# Self-perception about psychic suffering in individuals with depressive symptomatology and suicide behavior

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## ABSTRACT

**Objective of the study:** To analyze the self-perception of psychological distress in individuals with depressive symptoms and its relationship with suicidal behavior in the general adult population. **Methodology:** Exploratory, descriptive, qualitative research, using thematic Content Analysis. Interviews were carried out through a semi-structured questionnaire with 200 participants over 18 years old, domiciled in Poços de Caldas, MG, between January 2017 and October 2018. **Results:** Participants showed no perception of depression and death wish as a way out of suffering mental illness caused by depression; justified the loss of affection, fear, despair, lack of family support, rumination of ideas, conflicting family relationships, loss of self-esteem, and loneliness for the development of depression. **Conclusions:** Self-perception of depressive symptoms was related to not having a perception of depression or admission of the disorder, and sadness for the memories aroused. An association between depressive symptoms and suicidal behavior was present.

**Keywords:** Depression, Suicidal behavior, Mental health, Perception, Knowledge.

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## INTRODUCTION

According to Nóbrega, Leal, Marques, Vieira[1], although depression is not a silent disease, it is poorly diagnosed in daily clinical practice. In addition, it is estimated that only 34% of people with depression seek specialized help, and only one third find the help they need. Most of the time, people cannot recognize or name their disorder and often present somatic complaints, such as headache, anorexia, and stomach problems, decreased libido and weak erection, and lack of energy, which are quickly translated into diagnostic possibilities of some specific organic disease [2].

Added to this is the lack of ability and training of healthcare professionals to know the individual's life history, personal, family, professional, and social contexts, thoughts, feelings, and behaviors to elaborate the hypothesis of psychological suffering and its appropriate management in the psychosocial care network [3,4].

When not diagnosed or properly treated, depression becomes one of the main risk factors for suicidal behavior, including thoughts of self-destruction, threats, gestures, attempts, and suicide itself[5]. It is noteworthy that the relationship between depression and suicidal behavior occurs in a feedback process through depressive symptoms. Examples of these symptoms are low mood, social isolation, anhedonia, changes in mood, appetite, sleep, agitation, or psychomotor slowness, fatigue and loss of energy, feelings of worthlessness and excessive or inadequate guilt ideation, decreased ability to think or concentrate, or indecision nearly daily. These trigger recurring thoughts of death, generating a vicious cycle that increases depressive symptoms and the likelihood of suicide. Thus, this participant grows apart from friends and closest people, and shows a lack of interest in work, leisure, and any other daily activity [2].

The presence of suicidal ideation is, in itself, an important sign of psychological suffering and requires increased attention in clinical evaluation. A psychiatric disorder may be present, requiring prompt recognition and proper treatment [2,6].

Thus, the present study aimed to analyze the self-perception of psychological suffering in individuals with depressive symptoms and suicidal behavior in the general population in the city of Poços de Caldas, Minas Gerais, Brazil.

## METHOD

### *Design and participants*

This is a descriptive exploratory study, with a qualitative approach, conducted in the city of Poços de Caldas, MG, a medium-sized city in the South of the state. The data collection period was from January 2017 to October 2018.

The population consisted of participants residents in Poços de Caldas, MG. The probability sample was stratified random and defined by convenience to 200 individuals, randomly chosen between the center and the three cardinal points of the city (South, East, and West), keeping the proportion of 50 individuals per geographical area. The exclusion of the Northern area was because it is a preserved forest area in the municipality and has no houses. We divided the number of by the number of neighborhoods in the regions. We ensured an equal division of interviewees per neighborhood. We draw a street from each neighborhood, and the collection started at the lowest house number on the street. Then, we approached the other side of the street, respecting the alternation of two houses between one interviewee and another. Such care was necessary to avoid communication among neighbors and contamination of the participants' answers. The inclusion criteria were individuals of both genders; aged over 18 years; living and residing in Poços de Caldas, MG, for twelve months or more, and who presented cognitive conditions to participate in the study.

