14 years
Professional 3	53 years old	Masculine	White	Pediatrician	03 years	31 years
Professional 4	27 years old	Feminine	White	Social worker	01 year	06 years
Professional 5	36 years old	Masculine	White	Psychologist	03 years	10 years
Professional 6	38 years old	Masculine	White	Pharmacist	06 years	13 years
Professional 7	43 years old	Feminine	White	Speech therapist	01 year and 08 months	15 years
Professional 8	37 years old	Feminine	Black	Social educator	04 years	10 years
Professional 9	39 years old	Feminine	Brown	Psychologist	01 year	07 years
Professional 10	41 years old	Feminine	White	Educational psychologist	01 year and 06 months	15 years
Professional 11	31 years old	Feminine	White	Social worker	05 years	05 years
Professional 12	34 years old	Masculine	White	Social educator	03 years	06 years
Professional 13	35 years old	Feminine	White	Occupational therapist	10 years	14 years
Professional 14	28 years old	Feminine	Brown	Nursing Technician	04 years	06 years
Professional 15	39 years old	Feminine	White	Psychologist	09 years	12 years
Professional 16	29 years old	Feminine	White	Psychologist	01 year	06 years
Professional 17	25 years old	Masculine	Black	Nurse	01 year and 07 months	01 year and 07 months
Professional 18	43 years old	Feminine	Brown	Psychologist	01 year	19 years
Professional 19	33 years old	Feminine	White	Psychologist	02 years	05 years
Professional 20	40 years old	Masculine	White	Psychologist	03 years and 06 months	12 years

Interview	Age	Sex	Race/Color	Profession	Time in service	Experience
Professional 21	35 years old	Feminine	Black	Nurse	06 years	10 years
Professional 22	46 years old	Feminine	White	Psychologist	02 years	18 years
Professional 23	33 years old	Feminine	White	Nurse	**06** years	10 years
Professional 24	35 years old	Masculine	White	Psychologist	10 years	10 years
Professional 25	46 years old	Feminine	White	Social worker	13 years	18 years
Professional 26	43 years old	Feminine	White	Psychologist	08 years	18 years
Professional 27	35 years old	Feminine	White	Nurse	02 years	09 years
Manager 1	62 years old	Feminine	White	Occupational Therapist	15 years	26 years
Manager 2	37 years old	Masculine	White	Occupational Therapist	01 year	16 years
Manager 3	42 years old	Feminine	Brown	Psychologist	02 years	18 years
Manager 4	47 years old	Feminine	Black	Occupational Therapist	01 year	11 years
Manager 5	43 years old	Feminine	White	Psychologist	06 years	10 years

Source: Survey data

The adolescents were aged 14 to 19 years, identified as cisgender women and transgender men, white, mixed-race, and black. The number of suicide attempts ranged from one to four, using the method of exogenous poisoning with medication (Table 2).

Table 2. Sociodemographic characterization and context of suicide attempts among adolescents, São Paulo, SP, Brazil, 2025

Interview	Age	Gender identity	Race	N. suicide attempt	Method used
Teenager 1	15	transgender man	Brown	4	Exogenous poisoning with medications
Teenager 2	14	Cisgender woman	Brown	1	Exogenous poisoning with medications
Teenager 3	17	Cisgender woman	Brown	1	Exogenous poisoning with medications
Teenager 4	19	Cisgender man	white	3	Exogenous poisoning with medications
Teenager 5	18	Cisgender man	white	2	Exogenous poisoning with medications
Teenager 6	15	Cisgender woman	brown	1	Exogenous poisoning with medications
Teenager 7	16	Cisgender woman	brown	2	Exogenous poisoning with medications

Teenager 8	18	Transgender man	brown	3	Exogenous intoxication with medications and alcohol use
Teenager 9	19	Cisgender woman	black	2	Exogenous poisoning with medications

Source: Survey data

The data regarding how professionals, managers, and adolescents understand the psychosocial circumstances in the lives of adolescents with a history of self-harm are presented through thematic categories. The first thematic category maps weakened family bonds, while the second refers to the marks of violence, and the third discusses the invisibility of mental suffering among young people.

