Depressive symptoms and suicidal behavior in the general population of a city from minas gerais

Sintomas depressivos e comportamento suicida em população geral de cidade mineira

Síntomas depresivos y comportamiento suicida en la población general de una ciudad de minas gerias

ABSTRACT:
Objective: to analyze the presence/intensity of depressive symptoms and relate them to suicidal behavior in the general adult population. **Method:** exploratory and quantitative study, interviews with a semi-structured questionnaire, guiding questions for depression/suicidal behavior, depression psychometric scales, draw of loci; non-probabilistic sample and stratified by convenience, 50 participants per geographic area. **Results:** of the 200 participants, 71 (36.5%) presented depressive symptoms (above the national mean) and 62 (84.92%) had previous depression symptoms. Prevalence of moderate (37.08%) and severe (15.1%) symptoms was noticed and time since the depression diagnosis was from 0 to 5 years (41.1%). The participants without previous symptoms presented greater severity of depressive symptoms; mostly women, young adults, white-skinned, married, employed, living with family members, with clinical comorbidities undergoing treatment, and living in an area of social vulnerability (31.50%). 26 (13%) participants reported suicidal behavior, 13 (50.0%) in the last 5 years; 15 (57.7%) were undergoing treatment and, of these, 06 (40%) for 3 months; 03 (11.5%) in psychiatric hospitals, and 11 (42.3%) with suicidal ideation not undergoing treatment. There was a relationship between depression and suicidal behavior. **Conclusion:** the results support the implementation of public prevention/treatment policies.
Descriptors: Depression; Suicidal behavior; Epidemiology; Mental health; Psychometry.

Giovanna Vallim Jorgetto[1]
 0000-0001-6910-4463

João Fernando Marcolan[1]
 0000-0001-8881-7311

[1]Programa de Pós-Graduação em Enfermagem da Escola Paulista de Enfermagem/UNIFESP. São Paulo/SP, Brasil.

RESUMO:
Objetivo: analisar a presença/intensidade sintomatologia depressiva e relacionar com comportamento suicida em população geral adulta. **Método:** estudo exploratório, quantitativo, entrevistas com questionário semiestruturado, questões norteadoras para depressão/comportamento suicida, escalas psicométricas de depressão, sorteio de locais; amostra não probabilística, estratificada, por conveniência; 50 participantes por área geográfica. **Resultados:** Dos 200 participantes, 73 (36,5%) apresentaram sintomatologia depressiva (maior que a média nacional), e 62 (84,92%), depressão prévia. Notou-se: prevalência de intensidade sintomatologia moderada (37,0%) e grave (15,1%) e o tempo de diagnóstico de depressão, de 0 a 5 anos (41,1%). Participantes sem sintomatologia prévia apresentaram maior severidade dos sintomas depressivos, em sua maioria, mulheres, adultos jovens, brancos, casados, empregados, pessoas que viviam com familiares, pessoas que possuíam comorbidades clínicas em tratamento, pessoas que moravam em área de vulnerabilidade social (31,50%). Relataram comportamento suicida 26 participantes (13%), 13 (50,0%) nos últimos 5 anos; 15 (57,7%) realizaram tratamento, dos quais 06 (40%) há 3 meses; 03 (11,5%) trataram em hospitais psiquiátricos; 11 (42,3%) com ideação suicida sem tratamento. Houve relação entre depressão e comportamento suicida. **Conclusão:** resultados embasam implantação políticas públicas de prevenção/tratamento.
Descritores: Depressão; Comportamento suicida; Epidemiologia; Saúde mental; Psicometria.

Corresponding author
Giovanna Vallim Jorgetto
E-mail: giovanna.jorgetto@prof.fae.br

RESUMEN:
Objetivo: analizar la presencia/intensidad de síntomas depresivos, y relacionarlos con conductas suicidas en la población adulta general. **Método:** estudio exploratorio y cuantitativo, entrevistas con cuestionario semiestructurado, preguntas orientadoras para depresión/conducta suicida, escalas psicométricas de depresión, sorteo de lugares; muestra no probabilística y estratificada por conveniencia; 50 participantes por área geográfica. **Resultados:** de los 200 participantes, 73 (36,5%) presentaron síntomas depresivos (superior a la media nacional) y 62 (84,92%) tenían depresión previa. Se notó prevalencia de sintomatología moderada (37,0%) y grave (15,1%), además de tiempo desde el diagnóstico de depresión de 0 a 5 años (41,1%). Los participantes sin síntomas previos presentaron mayor gravedad de los síntomas depresivos; en su mayoría mujeres, adultos jóvenes, de raza blanca, casados, con empleo, que viven con integrantes de la familia, presentan comorbilidades clínicas, en tratamiento, y viven en una zona de vulnerabilidad social (31,50%). 26 (13%) participantes informaron conductas suicidas, 13 (50,0%) en los últimos 5 años; 15 (57,7%) estaban en tratamiento y, de ellos, 6 (40%) hace 3 meses; 3 (11,5%) en hospitales psiquiátricos y 11 (42,3%) con ideación suicida sin tratamiento. Se registró una relación entre depresión y conductas suicidas. **Conclusión:** los resultados apoyan la implementación de políticas públicas de prevención / tratamiento.
Descriptores: Depresión; Conductas suicidas; Epidemiología; Salud mental; Psicometría.