### *Data collection procedure*

Concerning the data collection procedure, we used psychometric scales for depressive symptomatology, applied in the following order: Beck Depression Inventory, Hamilton Rating Scale for Depression, and Montgomery-Asberg Rating Scale for Depression. For these scales, we asked the participant to answer, for each item, which alternative best described their feelings in the last week, including the day of the survey. The next step was an interview with the use of a semi-structured questionnaire consisting of items referring to the participants' sociodemographic profile, data regarding previous history of depression, and questions formulated based on the research objectives: *What*

*is your perception about the psychological suffering that you reported/was detected by the scales?* and *Describe your perception about the depressive symptomatology in relation to suicidal behavior*. The interviews took place at the participant's home, in a private manner, which guaranteed the confidentiality of the information, after explanining of what the research comprised and, after having responded to any concern. Once the participant agreed to participate, we asked them to sign an Informed Consent Form. We audio-recorded the interview for verbatim transcription.

### *Data analysis*

The data collected from the interviews were analyzed using thematic content analysis, comprehending the phases of pre-analysis, material exploration, treatment of results, inference, and interpretation[7].

## *Ethical aspects*

Concerning ethical aspects, we ensured compliance with the norms regulating research with human beings. The study took place after approval by the Research Ethics Committee of the Federal University of São Paulo, under no. 1813770/2016.

# RESULTS

Sociodemographic profile of the participants

Two hundred participants engaged in this study. The analysis of the sociodemographic profile showed a majority composed of women, aged between 29 and 39 years and over 60 years, white, Catholic, married, with children (most reported two children), incomplete elementary school and complete high school. They lived with up to three people in the household, living with partners/children/spouses, either performed unpaid work, were unemployed or retired, with individual and family income between two and five minimum wages and referring as leisure activity being with friends.

Evaluation of psychometric scales used to assess depressive symptoms

As for the three psychometric scales applied to evaluate depressive symptoms, most participants with previous symptoms showed scores of mild depression, while the group with no previous symptoms showed higher percentages for moderate and severe intensity. There were also one-third of the participants over 61 years of age with positive scores for depressive symptoms, mainly in mild and moderate intensity, through the psychometric scales used in this study.

Suicidal behavior was present in all participants who had depressive symptoms indicated by the scales and more accentuated for those who presented higher scores in the moderate and severe groups.

After transcribing the guiding questions, we analyzed the participants' speeches, determining significant record units, which covered the aims proposed for this study and other points of interest. Thus, two thematic categories emerged, one related to the perception or lack thereof of depressive symptoms by the participants, while the other related to the relationship between depressive symptoms and suicidal behavior.

## *Perception or lack thereof by the participants of depressive symptoms*

Questions related to the perception or absence of perception of psychological suffering by the participants emerged in this category. The absence related to the perception of psychological suffering and the worsening of depressive symptoms only occurring after interviews and the application of psychometric scales, when the answers relived moments of affective losses, marital separations due to adultery and unemployment, among others. Some of the participants verbalized relief in being able to externalize their personal stories to the interviewer. Thus, four thematic items were listed: Perception of being depressed, Perception of relief after the interviews, Perception of worsening of the feeling of depression when interviewed, and Perception of not being depressed.

Perception of being depressed

Concerning the perception of being depressed, when we analyzed the content of the participants' speeches, the awareness of suffering from depression emerged to some of them. The speeches below demonstrate their awareness of the depressive symptoms, linked to personal or life problems, which triggered feelings of loneliness, sadness, and social isolation, among others.

*E12= Right now, I feel deep loneliness in my heart and this is killing me, killing my will to live.*

*E24= I feel like I am depressed. I cannot work on what I like; I do not like my job…*

*E49= Right now, I am just so depressed that I no longer want to be close to my family and friends. I cannot stay close to my family, although I am undergoing treatment at the Psychosocial Healthcare Center (CAPS).*

*E67= I liked answering these questions because I often feel alone and it feels good talking to people. I think that now that I have answered these questions, I am a bit depressed.*

Perception of relief after the interviews

Concerning the perceived sense of relief after interviews, described by participants after answering the guiding questions and study instruments, it was verbalized by the positive experience of sharing their personal stories with the interviewer.

E16= Posso dizer com segurança que me senti bem ao responder as perguntas. I can definitely say that I felt good answering these questions. It eased my feelings. It was great talking to you.

E17= I was glad for expressing how I feel, it felt good.

E21=...by sharing my stories, I felt better.

E22= I felt alarmed and relieve by answering these questions. You need to ask these to more people...