Despite the segmentation of themes, the subjects are inseparable and, in common, reveal latent perceptions that harbor paradoxes, tensions, and ambivalences, intensified in the references of youth in modern society, and also manifest the spectrum of the complexity of mental suffering involving the attempt to manage one's own vital death, now under examination.

Weakened family ties in the lives of adolescents who attempted suicide

The analysis of the interviews revealed that family conflicts represent a central element in the trajectories of psychological suffering among adolescents. Professionals and managers reported that these adolescents frequently live in contexts of intergenerational relationships marked by excessive demands, lack of listening, and rejection of their identities and choices, especially concerning sexual orientation and gender identity.

> […] *these are teenagers who experience a great deal of family pressure regarding issues related to adult life. Teenagers whose families are constantly pressuring them about the job market and their studies. And these teenagers are actually trying to live their adolescence* […] *families have many conflicts at home, the teenager doesn't have a good relationship with their father, mother, or other members of the household, and there are issues related to gender identity, sexual orientation, and the choices these teenagers make are not well accepted, and they can't cope with these situations, which ends up causing a lot of psychological suffering and reaches a point where they try to end their own lives because they don't feel accepted* (Prof. 11, 31 years old, cisgender woman, white, social worker, works at CAPS IJ II and has 5 years of experience).

From the adolescents' own perspective, emotional neglect, the absence of stable bonds, and feelings of isolation were recurring elements. Accounts such as maternal absence, paternal rejection, and isolation within the home environment illustrate the fragility of these relationships.

> […] *I think one of the reasons that made me think about this was because of my family, because I felt very rejected, I felt very neglected because of that, my father didn't talk to me much, he didn't talk to me that much, he didn't give me that much affection. My mother abandoned me when I was six months old, it was just me and my father, and I felt very lonely because my father would go to work and I would stay home alone* (Adolescent 6, 15 years old, cisgender female, mixed race, heterosexual).

> […] *I never had a very good relationship with my family, from a very young age I was very neglected emotionally and when I started to understand this, it became more complicated for me* […] *at that time my mother thought that being trans was something curable, so for her I just had some problem in my head, I was sad and that's why I was like that* (Teenager 8, 18 years old, transgender man, white, pansexual).

Furthermore, the managers highlighted that the family configuration in the investigated territories differs from the conventional nuclear model, with family arrangements frequently involving single mothers or grandmothers as caregivers. This overload, coupled with the individual responsibility imposed by the socioeconomic context, compromises the ability to identify the suffering of adolescents.

> *In this territory, the expected family structure of father, mother, and everyone else doesn't exist; families are made up of single mothers and grandparents who also provide significant care. Therefore, there is this family fragility and daily contact, even observing the suffering that these adolescents are experiencing in their daily lives, and this leads to conflicts. Many situations are dismissed as trivial matters, or as "I give them everything, this adolescent has everything, so why are they doing this?" There's a difficulty, a lack of critical analysis of the health problems these adolescents are experiencing* (Manager 3, 42 years old, cisgender woman, mixed race, occupational therapist, 2 years at CAPSi II, 18 years of experience).

The data show that the absence of strong emotional bonds, the rejection of identity aspects, and emotional neglect are key determinants of the psychological suffering that precedes attempts to effect one's own death, requiring a care approach sensitive to family dynamics and the sociocultural specificities of the territories.

Traces of violence in the lives of teenagers who attempted to annihilate each other

Violence appears as a cross-cutting element in the life stories of adolescents who attempted suicide, as reported by professionals, managers, and the young people themselves.

The types of violence mentioned include physical, psychological, and sexual assaults, as well as bullying, racism, and xenophobia, often intertwined with gender and race.

In several reports, professionals emphasize that many adolescents have experienced episodes of sexual violence within the family, often unrecognized or neglected. This oppression was especially evident among female adolescents, especially Black or mixed-race girls, suggesting intersections of gender vulnerability and racial fragility.

