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RESEARCH ARTICLE

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PREVALENCE OF DEPRESSIVE SYMPTOMS IN ELDERLY PEOPLE LINKED TO SOCIAL INSTITUTIONS IN THE CEARENS INTERIOR

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ABSTRACT

Depression is characterized as a subjective diagnosis psychopathology, in order to cause changes in the individual affected with cognitive evidence. Therefore, the aim of this study was to promote the tracing of traces of depressive symptoms in the elderly belonging to two different social institutions in the interior of Ceará. The sample consisted of 105 elderly people, with an average age of 65 years or more. The first collection took place in March 2015 to February 2016, the second in June 2017 to August of the same year. At the first institution, 15.1% had no trace, 15.1% had traces, and 69.8% already fit the occurrence of advanced depressive symptoms. In the second, 36.5% had no traces, 23.1% had mild to moderate and 40.4% already had symptoms of depression. Given the facts, there were greater traces in the Reference and Social Assistance Center and symptomatology in the Basic Health Unit.

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INTRODUCTION

Depression is characterized as a subjective diagnosis psychopathology, in order to cause changes in the individual affected with cognitive evidence, which makes it a differential in terms of symptoms, severity, course and prognosis (OLIVEIRA & GONSALVES, 2020). In turn, when related to the geriatric portion, the perception on the part of professionals becomes even more complex, especially with regard to its variety of signs and symptoms amid the particularities of each patient (SIMEÃO et al., 2018). For the purposes of this information, the elderly population has increased substantially in recent decades, with justification for the increase in life expectancy in most underdeveloped and developing countries (WHO, 2018). In this sense, this Brazilian parcel is classified in an age group of 65 years or more, so that by 2032 they have significant indexes that correspond to 14.32% in relation to the

total population of the country according to the World Health Organization Parameters - WHO (IBGE, 2019). Given the information, the WHO also predicted that depression would be the second most prevalent health condition, behind only ischemic heart diseases, which are at the top of the list of afflictions until this year 2020 (KESSLER & BROMET, 2013). As a result, recent studies have suggested that the majority of the elderly who committed suicide had depression as an assumption, although several other reasons may also be involved in most cases (OONAROM et al., 2020). It is worth mentioning that this outcome occurs silently, which requires in-depth knowledge on the part of teams and caregivers regarding the signs of evidence. Still within this perspective, the pathology in question has symptoms of a physical and psychological character, since it directly interferes with the performance of daily activities in a deficient or disabling manner (ARAFAT et al., 2019). In addition, it has peculiar

characteristics such as significant decrease or increase in weight and appetite, insomnia or hypersomnia, fatigue, psychomotor agitation or delay, lack of concentration or decision-making power, feelings of worthlessness and guilt and recurring thoughts of death or suicidal ideation (BOB, 2013; BARBOSA et al., 2011). It is also clear from the context that these specific groups attend social institutions such as the Basic Health Unit (UBS) and the Psychosocial Care Center (CAPS) to monitor any chronic illness, or to carry out assistance activities directed at the community. However, Nurses have some difficulty regarding the identification of depressive traces, which makes use of psychometric scales in order to identify and subsequently intervene in an appropriate and targeted manner (TREVISAN et al., 2016). These spaces make it possible to bring together elderly people of different ages through a range of activities that range from clinical consultation itself to campaign or leisure events, such as occupational actions based on multiprofessional guidance. In this regard, it is worth noting that social programs are implemented with the main aim of meeting the needs and demand of the population, especially in the elderly (ANDRADE et al., 2019), through needs and demand. Such challenges lead us to reflect on the importance of tracking this type of symptomatology, therefore, these psychometric scales are used with great frequency. Thus, they are classified as fundamental tools in nursing care, as it is a type of innovative technology, the basis of which would be to optimize the service and specify by means of its parameters the prevalence based on its investigative properties (ALHO et al., 2020).

