

**PERCEPTIONS,
PHYSICAL AND
PSYCHO-EMOTIONAL
COMPLAINTS AMONG
STUDENTS: A CROSS-
SECTIONAL STUDY
BEFORE THE PANDEMIC**

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Abstract: Goal: To verify the prevalence of physical complaints and symptoms of anxiety, depression and lack of hope among speech-language pathology students and their relationship with other symptoms and clinical reports. **Method:** Observational and cross-sectional study carried out with academics from a higher education institution. The following instruments were used for data collection: a structured sociodemographic and health questionnaire and the Beck Inventories (*Beck Depression Inventory – BDI*; *Beck Anxiety Inventory – BAI*). **Results:** 119 academics participated in the research, aged between 18 and 40 years, average of 21.65 ± 3.84 years. The volunteers were mostly female, single and with a positive self-perception of health. The intensity of depression and anxiety symptoms were significantly higher ($p < 0.05$) among students with previous psychiatric history and neuropsychological modification or alteration. Participants with some level of Suicidal Ideation ($N=28$; 23.7%) had higher means of symptoms of depression, anxiety and lack of hope. **Conclusion:** The data confirm the growing movement of psychic suffering in the university context and show a repressed demand for comprehensive care. This reinforces the need to guide the theme, clarify and sensitize the institution and the actors involved in the care process.

Keywords: Depression, Anxiety, lack of hope, Suicidal Ideation, Sadness, Ache.

INTRODUCTION

A panoramic look at the 20th and 21st centuries reveals a growing movement in the prevalence of neurological and psychiatric disorders and their multiple consequences. Psychic suffering coated with prejudice and neglected throughout history has become a topic of scientific, popular and media interest today. The process of mental balance brings with it several quantitative, qualitative,

evaluative, historical-political, sociocultural and economic assumptions. This way, its decomposition is verified as a way of approaching, delimiting, labeling, judging and treating. From this perspective, holistic health care includes promotion, prevention, health maintenance, treatment and follow-up and, in this approach, it must integrate primary care and holistic therapy (1-4).

Mental disorders and their correlations with chronic diseases and physical symptoms affect millions of people, however, many of these disorders remain without proper diagnosis and treatment, and cause individual and collective harm with psychosocial and economic consequences (1, 5). In addition to psychological suffering and incapacity resulting from mental imbalances, the vulnerability of these people demands legislation to protect and promote their well-being and improve their quality of life (6).

Depressive and anxiety disorders are considered common mental disorders, with prevalence in the population and strong impact on mood, perception, emotions, sensations and feelings of affected individuals. The W.H.O. (World Health Organization) has estimated that, globally, there are more than 300 million people with depression; this represents 4.4% of the world population, with a prevalence of women, mainly in adulthood. In Brazil, according to the National Health Survey (PNS) in 2013, 7.6% of the adult population received a diagnosis of depression at some point in their lives, with a higher frequency in women (10.9%) than in men (3.9%) (7). In 2019, the prevalence of depression in Brazil was 10.2%, that is, 16.3 million people, with a higher prevalence in females (8)

Research carried out with university students detected a prevalence of severe depression (5.7%) and anxiety (8.5%) among Speech-Language Pathology and Psychology

students in the state of São Paulo (9) and 62.9% of depressive symptoms among health students (medicine, dentistry and nursing) of the Tiradentes University of Aracaju-Sergipe (10). A study carried out in 2018 with 114 students from the Occupational Therapy course at the Federal University of Paraíba (UFPB) showed a prevalence of 40.3% of Moderate and severe depressive symptoms, 44.1% of anxiety and 25.5% of Suicidal Ideation. Most respondents reported Sadness (57.1%) and Pessimism about the future (51.8%) (11). Other studies found a prevalence of 45.7% of depression in medical students at the Federal University of Amapá (12) and positive indicators of anxiety (26.5%) and depression (8.0%) among students of the courses of Biology, Ecology, Physical Education and Pedagogy at UNESP, Biosciences Institute of Rio Claro (13). These data confirm the prevalence of mental disorders among university students, some of them, many times, higher than those described in the general population (14).