INTRODUCTION

Since the second half of the 20th century, an increase in the prevalence of depression has been observed, and the age at onset has become increasingly younger. Thus, the high and growing prevalence of depression in populations from all continents and the serious impacts it produces configure the disorder as one of the most serious public health problems at the beginning of the 21st century [1].

According to projections from the World Health Organization, depression will be the most prevalent illness on the planet by 2030, ahead of cancer and some infectious diseases, being the first cause of disability and the second leading cause of years lived with disability in the world, affecting more women (13.4%) than men (8.3%) [1].

Suicidal behavior encompasses thoughts of self-destruction and self-aggression, manifested by suicidal gestures and suicide attempts and, finally, consummated suicide. Its etiology is multifactorial, with depression as an important predisposing factor [1,2].

The WHO estimates that 322 million people worldwide suffer from depression [1] and, in its 2017 report, it points out that 788,000 people died due to suicide in 2015, one death due to suicide in the world every 40 seconds, representing almost 1.5% of all deaths worldwide. Suicide is the third leading cause of death in the world for people aged between 15 and 44 years old [1].

Regarding the Brazilian data, 12 million Brazilians suffer from depression - 5.8% of the population, a rate above the global mean, which is 4.4% [1]. In 2016, there were 13,467 deaths due to suicide in Brazil, with the 6.5 per 100,000 rate reaching the 6th place among the Latin American countries in number of suicides, showing an increase in the number of suicide cases in Brazil and throughout Latin America [1].

In a study conducted with data obtained from the Mortality Information System (*Sistema de Informações sobre Mortalidade*, SIM) of the Unified Health System Department of Informatics (DATASUS), in a historical series comprising the years 1996 to 2016, it was concluded that there was a 29.4% increase in the mortality rate due to suicide in Brazil, from 4.29 to 5.55 per 100,000 inhabitants [2]. Lack of population-based studies related to the them is also evidenced in Brazil.

Based on literature data, it was assumed that we would find a high incidence of depression in residents of the city of Poços de Caldas/MG, correlated with the presence of suicidal behavior, therefore with an increased risk for the emergence of intentional death in part of these participants. This fact points to the need for public policies for the prevention and attention to depression and suicidal behavior, as they represent preventable deaths in most of the cases. Thus, the current study is justified because it considers that the city under study, as well as the region, has no population-based studies regarding the topic, being the largest city in the South of the state of Minas Gerais and a health hub for nearly 110 surrounding cities, as well as having only one CAPS II and one CAPS alcohol and drugs II for the population of the municipality and surrounding cities, with no specific program for suicidal behavior. Therefore, this study makes it possible for those responsible for public health in the city and region to have a wealth of data for planning and implementing interventions aimed at assisting the distress arising from depressive symptoms and preventing/reducing the risks of suicide. This study aimed at analyzing the presence and intensity of depressive symptoms and at relating them to suicidal behavior in a general adult population.

METHOD

This is a descriptive-exploratory study with a qualitative approach, conducted in Poços de Caldas/MG. The data collection period was from January 2017 to October 2018. The participants were explained what the research comprised, any doubts were resolved and, after consent to participate, interviews were carried out at a date, place and time accepted by the participants.

The population consisted of people living in Poços de Caldas/MG. The non-probabilistic and stratified sample was defined by convenience at 200 individuals, randomly chosen from the center and the three cardinal points of the city (South, East and West), keeping a proportion of 50 individuals per geographical area. Exclusion of the North zone was due to the fact that it is a preserved forest area in the Municipality and for not having any housing. The number of interviews was divided by the number of neighborhoods in the regions so that there was an equal division among the number of participants per neighborhood. There was a street draw in each neighborhood and collection was initiated with the lowest residence number on the street; subsequently, approaches were carried out on the other side of the street, respecting alternation of two houses between one participant and the others. Such precaution was taken in order to avoid communication between neighbors and contamination of the participants' answers.

The inclusion criteria were as follows: individuals of both genders; over 18 years of age; living in Poços de Caldas/MG for 12 months or more, and in due cognitive conditions to participate in the study. The non-inclusion criteria corresponded to those that were not at the chosen residence at the data collection moment and to those who refused to participate; and the exclusion criteria were participants who, after the interview, requested withdrawal of the data.

