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Research Article

Risk Factors Associated with Suicidal Behavior and its Interpretation with Humanistic Theories in Nursing Students

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Abstract

Background: Suicide is a worldwide problem caused mainly by feelings such as frustration, loss of values such as dignity, respect for self and neighbor. Young university students are in a "vulnerable" stage for the development of suicidal risk behaviors, which implies profound biological, psychological and social transformations, largely generating crisis, conflicts and contradictions.

Materials and Methods: A cross-sectional study included 2,624 nursing students where the Suicidal Risk Assessment in Adolescents (IRSA) was applied, made up of 107 questions in 8 dimensions of suicidal behavior: suicidal risk factors not modifiable, modifiable, depression-anxiety, suicidal ideation, precipitating factors, beliefs and protectors to suicide.

Results: The history of suicide attempt (HIS) was presented in 20% and 61% reported having suicidal ideation. Students with HIS had significantly higher frequency of risk factors vs. students without HIS; the proportion of protective factors was significantly higher in those without HIS. The highest frequency with HIS was between 20 to 25 years, in the female sex and in face-to-face careers.

Conclusion: The results show that suicidal behavior in nursing students of the CUCS, UDG, should be considered a problem of public health; The humanistic approach allows us to realize an existential void and the lack of a sense of life to face the demands of modern society that limit the development of human potential to cover the basic needs of human coexistence and self-regulation.

Keywords: *Risk Factors; Suicide; Suicidal Behavior; Students; Sense of Life*

Introduction

We can place young university students, in particular nursing students at the University Center for Health Sciences (CUCS) at a stage in the human life cycle, between adolescence and young adults. Throughout history, this stage has been considered "vulnerable" for the development of suicidal risk behaviors, which implies profound biological, psychological and social transformations, largely generating crisis, conflict and contradiction.

The scientific and technological advances of modern societies are changing the "task of being adolescents": While individual achievement and competitiveness are privileged, at the same time they promote the loss of values such as dignity, self-respect and neighbor [1]. The aforementioned can condition adolescents' sense of existential emptiness, loss of sense of life, lack of co-responsibility with the other to carry out the common task of personal growth.

Humanism is a current response to the problem of suicide in adolescents: it emphasizes that the understanding of the human being should be integral to the development of human potential [2].

Problem Statement

Suicidal behavior, according to data from the World Health Organization (WHO) and the Pan American Health Organization (PAHO), consider it to be a public health problem worldwide.

Lack of access to adequate care is one of the factors that increases stigma with suicidal behavior; which can be associated with a lack of knowledge on the subject. One of the ways to address it is through community-based educational programs targeted at specific risk groups.

Most suicides can be prevented. The WHO advises, among other things, to reduce access to the means to commit suicide (pesticides, medicines, firearms); treating people with mental disorders, and in particular those with depression, alcoholism or schizophrenia; monitor patients who attempted to kill themselves; promote a responsible treatment of the subject in the media; and train primary health care professionals to detect and manage suicidal behavior [3].

Magnitude of suicide in the world [3]:

- 250 thousand suicides per year are of adolescents and young people under 25 years of age.
- 20 people try to commit suicide for each one who succeeds.

Magnitude of suicide in America [3]:

- Suicide ranks 20th among all causes of mortality in America.
- Suicide mortality is four times higher in men than in women.

Among other risk factors associated with suicide in adolescents for the development of suicidal behavior is the presence of depression, alcohol consumption, drugs and a relevant aspect could be hopelessness to continue living [4,5].

All of the above shows that suicide in adolescents is a serious public health problem and that it can be largely preventable, if the risk profile of the students is identified and effective intervention is made to modify the risk factors.

Based on the above, the following research question can be asked: What are the risk factors associated with suicidal behavior in nursing students at the University Center for Health Sciences at the University of Guadalajara?