E23= It felt good answering the questions...

E25= It felt good to answer. Through these questions, I somehow expresse what I really feel, because depression is an arduous and difficult battle. We can only overcome it through medical and family help.

Perception of worsening of the feeling of depression when interviewed

There was also the perception of a worsening of depression when interviewed, expressed by verbalizing memories of psychological suffering throughout life, such as marital separations, emotional losses, and others.

E1=...I was sad because I remembered the bad things that happened. My separation. My husband's affair…

E3= I was sad to think of bad things that happened in this sad period of my life. My will to die.

E11= I was sad because I remembered the worst moments of my life, my brother's death and when I became depressed and did nothing but cry.

E45= I was down because it was a very difficult time that I remembered when I was unemployed. But I do not think I am depressed. Now I am fine, working and everything is getting back on track.

Perception of not being depressed

However, the most striking and worrisome thing was the lack of perception of depression, even when the scales detected depressive symptoms in mild, moderate, and severe levels. The participants referred that such verbalized feelings, such as sadness and low mood, related to the circumstances experienced in their daily lives and not to the already installed depressive condition.

*E5= I think it is the circumstances of the moment, how I feel. I am not sick, but everything I go through with my alcoholic husband and drug addicted son makes me feel this way.*

*E56= I did not feel that I was depressed. But thinking about it, I might be a little bit depressed, yes. I feel really sad sometimes.*

*E58= No. I think there are days when you feel down and have thoughts and bad feelings that stay in your head all the time and when you remember bad things that happened in your life you get this bad feeling.*

*E61= I do not think I am. I just feel sad sometimes and disappointed with life.*

## *Participants' perception of the relationship between depressive symptomatology and suicidal behavior*

Concerning the relationship between depressive symptoms and suicidal behavior, we found that the perception of the severity of depression itself, as well as feelings of hopelessness, psychiatric comorbidities (panic syndrome and anxiety disorder), unemployment, overwork, and a psychologically stressful work environment were factors that triggered or aggravated suicidal behavior.

It is evident in the speeches the sense of the development of depression and its relation with suicidal behavior, that death is the solution to the intense psychological suffering triggered by the symptoms experienced.

E2= I feel that depression is a disease that makes no sense, people judge it, but they can't imagine how difficult it is, it kills us day by day. The desire to kill oneself is because the person feels that it would be a relief, the end of the disease, which ends up being the end of life for many.

E13= Depression is a devastating illness that destroys the person who is depressed and the people who live close to the depressed person. Everything becomes difficult, complicated. It makes you want to lock yourself in a dark room and never leave that place again until you die and no more suffering for anyone.

E7= Depression is something without explanation. I do not know how to say it, I think there is no solution. When it is very strong, as I am only thinking pessimistically, I think that life is not worth living anymore because I have no pleasure in enjoying anything outside my room. I just want to stay locked up and think that it could be different if my son did not take his own life. I know that I have another son and I should not be like this, because he also depends on me, but I cannot, I am trying, but every day that passes I get sadder and feel like dying. I cannot get out of it; I live on sleeping pills...

E43= I think that depression is when the person loses self-love and when this happens the person sinks and the desire to kill themselves appears.

E66= Depression is a weakness, a human failure, and when one finds oneself weak and failing, the desire to take one's own life arises as a form of relief.

## DISCUSSION

As for the sociodemographic profile, it is noteworthy that such data are partially in agreement with the literature, which states that being a woman, young or elderly adults, low education, unemployment, and low income are predisposing factors to depressive symptoms and suicidal behavior [2,6,8,9]. However, there was a discrepancy in the data found in this study regarding marital status and skin tone, in comparison with the data found in the literature, which brings as risk factors for depression and suicide spinsterhood and widowhood, linked to loneliness and loss of a support network, and the Black and brown skin tone. In Brazil and globally, skin tone data relates to greater social vulnerability, and such vulnerability becomes a risk factor for depressive symptoms and suicidal behavior throughout life, including less access to health services [2,9].

Concerning the perception of the depressive state, a study by Peluso, Blay [10] in the city of São Paulo, consisting of more than 500 interviewees, found that most of the answers were grouped as mental health problems (48.0%), personal or life problems (37.6%) and physical problems (5.4%), data similar to those obtained in our study, although here the reports were strongly related to personal or life problems. In this same study, regarding the question about identification as a mental disorder, 19.2% of the sample believed that the situation described was a mental disorder, data superior to that of our study in which 12.5% of the participants recognized their depressive symptoms.