The data collection instruments used were psychometric scales for depressive symptoms, applied in the following order: Beck Depression Inventory, Hamilton Depression Rating Scale, and Montgomery – Asberg Depression Rating Scale. For the scales, the participants were asked to answer, for each item, which alternative best described their feelings during the last week, including the day of the survey. Subsequently, the interviews were conducted by means of a semi-structured questionnaire prepared by the researchers with data referring to the sociodemographic profile, such as gender, age, neighborhood and region of residence, skin color/race, religion, marital status, schooling,

number of people living in the household, and work activity; as well as data regarding the family's history of illness, personal history, history of depression, and suicidal behavior. It contained three guiding questions addressing the perception about the risk and protective factors for depression and suicidal behavior, the perception about the psychological distress that was reported/detected by the scales, and the perception about the depressive symptoms in relation to suicidal behavior.

Data analysis was carried out according to the scores established for each psychometric scale and to the statistical treatment of the results of each scale with the sociodemographic variables by means of tests. When indicated, the Chi-Square or Fisher's Exact tests were applied to compare proportions between groups. Linear correlations were performed between all three depression rating instruments, according to Pearson's methods. Results with Type I error likelihood below 5.00% ($p<0.005$) were considered as statistically significant. The data were tabulated and analyzed in SPSS (Statistical Package for Social Sciences), version 20.0.

The research was approved by the Research Ethics Committee of the Federal University of São Paulo under opinion number 1,813,770 and, for its development, the ethical precepts instituted in Resolution 466/12 of the National Health Council were met, with use of the free and informed consent form.

RESULTS

The sample of this study consisted in 200 participants. Table 1 presents the distribution of the participants according to sociodemographic aspects, divided into groups with presence and absence of depressive symptoms and the statistical analysis, by means of Fisher's exact test.

Table 1 - Socioeconomic/Sociodemographic characterization of the participants with and without depressive symptoms. Poços de Caldas/MG, 2020.

Variables	Total	Presence of depressive symptoms	Absence of depressive symptoms	p-value
Gender				
Female	122 (61.0%)	57 (78.1%)	65 (51.2%)	<0.001
Male	78 (39.0%)	16 (21.9%)	62 (48.8%)	
Children				
Yes	153 (76.5%)	67 (91.8%)	86 (67.7%)	<0.001
No	47 (23.5%)	06 (8.2%)	41 (32.3%)	
Schooling				
Illiterate	03 (1.5%)	01 (1.4%)	02 (1.6%)	0.001
Functionally Illiterate	02 (1.0%)	------	02 (1.6%)	
Incomplete Elementary School	58 (29.0%)	20 (27.4%)	38 (29.9%)	
Complete Elementary School	19 (9.5%)	12 (16.4%)	07 (5.5%)	
Incomplete High School	20 (10.0%)	14 (19.2%)	06 (4.7%)	
Complete High School	40 (20.0%)	12 (16.4%)	28 (22.0%)	
Incomplete Higher Education	09 (4.5%)	01 (1.4%)	08 (6.3%)	
Complete Higher Education	41 (20.5%)	13 (17.8%)	28 (22.0%)	
Specialization	08 (4.0%)	------	08 (6.3%)	
Individual Income				
No income	23 (11.5%)	22 (30.1%)	01 (0.8%)	<0.001
Up to 2 minimum wages	75 (37.5%)	34 (46.6%)	41 (32.3%)	
From 2 to 5 minimum wages	76 (38.0%)	15 (20.5%)	61 (48.0%)	
More than 5 minimum wages	20 (10.0%)	02 (2.7%)	18 (14.2%)	
Did not report	06 (3.0%)	------	06 (4.7%)	
Unemployed				
Yes	23 (11.5%)	22 (30.1%)	01 (0.8%)	<0.001
No	177 (88.5%)	51 (69.9%)	126 (99.2%)	
Use of social networks				
Facebook	177 (88.5%)	50 (68.5%)	127 (100.0%)	<0.001
None	------	21 (28.8%)	------	<0.001

Source: Prepared by the researchers according to research data (2020).

The data presented in the table above evidence prevalence of depressive symptoms in individuals aged between 29 and 39 (26%) and between 62 and 83 years old (19.5%), Caucasian (84%), Catholic (69%), married (62%), with two children (46%), living with up to 3 people in the household (26.5%), living with partner/children/spouse (62%), performing unpaid work activities (25.5%) and retired (18.5%), with family incomes of 2 to 5 minimum wages (50.5%) and spending time with friends as recreational activity (36%).

Table 2 shows the data regarding the presence and intensity of depressive symptoms by applying the scales to participants with and without previous diagnosis.

Table 2 - Presence and intensity of depressive symptoms according to the psychometric scales for participants with and without previous diagnosis. Poços de Caldas/MG, Brazil, 2020.