Depressive disorder is characterized by deep and persistent sadness, loss of interest or pleasure, feelings of guilt or lack of hope, and low self-esteem. In addition, the clinical picture involves changes in sleep, appetite, circadian and neuroendocrine rhythms, feelings of tiredness, lack of concentration and suicidal thoughts and, in this perspective, impairs the individual's mental functioning, work and academic capacity (5, 15-17).

The chronicity, recurrence and disability resulting from depression impact several areas of life. Prolonged physical and psychological changes compromise daily life and occupations and, thus, the improvement of symptoms does not necessarily imply the recovery of functionality, routine and significant activities; consequently, the treatment of mental disorders must go beyond the remission of symptoms: it needs to contemplate all dimensions of being and

living (5, 18-20).

The university environment is plural, its stressors and anxiogenic factors associated with personal vulnerability favor the growing movement of psycho-emotional and psychiatric disorders among young students. To serve this heterogeneous public, it is necessary to know their profile, their state of health and well-being, the risk and protection factors and, finally, the demand for comprehensive care (emotional, psychosocial, affective and spiritual aspects).

In order to solve the mismatch between the prevalence of mental disorders and the offer of reception and care, it is necessary to research and give visibility to those who, without diagnosis and treatment, walk alone and without adequate social support. Thus, the more research and information, the greater the possibility of successful interventions. This study aims to verify the prevalence of depressive, anxiety and lack of hope symptoms among Speech-Language Pathology and Audiology students at UFPB and compare it with other symptoms and clinical reports.

METHOD

This is an observational, cross-sectional and quantitative study carried out at UFPB, in which the convenience sample was composed of students from the 1st to the 8th period, regularly enrolled in the Speech Therapy course, aged over 18 years. The project was approved by the Research Ethics Committee of the CCS/UFPB (opinion number: 2,784,383; CAAE 92087118.6.0000.5188) and all volunteers were informed about the research objectives and the anonymity of the questionnaire, signing a Free Consent Form and Enlightened (ICF) when they opted for participation.

Classroom data collection took place during the second half of 2018 and the first half of 2019, at the Health Sciences Center,

Department of Morphology and Speech Therapy and Occupational Therapy Complex at UFPB. The population of this study consisted of 198 Speech-Language Pathology and Audiology students active in the second half of 2018. Students under 18 years of age, who were not in the classroom or who did not accept to participate in the research were excluded from the sample (Figure 1).

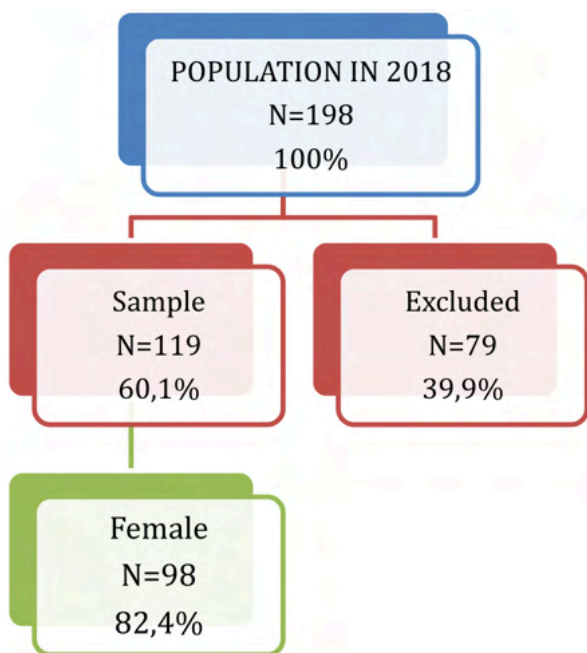


Figure 1. Diagram with the population and volunteers included in the survey.

Four instruments were used for data collection: a structured questionnaire and three Beck inventories (Beck Depression Inventory - BDI; Beck Anxiety Inventory - BAI; Beck Hopelessness Scale - BHS) validated in Brazil (21, 22). The questionnaire gathered independent variables with sociodemographic questions, about lifestyle and health history. The inventories, BDI and BAI, are psychometric self-report scales with 21 items, each with four ALTERNATIVES, and a recall period of one week including the day of completion. Scores ≥ 20 were considered positive for depression and ≥ 16

positive for anxiety. The BHS is a 20-item dichotomous scale to check the intensity of PesYesism. The total lack of hope inventory score can vary from 0 to 20 points, with a score ≥ 9 considered as a cut-off point (21).