> […] *most of them bring histories of sexual violence, and when sexual violence is not processed in the first instance, it becomes a trauma that is very difficult to overcome later, mainly because the violence is repeated across generations. Discussions involving gender and race have emerged, and because these are Black girls who already suffer violence in their daily lives, they cannot bear the pain that remains, the physical violence within the family, and the pain left by the physical marks of sexual violence, along with a certain hopelessness about what lies ahead.* (Manager 2, 37 years old, cisgender male, white, occupational therapist, has worked at CAPSi III for 1 year and has 16 years of experience).

Among adolescents, reports confirmed recurring situations of domestic violence and intrafamilial abuse, with cumulative negative influences on their mental health.

> […] *in Maranhão I faced some very difficult situations with my family there, I was hurting myself trying to get through it and it got worse because of my grandmother's treatment, because my grandmother would hit me, insult me. I also suffered abuse* [physical and psychological violence] *from my cousin, sexual abuse from my aunt. And this got worse until I reached where I am now* (Adolescent 7, 16 years old, cisgender female, mixed race, heterosexual).

Bullying at school was also widely cited, involving practices of humiliation, exclusion, and physical assault, usually motivated by body characteristics, appearance, and skin color. The difficulty of school institutions in recognizing and intervening in these situations contributed to exacerbating the suffering of adolescents.

> […] *at school I couldn't get good grades because I was depressed and because they* [classmates] bullied me *a lot, it was related to my appearance, my features, trivial things, like my chin, my nose, my body, my skin, and because of that, I couldn't concentrate on my lessons and I couldn't do things* (Adolescent 6, 15 years old, cisgender female, mixed race, heterosexual).

> […] *The teenagers had very difficult life stories, bullying appears too often,* bullying *at school, and it's* bullying *that wasn't identified by the family, that dragged on, the school itself also didn't have a way of dealing with* bullying *, and when it does come to light, it involves experiences with their own bodies, feeling ugly, having a very difficult issue with self-image* (Prof. 13, 35 years old, cisgender woman, white, occupational therapist, has worked at CAPSi II for 10 years and has 14 years of experience).

Beyond family and school violence, the study identified the negative influx of xenophobia experienced by Latin American immigrant adolescents, especially Black adolescents, residing in territories marked by social and racial segregation.

> […] *It is difficult for them* [teenagers] *to bring up the issue of race, but this territory is traversed by a racial issue not only concerning Black people, but also the issue of Black immigrants, and it is a divided territory in that sense. But when we listen to the teenagers' accounts, the phase of violence that often happens in schools comes up, not only within the family, but also a kind of apartheid, because it involves Brazilian populations and immigrant populations, mainly Latin American ones, in this territory* (Prof. 9, 39 years old, cisgender woman, mixed race, psychologist, has been working at CAPSi II for 1 year and has 7 years of experience).

These findings demonstrate that violence is not an isolated event, as it constitutes a structural component of these adolescents' experiences. Their trajectories are marked by successive layers of exclusion, which include, in addition to direct violence, the absence of institutional, family, and community protection —factors that exacerbate psychological suffering and suicidal ideation.

Invisible trajectories of mental suffering and suicide attempts

The participants' accounts reveal that mental suffering among adolescents is often made invisible in daily life, manifesting itself through social isolation, loneliness, eating disorders, non-suicidal self-harm, and depressive symptoms. This suffering accumulates over time and is aggravated by the lack of recognition and validation from family and support networks.

Being isolated and experiencing loneliness are emerging as central elements in the trajectories of adolescents, associated with social rejection and the absence of meaningful emotional bonds.

> *Most cases are related to some kind of depressive condition, often accompanied by self-harm* […] *these are teenagers who don't have a very large social network, they become more isolated, some don't even leave the house* (Manager 5, cisgender woman, 43 years old, white, psychologist, has worked at CAPSi III for 6 years and has 10 years of experience).