Scales	Total	Presence of previous depressive symptoms	Absence of previous depressive symptoms	p-value
BDI				
Mild	37 (50.7%)	34 (54.8%)	03 (27.3%)	0.106
Moderate	27 (37.0%)	22 (35.5%)	05 (45.5%)	
Severe	09 (12.3%)	06 (9.7%)	03 (27.3%)	
HAM-D				
Mild	35 (47.9%)	32 (51.6%)	03 (27.3%)	0.003
Moderate	27 (37.0%)	23 (37.1%)	04 (36.4%)	
Severe	11 (15.1%)	07 (11.3%)	04 (36.4%)	
MADRS				
Mild	35 (47.9%)	32 (51.6%)	03 (27.3%)	0.003
Moderate	27 (37.0%)	23 (37.1%)	04 (36.4%)	
Severe	11 (15.1%)	07 (11.3%)	04 (36.4%)	

Source: Prepared by the researchers according to research data (2020).

The results obtained by applying the psychometric scales of this study evidence congruence between them, with emphasis on moderate to severe intensity symptoms.

As for the history of illness in a family member of the participants, the data evidenced statistical significance for the group with depressive symptoms detected through the scales for the following: pre-existing diseases (p-value < 0.001), presence of mental disorders (p-value < 0.001), use of alcohol/drugs (p-value < 0.001), and with a statistically significant degree of kinship for the children group (p-value = 0.022). When the treatment locus was observed, public health care facilities were the most cited, such as BHUs and secondary care.

The analysis of family illness for the sample as a whole, and separately for the groups with and without presence of depressive symptoms, showed to be statistical significant for the presence of chronic degenerative disease such as Diabetes Mellitus and Systemic Arterial Hypertension, mental disorders, and use of alcohol/drugs.

As for the data referring to the participants' own history of clinical diseases and mental disorders,

it was verified that they were statistically significant for the question about presence of Systemic Arterial Hypertension (SAH) and Diabetes Mellitus (DM) - (p-value < 0.001), with 70% prevalence in the group of participants with previous depressive symptoms. As for having some mental disorder, this was mentioned by 77 (38.50%) participants (p-value < 0.001), of which 62 (80.51%) cited depression, 12 (15.58%) anxiety, and 02 (2.59%) bipolar disorder, with a higher concentration in treatment time between 12 and 17 years in the group with previous symptoms. Of those diagnosed with depression according to the scales, 12 (20.3%) reported undergoing no treatment and, of those that reported treatments, 54 (83.1%) were on exclusive drug treatments. A total of 25 (12.5%) participants with depressive symptoms reported being treated in public health services, mainly primary care.

Table 3 shows the distribution of the participants as to previous diagnosis of depression and treatment for the sample as a whole, and separately for those with and without the presence of depressive symptoms, detected through psychometric scales.

Table 3 - Previous depression diagnosis and treatment with and without presence of depressive symptoms. Poços de Caldas/MG, Brazil, 2020.

Variables	Total	Presence of depressive symptoms	Absence of depressive symptoms	p-value
Previous depression diagnosis				
Yes	62 (31.0%)	62 (84.9%)	0 (0.0%)	<0.001
No	138 (69.0%)	11 (15.1%)	127 (100.0%)	
Time since diagnosis (years)				
0-5	30 (48.4%)	30 (48.4%)	---- (—)	
6-11	13 (21.0%)	13 (21.0%)	---- (—)	
12-17	10 (16.1%)	10 (16.1%)	---- (—)	
18+	09 (14.5%)	09 (14.5%)	---- (—)	
Treatment				
Yes	54 (87.1%)	54 (87.1%)	---- (—)	
No	08 (12.9%)	08 (12.9%)	---- (—)	
Locus				
BHU	25 (46.3%)	25 (46.3%)	---- (—)	
CAPS	08 (14.8%)	08 (14.8%)	---- (—)	
Specialties Ambulatory Service	08 (14.8%)	08 (14.8%)	---- (—)	
Private Physician	13 (24.1%)	13 (24.1%)	---- (—)	
Treatment time (years)				
0-5	36 (66.7%)	36 (66.7%)	---- (—)	
6-11	05 (9.3%)	05 (9.3%)	---- (—)	
12-17	10 (18.5%)	10 (18.5%)	---- (—)	
18+	03 (5.6%)	03 (5.6%)	---- (—)	

