ABSTRACT: The aim was to assess the self-esteem of community-based elderly and verify its association
with socio-demographic and health variables. The epidemiological survey was held in the urban region of Uberaba,
a city in the state of Minas Gerais, with 980 elderly people. The Rosenberg Self-Esteem, Katz, Lawton and Short
Geriatric Depression Scales were used and, for descriptive analysis, the Mann-Whitney and Kruskal-Wallis tests,
Spearman’s correlation and multiple linear regression were used (p<0.05). The data were collected between
August 2012 and March 2013. The female gender was predominant, 70-80 years, married, income one minimum
wage, between four and seven years of education, who lived with their children. The median number of illnesses
was five. The median self-esteem score was ten. The predictors of worse levels of self-esteem were higher age
(p<0.01), lower education (\(p=0.021\)) and signs of depression (\(p<0.001\)). The community-based elderly presented
high self-esteem and signs of depression were the main predictor of low self-esteem.

DESCRIPTORS: Self-esteem; Aged; Elderly health care; Geriatric nursing.

SELF-ESTEEM OF COMMUNITY-BASED ELDERLY AND ASSOCIATED FACTORS: A
POPULATION-BASED STUDY*

Michelle Couto Salerno1, Alison Fernandes Bolina2, Flavia Aparecida Dias3, Nayara Paula Fernandes Martins1, Darlene Mara
dos Santos Tavares4

1Nursing Undergraduate. Universidade Federal do Triângulo Mineiro. Uberaba, MG, Brazil.
2RN. Ph.D. Candidate in Nursing. University of São Paulo. Ribeirão Preto, SP, Brazil.
3RN. Ph.D. Candidate in Health Care. Universidade Federal do Triângulo Mineiro. Uberaba, MG, Brazil.
4RN. Ph.D. in Nursing. Faculty at Universidade Federal do Triângulo Mineiro. Uberaba, MG, Brazil.

RESUMO: Objetivou-se avaliar autoestima de idosos comunitários e verificar sua associação com variáveis
sociodemográficas e de saúde. O inquérito epidemiológico ocorreu na zona urbana de Uberaba, estado de Minas Gerais,
no qual participaram 980 idosos. Utilizaram-se Escalas de Autoestima de Rosenberg, Katz, Lawton e Depressão
Geriátrica Abreviada e análise descritiva com testes de Mann Whitney, Kruskal Wallis, correlação de Spearman e regressão
linear múltipla (p<0.05). A coleta de dados ocorreu entre agosto de 2012 e março de 2013. Predominou o sexo
feminino, 70-80 anos, casados, renda de um salário mínimo, quatro a sete anos de estudo, que moravam com filhos. A
mediana foi de cinco doenças. Os escores de autoestima apresentaram mediana de 10. Os preditores dos piores
níveis de autoestima foram maior idade (p<0.01), menor escolaridade (p=0.021) e indicativo de depressão (p<0.001).
Os idosos comunitários apresentaram elevada autoestima e o indicativo de depressão foi o preditor principal da baixa
autoestima.

DESCRITORES: Autoestima; Idoso; Atenção à saúde do idoso; Enfermagem geriátrica.

REGISTRO DE IDOSOS COMUNITÁRIOS E FATORES ASSOCIADOS: ESTUDO DE BASE POPULACIONAL

RESUMEN: Estudio cuyo objetivo fue evaluar la autoestima de ancianos comunitarios y verificar su asociación con
variables sociodemográficas y de salud. La investigación epidemiológica ocurrió en la zona urbana de Uberaba,
estado de Minas Gerais. Participaron 980 ancianos. Fueron utilizadas Escalas de Autoestima de Rosenberg, Katz,
Lawton Depresión Geriátrica Abreviada y análisis descritivo con testes de Mann Whitney, Kruskal Wallis, correlación de Spearman y regresión linear múltipla (p<0.05). Los datos fueron obtenidos entre agosto de 2012 y marzo de 2013. Fueron predominantes el sexo femenino, 70-80 años, casados, renta de un salario mínimo, cuatro a siete años de estudio, que vivían con hijos. La mediana fue de cinco enfermedades. Los scores de autoestima presentaron mediana de 10. Los preditores de los peores niveles de autoestima fueron mayor edad (p<0.01), menor escolaridad (p=0.021) e indicativo de depresión (p<0.001). Los ancianos comunitarios presentaron elevada autoestima y el indicativo de depresión fue el preditor principal de la baja autoestima.