Adolescents reported difficulty coping with interpersonal and emotional conflict, often facing these challenges alone. Low self-esteem and body dissatisfaction were also recurrent, especially among female adolescents. These aspects are frequently associated with experiences of *bullying* and emotional violence, increasing suffering and contributing to self-harm as an emotional regulation strategy.

> *I moved to a new city when I was 10 years old. At first it was very difficult, a new city, I didn't know anyone, I was always alone* […] *I started to feel very bad, I refused food, I vomited and I started to lose a lot of weight. When I attempted suicide, five years later, I was in a very delicate moment in my life, I felt conflicted with myself* (Adolescent 3, 17 years old, cisgender female, heterosexual, mixed race).

> *Since I started entering this phase of adolescence, I started having a lot of fights with my mother, and many things she said that I took to heart, and I felt very bad. I started feeling a very strong pain inside, in my head. I didn't want to be alive; it would be better for people. I was hindering the lives of many people, and I started doing things like cutting myself, even trying to kill myself, because it seems like I have to deal with everything alone* (Adolescent 2, 14 years old, cisgender female, heterosexual, mixed race).

Participants also reported family neglect when there are signs of distress, which contributed to the worsening of the adolescents' emotional state. Lack of listening and dismissal of symptoms were identified as barriers to prevention.

> *I believe that many suicide attempts happen because there is no listening ear at home. Many people say they attempt suicide because they didn't believe the person was suffering. A depression that the family doesn't accept, they say it's just a bit of a fuss, and then it gets worse. We had a case of a girl who jumped off an overpass; she broke both knees and fractured her spine. During a visit, we asked her why she did it, and she said that nobody believed her. She did it so that people would believe that she really wanted to die* (Prof. 14, 28 years old, female, nursing technician, mixed race, 4 years at CAPS IJ and seven years of experience).

These results show that suicide attempts among adolescents cannot be understood outside the context of accumulated vulnerabilities and the absence of effective support mechanisms. Mental suffering, when ignored, contributes to the intensification of mental pain and leads to the adoption of extreme behaviors as a way to communicate or end this suffering.

The intangible nature of suffering in the adolescents investigated highlights the need for care practices that are sensitive to the multiple dimensions of emotional pain, as well as intersector action to identify early signs of risk and strengthen protective factors in the family, school, and community environment.

DISCUSSION

The thematic category of weakened family bonds denotes that family conflicts represent a central factor in the psychological suffering of adolescents who attempted suicide, both nationally[4,7,8,10,16] and internationally[9,11,16,17]. The literature[7-9,11,13,18] confirms that authoritarian parenting patterns, lack of listening, rejection of gender and sexual identity, as well as the burden on single-parent families[6], especially maternal ones, are associated with the increase in suicidal ideation among young people. Research with 6,233 Chinese adolescents[13] found that they were three times more likely to have suicidal behaviors when witnessing family fights. Conflicts between parents are likely to produce emotional insecurity, associated with feelings of guilt and emotional dysregulation[8,9,11,13,17].

Research in Canada[9] found that family conflict acts both as a precipitating factor for the feeling of imprisonment and hopelessness of adolescents and for the absence of dialogue in the family relationship. Similar to the findings of this essay, religious intolerance in the lives of Indonesian family members directly interfered with the expression of gender and sexual identity of adolescents, leading to distancing in relationships and psychological pain [19]. The absence of hermeneutic dialogue[12], in which social agents do not involve themselves

and do not transform themselves in the interaction, leads to a unilateral relationship that annihilates the understanding of the world in the experience of adolescents, which is conducive to causing mental suffering and increasing the risk of self-harm.

The thematic category marks of violence discusses the practices of violence in childhood that translate into abandonment and the absence of safe relationships to communicate the sensations and feelings aroused by this trauma. When experienced, this is associated with negative long-term consequences for health and well-being[4-11,13,17] and a feeling that life is not worth living.