An example in question would be the Center for Epidemiological Studies Depression Scale (CES-D), or in translation into Portuguese Population Tracking Scale for Depression (ADLOFF, 1997). The present instrument is composed of 20 questions of which are applicable to different audiences, including the geriatric (MARCO et al., 2020). On the other hand, CES-D has good adaptability, not only with reference to a specific type of group, but also in the investigation of traces that may reveal guiding points for a possible diagnosis. Regarding institutionalized elderly, it is possible to explain their main weaknesses in view of the paths evidenced by psychological disorders (WIBELINGER et al., 2020). The foregoing draws attention to the importance of investigating depressive symptoms in the elderly, whether they are in a family or institutionalized environment, to avoid underreporting due to its typically silent onset (AMARAL et al., 2020). On the other hand, it is up to the nurse professional to adapt the investigative technologies, in this case psychometric ones, with a focus on care in this type of public and disease in the same axis. Given the above, the present study aimed to promote the tracing of traces of depressive symptoms in the elderly belonging to two different social institutions in the interior of Ceará using the population-based psychometric screening scale for depression.

METHODOLOGY

Kind of study: This is a descriptive, observational, cross-sectional study with a quantitative approach. In descriptive research, the researcher seeks to know and interpret reality, without interfering to modify it. In this sense, the descriptive study aims to discover and observe phenomena, seeking to describe, classify and interpret them (RUDIO, 2001). As for the observational method, it aims to systematically see and record facts, circumstances and concrete situations that have

been defined and that are linked to the problem of the study. In addition, in the transversal criterion, the exposure and the outcome of the research are evaluated together at the same time point (DYNIEWICZ, 2009). In addition, quantitative research seeks facts with predetermined variables subjected to measurement and results obtained expressed numerically (APPOLINÁRIO, 2004).

Study location: The research was carried out in institutions of a social character and with different functionalities, the purpose of which was to address a considerable number of participants involved. To this end, we opted for two Reference Centers for Social Assistance (CRAS) and one Basic Health Units (UBS) located respectively in the Cities of Redenção and Acarape, both in the State of Ceará, Brazil. In these establishments, people with diabetes and hypertension are monitored on predetermined days, in addition to socio-cultural activities such as the first establishment mentioned. In this sense, the function of social institutions in this region has the mission of ensuring the quality of life of the elderly and promoting health through actions, especially in those individuals in situations of vulnerability, since it mostly serves communities in need of centers and periphery of these cities. Thus, the project was carried out by means of prior authorization from the university promoting and managing the units.

Population and Sample: The sample consisted of 53 elderly people in both CRAS and 52 in the UBS, totaling 105 in all, with an average age of 65 years or more. Still in this focus, the inclusion criteria were to have an active registration at these institutions, present physical and mental conditions to answer the instruments and accept to participate through the Informed Consent Term (ICF) after previous explanation. Participants who did not meet the requirements mentioned above were excluded.

Data collection instrument: For data collection, two instruments were used. The first consists of sociodemographic and clinical data containing information such as: identification data, sex, age, nationality, place of birth, self-reported color, monthly family income, religion, follow-up period at the PSF, work situation, marital status, housing conditions, conjugate, family history of illnesses, history of chronic illnesses and psychic alterations beyond lifestyle. The second, is a technology to assess the occurrence of traces of depressive symptoms itself, in this case, we opted for the Center for Epidemiological Studies - Depression (CES-D) or in translation into Portuguese Population Tracking Scale for Depression. CES-D was developed with the purpose of detecting depressive symptoms in adult populations (SILVEIRA & JORGE, 2000). This instrument was based on other scales of depressive symptoms and has been widely used for clinical purposes in any age group (SILVEIRA & JORGE, 2000; FELCK et al., 2002). Thus, it consists of 20 items of self-report which detects relevant symptoms of depressive traces. Still in this context, the symptoms refer to the week preceding the application of the scale, and comprise items related to mood, behavior and perception (RADLOFF, 1997). Inventory items refer to the occurrence of irritability, decreased appetite, discouragement, self-deprecation, lack of concentration, feeling depressed, unwillingness to work, pessimism, feeling of failure, feeling of guilt, fear, sleep disturbance, feeling of unhappiness, decreased speech, loneliness, devaluation, deficit in the enjoyment of life, crying

crises, sadness, tiredness and social withdrawal. In this type of technology, a cut-off score > 15 is used, which would indicate the presence of significant depressive symptoms (FREEMAN et al., 2006; SILVEIRA & JORGE, 2000; TAVARES, 2004). The score obtained was interpreted based on the score ratio of each question, so that the result less than 15 is classified as without traces; between 15 to 21 with the presence of symptoms; and greater than 21, depressive symptoms already installed. Given the facts, it was decided to apply the questionnaires in the form of an interview, since the majority had a low level of education. Another measure for better understanding was the use of synonyms and the formation of phrases equivalent to those of the instrument (CES-D) without losing its original meaning, adapting to the regionality and local culture of each investigated group.