DESCRITORES: Autoestima; Anciano; Atención a la salud del anciano; Enfermería geriátrica.

INTRODUCTION

Self-esteem can be defined as “the feeling, appreciation and consideration a person feels for him/herself, that is, how much that person likes him/herself, sees him/herself and what (s)he thinks about him/herself”\(^{(1,48)}\). These feelings are constructed in the course of life according to the experiences gained\(^{(2)}\).

In the elderly population, the situations of dislike and rejection in the family and social sphere further the development of low self-esteem. In addition, the physical, psychological, social and environmental limitations advanced age entails can contribute to this condition\(^{(3)}\). Nevertheless, the elderly can develop strategies to improve their self-esteem, like the valuation of the positive aspects of aging for example, as well as the knowledge gained over the years\(^{(4)}\).

A Brazilian study found high self-esteem among elderly who attended a Comprehensive Health Care Center (Md=36)\(^{(5)}\). In another study, self-esteem was associated with positive perceived health (p=0.003) and male elderly aged 70 years and older obtained a higher average than elderly between 60 and 69 years of age (p=0.04). No relation was observed between self-esteem and marital status (p=0.590), education (p=0.316), sex (p=0.352) and income (p=0.602)\(^{(2)}\).

An international research of community-based elderly found that the home arrangement was associated with self-esteem; people who lived with their family had higher levels of self-esteem when compared to people who lived alone (p<0.001)\(^{(6)}\). In addition, the scientific literature has suggested that depression, the number of illnesses and functional disability negatively affect self-esteem\(^{(2,7)}\).

Nevertheless, Brazilian surveys on the theme were developed with elderly populations who attended community centers\(^{(2,5)}\). This fact can contribute to the high self-esteem in the findings, as a result of socialization possibilities. In this perspective, the need to get deeper into this theme among Brazilian community-based elderly is observed, through population-based epidemiological studies.

Considering that self-esteem is a feeling that helps to overcome the physical, psychological and social limitations deriving from the advancement of age\(^{(3)}\), identifying the aspects related to this condition in the community-based elderly can provide support to primary health care professionals in order to plan the health promotion process, with a view to healthy aging.

Hence, the objective was to assess the self-esteem scores of community-based elderly and verify their association with the socio-demographic and health variables.

METHOD

An epidemiological, population-based study with a cross-sectional, observational and analytic design was undertaken in the urban region of a city in the interior of Minas Gerais.

To calculate the sampling population, the confidence level considered was 95\%, test power 80\%, error margin 4\% for estimated intervals and an estimated proportion of \(\pi=0.5\) for the proportions of interest. The researchers departed from a sample of 2,149 elderly.

The inclusion criteria were: age 60 years or older; without cognitive decline and living in the urban region of Uberaba, a city in the state of Minas Gerais. In total, 980 elderly complied with the inclusion criteria, while those who refused to participate in the study (37), were hospitalized (14), died (266), were not found after three consecutive visits (183), changed address (193) or other reasons (316) were excluded. It is highlighted that 160 elderly presented cognitive decline.

The data were collected at the elderly people’s homes between August 2012 and March 2013. To characterize the socio-economic and demographic and health data, a structured tool was used, constructed by the Collective Health Research Group.

To measure the self-esteem, the Rosenberg Self-Esteem Scale was used\(^{(1)}\), which contains ten randomly distributed items. Each item is scored between zero and three. When adding up all questions, the sum ranges between 0 and 30 points\(^{(1)}\), the lowest scores being associated with high self-esteem and 30 points with the lowest self-esteem.

To assess the functional ability, the version of the Katz (1963) and Lawton (1969) scales validated in Brazil were used\(^{(8,9)}\). The modified Katz scale consists of six objective questions that investigate the Basic Activities of Daily Living (BADL). For each investigated task, alternatives are offered, that is, whether the elderly accomplish the task independently or not. Each positive answer
is equivalent to one point, so that, at the end, the elderly are classified as independent for BADL when they reach 5-6 points; moderately dependent, 3-4; and important dependence, 0-2\(^{(8)}\).

The Lawton scale consists of nine Instrumental Activities of Daily Living (IADL). For each question there are three alternatives: performs without help (3 points), performs with partial help (2 points), is unable (1 point). The maximum score is 27, with the following functional classification: 27 to 19 points, considered independent; between 18 and 10 partially dependent; and inferior to nine dependent\(^{(9)}\).