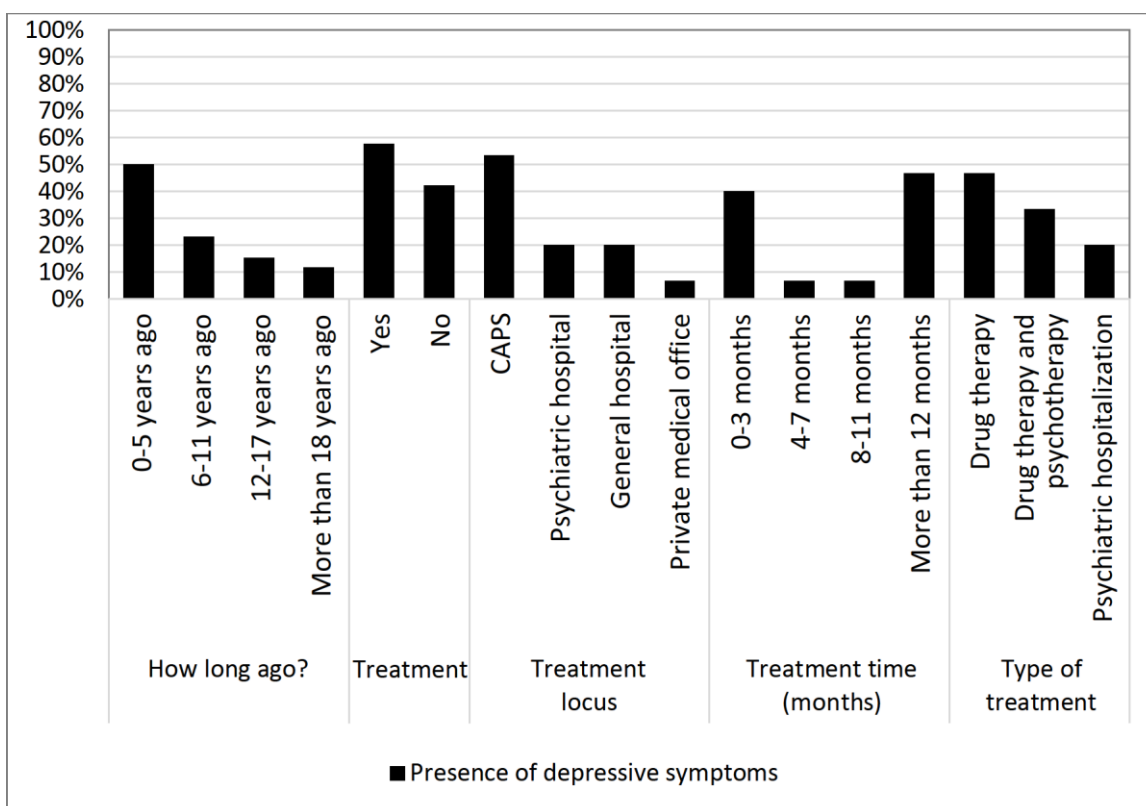Source: Prepared by the researchers according to research data (2020).

For the question regarding the time since diagnosis and treatment time, a discrepancy emerged for analysis, as 30 (48.4%) participants presented diagnosis times of up to 5 years, but 36 (66.7%) of those who were treated reported treatment time in the same period, which shows that 6 (8.21%) participants initiated their treatments before being diagnosed with a depressive disorder.

When presence of depressive symptoms was analyzed by geographical regions of the municipality of Poços de Caldas/MG, it can be seen that the South region presented more significant percentages (p-value = 0.096), accounting for 23 (31.5%) participants. The South region presents the highest social vulnerability level of the municipality in question.

Figure 1 presents the distribution of the participants with depressive symptoms and prior history and treatment for suicidal behavior.

Figure 1 - Antecedents and treatment for suicidal behavior in the participants with depressive symptoms. Poços de Caldas/MG, Brazil, 2020.

Source: Prepared by the researchers according to research data (2020).

Figure 1 allows verifying that suicidal behavior was present in 26 (13%) participants of the total sample, all of whom reported previous depressive episodes (p-value < 0.001). It is noted that all those who reported suicidal behavior had depressive symptoms indicated by the psychometric scales used and mentioned depression as the reason for suicidal ideation. There are 11 (42.3%) participants with suicidal behavior who reported having undergone no treatment for suicidal ideation or attempted suicide. Regarding treatment, 15 (57.7%) of the participants with suicidal behavior reported having undergone it, of which 13 (50%) did so in the last 5 years, 06 (40%) for a period of up to 3 months, and 07 (46.7%) for a period longer than 12 months. For 15 (57.7%) of the participants with suicidal behavior, when in treatment, they only made use of medication and 03 (11.5%) received due treatment in psychiatric hospitals.

DISCUSSION

Predominance of female participants can be observed in the current study, and the data corroborates those in the international literature [3,4] and from the WHO [1]. Explanations for the higher female prevalence of depression include hypotheses for hormonal changes, pregnancy, puerperium [5] and, mainly, gender inequality and female devaluation in the labor market and due to the culture [1].

For the relationship between age group and depression, this study did not evidence statistical significance, although the age groups most affected by depressive symptoms were those from 29 to 39 years old and over 50 years old, which is in line with the age groups with higher involvement of depressive disorder cited by the WHO [1], showing an association of depression in adulthood related to the pressure exerted on the individuals to consolidate professionally and personally, attain economic stability, economic pressures, frustrations at work or in relationships and concerns about young children, which generates significant mental distress [6]. In the age group above 60 years old, the causes are linked to factors such as widowhood or singlehood, breakup with the family, loss of social contacts and consequent loneliness, previous history of depression, stressful life events, little social support, low schooling levels and precarious financial situation, loneliness, retirement and work inactivity

and associated diseases, data that are in line with those obtained in this study [7].