The narratives revealed multiple forms of physical, psychological, and sexual violence, bullying, and racism, frequently linked to social markers of difference, such as gender and race. Notably, one of the factors related to suicide attempts among adolescents was sexual violence, comprised of various types of sexually violent behavior and non-consent [4,5,7,10,11]. A longitudinal investigation in the United States, with 10,301 adolescents, on the effects of racial discrimination, identified 13.01% with suicidal ideation and, of these, 2.88% with a high risk of racism[20]. Similar results were found in the Brazilian context[5,6,8,10,18,21,22]. Professionals and managers bring to the surface the reality common to Black adolescence: hopelessness in defining life projects, both due to economic aspects and violence, and due to the concrete or symbolic demarcation of social spaces to which their access is denied[10,11,20-22]. Constant exposure to violence, discrimination and social exclusion directly and negatively influences mental health, creating a cycle of intergenerational trauma that compromises the well-being and quality of life of the black population in Brazil[21].

Social contradictions, understood as economic, racial, territorial inequalities and ways of belonging to society, are present in the various forms of violence against adolescents[12]. Thus, it can be inferred that violence should not be fragmented and reduced to isolated facts, but understood as a social phenomenon in all its complexity, which exposes adolescents to violence[12].

It is noteworthy that the adolescents did not discuss in their accounts the impact of violence and racism on their psychological suffering, which corroborates the Brazilian study suggesting that these individuals do not recognize violence among themselves[7]. Thus, it can be inferred that racial-identity elaborations are still a topic that needs to be explicitly discussed with adolescents due to the intangibility of the repercussions of racism, through moral and economic exclusion, which increases the vulnerability of Afro-descendant adolescents to physical and mental illness[4,11,20-22].

It is necessary to delineate suicide attempts among black Venezuelan and Colombian adolescent immigrants. There is no data in the literature on self-destructive behavior in this population, however, the idea is advocated that ethnic and racial discrimination is likely to influence the well-being of ethnic and racial minorities and young immigrants and, with other factors, mediate the risk for suicide[22].

The experience of bullying and discrimination in school and family environments, coupled with the absence of institutional response[4], contributes to the worsening of psychological suffering. A study in Malaysia[23] with 10,301 school adolescents shows that 17% of those who reported suicide attempts were victims of bullying. People who suffer from school bullying are characterized as being young people aged 13 to 15 with a combination of low self-esteem and body dissatisfaction resulting from the suffering generated by daily school life in which they are humiliated by schoolmates through name-calling, insults, unpleasant remarks and fights, pushes, kicks[7,10,16,17,23,24]. Bullying experiences increase the chances of suicide attempts fourfold[23]. Bullying is considered a trauma that carries psychological repercussions. It is worth noting that both trans boys and girls have been victims.

In the thematic category encompassing intangible trajectories of suffering and suicide attempts, there was a predominance of mentions of social isolation as a result of dissatisfaction with their relationships with family members and friends[8,9,18,25,26] as well as the unpreparedness of the family caregiver to support adolescents, which is a barrier to adolescents to receive emotional support from adults they trust when they are emotionally overwhelmed [9] .

Adolescents reported experiences of eating disorders due to dissatisfaction with body image and low self-esteem. A systematic review and meta-analysis identified a prevalence of attempted suicide in 22% of young people and women with eating disorders[27]. Body dissatisfaction exists among Brazilian adolescents who attempted suicide[10], which explains the results. In England, one in three people with eating disorders report a history of childhood violence, and this is twice as common among those who die by self-harm[28]. The clinical complexity of eating disorders[28] explains why eating disorders are not mentioned by professionals and managers.

Non-suicidal self-injury (NSI), depressive symptoms, and suicidal ideation are associated with suicide attempts among adolescents[10,11,18,19,29]. Indeed, adolescents who employ multiple NSI methods are at greater risk of suicidal thoughts and behavior, especially when they perceive that their NSI methods are no longer effective for emotional regulation

[10,11,18,19,29]. A systematic review[18] found that NSI intensifies over time and can reduce the ability to perceive bodily sensations, increasing more lethal self-harm and, consequently, is also likely to increase the probability of attempting suicide. NSI represents an indicator of suffering that, if left untreated, will certainly increase the repetition of inflicting pain and physical harm on oneself and increase the absence of fear of death.