Data collection procedure: Data collection took place from March 2015 to February 2016 at the Reference and Social Assistance Centers, and at the Basic Health Unit from June 2017 to August of the same year. The researchers in question underwent previous training focused on the type of approach and good practices of confidentiality and professional ethics. Another point was related to the use of CES-D regarding the subjectivity of the answers and transcription for the instrument, that in case of doubt, the question was duplicated at the end of the others, in addition to counting and coded organization. Firstly, the participants were analyzed regarding the inclusion criteria, and later the research topic, those responsible and objectives were mentioned, and then the Informed Consent Form was presented, with rules and rights for each participant. After consent, the instruments were applied. For the best comfort of the volunteers, they were directed to a reserved room free of noise or circulating people, in which it was possible to establish a bond of trust with the investor through confidentiality. In the face of the emotions presented, the researcher can systematically exercise the impersonal stance, so as not to interfere with the flow of the interview and exercise impartiality according to the ethical and moral precepts regarding the type of research presented here.

Statistics and ethical aspects: The data were tabulated and analyzed descriptively, in absolute and relative frequency of the variables of interest, then organized in an Excel spreadsheet version Microsoft Windows XP and then imported into the Statistical Package for the Social Sciences - SPSS, version 20.0. Continuous variables with normal distribution were compared using Analysis of Variance (ANOVA) and non-parametric variables, using the Kruskal-Wallis test, calculating their means and standard deviations. The level of significance adopted for all statistical tests will be 5% ($p < 0.05$). The work was approved by the ethics committee with research involving human beings from the University of International Integration of Afro-Brazilian Lusophony (CEP / UNILAB) according to the present CAAE protocol: 46370615.3.0000.5576 and Opinion No. 1,366,101, obeying resolution 466/12 National Health Council regarding the autonomy and freedom of the subjects involved.

RESULTS

Based on the findings, it was notorious to notice that there were significant data regarding the presence of depressive traces in the individuals investigated in the different institutions. Thus, in the CRAS, among the elderly, 44 (83%) were female and only 09 (17%) male.

Table 1. Sociodemographic data of the elderly at the Reference and Social Assistance Center in Redenção and Acarape, Ceará in 2016

Variable	(n)*	(%)**
CRAS identification		
Reference and Social Assistance Center – Acarape	31	58,5
Reference and Social Assistance Center – Redenção	22	41,5
CRAS Registration Period		
0 to 60 months	30	56,6
121 to 180 months	12	22,6
61 to 120 months	11	20,8
Gender of volunteers		
Feminine	44	83,0
Male	9	17,0
Age of Volunteers		
65 to 69 years	34	64,2
70 to 79 years	17	32,1
> = to 80	2	3,8
Volunteer Color		
Not White	43	81,1
White	10	18,9
Volunteer education level		
Elementary School	36	67,9
Illiterate	10	18,9
High school	7	13,2
Volunteer marital status		
With companion	27	50,9
No companion	26	49,1
Volunteer coexistence		
Not alone	46	86,8
Alone	7	13,2
Voluntary income source		
Fixed income	44	83,0
Non-fixed income	9	17,0
Volunteer occupation		
Retired	30	56,6
Self-employed	12	22,6
Employee	11	20,8
Volunteer religion		
Catholic	50	94,3
Evangelical	3	5,7
Volunteer housing infrastructure		
Complete infrastructure	27	50,9
Incomplete infrastructure	26	49,1
History of chronic and psychological illnesses in the volunteer's family		
Yes	34	64,2
No	19	35,8
Family history of physical or mental illness		
No	24	45,3
Yes	20	37,7
Do not remember	9	17,0
Have any disease		
Yes	39	73,6
No	14	26,4
Type of illness of volunteer		
Chronic	34	64,2
Does not have	14	26,4
Not chronic	5	9,4
Follow up		
Yes	40	75,5
No	13	24,5
Make use of medication		
Yes	35	66,0
No	18	34,0
Type of medication use		
Medication does not continue	51	96,2
Medication continues	2	3,8
Uses psychotropic medications		
No	51	96,2
Yes	2	3,8
The volunteer is sedentary		
No	53	100,0
Yes	0	0
The volunteer is obese		
No	49	92,5
Yes	4	7,5
The volunteer is a smoker		
Yes	3	5,7
No	49	92,5
Physical active practice		
Yes	32	60,4
No	21	39,6
Type of physical activity		
With guidance	47	88,7
Without guidance	6	11,3