The skin color/race, marital status and religion factors presented no statistical significance for presence or absence of depressive symptoms in the group participating in this study; however, these results contradict the studies that noticed higher prevalence of depression in black-skinned participants when compared to white-skinned subjects, considering the economic and social inequalities in different contexts in Brazil [5, 8], which does not differ from data found in a study conducted with more than 3,000 individuals [9], in which the authors concluded that the trend corresponded to higher prevalence of depressive disorder in non-white-skinned people, data corroborated by the WHO itself [1]. The literature suggests singlehood and widowhood as predisposing factors for depression due to the associated loneliness, oftentimes related to the loss of a support network [1]. For religion, our data also did not present statistical significance and are in contradiction with the literature, which points to religiousness as a protective factor against psychological distress [1].

The number of children neither improves nor worsens the weight of motherhood/fatherhood as a risk factor for depressive symptoms (p = 0.860), findings that are supported by the literature [10].

Low schooling levels emerged as a risk factor for depressive symptoms (p = 0.001), which can be explained by the fact that this factor implies employability with low salaries, greater professional instability and frequently, underemployment and the limitations resulting from this economic limitation and, thus, serve as triggers for depressive symptoms [1,11,12].

As for the impact of socioeconomic factors on the incidence of depression, the results show some important characteristics, as the relationship between depression and unemployment was present in this study, corroborating the international [1] and national [13, 14] literature on the causality between unemployment and income and depression since, when basic material needs are not met, there is a tendency for depressive symptoms to appear [15, 16]. In Brazil, data from the IBGE [17] indicate that the unemployment rate between February and April 2017 reached 13.6%, which represents 14 million people without work or looking for a job in the country, figures that are similar to the one found in our study, which was 11.5% in the sample studied. In addition, having a job, although in precarious working conditions, is also considered a trigger for depressive symptoms [1].

The role of the social networks and Internet access was statistically significant for the absence of depressive symptoms. The services most resorted to by the participants, Facebook and Instagram, were significant for the number of subjects without depressive symptoms who reported using these two services (p < 0.001 and p < 0.009, respectively), data that are similar to those found in the study developed in the United States of America (USA) [18]. The participants without Internet access presented depressive symptoms (p < 0.001) and our data may be in line with a research study conducted in the University of Pennsylvania (USA) [19], which concluded that social media use reduces loneliness and depression.

It was observed that 36.5% of the sample of this study presented depressive symptoms through the application of the evaluation scales, a result higher than the general world population, with a weighted mean of depression between 16 to 20% [1], and for the Brazilian population, with a weighted mean of depression between 5.8% to 7.6% [1], which represents from around 12 to almost 16 million Brazilians living with depression. The reason for such prevalence in the city under study is found in the results of this study, which showed a majority of women, young or over 60 years old, with chronic diseases such as diabetes and hypertension, unemployed, low income and schooling levels, with family members who use alcohol and drugs, and have self-reported previous own mental disorders or in the family, whose variables are indicated as risk factors for depressive symptoms [1].

As for the family mental disorders, anxiety, depression and schizophrenia were mentioned, and these data were corroborated by a population-based study [20]. Other authors [1, 21] also point out that having a family member with a mental disorder is a risk factor for the onset of mental disorders in other family members. When asked about family members who use drugs, the data refer us to weary cohabitation, acting as a trigger for depressive conditions, as found in other studies [1], [9,20]. As for the type of drugs used, alcohol and crack were predominant, in line with WHO [1] data on alcohol and nicotine being the drugs of greatest consumption worldwide and in the 3rd National Survey on drug use by the Brazilian population conducted by FIOCRUZ, with alcohol as the one presenting the highest consumption in Brazil [22].

As for the chronic diseases (comorbidities) in close family members, such as Diabetes Mellitus and hypertension, they are considered an important risk factor for depression, due to the emotional stress they cause over an indefinite care period, which can last from months to many years [1, 23].

A total of 12 (19.35%) of the 62 participants self-reported previous mental disorders and not undergoing treatment, which is unacceptable, as untreated people with depression suffer greater distress, discrimination, social isolation, interruption or decreased performance in studies and work, alcohol and other drug abuse, and increased mortality due to suicide and homicide [1], as well as worsening and chronification of the disorder.

Most of the participants who received treatment were exclusively on medication, contrary to the assumptions of the Brazilian Psychiatric Reform advocating multiprofessional treatments with psychosocial rehabilitation, psychotherapy and integrative and complementary practices in the effective treatment of mental disorders [24]. On the other hand, there is lack of mental health services, as the city where the study was carried out has only one CAPS type II for the treatment of the entire population in mental distress. Such inefficiency of the public health policies does not address the problem related to mental disorders in an efficient

way and with regard to the magnitude that it represents for the individual, the family and collective health itself.