To assess the signs of depression, the Short Geriatric Depression Scale was used, adapted to the reality in Brazil\(^{(10)}\). This scale consists of 15 objective questions; scores superior to five are considered positive for signs of depression\(^{(10)}\).

The research variables were: sex; age range, in years (60\(\leq\)70, 70\(\leq\)80 and 80 or more); marital status (never married or lived with partner; lives with husband/wife or partner; widowed; separated or divorced; education, in years of study (no education, 1\(\leq\)4, 4\(\leq\)8, 9\(\leq\)11, \(\geq\)11); monthly individual income in minimum wages (no income,\(<\)1, 1\(\leq\)3, 3\(\leq\)5, \(>\)5); housing arrangement (lives alone, with professional caregiver, with partner only, with another person of same generation, with children, grandchildren, other arrangements), number of illnesses (1\(\leq\)4, 4\(\leq\)6, \(\geq\)6), functional ability in BADL (bathing, dressing, personal hygiene, transferring, toileting and feeding) and IADL (telephone, shopping, managing finances, preparing one's own meals, cleaning, doing housework, washing and ironing, taking medication correctly and getting beyond walking distance using transportation), number of illnesses (1\(\leq\)4, 4\(\leq\)6, \(\geq\)6), self-perceived health (very bad, bad, regular, good, excellent) and signs of depression (yes, no).

An electronic worksheet was constructed in Excel\(^{®}\). The collected data were processed in two databases, which were submitted to consistency analysis. In case of inconsistencies, the researchers returned to the original collection form for correction. Next, the data were transported to the software Statistical Package for Social Sciences (SPSS) version 17.0 for analyses.

Descriptive analysis was applied through absolute and percentage frequency distribution. To verify the factors associated with self-esteem, preliminary bivariate analysis was used. The nominal variables were recategorized and were made dichotomous: marital status (without or with partner), income (without or with), domestic arrangement (lives alone or not), signs of depression (yes and no) and functional disability for BADL (yes or no) and IADL (yes and no). The self-perceived health was also recategorized (very bad-bad, regular, good-excellent). The normality of the data was verified using the Kolmogorov-Smirnov test. The tests used were Mann-Whitney, Kruskal-Wallis and Spearman correlation. Variables with \(p<0.1\) were included in the multivariate model using multiple linear regression. In this model, statistical significance was set at \(p<0.05\).

Approval for the study was obtained from the Ethics Committee for Research Involving Human Beings at Universidade Federal do Triângulo Mineiro, under protocol No. 2.265. The elderly signed the Informed Consent Form before their data were collected.

RESULTS

Most of the elderly (n=980) were female (64.3%); aged 70\(\leq\)80 years (50%); married (42.6%) followed by widow(er)s (42%); 4\(\leq\)8 years of education (34.5%), monthly individual income of one minimum wage (50.2%) and lived with their children (35.1%).

Table 1 displays the socio-demographic and economic characteristics of the study population. Independent elderly prevailed in all BADL (95.8%). The activities with the highest percentage of dependent elderly were toileting (3%) and bathing (1.5%).

In the IADL, partially dependent elderly prevailed (69.6%); higher percentages of dependent elderly were found for the following activities: trips (28%) and housework (19.1%).

Most of the elderly presented good self-perceived health (40.8%), followed by regular (40.2%), signs of depression represented 25.6%. Table 2 below displays the health characteristics of the research population.

The median number of associated diseases was five, ranging between zero and 17. The median self-esteem score was ten, considered high, ranging from zero to 24.

To verify the factors associated with self-esteem, initially, bivariate analysis was applied. The variables that complied with the criterion established (\(p<0.1\)) were inserted in the multiple
Table 1 – Frequency distribution of socio-demographic and economic variables of the elderly. Uberaba, MG, Brazil, 2013