* (n) Sample, ** (%) numerical percentage.

The predominant age group was 65 to 69 years old with 34 (64.2%), followed by 17 (32.19%) between 70 and 79 years old and 2 (3.8%) with ≥ 80 years old. More than two thirds of the elderly (67.9%) had completed elementary school and the illiterate account for 10 (18.8%). Another 7 elderly (13.3%) had completed high school (Table 1).

Table 2 - Sociodemographic data of the elderly at the Basic Health Unit Headquarters I and II in Redenção, Ceará, in 2017

Variable	(n)*	(%)**
Registration Unit		
PSF Dr. Dilberto Prata Mota SEDE I	36	69,2
PSF Dr. Dilberto Prata Mota SEDE II	16	30,8
Follow-up period (in months)		
0 to 60 months	11	21,2
61 to 120 months	18	34,6
121 to 180 months	14	26,9
More than 180 months	9	17,3
Sex		
Male	15	28,8
Feminine	37	71,2
Age		
65 to 69 years	25	48,1
70 to 79 years	17	32,7
Over 80 years	10	19,2
Self-referenced color		
White	15	28,8
Not White	37	71,2
Education		
Illiterate	18	34,6
High school	3	5,8
Fundamental	31	59,6
Marital status		
Married	29	55,8
Divorced	2	3,8
Others	2	3,8
Not married	3	5,8
Widower	16	30,8
Monthly family income		
1 to 2 salaries	51	98,1
more than 3 salaries	1	1,9
Who do you live with		
Not alone	45	86,5
Alone	7	13,5
Source of income		
fixed income	49	94,2
non-fixed income	3	5,8
Occupation		
Retired	49	94,2
Self-employed	2	3,8
Employee	1	1,9
Religion		
Catholic	43	82,7
Evangelical	6	11,5
Others	3	5,8
Housing conditions		
Complete Infrastructure	19	36,5
Incomplete Infrastructure	33	63,5
History of chronic diseases and history of psychiatric disorders		
Yes	52	100,0
History of chronic diseases and history of psychiatric disorders		
Diabetes	1	1,9
Hypertension	28	53,8
Hypertension, Diabetes	16	30,8
Hypertension, Diabetes, Other	5	9,6
Hypertension, Other	2	3,8
Family history of physical or mental illness		
No	18	34,6
Yes	34	65,4
Family history of physical or mental illness		
Diabetes	7	13,5
Hypertension	17	32,7
Hypertension, Diabetes	7	13,5
Hypertension, Other	1	1,9
Others	2	3,8
Has a disease		
Yes	52	100,0

Do you have a disease? What type?		
Chronic	50	96,2
Chronic, not chronic	2	3,8
Make use of medication		
Yes	52	100,0
Do you use medication? What type?		
Medication continues	51	98,1
Continuous medication, psychotropic	1	1,9
The volunteer is sedentary		
No	36	69,2
Yes	16	30,8
The volunteer is obese		
No	39	75,0
Yes	13	25,0
The volunteer is a smoker		
Ex-smoker	18	34,6
No	32	61,5
Yes	2	3,8
The volunteer is an alcoholic		
Ex-alcoholic	13	25,0
No	38	73,1
Yes	1	1,9
Do you practice physical activity?		
No	28	53,8
Yes	24	46,2
What physical activity do you practice		
Activity without guidance	2	3,8
Activity under guidance	7	13,5
Walking	9	17,3
Walking, Activity without guidance	1	1,9
Walking, Activity under guidance	3	5,8
Dance	1	1,9
Dancing, Walking	1	1,9

* (n) Sample, ** (%) numerical percentage.