We emphasize that in the study conducted by Viana, Andrade [1], low educational level related to the preference for causes of spiritual/moral and biological nature of depression. This agrees with our data, given we found an important verbalization of risk factors for depression linked to the absence of faith and, in our study, we had a significant majority of participants self-reporting as illiterates or as having completed high school, with statistical significance in the relationship between low education and depressive symptoms.

A study by Lin, Peruchi, Souza, Furlanetto, and Langdon[12] on the perception and expression of depressive symptoms, loneliness, social isolation, distance from family, and difficulties at work characterized the perception pattern of depression, data similar to those found in the reports above.

By having the opportunity to describe their mental states, problems, and feelings to another person, the participants themselves start to clearer perceive what they are feeling and, frequently, this helps them to put their problems in perspective, which brings a certain feeling of control and distance between the participants and the problem that became the object of their speech[13]. This was the case in the participants' speeches, and this is part of the importance of therapeutic listening, in which the participants can be heard, without judging values, as well as listening to themselves and, at the same time, reasoning about his problem[14].

The participants, when verbalizing what they feel, are relieved to be able to verbally express their feelings and thoughts in an adequate manner, tending to increase the feeling of satisfaction, so important in the recovery from depressive symptoms [15].

We emphasize that in a study developed by Moll, Silva, Magalhães, Ventura[16], participants suffering from depression and others with bipolar disorder confirmed that the simple fact of finally having received a diagnosis that explains their profound mood swings produces a certain relief and reduces the guilt feeling. This is

because it signals the possibility of treatment and control of their disorder, and this can and should be used in their therapeutic listening.

As in the statements above, "I felt sad" or "I was sad" were the expressions used by most participants to describe the feeling aroused by the memory of past sufferings or the report of old losses. We can understand this as a reliving of past hurts and traumas, since all the interviewees above placed the responsibility for their current depressive symptoms in the past.

It is important to stress here that the symptoms described above by the participants of our study can occur because they have a more intense perception of their psychological suffering when interviewed, a fact related to depressive states and corroborated by authors such as Silva, Wendt, Argimon[17], Oliveira, Mazzaia and Marcolan[18] and Ely, Nunes, Carvalho[19]. A study by Silva, Aguiar, Vieira, Costa, Carneiro[20] also verified this feeling of worsening depressive symptoms. We emphasize that we advised and referred these participants for evaluation at the CAPS II in the city where we conducted the study.

We noticed in the aforementioned quotes mechanisms of rationalization and denial of those who suffered from depressive symptoms. In the sense of rationalization, Blaya, Kipper, Heldt, Isolan, Ceitlin, Bond et al.[21] state that this is an immature defense mechanism of the human psyche. It works to accept the pressure of the superego, to disguise true motives, make the unacceptable more acceptable, and as an obstacle to growth, because rationalization prevents the person from accepting and working with the genuine motivating forces, which cause intense psychic pain.

Tavares[22] also states that to deny depression is to symbolically deny the failure of the participant in participating in the culture of narcissism and spectacle. This is because we live in a culture in which the image has more value than the being, in which the participant starts to live in a particularly narcissistic way, since the self becomes the object of libidinal investment and the other is used as a resource for immediate pleasure. In this sense, the participant lives in the function of the image, the masks that represent them.

Purgato, Gastaldon, Papola, van Ommeren, Barbui, Tol[23] and Blaya, Kipper, Heldt, Isolan, Ceitlin, Bond et al. [21] in their studies with severe depressed participants showed an increase in the use of immature defenses, such as denial and rationalization by the participants and that such use worsened the long-term prognosis of the depressive disorder.

We emphasize that the perception formed by our experiences facing the disease can be influenced by common sense social beliefs. Some participants relate the depressive disorder to absence of faith [24]. In depressive states, the self-perception and the ability to recognize that one suffers from a mental disorder is tinged and distorted by feelings of helplessness, abandonment, loneliness, victimization, guilt, loss of self-esteem, and the incapacity to perceive positive compensatory aspects, due to the reduction of sensitivity to pleasure [23].