The Beck Depression Inventory is one of the instruments widely used in research to assess the intensity of depressive symptoms, classifying them into four levels: minimal, Light, Moderate and Serious (21, 23). The items refer to Sadness, PesYesism, feelings of failure, dissatisfaction, guilt, punishment, self-dislike, self-accusation, suicidal ideas, crying, irritability, social withdrawal, indecision, self-image, difficulty working, fatigability, changes in appetite, weight and sleep pattern, somatic concerns, and loss of libido (21). This way, the BDI measures, through a group of 21 statements, with four scores (0-3), the latent trait of intensity of depressive symptoms, being an aid in the identification and monitoring of the stage of depression and its outcome (24, 25).

The application of the questionnaire and Beck Inventories made it possible to characterize the sample, verify the prevalence of symptoms and compare the independent variables with the average scores obtained in the Beck inventories. Descriptive data analysis and the chi-square test were performed, considering $p < 0.05$ statistically significant. To compare means, analysis of variance was used. Statistical analysis was performed using the SPSS 25 program, at a significance level of 5%.

RESULTS

119 academics participated in the research, aged between 18 and 40 years, with average of 21.65 ± 3.8 years, median and mode of 21 years. It was observed that the volunteers were mostly female (82.4%), single (90.8%) and Christian (76.5%). Most respondents declared not to smoke (96.6%), not to drink (67.2%),

not to practice physical activity (68.9%) and not to have health insurance (72.3%). The average of BDI, BAI and BHS inventories described in Table 1 were, in general, lower than the pre-established cut-off points. The highest averages of the inventories were observed in the variables gender, period of the course and health plan.

In the evaluated sample, the categorical variables in Table 1 did not exert significant effects on the BDI, BAI and BHS means, except for the health insurance variable ($p=0.04$). The absence of a health plan may, at some point, bring suffering due to the difficulty, or even the impossibility of accessing the necessary health services. Self-reported smoking (3.4%) was lower than the national prevalence in 2019 (12.8%) (8).

The averages of the Beck Inventories were higher among male students, self-reported fluid and married students. However, the literature reports a prevalence of depression and mental distress in females (26-31). Research carried out with women in Juiz de Fora (MG), for example, detected a prevalence of depression among single women or without partners. They also found that living with a partner, having social support and practicing physical activity are protective factors against depression (32). However, in the results of this study, sociodemographic variables and modifiable habits (alcoholism, smoking and physical activity) did not significantly influence the average of depressive symptoms, anxiety and lack of hope scores. It is worth noting that alcoholism, smoking and physical inactivity, when present, are strongly associated with mental disorders, such as depression and depressive mood. The practice of physical activity can be a significant factor for the promotion of mental health and well-being (27, 32, 33).

HEALTH HISTORY: PERCEPTIONS, REPORTS AND COMPARISONS

Regarding health-related aspects, most students (71.4%) in the sample have a positive self-perception and considered their own health to be good (46.2%), very good (21.8%) or excellent (3.4%). Students with poor health perception ($N=3$; 2.5%) had higher means of BDI (25.3 ± 10.3) and BAI (22.7 ± 4.9). Despite the prevalence of positive self-perception of health, there were students with reports of clinical diseases and multiple complaints of physical and psycho-emotional symptoms. Thus, many students reported feeling sick (28.6%) and feeling pain every day (27.7%). In addition, the data collection showed a history of psychiatric/psychological/neurological follow-up, self-reported headache (63.9%), allergy (46.2%), Sadness (41.2%), insomnia (38.7%), anxiety (38.7%), dizziness (35.3%), Nightmares (32.8%), vertigo (24.4%), Temporomandibular Disorder (TMD) (21.0%), bruxism (12.6%), clinical depression (10.1%) and psoriasis (5.0%). Table 2 presents the self-reported complaints by the volunteers compared with the intensity of depressive symptoms (BDI) and anxiety (BAI) with statistically significant values ($p \leq 0.05$).