A number of studies also point out that the depressed person's attitudes and beliefs in relation to the depressive symptoms and treatment are strongly related to adherence/non-adherence to the treatment, such as presence of medication-associated side effects, time and complexity of the treatment, and stigma related to the disorder [24].

As for the participants with moderate and severe depression and who were unaware of this fact, it shows lack of knowledge about the symptoms associated with depression, indicating adaptation to distress and chronification. This is a reminder of the importance of screening for depression in the general population; it also refers us to the idea that informing the general population about the signs and symptoms that characterize depression is an important preventive tool, as knowledge about the initial symptoms of a depressive state can lead patients and their families to seek professional help before the disorder worsens [2].

As for suicidal behavior, when untreated or treated inefficiently or for an inadequate period of time, it significantly increases the risk of suicide, with previous history of suicidal behavior being the most important predictor of death due to suicide in the general population [1]. There was a statistical relationship for suicidal behavior in the sample. It is noted that there was statistical significance between suicidal ideation and depression in our study.

Consequently, attention must be paid to the absence of consideration to the topic in Brazil, which is present when we evidence that 8 participants with suicidal ideation did not report undergoing treatment and, of those who did, 40% received it in the last 3 months, thus showing the risk run by these participants attempt against their own lives. It is noted that all those who reported suicidal behavior had depressive symptoms indicated by the scales, related to depression as an important risk factor for suicide, as widely found in the literature [1,24,25].

CONCLUSION

It is concluded that the prevalence of depressive symptoms in the general population of the municipality was higher than the world, national, and state mean values, with prevalence of moderate/severe symptom intensity. The participants with previous symptoms presented higher severity of depressive symptoms. The relationship between depression and suicide was present, linked to the female gender, having children, unemployment, low schooling and income levels, having family members who use drugs, especially close relatives such as children/parents and those with chronic diseases and mental disorders, having mental disorders, especially depression, and having chronic diseases such as diabetes and hypertension.

Regarding the study limitations, we highlight the need for a broader study, which contemplates the several cities surrounding the municipality in question, in order to establish greater complementarity between the mental health structures and services that make up these cities.

As a contribution of this study, the data show for the first time the panorama of depressive symptoms in the general population of Poços de Caldas/MG, which will allow municipal and regional managers to plan and implement public policies to deal with the issues addressed. It is also important to highlight the importance of this study for Nursing, as this collective at the forefront of direct assistance among health professionals, with emphasis on preventive actions and primary care, a state-of-the-art role in the application of psychometric scales for early detection and intervention regarding depressive symptoms and suicidal behavior, in order to allow for greater scope and autonomy of professional performance, with qualified and responsive actions.

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REFERENCES

1. World Health Organization. Suicide in the world: global health estimates; 2019.

2. Marcolan JF, Silva DA. O comportamento suicida na realidade brasileira: aspectos epidemiológicos e da política de prevenção. Revista M. 2019;4(7):31-44. Disponível em: http://dx.doi.org/10.9789/2525-3050.2019.v4i7.31-44.

3. Manish K, Grannemann BD, Trombello JM, Clark EW, Eidelman SL, Lawson T, et al. A structured approach to detecting and treating depression in primary care: VitalSign6 Project. Annals Family Medic 2019;17(4):326-35. Disponível em: https://doi.org/10.1370/afm.2418

4. Searle K, Blashki G, Kakuma R, Yang H, Zhao Y, Minas H. Current needs for the improved management of depressive disorder in community healthcare centers, Shenzhen, China: a view from primary care medical leaders. Int J Ment Health Syst. 2019;13:47. Disponível em: doi.org/10.1186%2Fs13033-019-0300-0.

5. Gonçalves AMC, Teixeira MTB, Gama JRA, Lopes CS, Silva GA, Gamarra CJ, et al. Prevalência de depressão e fatores associados em mulheres atendidas pela Estratégia de Saúde da Família. J bras Psiquiatr. 2018;67(2):101-109. Disponível em: http://dx.doi.org/10.1590/0047-2085000000192.

6. Melo AK, Siebra AJ, Moreira V. Depressão em Adolescentes: revisão da literatura e o lugar da pesquisa fenomenológica. Psicol cienc Prof.

2017;37(1):18-34. Disponível em: https://doi.org/10.1590/1982-37030001712014.

7. Gullich I, Duro SMS, Cesar JA. Depressão entre idosos: um estudo de base populacional no Sul do Brasil. Rev bras Epidemiol. 2016;19(4):691-701. Disponível em: http://dx.doi.org/10.1590/1980-5497201600040001.

8. Smolen JR, Araújo EM. Raça/cor da pele e transtornos mentais no Brasil: uma revisão sistemática. Ciênc. Saúde Coletiva 2017;22(12):4021-30. Disponível em: http://dx.doi.org/10.1590/1413-812320172212.19782016.

