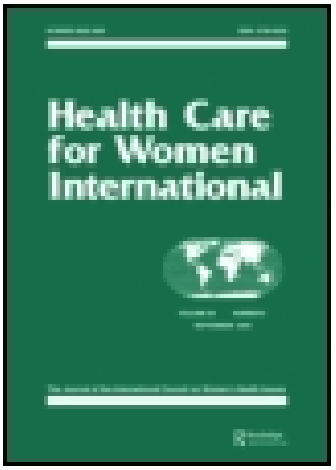

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Self-Esteem of Adult Women Living in a Peripheral Area of São Paolo City, Brazil

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Self-Esteem of Adult Women Living in a Peripheral Area of São Paolo City, Brazil

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*Our purpose was to determine the level of self-esteem (SE) and its associations with women's sociodemographic characteristics and social status. Adult women (*N = *120) living in a peripheral area of Sao Paulo City in Southeastern Brazil were randomly included in our study. We found significant associations between higher SE scores and higher schooling (*p = *.02), participation in religious meetings in the church (*p = *.022), and practice of leisure activities (*p < *.001). The inclusion of a broader range of activities should be provided in health care and educational settings aiming at the improvement of women's SE levels.*

In this article, we explored the levels of women's self-esteem (SE) through the Rosenberg SE Scale (RSES; Rosenberg, Schooler, & Schoenbach, 1989), and its association with their sociodemographic characteristics and social status determined through the Social Reproduction Index (SRI; Trapé, 2012). The SE level, one of the most studied constructs in psychology, permits one to classify a personal self-reported condition. The SRI is an instrument used to classify the social status of a person. Precise data related to the associations among SE level, sociodemographic characteristics, and women's social status can be useful to plan and implement health promotion (HP) projects according to the women's personal characteristics.

A detailed reading of this article is of interest to the international interdisciplinary audience because there are thousands of women around the world living in peripheral areas of large cities. Our study findings are

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demonstrating that the levels of women's SE can be improved through provision, facilitation, and encouragement to participate in religious meetings in the church and to practice leisure activities. Through our research findings, we can demonstrate the importance of higher levels of education for the women's SE. A higher educational background permits the search and incorporation of a broader range of leisure activities in women's daily life.

We learned that SE, the way a women evaluates herself, is experienced subjectively by the woman herself, independent of the region or country in which she lives (Andrade, Sousa, & Minayo, 2009). An increased SE includes the possibility of living better, overcoming challenges, and experiencing opportunities in more rich and appropriate ways (Branden, 1995). SE, a result of personal and social attributes, is influenced by several elements such as daily occurrences and life experiences (Andrade et al., 2009).

Evans (1997), Cid, Merino, and Stiepovich (2006), and Alexander (2010) have reported that higher levels of SE influenced positively women's health status and promoted the adoption of constructive self-care behaviors. Women with higher levels of SE also could make decisions about their life in more appropriate and free ways. Josephs, Markus, and Tafarodi (1992) also reported that women with higher SE levels demonstrated a better capacity to establish and maintain connections with others.

On the other hand, women with lower SE levels suffered harmful effects including decreased health status (Wilkinson & Marmot, 2003), had higher risk of suffering emotionally, and were more likely to be socially isolated and depressed. These women also adopted self-destructive attitudes including a higher rate of illicit substance abuse (Assis & Avanci, 2004; Mann, Hosman, Schaalma, & de Vries, 2004). A researcher has found associations between lower levels of SE and injuries related to work and income. Women living in lower social status had an increased possibility of being stressed and depressed. Although these women showed higher resilience, mental health related problems emerged among them (Ridge, 2009).

Conversely, some researchers have observed that women with lower social status have better knowledge about the strategies to overcome the difficulties confronted daily. Therefore, these researchers concluded that the potential of socially vulnerable people to strengthen their quality of life, including the adoption of self-care measures to improve their SE, should be encouraged (Canvin, Marttila, Burstrom, & Whitehead, 2009).

Axelsson and Ejlertsson (2002) have explored the intersections among SE, self-reported health status, and the existence of social support. They found that unemployed women had lower levels of SE if compared with women who were currently working or studying. Women with lower SE and adequate parental support were especially vulnerable to mental problems. Among these North American women, 76% reported at least three mental health symptoms.

The findings discovered by these researchers are demonstrating that the level of SE is influenced by several elements. We focused on the women living in a peripheral area of a large Brazilian city in this study. The social status of these women was determined through SRI, an instrument elaborated by Trapé (2012), a Brazilian researcher. Trapé (2012) expanded on the SRI, considering the health–illness as a process permeated by two main determinants: the ways to work, determined by the capitalist mode of production, and the ways to live, influenced by the capitalist accumulation process.