The intensity of symptoms of depression and anxiety, represented by the averages of the BDI and BAI in Table 2, were significantly higher ($p < 0.05$) among students with a previous psychiatric history and neuropsychological modification or alteration. The analysis of the results reveals, therefore, a combination of somatic symptoms with psycho-emotional and neurological complaints. The results show psychological distress and a bilateral relationship between depression and anxiety with other neurological and psychiatric disorders. These data are worrying, given the worldwide prevalence and rise of mental

VARIABLES	N	%	AVERAGE BDI ± DP	AVERAGE BAI ± DP	AVERAGE BHS ± DP	
General Average of Inventories	119	100	13,37 ± 9,6	13,63 ± 9,6	4,75 ± 3,8	
Gender	Female	98	82,4	13,06 ± 9,0	13,34 ± 9,3	4,71 ± 3,6
	Male	20	16,8	14,00 ± 11,7	15,05 ± 11,1	4,79 ± 5,0
	Fluid	01	0,8	31,00 ± 0,0	26,00 ± 0,0	9,00 ± 0,0
Marital status	Single	108	90,8	13,10 ± 9,1	13,17 ± 9,2	4,75 ± 3,9
	Married	09	7,6	18,00 ± 14,8	17,22 ± 13,8	5,11 ± 3,4
	Others	02	1,7	7,00 ± 0,0	22,50 ± 9,2	3,50 ± 0,7
Period	1°	18	15,1	11,83 ± 9,9	12,94 ± 7,1	4,67 ± 3,1
	2°	20	16,8	11,15 ± 6,8	14,10 ± 10,4	4,30 ± 3,9
	3°	14	11,8	17,86 ± 11,6	20,71 ± 10,6	6,54 ± 4,9
	4°	17	14,3	13,41 ± 7,5	11,82 ± 7,4	4,47 ± 2,3
	5°	01	0,8	23,00 ± 0,0	16,00 ± 0,0	2,00 ± 0,0
	6°	16	13,4	16,19 ± 13,1	13,38 ± 9,2	5,75 ± 5,2
	7°	21	17,6	11,10 ± 7,7	11,29 ± 10,5	3,75 ± 3,2
	8°	12	10,1	13,50 ± 10,1	12,42 ± 10,8	4,67 ± 3,9
Smoking	No	115	96,6	13,40 ± 9,7	13,78 ± 9,7	4,81 ± 3,8
	Yes	04	3,4	12,50 ± 8,2	9,25 ± 5,4	3,00 ± 1,4
Alcoholism	No	80	67,2	13,23 ± 10,3	13,11 ± 9,8	4,58 ± 3,6
	Yes	39	32,8	13,67 ± 8,0	14,69 ± 9,3	5,11 ± 4,2
Physical activity	No	82	68,9	13,56 ± 9,7	13,67 ± 10,3	4,82 ± 3,8
	Yes	37	31,1	12,95 ± 9,5	13,54 ± 8,3	4,61 ± 3,9
Health insurance	No	86	72,3	12,63 ± 9,4	12,87 ± 9,6	4,31 ± 3,4
	Yes	33	27,7	15,30 ± 9,9	15,61 ± 9,5	5,94 ± 4,5*

BDI = Beck Depression Inventory; BAI = Beck Anxiety Inventory; DP = Standard deviation. * $p=0,04$

Table 1. Characterization of the sample composed of Speech-Language Pathology and Audiology students from UFPB, João Pessoa (PB), and respective averages of the depression (BDI), anxiety (BAI) and lack of hope (BHS) (N = 119).