Regarding marital status, just over half had a partner 27 (50.9%) and 26 (49.1%) did not have it as shown in Table 1. In this regard, although the degree was identified, it was sought to define in the data tabulation the presence or absence of partners, considering that the presence or absence of a company could have a differential in the quality of life of this specific public. As for spirituality, 100% of the sample declared to have religion, with almost 50 (94.3%) declaring themselves Catholic and 3 (5.7%) evangelicals. It should be noted in this regard that the variable of importance used was whether or not to have a religion, not giving much focus to their specificity. Regarding the data related to the history of morbidities, it was found that 39 elderly (73.6%) had some definite chronic disease and 14 elderly (26.4%) reported not having this type of pathology (Table 1). Regarding the research carried out at the Basic Health Unit, it can be seen that the number of volunteers differs considerably between the two units, so that Headquarters I had 36 volunteers (69.2%) while Headquarters II with 16 participants (30.8%), justification for the days of attendance according to institutional routine for consultations of hypertensive and diabetic patients, since Unit II reserves two days a week for this public, while I has only one day for this attendance. The observed follow-up period was 11 with 0 to 60 months (21.2%), 18 from 61 to 120 months (34.6%), 14 from 121 to 180 months (26.9%) and 9 with more than 180 months of follow-up (17.3%) according to Table 2. The age of the volunteers was measured in classes, in which 25 (48.1%) elderly people were between 65 and 69 years old, 17 (32.7%) between 70 and 79 years old and 10 (19.2%) over 80 years old. Regarding the users' sex, 37 (71.2%) and 15 (28.8%) elderly men were prevalent. Most volunteers (31) replied that they attended elementary school, that is, 59.6% of respondents, while 18 (34.6%) were illiterate, and only 3 (5.8%) finished high school (Table 2). All respondents had a religion that is distributed among 43 Catholics (82.7%), 6 Evangelicals

(11.5%), in addition to 3 (5.8%) who did not specify. It was observed that the majority of the elderly were married 55.8% (29), followed by widowers 30.8% (16), 5.8% single (3), divorced and others with 3.8% both (2). These data can be justified by the fact that the majority of the sample did not live alone (86.5%) with 45 reports and only 7 lived without family members or caregivers (13.5%) as shown in Table 2. All participants have a history of chronic illnesses or psychological changes and, fitting the inclusion criteria. Two volunteers also mentioned having a non-chronic disease. The distribution resulted in the following frequencies: 1.9% with diabetes (1), 53.8% have hypertension (28), 30.8% have hypertension and diabetes (16), 9.6% hypertension, diabetes and others (5), 3.8% hypertension and other manifestations (2). All 52 volunteers also used continuous medication and only 1, psychotropic drugs (Table 2). With regard to family history of physical or mental illnesses, 34 (65.4%) claim to have cases in the family and 18 (34.6%) had no family members with physical or mental impairments. Of those who responded positively to the previous statement, it was possible to obtain the following percentages: 13.5% diabetes (7), 32.7% Hypertension (17), 13.5% hypertension and diabetes (7), 1.9% hypertension and others (1), 3.8% Others (2) shown in Table 2. Table 3 describes the final results of the CES-D cut-off score applied to the CRAS of Redenção and Acarape, in which we obtained a percentage of 8 participants who did not show a trace of depression (15.1%), 37 with presence and 8 fits already in the occurrence of depressive symptoms already present. Based on the descriptive analysis, it presented an average (M) of 21.6 with a standard deviation (SD) of 5.55 (established $P < 0.05$) and variance of 2. As interpreted in the data, a percentage greater than 50% of the sample presented depressive symptoms (69.8%), followed by 15.1%, with a cut-off score above 40, labeled in this study with depression already occurring.

Table 3. Cut-off score on the CES-D scale of the elderly referring to the Reference and Social Assistance Center of Redenção and Acarape, Ceará in 2016

Parameters	(n)*	%	(m)**	(sd)***
With trace of depression	37	69,8		
No trace of depression	8	15,1	21,6	5,55
Occurrence of advanced depressive symptoms	8	15,1		
Total	53			

* (n) Sample. ** (m) Weighted average. *** (sd) Standard deviation ($P < 0.05$).