Justification

The determination of suicidal behavior in students of the Nursing degree of the CUCS of the University of Guadalajara (U de G), is essential to develop and support a proposal that allows to identify, understand and explain the factors that can prevent, promote or avoid

the suicide attempt or execution in a population traditionally vulnerable to external and internal exposures. From the perspective of human development [6], the phenomenon of suicide could be explained through multidisciplinary participation and by the principle that every human being is capable of promoting their growth; considers the person comprehensively and at the same time explains the basic mechanisms for promoting values as an individual and collective responsibility.

It is important to mention that there is no suicide record typical of the U of G and therefore the magnitude of the problem in the students cannot be evidenced. Although risk factors and the frequency of suicide in U of G students have not yet been documented with rigorous research, empirical data shows that students (generally adolescents) constitute a vulnerable population and are exposed to various factors. risk: drug addiction, smoking and alcohol abuse, school environment, lack of school support, presence of Bulling, inadequate management of emotions, dysfunctional relationships in love, unwanted pregnancy, dysfunction and lack of family support, among others [4,5].

Overall Objective

To determine the risk factors associated with suicidal behavior in students of the Nursing degree at the University Center for Health Sciences of the University of Guadalajara.

Conceptual framework of suicide

The misconceptions that people have about suicide make the scientific approach more difficult, so it is necessary to make some conceptual clarifications before presenting an overview on the subject.

The application of the term to diverse behaviors and the multiple considerations on suicide have only contributed to the increase in conceptual dispersion. Shneidman [7] exposes some difficulties that revolve around suicide. The first refers to the fact that the word "suicidal" is applied interchangeably to the person who has committed, attempted and thought of suicide.

The second confusion is related to the temporality of the act and the concept of "suicide" is applied to designate both a person who committed suicide in the past and to define a person who currently commits a suicidal act. The third confusion is related to the purpose, that is, the intention of the act.

The term suicide and suicide is relatively new [8], some sources place it in Great Britain in the 17th century, others in France in the 18th century, traditionally it has been argued that the word had its origin in Abbé Prévost in 1734, from which the Abbot Desfontaines 1737 and Voltaire and the encyclopedists took it up.

The French academy of the language included it in 1762 as "the act of the one who kills himself" and the Dictionary of the Royal Spanish Academy in the fifth edition published in 1817 with a Latin etymology parallel to that of homicide, Sui (from himself) and Cadere (kill) "It is said of the act or of the conduct that damages or destroys the agent himself".

Some authors such as Pokorny [9] propose the term "completed suicide" for death by suicide and "suicidal behavior" for a series of related terms such as suicide attempt, suicidal ideation, threat, etc. While authors such as Van Egmond and Diekstra (1989) in: Villardón GL [10] adhere to the concept of "Parasuicide" coined by Kreitman in 1969, quoted in: (Sarró, 1984) when considering that suicide has an intentionality of To die that they do not have all the self-destructive behaviors, and therefore the parasuicide supposes a self-injurious behavior for the subject but consciously non-fatal, while the suicide attempt is understood as a failed suicide. In this sense, parasuicide is equivalent to the concept of "suicide gesture" used by other theorists.

In 1980 Farberow coined the concepts of Direct Self-Destructive Behavior (CAD) and Indirect Self-Destructive Behavior (CAI) in the first group all those that suppose a conscious and intentional autolytic behavior, whether or not death is sought. The CAI would integrate

all the behaviors that Shneidman [11] classified as "sub-intentional" to identify those deaths in which the subject unconsciously influences to accelerate his death.

These various ways of classifying suicidal behavior can be grouped according to Ellis (1988) into: the descriptive dimension, the situational dimension, the psychological-behavioral category and the teleological one. And, to know more objectively a suicidal act, it is necessary to take into account the aspects of lethality, certainty, intent, mitigating circumstances and the harmful method used [9]. However, I consider that each suicidal act is a unique act that has its history and is only understood and explained from the act and the actor himself.

For practical reasons throughout the text and regardless of making the conceptual definition referring to a variable at the time, the term "suicidal behavior" will be used for an inclusive general name; and in necessary situations of the use of the specific concept, I will use "suicide" to indicate consummate suicide, "suicide attempt" to refer to the independent failed act.