<table>
<thead>
<tr>
<th>Variables</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>630</td>
<td>64.3</td>
</tr>
<tr>
<td>Male</td>
<td>350</td>
<td>35.7</td>
</tr>
<tr>
<td>Age range (in years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>60-70</td>
<td>283</td>
<td>28.9</td>
</tr>
<tr>
<td>70-80</td>
<td>490</td>
<td>50</td>
</tr>
<tr>
<td>80 years or older</td>
<td>207</td>
<td>21.1</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has never married or lived with a partner</td>
<td>48</td>
<td>4.9</td>
</tr>
<tr>
<td>Lives with a partner</td>
<td>417</td>
<td>42.6</td>
</tr>
<tr>
<td>Widowed</td>
<td>412</td>
<td>42</td>
</tr>
<tr>
<td>Separated/divorced</td>
<td>103</td>
<td>10.5</td>
</tr>
<tr>
<td>Education (in years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No education</td>
<td>212</td>
<td>21.6</td>
</tr>
<tr>
<td>1-4</td>
<td>274</td>
<td>28</td>
</tr>
<tr>
<td>4-8</td>
<td>338</td>
<td>34.5</td>
</tr>
<tr>
<td>8</td>
<td>48</td>
<td>4.9</td>
</tr>
<tr>
<td>9-11</td>
<td>25</td>
<td>2.6</td>
</tr>
<tr>
<td>11 or more</td>
<td>83</td>
<td>8.5</td>
</tr>
<tr>
<td>Individual income (in minimum wages)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No income</td>
<td>82</td>
<td>8.4</td>
</tr>
<tr>
<td>&lt; 1</td>
<td>15</td>
<td>1.5</td>
</tr>
<tr>
<td>1</td>
<td>492</td>
<td>50.2</td>
</tr>
<tr>
<td>1-3</td>
<td>310</td>
<td>31.6</td>
</tr>
<tr>
<td>3-5</td>
<td>48</td>
<td>4.9</td>
</tr>
<tr>
<td>&gt; 5</td>
<td>30</td>
<td>3.1</td>
</tr>
<tr>
<td>Did not answer</td>
<td>3</td>
<td>0.3</td>
</tr>
<tr>
<td>Housing Arrangement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alone</td>
<td>181</td>
<td>18.5</td>
</tr>
<tr>
<td>With professional caregiver only</td>
<td>4</td>
<td>0.4</td>
</tr>
<tr>
<td>With partner only</td>
<td>221</td>
<td>22.6</td>
</tr>
<tr>
<td>With others of same generation (with or without partner)</td>
<td>83</td>
<td>8.5</td>
</tr>
<tr>
<td>With children (with or without partner)</td>
<td>344</td>
<td>35.1</td>
</tr>
<tr>
<td>With grandchildren (with or without partner)</td>
<td>76</td>
<td>7.8</td>
</tr>
<tr>
<td>Other arrangements</td>
<td>70</td>
<td>7.1</td>
</tr>
<tr>
<td>Did not answer</td>
<td>1</td>
<td>0.1</td>
</tr>
</tbody>
</table>

Table 2 – Frequency distribution of the elderly participants’ health variables. Uberaba, MG, Brazil, 2013

<table>
<thead>
<tr>
<th>Variables</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>BADL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Independence for all six functions</td>
<td>939</td>
<td>95.8</td>
</tr>
<tr>
<td>Dependence for at least one function</td>
<td>41</td>
<td>4.2</td>
</tr>
<tr>
<td>IADL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complete dependence</td>
<td>6</td>
<td>0.6</td>
</tr>
<tr>
<td>Partial dependence</td>
<td>682</td>
<td>69.6</td>
</tr>
<tr>
<td>Independent</td>
<td>292</td>
<td>29.8</td>
</tr>
<tr>
<td>Self-perceived health*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very bad</td>
<td>28</td>
<td>2.9</td>
</tr>
<tr>
<td>Bad</td>
<td>56</td>
<td>5.7</td>
</tr>
<tr>
<td>Regular</td>
<td>394</td>
<td>40.2</td>
</tr>
<tr>
<td>Good</td>
<td>400</td>
<td>40.8</td>
</tr>
<tr>
<td>Very good</td>
<td>101</td>
<td>10.3</td>
</tr>
<tr>
<td>Signs of depression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>251</td>
<td>25.6</td>
</tr>
<tr>
<td>No</td>
<td>729</td>
<td>74.4</td>
</tr>
</tbody>
</table>

* Did not answer 0.1%.