As for the CES-D cut-off score in the elderly who attended the BHU in the Headquarters I and II teams, Table 4 shows that 19 elderly (36.5%) do not have symptoms of depression, 12 (23.1%) with traces and 21 with symptomatology already installed. The average of the samples was 19.62 and the standard deviation was 8.85. These data, interpreted according to the severity of the depression, using the cutoff points: less than 15, without symptoms of depression; between 15 to 21, with traces, and greater than 21 with symptoms.

Table 4. Cut-off score of the CES-D scale of the elderly referring to the Basic Health Units in Redenção, Ceará in 2017

Parameters	(n)*	%*	(m)**	(sd)***
With traces of depression	12	36,5		
No traces of depression	19	23,1	19,62	8,85
Occurrence of advanced depressive symptoms	21	40,4		
Total	52			

* (n) Sample. ** (m) Weighted average. *** (sd) Standard deviation ($P < 0.05$).

Performing another frequency, it was found that 59.6% had significant depressive symptoms while 40.4% did not. That is, in more than 50% of the sample, significant depressive symptoms are present.

DISCUSSION

The purpose of the study is to compare the occurrence of depressive symptoms in different social institutions, primarily in the elderly who actively attended some type of activity in these establishments. Thus, it is possible to investigate before the variables presented relevant points that guide the reasons or factors that trigger the pathology in question. In this approach, depression, as it is considered a subjective disease, tends to be masked or underreported, especially in the elderly person, who already has a series of weaknesses related both to old age and to being affected by morbidities. Then, attention is focused on predisposing factors, including within the family environment itself, which in more severe cases may imply suicidal behavior (BARROSO et al., 2018). Still in this perspective, in this study it was observed that most of the elderly who attend social institutions were female, showing a certain resistance of the male portion. Therefore, similar studies with the same characteristics present a percentage difference between the sexes of around 15% variation (NOGUEIRA et al., 2014), so that an inferential comparison cannot be made regarding this disproportion, since male absenteeism can be misleading. However, it evidences a panorama of the lack of this public in health care services. Regarding the age group, there was a higher prevalence around 65 to 69 years in both institutional modalities, as it demonstrates a greater interest of these individuals in the beginning of the third age, in which it corroborates for an earlier health monitoring, with a good part related to physical illnesses. In this perspective, the quality of services must promote quality care, not only with regard to physical care, but also with mental health, including the continuous screening of psychopathologies (ANDRADE et al., 2020).

Another factor that deserves attention was the education variable, which presented a significant percentage in relation to complete fundamental education, both in the elderly from CRAS (67.9%) and from UBS (59.6%). In this regard, there is a close relationship in the level of education and the involvement of depressive symptoms, since the acquisition of knowledge about this disease allows a more effective screening, as the individual acquires the ability to distinguish their disorders. Based on the above, research shows that in Brazil there is still a low level of education among the elderly population, indicating a percentage of 4 to 7 years of study (39.2%), which is still quite reduced in view of the educational advances of the country (MOLINA et al., 2020). In this way, education comes as a contribution tool in the self-care of the geriatric patient, walking with the professional in the diagnosis and screening. Perhaps, it was also found that most of the sample had a partner, with 50.9% in the CRAS and 55.8% in the UBS. It is undeniable to mention that the company in the third age has a fundamental emphasis on quality of life, so that there is a better predisposition for sentimental support and sharing of emotions. Contrary to our study, another pointed out that in an investigated population, 37.5% were widowed and were more subject to depressive vulnerability, a justification that is correlated with grief and lack of interest on the part of family members and caregivers in treating it as a natural process (OLIVEIRA et al., 2020), subduing as a reflex in the