9. Quadros LCM, Quevedo LA, Gonçalves HD, Horta B, Motta JVS. Common Mental Disorders and Contemporary Factors: 1982 Birth Cohort. Rev Bras Enferm. 2020;73(1):e20180162. Disponível em: http://dx.doi.org/10.1590/0034-7167-2018-0162.

10. Bastos FIPM, Vasconcellos MTL, De Boni RB, Reis NB, Coutinho CBS (Org.). III Levantamento Nacional sobre o uso de drogas pela população brasileira. Rio de Janeiro: FIOCRUZ/ICICT; 2017.

11. Hoebel J, Maske UE, Zeeb H, Lampert T. Social inequalities and depressive symptoms in adults: the role of objective and subjective socioeconomic status. PLoS One. 2017;12(1):e0169764. Disponível em: http://dx.doi: 10.1371/journal.pone.0169764.

12. Freeman A, Tyrovolas S, Koyanagi A, Chatterji S, Leonardi M, Ayuso-Mateos JL, et al. The role of socio-economic status in depression: results from the COURAGE (aging survey in Europe). BMC Public 2019;16(1):1098. Disponível em: http://dx.doi:10.1186/s12889-016-3638-0.

13. Magalhães C, Gomes D. Constituição e feminismo entre gênero, raça e direito: das possibilidades de uma hermenêutica constitucional antiessencialista e colonial. Rev História: Debates e Tendências. 2018;18(3):343 -65. Disponível em: http://dx.doi.org/10.5335/hdtv.18n.3.8593.

14. Ipea. Instituto de Pesquisa Econômica Aplicada. Políticas Sociais: acompanhamento e análise. Brasília: Ipea; 2018.

15. Ornek KO, Weinmann T, Waibel J, Radon K. Precarious employment and migrant workers' mental health: a protocol for a systematic review of observational studies. Systematic Reviews 2020;9:50. Disponível em: http://dx.doi.org/10.1186/s13643-020-01313-w.

16. Rönnblad T, Grönholm E, Jonsson J, Koranyi I, Orellana C, Kreshpaj B, et al. Precarious employment and mental health: a systematic review and metaanalysis of longitudinal studies. Scand J Work Environ Heal. 2019 Sep 1;45(5):429-443. Disponível em: http://dx.doi.org/10.5271/sjweh.3797.

17. Instituto Brasileiro de Geografia e Estatística. Pesquisa nacional por amostra de domicílios contínua - 2017. Rio de Janeiro: Instituto Brasileiro de Geografia e Estatística; 2017.

18. Sabik NJ, Falat, J, Magagnos, J. When Self-Worth Depends on Social Media Feedback: Associations with Psychological Well-Being. Sex Roles. 2020;82(7-8):411. Disponível em: http://dx.doi.org/10.1007/s11199-019-01062-8.

19. Hunt M. Social media use increases depression and loneliness. Arts, humanities, & social sciences. 2018. Disponível em: https://penntoday.upenn.edu/news/social-media-use-increases-depression-and-loneliness.

20. Senicato C, Azevedo RCS, Barros MBA. Transtorno mental comum em mulheres adultas: identificando os segmentos mais vulneráveis. Ciênc. Saúde Coletiva. 2018;23(8):2543-54. Disponível em: http://dx.doi.org/10.1590/1413-81232018238.13652016.

21. Huang CJ, Lin CH, Wu JI, Yang HC. The relationship between depression symptoms and anxiety symptoms during acute ect for patients with major depressive disorder. International Journal of neuropsychopharmacology. 2019;22(10):609–15. Disponível em: http://dx.doi.org/10.1093/ijnp/pyz038.

22. Bispo JC, Molesini JAO, Pitta AMF. Centros De Atenção Psicossocial Da Bahia: Vínculos Empregatícios. Revista Baiana de Saúde Pública. 2017;40:772-84. Disponível em: http://dx.doi.org/10.22278/2318-2660.

23. Rasouli N, Malakouti SK, Rezaeian M, Saberi SM, Nojomi M, De Leo D, et al. Risk factors of suicide death based on psychological autopsy method; a case-control study. Arch Acad Emerg Med. 2019;7(1):e50. Disponivel em: https://pubmed.ncbi.nlm.nih.gov/31602433/.

24. Souza C, Moreira V. Tristeza, depressão e suicídio melancólico: a relação com o Outro. Arq Bras Psicol. 2018;70(2):173-85. Disponível em: http://dx.doi.org/10.1590/2175-3539/2015/0193857.

25. Stein DJ. Lim CCW, Roest AM, Jonge P, Aguilar-Gaxiola S, Al-Hamzawi A, et al. The cross-national epidemiology of social anxiety disorder: Data from the World Mental Health Survey Initiative. BMC Med. 2017;15(1):143. Disponível em: http://dx.doi.org/10.1186/s12916-017-0889-2.