Table 3 – Regression Model of factors associated with self-esteem of elderly people. Uberaba, MG, Brazil, 2013

<table>
<thead>
<tr>
<th>Variables</th>
<th>Initial Model</th>
<th>Final Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Variables</td>
<td>β</td>
<td>p</td>
</tr>
<tr>
<td>Female gender</td>
<td>0.035</td>
<td>0.254</td>
</tr>
<tr>
<td>Age</td>
<td>0.067</td>
<td>0.024</td>
</tr>
<tr>
<td>Absence of partner</td>
<td>0.005</td>
<td>0.871</td>
</tr>
<tr>
<td>Absence of education</td>
<td>-0.063</td>
<td>0.027</td>
</tr>
<tr>
<td>Absence of income</td>
<td>0.011</td>
<td>0.685</td>
</tr>
<tr>
<td>Functional disability for BADL</td>
<td>0.055</td>
<td>0.056</td>
</tr>
<tr>
<td>Functional disability for IADL</td>
<td>0.006</td>
<td>0.643</td>
</tr>
<tr>
<td>Presence of signs of depression</td>
<td>-0.395</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Self-perceived health (very bad/bad)</td>
<td>0.092</td>
<td>0.004</td>
</tr>
<tr>
<td>Self-perceived health (regular)</td>
<td>0.117</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Number of diseases</td>
<td>0.022</td>
<td>0.482</td>
</tr>
</tbody>
</table>
linear regression model: sex (Z=-2.357; \( p=0.0180 \))
age (\( r=0.113; \ p<0.001 \)), marital status (\( \beta=2.526; \ p=0.012 \)),
education (\( r=-0.114; \ p<0.001 \)), income 
(\( \beta=-2.344; \ p=0.019 \)), functional ability for BADL 
(\( \beta=-4.938; \ p<0.001 \)) and IADL 
(\( \beta=-2.769; \ p=0.006 \)),
signs of depression (\( Z=-16.364; \ p<0.001 \))
and number of 
diseases (\( r=-0.194; \ p<0.001 \)).

Table 3 below displays the multivariate linear 
regression analysis of the factors associated 
with self-esteem among the elderly in the city of 
Uberaba, 2013.

In the multivariate analysis, the predictors 
of worse levels of self-esteem were: higher 
age (\( \beta=0.07; \ p<0.01 \)), lower education (\( \beta=-0.065; \ p=0.021 \)), presence of signs of depression (\( \beta=-0.407; \ p<0.001 \)) and very bad-bad 
(\( \beta=0.0110; \ p<0.001 \)) 
and regular self-perceived health (\( \beta=0.0120; \ p<0.001 \)).
Signs of depression were the main predictor of 
worse self-esteem.

DISCUSSION

Most women in this study reflect the Brazilian 
data (55.7%), which may be related with the higher 
mortality rates among men\(^{11}\). On the other hand,
the results evidenced with regard to the age range 
diverge from Brazilian findings in which 55.5% of 
all elderly were 60–70 years\(^{(1)}\). This divergence 
can be related with the fact that the Research 
Group in Collective health has monitored the 
population in this study since 2005.

The predominance of married elderly was 
similar to a survey undertaken in São Paulo-SP, in 
which 58.9% of the elderly lived with a partner\(^{(12)}\). 
The percentage of widow(er)s also supports a 
study of elderly users of the public health network 
in Natal-RN (40%)\(^{(3)}\).

In Brazil, the predominant domestic 
arrangement has been elderly living with 
their children (30.7%)\(^{(11)}\), similar to the present 
research. Brazilian estimates also supported the 
findings on the monthly individual income, in 
which most elderly (38.6%) received between 
half and one minimum wage\(^{(11)}\); at the time of the 
data collection, the minimum wage amounted to 
R$678.00\(^{(33)}\).

As regards the health characteristics of the 
research population, the higher percentage of 
dependent elderly for BADL is in line with a 
study undertaken among elderly from Lafaiete 
Coutinho-BA, in which the following prevailed: 
sphincter control (8.5%), mainly urinary
incontinence (7.6%) and bathing (5.4%). For 
IADL, however, the percentages were higher for 
dependence when compared to the same study 
(41%). The authors identified that the activities 
with the largest proportion of dependent elderly 
were using the telephone (36.6%) and visiting 
places alone (25.1%)\(^{(14)}\), differently from this study.

The percentage of elderly with good self-
perceived health was lower to the surveys in 
Campinas-SP (64.2%)\(^{(12)}\). This fact may have been 
influenced by the percentage of elderly in this 
study who presented functional problems and 
associated morbidities.

The prevalence of signs of depression is in line 
with the findings in Montes Claros-MG (20.9%) \(^{(15)}\). 
This result may be related with the number of 
associated diseases among the elderly.