senile phase. In addition, when drawing a parallel with beliefs and spirituality, 100% in both categories of participants had religion, with subclassification in Catholics (94.3%), Evangelicals (5.7%) in CRAS, and Catholics (82, 7%), evangelicals (11.5%) and others (5.8%) at UBS, exposing a very similar amount. In this context, religiosity brings a series of meanings, especially that of coping with problems that arise in the course of life, in the elderly it is no different, as the practice becomes routine in these adepts as a point of support in those affected by chronic pathologies. such as diabetes mellitus and systemic arterial hypertension (COSTA & HUMBOLDT, 2020). Regarding the commitment for Chronic Noncommunicable Diseases (NCDs), at CRAS there was a percentage of 73.6%, while at UBS 100%, that fit in this item for the reason that the time of the approach coincided with the consultation days, mainly in the clinical picture of Systemic Arterial Hypertension and Diabetes Mellitus. In addition, one of the factors triggered by depressive symptoms can be related to the onset of this type of disease, in order to make it an obstacle in certain cases in the performance of daily tasks or sudden changes in lifestyle. Thus, a study carried out in southern Brazil shows a prevalence of 39.1% in the elderly approached (CORRÊA et al., 2020), classified with the same clinical condition, that is, the non-acceptance of morbidities could imply the lack of interest for continuous treatments and consequently a feeling of helplessness. Regarding the use of psychotropic drugs, there was a discrepancy in the values, in which 51 volunteers in the CRAS said they used it continuously, whereas in the UBS only 1 participant claimed to use it. It is clearly seen before the parameters that there is a related factor, whether they are linked to the assistance of the Basic Health Unit or the omission of response due to embarrassment. Most of this type of medication is intended for the treatment of psychopathologies, with prescription in the last case of uncontrolled disorders, which is seen as a prejudice against the social view. Parallel to our study, another study carried out at a Long Term Care Institution for the Elderly (ILPI) pointed out that 54.6% used it inappropriately with a prohibited indication for this specific public (MOREIRA et al., 2020), which makes dependency a crucial factor in the quality of life of these patients.

With regard to building a parallel with the main axis of this research, Table 3 shows a cut-off score for CES-D applied in CRAS with 69.8% (SD, 555) of elderly people with vestiges of depressive symptoms, in comparison with the UBS with a lower index of around 35.6% (SD, 885) of the interviewees as shown in Table 4. Similar results were found when comparing the relationship of social support and the appearance of traces (SD, 110), with 43.7% of the affected sample (SOUZA et al., 2017). Another survey carried out in a reference center in Minas Gerais obtained a percentage of 56.8% of elderly people with major depressive disorder (MARQUES et al., 2017), which translates into worrying results by regulars who do not show any sign outside psychometric analysis. On the other hand, it is also worth mentioning the female predominance in most studies on this theme, as was the case in Porto Alegre in Rio Grande do Sul, where there is a 35.5% prevalence of depressive symptoms in the studied elderly group (DP, 388), with a notorious predominance in women up to 69 years old (STAHNKE et al., 2020), showing similarity in this point with the study in question. Still in this context, a high score on the applied scale also prevailed, classified as occurrence of depressive symptoms already advanced, in a quantity of 15.1% in the participants of the Reference Center and higher in the

Basic Unit with 40.4%. In principle, regarding the latter, an increase in this parameter was noticeable in relation to the traces in relation to the depression already installed. In this process, it is important to note that this type of geriatric disorder is very present in Primary Care, as was the case with the results found in Maringá in Paraná, but using a more specific instrument called the Geriatric Depression Scale or the English Geriatric Depression Scale (GDS) in which 654 elderly people were affected (OLIVEIRA et al., 2017). In short, there was a higher prevalence of traces in the volunteers of the Reference and Psychosocial Assistance Center, however, it was also possible to notice symptoms already present in those who attended the Basic Health Unit. Thus, some peculiarities may be related, from the institutional functioning until the specificity of each individual house. Substantially, in the professional axis, adequate training is needed regarding the investigation of mental illness in the elderly, who are so underreported by health services and invisible to those affected by the lack of signs.

Conclusion

Therefore, the prevalence of depressive symptoms in the elderly who attend social institutions is a reality, especially in the interior of Ceará as shown in this study. In these parameters, there were greater traces in the Reference and Social Assistance Center and symptoms already classified in the Basic Health Unit. In addition, the study also guides about underreporting regarding this type of psychopathology, which makes the elderly part more vulnerable in the face of conditions and lifestyle. On the other hand, psychometric scales are still an effective tool when providing quality care, as well as investigating signs that evidence these types of disorders. Thus, the realization of new studies involving the theme enables better professional training in order to meet the needs of the geriatric public, and consequently the improvement of investigative technologies.

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