Orbach, Milstein, Har-Even, Apter, Tiano, Elizur[25] also argue that the decrease in the perception of depression leads to the worsening of the installed symptoms, increases the repulsion towards life and the attraction to death, which can trigger the suicidal intent. Fernandes, Marcolan[26] state that the non-perception of depressive symptoms causes a delay in searching for treatment and consequently worses the condition.

It is also worth mentioning that although these participants did not perceive themselves as depressed, the evaluations by the psychometric scales showed positive scores for depressive symptoms and we referred them to CAPS II in the city where we conducted the study.

Regarding the participants' perception of the relationship between depressive symptoms and suicidal behavior, there were consensual reports about it. Studies show that the difficulty of proper perception of the causes of depression and the lack of internal emotional resources to deal with stressful and difficult situations are characteristics of depressed individuals and worsen according to the intensity of the clinical condition, generating alterations in self-criticism and worsening in the feeling of psychological suffering[2,3,9]. As for death being verbalized as a solution to the intense psychological suffering triggered by the symptoms experienced, we must emphasize that this perspective of death appears in moderate and severe cases of depression [6]. This relates to our results, since the group with no previous symptoms presented higher percentages for the moderate and severe depressive symptoms, via psychometric evaluation scales. The literature also mentions among the feelings characteristic of severe depression, the feeling of helplessness before life and that there is no way out for the psychological agony one is suffering, as a trigger for suicidal behavior[2,6,9].

The relationship between hopelessness and suicidal behavior is understood as an important

trigger. This is because hopelessness assumes the form of self-defeating thoughts and a pessimistic view of the future, and is interconnected to depression [27], the devastating effect that the absence of meaning or purpose in life causes with its corrosive impact on the emotional, cognitive, and behavioral state 28, as we also observed in the participants of our study. The association between anxiety disorders and depression is well known [2,6,9,]. Studies indicated that, on average, 70% of participants suffering from depression concomitantly suffer from anxiety, and about 80% of those with anxiety present a condition associated with depression[29,30], since a feedback circuit is formed between anxiety and depression, potentiating symptoms, and serving as a trigger to hopelessness and desire to die.

Yet another association present in the reports, and found in the literature, was that between depressive symptoms and unemployment, overwork, and psychically stressful work environment, due to excessive demands and suicidal behavior[31,32]. It is noteworthy that mental health is harmed by the current contradictions between modernization and the expansion of social and labor precariousness, due to the maximization of competitiveness that generates intense demands, propitiating work-related illnesses, by labor violence, to which the workers are submitted, as well as unemployment or underemployment itself, with an increase in suicidal ideation[32].

In addition, an important association was guilt, which was fed back to the depressive state and triggered suicidal behavior. Karwowski[33] argues that guilt ideation is a frequent symptom in depressive conditions and that, if not treated properly, it becomes an important factor for depression and suicide, since it brings with it negative thought patterns.

Thus, it is important that health professionals, especially nurses, given the hours rendering care they have with depressed individuals and those with suicidal behavior, be trained to identify the symptoms of depression early and offer adequate and effective treatment[33]; in addition to effective strategies for preventive interventions for individuals with suicidal behavior in the Health Care Networks nationwide[2,3,9,34].

## CONCLUSION

We conclude that, regarding the self-perception of psychic suffering, the absence of perception of being depressed stands out, pointing to the worsening of the installed symptomatology and increased risk of suicidal behavior and death.

We must pay attention to the inefficiency of health services in the early detection of depressed individuals, to avoid worsening the condition and emergence of suicidal ideation.

Those who managed to have such perception were linked to situations experienced throughout life, such as emotional losses, lack of family support, loss of self-esteem, sadness, and loneliness. Hopelessness, the presence of psychiatric comorbidities, such as anxiety disorders, stressful work conditions, and unemployment also appeared as aggravating factors for suicidal behavior.

Finally, we understand the limitations of this research to be the reality portrayed only in the sample of the municipality of Poços de Caldas, MG. Thus, it does not allow the generalization of the data to the municipalities surrounding that city. We must also consider that these data are pioneering and portray the panorama of depressive symptomatology and its relationship with suicidal behavior in the adult population of Poços de Caldas, MG, which will allow municipal administrators to plan how to tackle the concerning issues.

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