Regarding the cause or form, "parasuicidal behavior" to all behavior without the conscious intention of causing death.

Humanist approaches to suicide behavior in adolescents

Frankl Victor, 1946

The humanistic-existential approach within psychology represents a "third force" [12], seen by many authors as a theory more attached to the philosophical nature, for treating among its lines the values, the nature of the human condition, condemn the use of diagnostic labels, for being seen as objectionable, which only serve as a typecasting of the human being and seal the therapeutic relationship, in addition to preferring a holistic point of view of the person.

Humanistic theory affirms that we are motivated by positive motivation and that we move towards higher levels of functioning, that is; that human existence is not limited only to solving latent conflicts, it maintains that personal realities are products of unique experiences and perfections, in addition, the subjective cosmos of an individual is more important than the events themselves, so to understand why people behave as they do, humanists must rebuild the world from the eyes of the individual.

Carl Rogers, 1980

One of the main representatives of humanism, Carl Rogers argued that men and women develop their personality around positive goals; Every organism is born with certain innate capacities and potentialities, "a kind of genetic project to which it adds substance as life progresses" [13]. The goal of human existence is to empower your abilities to become the best that you are intrinsically empowered. Tendency to Realization is the name that Rogers gives to this biological drive; affirms that it is a predisposition that characterizes all organisms.

Einstein, 2007 [14]

Maslow turns his attention to the hierarchy of established needs: "a satisfactory standard of living must be achieved first and only then can the task of finding a purpose and meaning to life be tackled" [12]; since he believed that the human being develops through several levels, towards his full potential. A few reach the highest level of development and it is called self-actualized. This inherent tendency of the individual to strive to achieve the realization of his full potential, that predisposition is what he calls "Self-actualization" [12].

Perls, dreams and existence

For Erikson, identity is solved as young people solve three fundamental problems: the first is related to the choice of an occupation, the second is the adoption of values "what to believe in and why to live" and the last day account of the development of a satisfactory sexual

identity. When young people have difficulty establishing an occupational identity, when their opportunities are artificially limited, the reason for life is not found, they risk engaging in behaviors with serious negative consequences such as criminal activity, early pregnancy or depression.

At this stage young people are susceptible to the search for the meaning of life outside the opinion of their parents [15] where self-identification emerges when young people choose values and people to be loyal to, instead of limiting themselves to parents' choices. For teens it becomes very important to trust themselves.

Risk factors of suicide behavior in adolescents

Depression

90% of adolescent suicides occur in individuals with a pre-existing psychiatric disorder, in approximately half of these, the psychiatric disorder has been present for two or more years and approximately one third of suicides have made a known prior suicide attempt [16].

The combination of depressive symptoms and antisocial behavior has been described as the most common antecedent of suicide in adolescents [17]. Almost three-quarters of those who eventually kill themselves show one or more symptoms of depression and may suffer from major depressive illness. Among the most frequent symptoms observed in depressed adolescents are: sadness, boredom, boredom and annoyance, loss of interest and pleasure in activities that previously aroused him, sleep disorders, insomnia or hypersomnia, restlessness, lack of concentration, irritability, dysphoria, moodiness, loss of energy to undertake daily tasks, feelings of exhaustion and exhaustion, repeated concerns with music, books and games related to the topic of death or suicide, manifesting wishes to die, feeling physically ill, without having any organic disease. Increased use of alcohol and drugs, lack of appetite or exaggerated appetite, rebellious behavior without a determining cause, expressing suicidal ideas or making a suicide plan, planning acts in which the chances of dying are not realistically calculated, crying for no apparent reason, social isolation avoiding the companies of friends and family, pessimism, hopelessness and guilt.

Depression in its different clinical manifestations, is the mental disorder that is most often associated with suicidal behavior.

Anxiety disorders

Anxiety disorders are estimated to increase the suicide risk of the general population by 6 to 10 times, however the suicide rate in disorders anxiety is less than in depressives. In many cases, alcohol abuse is considered to mask anxiety disorders [18].