The self-esteem scores found in this research 
(MD=10.0) were in line with a survey conducted 
in São Paulo-SP with a group of elderly who 
attended a Physiotherapy Outpatient Clinic 
(MD=9.91)\(^{(16)}\) and users of the public health 
network in Natal-RN (MD=9.37)\(^{(3)}\). The scientific 
literature shows that self-esteem is one of the 
main predictors of successful aging among the 
elderly. Nursing practice suggests that the actions 
performed should be capable of promoting a 
better self-esteem, aiming to enhance the degree 
of adaptation to aging, despite health problems 
and personal issues in this phase of life\(^{(37)}\).

In spite of the factors associated with worse 
levels of self-esteem, higher age was associated 
with low self-esteem, differently from a study 
undertaken in Florianópolis-SC \( p=0.05)\(^{(4)}\). It is 
known that aging can entail some changes that 
affect the self-esteem. Among these, memory 
difficulties stand out, which elderly have reported 
as one of the factors that interfere negatively in 
this condition\(^{(8)}\).

Therefore, the health professionals should 
develop group education activities to create 
spaces for discussion and reflection on the aspects 
related to aging and senility. These activities 
do not only favor socialization, but can also 
contribute to these individuals' empowerment 
in view of the challenges the aging process itself 
imposes, minimizing its impact on self-esteem.

On the opposite, in this same research, 
the authors suggest that the increase of self-
esteeam as age advances is possibly related to the 
acceptance of the changes inherent in the aging 
process itself\(^{(4)}\). In addition, over time, the elderly 
can develop adaptation mechanisms by valuing
the positive aspects of this phase of life and the knowledge gained over the years(4).

Lower education was a predictor of low self-esteem, but the same was not observed in a survey conducted in Santa Catarina involving physically active elderly (p=0.316)(2). Nevertheless, it is highlighted that learning contributes to individual development and encourages the search for further knowledge, mainly among people who did not have the opportunity to study. This search for knowledge positively affects the elderly’s self-esteem(4). The education level is associated with access to information, better social opportunities in the course of life, and also facilitates the supply of health services and, consequently, better living conditions(5).

The relation between signs of depression and self-esteem supports results demonstrated in a study among elderly people who performed physical exercise in Florianópolis-SC, which observed that, the higher the depression symptoms, the lower the self-esteem (p<0.001)(1). This fact has also been evidenced in situations of clinical diagnosis of the disease, as demonstrated in a survey conducted in Santa Catarina, in which elderly people with depression obtained a lower average self-esteem when compared to elderly without clinical symptoms of the disease (p=0.04) (18).

During elderly health care, the health professionals should heed signs of depression. Early detection and appropriate treatment can minimize the impact of this morbidity in terms of health-related aspects as well as self-esteem. Therefore, the geriatric depression scale is highlighted as a valid screening tool that is easy to use in clinical practice(10). Individuals with positive assessments should be forwarded for diagnostic confirmation and specialized professional monitoring.

Low self-esteem related with a worse perceived health is in line with a study developed in Santa Catarina, in which elderly who positively assessed their health obtained better self-esteem levels when compared to elderly with negative self-perceived health (p=0.003)(2). This result can be related to the existence of health problems among elderly with negative perceived health, influencing limitations for daily activities(2), interfering negatively in the self-esteem.

It is known that the physical aspects is closely related with the emotional and psychological status, but individuals with chronic conditions and who are sensitized to the control of their health condition are able to develop a balance that satisfies the route towards healthy aging(19). Therefore, nurses can develop health promotion strategies with this population, aiming for empowerment for self-care and monitoring of the health condition. In that sense, the health team should heed the psychobiological needs, health and living conditions of the elderly, aiming to contribute to their care(20).

CONCLUSION

This survey appointed that the community-based elderly presented high levels of self-esteem and the variables that were associated with low self-esteem were: higher age, lower education, presence of signs of depression and bad and regular self-perceived health. It should be highlighted that the signs of depression were the main predictor of this condition.

This study can contribute to further the knowledge on factors associated with the self-esteem of community-based elderly, but no conclusions can be drawn on causal relations among the research variables due to the cross-sectional design. Another limitation is the lack of scientific research on the theme, especially in the elderly population in general, making it difficult to discuss the study results. Other longitudinal studies are suggested, preferably on a larger scale, aiming to verify the factors that influence the self-esteem of community-based elderly.

FUNDING

Minas Gerais Research Foundation (FAPEMIG) and Brazilian Scientific and Technological Development Council (CNPq).

REFERENCES


3. Ferreira CL, Santos LMO, Maia EMC. Resiliência