VARIABLES		N	%	AVERAGE BDI ± DP	p-value	AVERAGE BAI ± DP	p-value
The person feels pain every day	No	86	72,3	11,31 ± 8,3	<0,01	11,30 ± 7,8	<0,01
	Yes	33	27,7	18,73 ± 10,7		19,70 ± 11,3	
Sadness or depression in the last seven days from pain	No	83	70,3	10,77 ± 7,5	<0,01	10,80 ± 7,5	<0,01
	Yes	35	29,7	19,86 ± 10,9		20,49 ± 10,8	
The person feels sick	No	85	71,4	10,72 ± 7,5	<0,01	10,66 ± 7,1	<0,01
	Yes	34	28,6	20,00 ± 11,0		21,06 ± 11,1	
The person underwent psychiatric treatment	No	103	86,5	11,32 ± 7,7	<0,01	12,11 ± 8,4	<0,01
	Yes	16	13,5	26,56 ± 10,1		23,44 ± 11,5	
The person underwent neurological treatment	No	109	91,6	12,62 ± 9,0	<0,01	12,86 ± 9,3	<0,01
	Yes	10	8,40	21,60 ± 11,8		22,00 ± 9,9	
The person underwent psychological treatment	No	81	68,1	10,85 ± 7,9	<0,01	10,95 ± 7,9	<0,01
	Yes	38	31,9	18,74 ± 10,8		19,34 ± 10,6	
Diagnosis of depression	No	107	89,9	11,87 ± 8,1	<0,01	12,53 ± 8,7	<0,01
	Yes	12	10,1	26,75 ± 11,8		23,42 ± 12,5	
Sadness	No	70	58,8	10,27 ± 7,4	<0,01	10,24 ± 7,6	<0,01
	Yes	49	41,2	17,8 ± 10,7		18,47 ± 10,2	
Headache report	No	43	36,1	10,98 ± 9,5	0,04	11,63 ± 9,7	0,09
	Yes	76	63,9	14,72 ± 9,4		14,76 ± 9,5	
Psoriasis	No	113	95,0	12,89 ± 9,0	0,02	13,25 ± 9,2	0,06
	Yes	6	5,0	22,33 ± 15,8		20,83 ± 15,0	
Insomnia	No	73	61,3	10,60 ± 7,9	<0,01	11,19 ± 8,4	<0,01
	Yes	46	38,7	17,76 ± 10,4		17,50 ± 10,3	
Nightmares	No	80	67,2	11,51 ± 8,3	<0,01	11,51 ± 8,8	<0,01
	Yes	39	32,8	17,18 ± 10,9		17,97 ± 10,0	

DP= Standard deviation; BDI= Beck Depression Inventory; BAI= Beck Anxiety Inventory.

Table 2. Comparison of perception, follow-up history and complaints reported by Speech-Language Pathology and Audiology students at UFPB, João Pessoa (PB), with the averages of the depression (BDI) and anxiety (BAI) inventories.

disorders and the ranking of causes of death by suicide among young people aged 15 to 29 according to the WHO (2016).

Pain was considered a predictor of depression in this university sample. The authors pointed to the complaint of daily pain as a risk for developing depressive symptoms (34). Pain is a complex and unpleasant sensory and emotional experience, it causes suffering and biopsychosocial damage, and its presence and intensity are related to psychiatric disorders and are associated with depression and anxiety (35-38).

DEPRESSIVE SYMPTOMS: PREVALENCE, LEVELS AND COMPARISONS

The prevalence of moderate and serious depression ($BDI \geq 20$) was 21.9%. The intensity of depressive symptoms was distributed between the minimum (48.7%), Light (29.4%), Moderate (18.5%) and Serious (3.4%) levels. average of BDI significantly increased ($p \leq 0.001$) with increasing scores and respective DEPRESSION LEVELS (Table 3). Furthermore, in the BDI the items Sadness (53.0%), PesYesism (33.6%) and suicidal ideas (23.6%) presented worrying frequency and averages of BDI (Table 4).

Data analysis revealed that there is a significant difference between the BDI means and the scores (0 to 3) of the items sadness, pesYesism and suicidal thoughts of the BDI itself, indicating that the higher the score of these items, the higher the final means of the BDI. The highest means of this were observed among participants with higher scores in the items pesYesism (46.00) and suicidal ideation (38.33 ± 6.7). The data in the Table demonstrate that a score greater than 1 in the BDI items pesYesism and suicidal ideation suggests a possible depression and the existence of suicidality and, therefore, the need for risk assessment (21).