Bipolar affective disorder

Self-elimination ideas and suicidal behavior are common in bipolar patients. Impulsiveness is a prominent behavior in bipolar affective disorder and is present even in euthymic periods [18].

Schizophrenia

Suicide is the leading cause of premature death in patients with schizophrenia. It is estimated that between 20 and 25% of schizophrenics attempt suicide and this rate is similar to affective disorders and 20 times higher than that observed in general [18].

Excessive consumption of drugs and alcohol is also frequent among children and adolescents who commit suicide, a maladaptive pattern of substance use is often present, with adverse consequences, non-compliance with important obligations, repeated use in situations where doing so is physically Dangerous and dangerous, associated with drug use are: sudden changes in friendships, in the way of

dressing and speaking, using the jargon of drug addicts, decreased academic performance and repeated unexcused absences from school, without being known what time has he used, changes in his habitual behavior at home, becoming irritable, isolated and without the desire to share with the rest of the family, thefts in his own home, or in that of other relatives, friends or neighbors to sell them and acquire the money with which to buy the drug, steal money from parents or lie to them about alleged purchases of articles Desired but nonexistent, changes in the schedules of the activities, predominating those carried out at night, signs of burns on clothes, blood stains, signs of punctures in the forearms or other drugs in the pockets [16].

The incidence of alcoholism in general is 10% and the risk of suicide in the life of patients of this type is estimated at 15%, a similar figure in affective disorders [18].

When depression and alcoholism are associated, the risk of suicide is 75 to 80 times greater than that of the general population, it is an important predictor of suicide.

Eating disorders

Suicides and parasuicidal behaviors are frequent in patients with eating disorders, especially related to high levels of impulsivity, which is more common in bulimia and in purgative type anorexia. It is suggested that there may be an alteration in the bioavailability of serotonin, a neurotransmitter that is related to impulsive behavior, suicidal behavior and eating disorders, in these cases [18].

Material and Methods

Cross-sectional study by census, the study population was stratified by groups and educational levels completed at the Nursing School of U de G. After reading and signing the written informed consent, an instrument was applied to assess suicide risk. in the participants [Instrument for Suicidal Risk Assessment in Adolescents (IRSA).

Selection of the sample

100% of the students of the Nursing Degree, Nursing Degree and Nursing Degree Virtual Mode were invited to participate one.

Statistical analysis

Suicidal risk was established based on the presence of a history of behavior with or without suicide attempt. For the comparison between the groups with and without suicide attempt, they were performed using the Student's t-test for independent samples in the case of nominal variables, and the Chi^2 test was used to compare the nominal variables.

Risk categories were established by distribution by quartiles in each of the dimensions and the distribution of the dimensions of suicide risk was compared according to each of the established categories [(no risk (percentile 1 to 25), mild risk (26^{th} to 50^{th} percentile), moderate (51^{th} to 75^{th} percentile) and high (> 75^{th} percentile)] and the percentage distribution of each of the evaluated dimensions grouped by level of suicide risk. A p value of < 0.05 was accepted as significant.

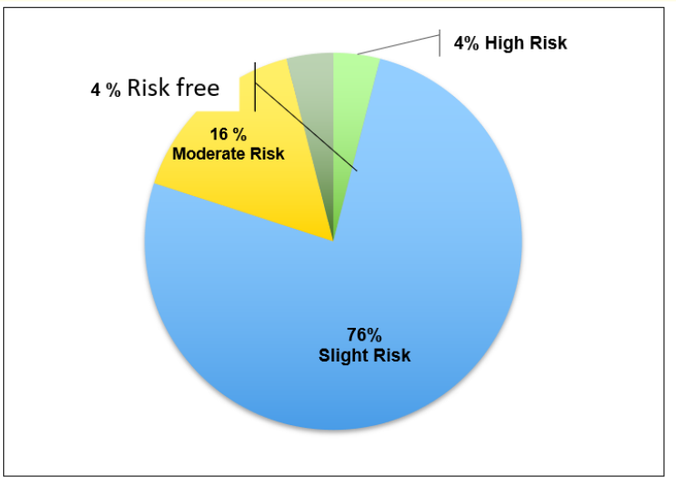
Additionally, the discussion of the results were interpreted from the humanistic perspective by two experts in human development.