The interpersonal theory of suicidal behavior[30] explains that three determinants play essential roles: a feeling of lack of belonging, in which there is isolation and disconnection relative to significant people; perceived weight and belief in one's own worthlessness, likely leading to the thought that the world could be better without someone; and acquired capacity for suicide, which consists of learned skills to harm oneself, often developed through repeated experiences with the aim of causing injury, pain and/or physical damage, including non-suicidal self-harm[10,11,18,19,29]. The negative psychosocial influx from the weakened support network is more sensitive in adolescence, as it constitutes a period of great social changes, biological maturation and, also, responsibilities.

Hermeneutics-dialectics[12] calls for sensitive, critical and empathetic listening to mental suffering among adolescents and challenges health professionals, educators and family members to interpretation, transposed to the visible and literal, in an interpretative game where suffering needs to be unveiled, even when it is masked.

The findings of this study point to the need for mental health care practices grounded in qualified listening, in a comprehensive mental health clinic supported by the recognition of psychosocial vulnerabilities, and in intersector action. Nursing, especially in primary health care, plays a strategic role in the early identification of risk factors and in establishing therapeutic bonds that value the uniqueness of adolescents. Thus, the leading role of nursing in the School Health Program is reinforced, where educational initiatives and actions should focus on promoting mental health and a non-judgmental dialogical space, so that adolescents can express anxieties and doubts in a horizontal relationship that prioritizes comprehensive and anti-racist care.

Incorporating an intersectional perspective into adolescent care allows for interventions that are more sensitive to social and cultural inequalities. Consequently, valuing adolescents' narratives strengthens mental health promotion and suicide prevention strategies that consider the culture and territory in which the adolescent lives.

It must be acknowledged that the study's limitations include the lack of representativeness of professions and the lower representation of male adolescents and other ethnic-racial identities. This makes it difficult to compare the data with other realities and to

conduct adolescent interviews online, hindering the observation of nonverbal and paraverbal communication. Consequently, a field diary was not used, and it was not possible to provide feedback on the research results to the participants. It is suggested that future investigations explore masculinities and their relationships with psychological distress and suicidal behavior, as well as the perceptions of professionals from other sectors and from primary and hospital care, thus expanding the empirical and theoretical basis relevant to the subject.

FINAL CONSIDERATIONS

The results of this study showed that suicide attempts among adolescents are embedded in a set of complex and cumulative psychosocial circumstances. The fragility of family bonds, marked by emotional neglect, identity rejection, and lack of emotional support, was identified by adolescents, professionals, and managers as a central element in the production of psychological suffering. The recurring existence of various forms of sexual, physical, and psychological violence, bullying, and xenophobia, within the family and school context, intensifies psychological suffering, especially among Black adolescents, girls, and transgender youth, reinforcing the structural dimension of suffering that precedes suicide attempts.

Psychological suffering among adolescents tends to remain invisible in daily life, manifesting itself silently and for prolonged periods through signs such as social isolation, non-suicidal self-harm, low self-esteem, depressive symptoms, and eating disorders, often unrecognized by families and institutions. The absence of qualified listening and the delegitimization of these manifestations contribute to the intensification of psychological pain and, in some cases, to suicide attempts as a way to express or interrupt this suffering. Professionals, adolescents, and managers demonstrated a similar understanding of the psychosocial circumstances surrounding suicide attempts, which can be justified by their involvement and experience with the topic in the management and provision of care.

The findings of this study identified the relevance of intersector care practices, especially with the participation of the school, given its centrality in the lives of adolescents. Such practices should consider gender, race, and territorial inequalities, promote the early detection of risk signs, and provide guidance to family caregivers for sensitive listening. Understanding the psychosocial circumstances associated with suicide attempts requires management actions directed at coordinating care, with contextualized interventions aimed at

social protection, strengthening affective bonds, and valuing the multiple dimensions of the mental pain experienced by these adolescents.

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Availability of data and material

Access to the dataset may be obtained by requesting it from the corresponding author.

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