More than half of respondents were classified as having some degree of depression between Light, Moderate and Serious. A study with 1,827 students revealed a relationship between academic performance and Major Depressive Episode in university students, with depression being an influencing factor in poor performance (27). Studies to verify the relationship between occupation, performance and psychological distress are necessary.

LEVELS OF ANXIETY

The overall BAI average was 13.6 ± 9.6 with a mode equal to 8.0, a level below the cut-off point. 36.98% of participants had Moderate or Serious anxiety levels. In the sample, age and sex had no significant effects on BAI means (Table 5).

Research carried out with 140 Speech-Language Pathology and Audiology students at UFPB in 2019, detected a prevalence of 79.3% of medium and high anxiety state. They also observed a prevalence of the following self-reported anxiety symptoms: nervousness (84.3%), inability to relax (74.3%), fear of the worst happening (65.7%), feeling hot (57.9%), heart palpitation or racing (53.6%), fear of losing control (52.9%) and indigestion or discomfort in the abdomen (52.1%) (39). Competitiveness in the university environment associated with expectations and demands can negatively impact the balance of young students (31), especially those with personal or social vulnerability.

LACK OF HOPE: LIGHTLS AND COMPARISONS

The general average of hopelessness or negative expectation regarding the future was 4.8 ± 3.8 , a light Lightl. A total of 17 students (14.5%) had a mean BHS ≥ 9 , therefore, a moderate to severe Lightl of hopelessness (Table 6).

BDI DEPRESSION LEVELS	N	%	BDI MIN-MAX	AVERAGE OF BDI	AVERAGE OF AGE
Minimum: 0-11	58	48,7	0-11	6,21±3,1	21,41±3,7
Light: 12-19	35	29,4	12-19	14,00±2,0	21,44±3,6
Moderate: 20-35	22	18,5	20-35	26,46±5,2	22,18±4,5
Serious: 36-63	4	3,4	37-46	39,75±4,3	24,00±4,7
Value of p				$p \leq 0,001$	$p = 0,53$

MIN-MAX = minimum value - maximum value of the BDI

Table 3. Prevalence of DEPRESSION LEVELS self-reported by participants and comparison with BDI and age means. João Pessoa-PB.

ALTERNATIVES (Scores of 0-3)	ITEMS OF BDI AVERAGE OF BDI±DP		
	Item 1 Sadness	Item 2 PesYesism	Item 9 Suicidal Ideation
0 - No	7,44±5,4	9,05±5,4	10,19±6,5
1	16,16±7,6	20,22±10,2	22,00±9,4
2	29,30±10,0	26,14±4,6	28,00±0,0
3	30,00±5,7	46,00±0,0	38,33±6,7

Table 4. Average of BDI according to alternatives of depression severity, represented by increasing scores from 0 to 3.

BAI LEVELS OF ANXIETY	N	%	AVERAGE OF BAI	AVERAGE OF AGE
Minimum:0-7	34	28,6	3,88 ± 2,4	21,56 ± 3,0
Light: 8-15	41	34,5	11,02 ± 2,4	21,85 ± 4,3
Moderate: 16-25	29	24,4	18,93 ± 2,7	20,93 ± 3,6
Serious: 26-63	15	12,6	32,60 ± 6,6	22,73 ± 4,7
Value of p			<0,001	0,5

Table 5. Prevalence of levels of self-reported anxiety symptoms by participants and comparison with BAI means and age. João Pessoa-PB.

BHS LIGHTLS OF LACK OF HOPE	N (%)	AVERAGE			
		BHS	AGE	BDI	BAI
Minimum: 0-4	71 (60,7)	2,42 ± 1,1	21,65 ± 3,8	8,65 ± 5,1	11,03 ± 8,4
Light: 5-8	29 (24,8)	6,07 ± 1,2	21,25 ± 3,7	16,17 ± 8,4	13,31 ± 7,0
Moderate: 9-13	12 (10,3)	10,50 ± 1,5	23,00 ± 5,2	27,50 ± 9,7	25,42 ± 0,2
Serious: 14-20	5 (4,3)	16,40 ± 2,0	21,20 ± 2,4	31,60 ± 5,2	25,4 ± 11,1
F statistic		F= 0,6		F=44,9	
Value: p		p=0,62		$p \leq 0,001$	
Linear Regression			$r = 0,54$		$r = 0,23$

Table 6. Prevalence of Lightls of hopelessness scores (BHS) compared with the mean age and depression (BDI) and anxiety (BAI) Beck scales (N=117).