Results and Discussion

A total of 2624 students, 79% female and 21% male, were included in the study, the average age was 22.7 years, with a standard deviation of 4.42, a minimum of 15 years and a maximum of 60 years. According to the profile of entrance in the nursing career, the majority of the participants correspond to face-to-face careers, a little more than 50% correspond to the category of Bachelor of Nursing (LE), a third to Basic Nursing (EB), while in virtual careers a smaller proportion participate, 10% in Bachelor of Virtual Nursing (LEV) and only 3% in the category of Virtual Basic Nursing (EBV).

The percentage risk distribution according to the classification in categories: no risk, light risk, moderate risk and high risk in the study population. It can be seen that 96% of the population showed some level of risk and few patients were classified as not at risk of suicide (Graph 1).

The estimate of the suicide risk of the participants who answered the question "Have I ever attempted suicide?" Is shown by 20% (Table 1).



Graph 1: *Percentage distribution of risk in the study population.*

Variable	CON HIS	SIN HIS	P
N (%)			
Age years	513 (20)	2044 (80)	
Sex	24 ± 5	22 ± 4	< 0.0001
Female	439 (85)	1571 (78)	< 0.0001
Admission profile, N (%)			
LE	242 (47)	1107 (54)	< 0.0001
LEV	10 (2)	241 (12)	
EB	248 (48)	630 (31)	
EBV	13 (2)	66 (3)	
Birthplace, N (%)			
Guadalajara, Jal.	436 (85)	1614 (79)	0.007
Zapopan, Jal.	23 (4)	133 (6)	
Tlaquepaque, Jal.	12 (2)	72 (3)	
Tonalá, Jal.	7 (1)	79 (4)	
Others	35 (7)	146 (7)	
School grade			
1st Half	60 (12)	288 (17)	< 0.0001
2nd Half	65 (13)	233 (13)	
3rd Half	43 (9)	267 (15)	
4th Half	40 (8)	212 (12)	
5th Half	34 (7)	180 (10)	
6th Half	55 (11)	190 (11)	
7th Half	14 (3)	130 (7)	
8th Half	72 (15)	63 (4)	
SS providers	107 (22)	165 (9)	

Table 1: *Comparison of the general characteristics of the sample according to the personal history of suicide attempt.*

Abbreviations: LE: Bachelor of Nursing; LEV: Bachelor of Virtual Nursing; EB: Basic nursing; EBV: Virtual Basic Nursing; SS: social service.

On average, the participants in the group with a history of suicide attempt were 2 years younger, the proportion of women was significantly higher, the proportion of students taking EB was significantly higher, followed by LE and lower proportions in LEV and EVB and predominantly from the Guadalajara Metropolitan Area compared to the group of participants with no history of suicide attempt; Regarding the level taken, it was observed that the highest proportions were at the most advanced levels: almost a quarter of the students in social service, followed by those who take the 8th semester, a little more than 10% for those who participate in the 1st, 2nd and 6th semester, these differences were significantly different (Table 2).

Variable	CON HIS	SIN HIS	P
In the past year, have my parents separated or divorced?	213 (43)	394 (19)	< 0.0001
At some point in my life, have I tried to hurt myself?	291 (57)	567 (28)	< 0.0001
Have I been sexually abused?	237 (46)	427 (21)	< 0.0001
Have we experienced domestic violence in my family?	259 (54)	427 (21)	< 0.0001
Has any member of my family tried to kill himself or committed suicide?	226 (47)	225 (16)	< 0.0001
Has a friend committed suicide?	200 (42)	273 (13)	< 0.0001
Have I thought about killing myself?	275 (58)	426 (21)	< 0.0001
Have I had to be treated or hospitalized for psychological problems?	257 (50)	372 (18)	< 0.0001

Table 2: *Comparison of unmodifiable risk factors for suicidal behavior.*
Abbreviations: WITH HIS: with personal history of suicide attempt; NO HIS: no personal history of attempted suicide. Cronbach's Alpha 0.754.
Source: Authors' elaboration.