The intensity of depressive and anxiety symptoms were significantly higher among participants with greater hopelessness. There was no significant difference between mean hopelessness and lifestyle scores (alcohol use, smoking and physical activity) or mean age of participants.

The data presented in Table 6 suggest a correlation between depression and hopelessness ($r=0.54$). This result confirms the data presented by Cunha (2017) when estimating a correlation of 0.55 with a significance $t < 0.01$ between BDI and BHS in a university sample.

Hopelessness involves negative, distorted and dysfunctional cognition in which words such as lack, deficit and displeasure are frequent in thoughts, sensations or narratives. All this associated with the absence of dialogue and dysfunctions of feelings, affectivity and behaviors has many negative individual, relational and academic consequences. Thus, hopelessness compromises affection, self-care, the production of life and health and, consequently, academic and professional performance, all of which represent a risk factor for suicide (40-42).

SUICIDE IDEAS

Participants with some Lightl of suicidal ideation ($N=28$; 23.7%) had higher means of symptoms of depression, anxiety and hopelessness (Table 7). Of this group, most were female, single, complaining of headache, sadness and nightmares (Figure 2).

The data in the table reveal a relationship between depression, anxiety and hopelessness with suicidal thoughts. These results demonstrate that a suicidal ideation score ≥ 1 plus a BDI ≥ 20 , BAI ≥ 16 and BHS ≥ 9 , suggest the existence of suicidality and, therefore, the need for risk assessment. Mental disorders have been associated with suicidal thoughts in other studies (43, 44).

Research carried out among health, nursing, physiotherapy, medicine and psychology students in the State of Piauí, Brazil, indicated 22.0% of suicidal ideation, with a prevalence in male and single students. Lifestyle (alcoholism, smoking and other drugs), bullying and a history of suicide attempts were associated with suicidal ideation among these students from Piauí (45). Another survey among health academics from Petrolina, state of Pernambuco, detected 36.0% of suicidal ideation in its university sample (44). These data corroborate the high prevalence of suicidal ideation described now in this research (23.7%).

The prevention and promotion of health and the production of life is the way. This involves a healthy lifestyle, medical follow-up, therapies and socioeconomic changes. It is important to check for psychiatric disorders, self-destructive thoughts and behaviors, social support, life history, and history of attempted suicide (45, 46). To all of this, the prevention of bullying in family, academic and social networks is included today.

CONCLUSION

The results reveal the psychic suffering of this community, with possibilities of aggravation by unexpected events such as the COVID-19 pandemic. The health status of academics demonstrates a demand for care to achieve broad physical, social, mental, emotional and spiritual well-being. The identification of these symptoms and associated factors is essential for the definition of public health policies aimed at the prevention, control and treatment of these diseases. The study thus denounces the great need to clarify and sensitize the institutions and actors involved for the provision of adequate care spaces, aiming at the process of reception, diagnosis and treatment for a better quality of life.

SCORE AND LIGHTLS OF SUICIDAL IDEAS	NUMBER (%)	AVERAGE OF AGE	AVERAGE OF BDI	AVERAGE OF BAI	AVERAGE OF BHS
0 - I don't have any ideas of killing myself	90 (76,3)	21,69±4,0	10,19±6,5	11,86 ± 8,8	3,69±2,7
1- I have thoughts of killing myself	24 (20,3)	21,29±3,6	22,00±9,4	18,25±9,0	7,61±4,4
2- I would like to kill myself	1 (0,9)	21,00±0,0	28,00±0,0	17,00±0,0	14,00±0,0
3- I would kill myself if I had the chance	3 (2,5)	24,00±2,0	38,33±6,7	33,00±7,6	13,00±1,7

Table 7. Comparison between Lightls of suicidal ideation and mean age and symptoms of depression, anxiety and hopelessness (N=118).