Regarding non-modifiable risk factors, it was significantly higher in the group with a history of attempted suicide risk compared to the group without a history of suicide attempt. The proportion of participants who answered affirmatively in all questions was significantly higher in the group with history of attempted suicide risk, except for the following two questions: Do I have the support of my family? and Do I have friends to lean on? (Table 3).

Variable	CON HIS	SIN HIS	P
In the last 6 months, have I used drugs (marijuana, cocaine, crack or others)?	226 (44)	415 (20)	< 0.0001
Have I consumed alcoholic beverages in the last 6 months?	249 (49)	659 (32)	< 0.0001
Are there often conflicts and fights in my family?	279 (55)	711 (35)	< 0.0001
Do I often get punished in my house by hitting me?	202 (42)	206 (10)	< 0.0001
Do I have the support of my family?	248 (52)	1528 (76)	< 0.0001
Do I often feel under pressure and too much responsibility?	338 (66)	1031 (51)	< 0.0001
Do I constantly fail in my studies?	193 (40)	404 (20)	<0.0001
Have I been expelled from school?	206 (43)	237 (12)	<0.0001
Do I often participate in beatings?	325 (63)	274 (13)	<0.0001
Have I had conflicts with the police?	218 (43)	415 (20)	<0.0001
Do I have friends to lean on?	260 (51)	1690 (89)	<0.0001

Table 3: *Comparison of modifiable risk factors for suicidal behavior.*
Abbreviations: WITH HIS: with personal history of suicide attempt; NO HIS: no personal history of attempted suicide. Cronbach's Alpha 0.477.
Source: Authors' elaboration.

Table 4 shows the comparison of responses to the questions that correspond to the dimension of risk factors for suicidal ideation by groups. The proportion of participants who answered yes to all questions was significantly higher in the group with a history of attempted suicide risk compared to the group without a personal history of attempted suicide, except for the following question: Have I written farewell letters in case I want to end my life?

Variable	CON HIS	SIN HIS	p
Have I thought of a plan or method to kill myself?	310 (61)	270 (13)	<0.0001
Have I been thinking about hurting myself lately?	198 (42)	219 (11)	<0.0001
Do I often want to die?	212 (41)	270 (13)	<0.0001
Have I thought about the method of hurting myself?	296 (58)	326 (17)	<0.0001
Have I written farewell letters in case I want to end my life?	141 (27)	500 (24)	0.16
Have I looked for methods to kill myself in magazines, the internet and other media?	151 (32)	303 (15)	<0.0001
Have I exposed myself to situations that put me on the brink of death?	202 (42)	468 (23)	<0.0001
Do I often speak of death or the wish to be dead?	199 (42)	249 (12)	<0.0001
Do I have access to firearms?	197 (41)	440 (22)	<0.0001
When do I get angry, cut myself, or do things that hurt me?	215 (45)	368 (18)	<0.0001
Have I ever thought that the best thing would be to be dead?	232 (49)	457 (23)	<0.0001

Table 4: *Comparison of risk factors for suicidal ideation.*
Abbreviations: WITH HIS: with personal history of suicide attempt; WITHOUT HIS with personal history of suicide attempt. Cronbach's Alpha 0.754.
Source: Authors' elaboration.

The comparison of the answers to the questions that correspond to the dimension of precipitating risk factors is shown. The proportion of participants who answered yes to all questions was significantly higher in the group with a history of attempted suicide risk compared to the group without a personal history of suicide attempt, except for the following question, which showed no significant difference. Have I had problems with my sexual preference or orientation? (Table 5).