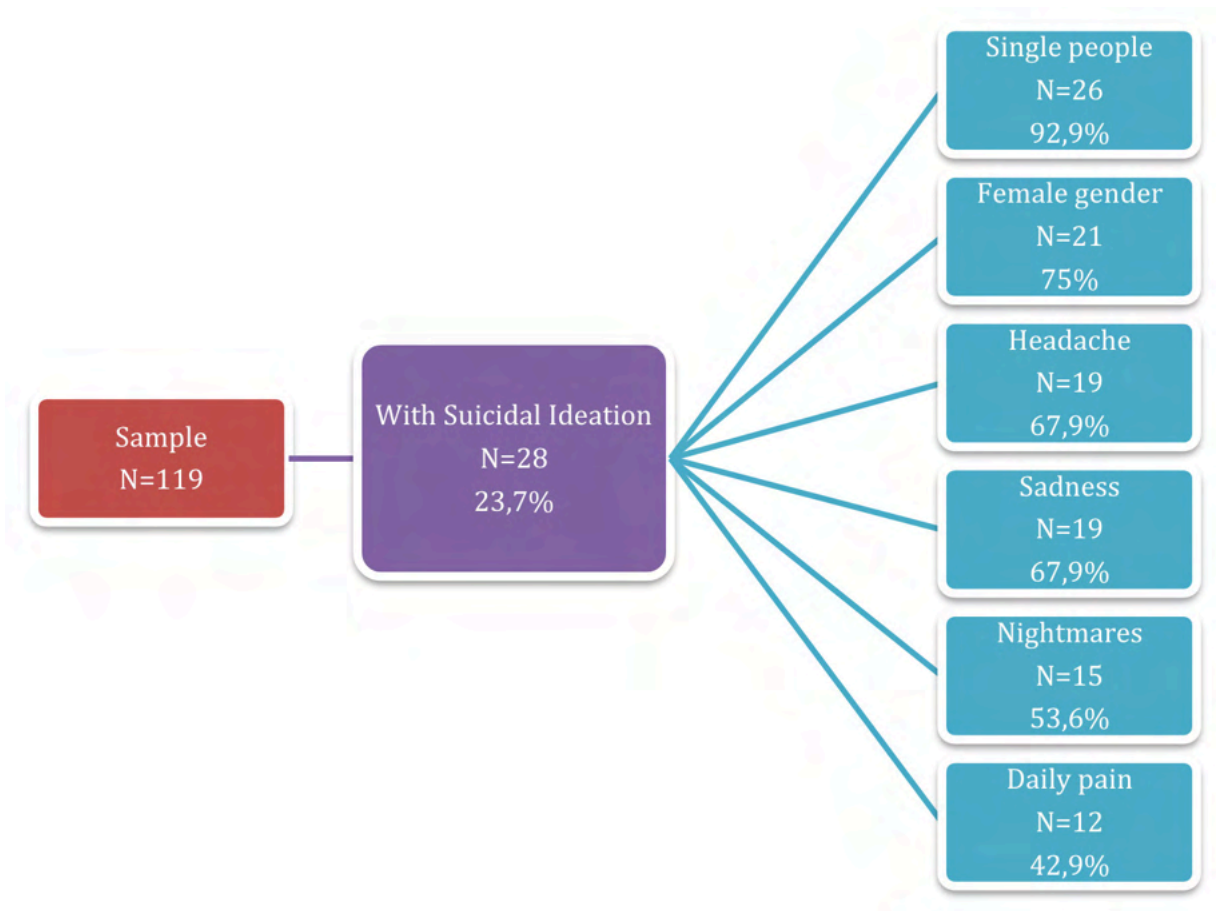


Figure 2. Diagram with the profile of students with self-reported suicidal ideation.

We emphasized that the results of this study reinforce the need and relevance of actions to promote healthy thoughts and behaviors. The research approach collaborates with the demystification of the themes and offers important elements to understand the health status and the needs of these academics. The student's health profile associated with spontaneous demand in the institution itself requires specific strategies for this academic community.

The limitations of the study are related to the use of a self-report instrument, without further evaluation and confirmation of the medical diagnosis of the volunteers, and the impossibility of inferring causality due to the nature of the research.

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