Variable	CON HIS	SIN HIS	p
Has a close friend or family member died recently?	280 (55)	575 (28)	<0.0001
Did I recently lose someone I loved very much?	249 (49)	725 (35)	<0.0001
Do I often feel very confused?	263 (55)	575 (29)	<0.0001
Am I very hurt because my relationship ended?	283 (60)	455 (23)	<0.0001
Are I verbally or physically attacked in the place where I study or work?	189 (40)	398 (20)	<0.0001
Do my study or work colleagues make life impossible for me?	215 (45)	384 (19)	<0.0001
Have I had a lot of problems with my family lately?	218 (46)	393 (20)	<0.0001
Have I felt humiliated and alone in the place where I work?	197 (41)	495 (25)	<0.0001
Have I recently ended my relationship?	328 (44)	706 (35)	<0.0001
Am I currently very upset with someone very special for me?	268 (52)	502 (25)	<0.0001
Have I had a traumatic experience recently?	216 (42)	432 (21)	<0.0001
Do I suffer from a disease that constantly distresses or despairs me?	225 (44)	447 (22)	<0.0001
Have I ever thought about hurting myself after ending a relationship?	253 (49)	279 (13)	<0.0001
Have I had problems with my sexual preference or orientation?	109 (20)	366 (18)	0.35

Table 5: *Comparison of precipitating risk factors.*
Abbreviations: WITH HIS: with personal history of suicide attempt; NO HIS: no personal history of attempted suicide. Cronbrach Alpha 0.888.
Source: Authors' elaboration.

Table 6 shows the comparison of responses to the questions that correspond to the dimension of protective factors for suicide. The proportion of participants who answered affirmatively on all questions was significantly higher in the group with no history of attempted suicide risk compared to the group with a personal history of attempted suicide, except for the following question, which showed no significant difference. Am I part of any youth group or organization?

Variable	CON HIS	SIN HIS	p
Am I a valuable person?	246 (48)	1532 (75)	<0.0001
Do most people like me?	225 (44)	1638 (80)	<0.0001
Are there people who are interested in me and what happens to me?	252 (49)	1719 (84)	<0.0001
Do I feel that life is worth it?	225 (44)	1517 (74)	<0.0001
Do I have friends to count on?	303 (59)	1564 (77)	<0.0001
Do I feel like I can trust the people in my family?	284 (56)	1684 (82)	<0.0001
Do I have plans for the future?	312 (61)	1600 (78)	<0.0001
Would they miss me if I miss?	135 (28)	1531 (76)	<0.0001
Do I feel good most of the time?	311 (65)	1563 (78)	<0.0001
Do I think I am capable of doing almost everything I set out to do?	226 (48)	1618 (80)	<0.0001
If I feel bad, do I look for someone to listen to me and help me?	242 (51)	1364 (68)	<0.0001
Am I part of any youth group or organization?	202 (42)	504 (20)	<0.0001

Table 6: *Comparison of suicide protective factors.*

Conclusion

- This study shows for the first time that the risk of suicide is high in the study population and that it should be considered as a health problem that has not been sufficiently warned.
- The percentage distribution of high risk is 4% vs. the frequency of prior attempt of 20%, suggesting that suicidal intent is likely to be distributed throughout the study population (no risk, mild, moderate and high risk).
- Younger participants had a higher frequency of previous suicide attempt.
- Students in face-to-face careers and those with higher school levels and in social service presented a higher frequency of previous suicide attempt.
- The distribution by age group and sex showed that half of the men had a previous suicide attempt and 40% of the women between the ages of 20 to 25 years; while it was observed that a third of the ages of 16 to 20 years had a history of previous suicide attempt.
- From the perspective of the person-centered approach, it is necessary to establish screening and suicide prevention programs for nursing students at the University Center for Health Sciences of the University of Guadalajara.
- Propose a descriptive-theoretical model for the development of human potential that helps to understand suicidal behavior both in the individual and in the social context that allows the realization of strategies appropriate to the needs of students in the nursing career at the University of Guadalajara. for the prevention, intervention and timely management of suicidal behaviors [19-27].

Funding Source

Own resources.

Conflict of Interest

No conflict of interest.

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