We performed this research to obtain answers to the following question: Is a woman's level of SE affected by her sociodemographic characteristics and social status? We did not find studies focusing specifically on this association in the scientific literature. Especially in Brazilian health care settings, although the families from lower social status predominate as clients, people from higher social status, especially retired women, also ask for support. Considering this characteristic of our country, we did this study to obtain a deeper knowledge about the associations among the women's SE level, their sociodemographic characteristics, and their social status. Our findings can contribute to planning and implementing meaningful HP activities.

We did this study aiming to measure the levels of SE according to the women's sociodemographic characteristics and their social status.

THEORETICAL FRAMEWORK

We used the concept of HP as the theoretical basis of this study. HP is the process of enabling people to increase their control of, and therefore improve, their health. The use of this concept was recommended by the members of the staff responsible for the Ottawa Charter of Health Promotion, at the end of the First International Conference on Health Promotion (World Health Organization [WHO], 2009).

According to the concept of HP, health is the main resource of social, economic, and personal growth and an important dimension of quality of life. Political, economic, social, cultural, environmental, behavioral, and biological factors can all be favorable or harmful to health. The improvement of health status through favorable use of the associated factors is one of the main objectives of the promotion of health. Through the incorporation of HP activities in daily life, the negative impact of low social status on health conditions can be reduced. Ensuring equal opportunities for the entire population and offering resources to enable them to achieve the fullest health potential are some current challenges of the provision of health care (WHO, 2009).

HP related activities assume special importance in developing countries where differences related to income, education, housing, and gender relations are still problems. The multitude of overlapping roles assumed by

women is a strong disparity in the scope of social and gender relations. Many vulnerabilities and barriers related to women's health emerge from this condition. The comprehensive approach to health, one of the main premises of the current Brazilian health policy (Brazil, Ministry of Health, 2004), should be incorporated by health care providers in their daily activities. In this sense, women should be seen as having autonomy and the potential to adopt self-care practices to improve their own health conditions. Through this approach to health care, the medical infrastructure itself might not be well developed, but health care providers can implement the premises of HP. The users of health care facilities have increased the possibilities to make choices in health related decisions and exercise more control over their own health (Brazil, Ministry of Health, 2006).

We considered the appropriateness of HP as the theoretical basis of this study, focused on women living in a peripheral area of a big city where the access to social and cultural resources is scarce. Findings related to the associations among women's SE level, their sociodemographic, and social status are important for health care providers who take responsibilities related to the promotion of women's health status, including their SE levels.

METHODS

Study Design

We did a cross-sectional study. We considered that SE could be self-reported or recorded by behavioral observation (Yoon, Kim, & Kim, 2011). In this sense, we assessed the levels of SE determined through the RSES (Rosenberg et al., 1989) and its association with social status and sociodemographic characteristics of women.

Sample and Setting

In this study, we invited women to participate who lived in an area under the responsibility of a Primary Healthcare Unit (PHU), located in a peripheral zone of the Metropolitan Area of Sao Paolo City, Southeastern Brazil. In this area, family health care was implemented as a public policy in 2001 (Elias et al., 2006). The professionals working in this PHU provide primary health care to 3,395 families. The area under the responsibility of these professionals is divided into four geographical subareas. The number of families living in each area was 851, 830, 850, and 864, totaling 3,019, 2,826, 2,757, and 3,024 people, respectively, with a total population of 11.626 people in this area. In this study, we included adult women from 18 to 59 years of age. We excluded from this study women who were pregnant or had any apparent mental disability.

Procedures

Our study sample was determined considering the one-tailed hypothesis test for a mean, with standard deviation of 4.3 (Dias et al., 2008). We adopted the power of test of 80% with level of significance equal to 5%. This equation resulted in $N = 120$. The number of women to be selected from each geographical area was calculated through division of N into the quantity of geographical subareas (120/4), resulting in 30 women from each area.

The first street and house in each area was determined through raffle. To include the next study participant, we approached the sixth house on the same side of the street. When two or more women according to inclusion criteria were living in the same house, we selected one of them randomly. When we did not find a woman matching the inclusion criteria, we approached the next house. We adopted similar criteria in the four subareas. None of the women refused to participate.

Instruments

We utilized two instruments to collect data. The first was the SRI (Trapé, 2012), and the second was the RSES (Rosenberg et al., 1989), validated for the Brazilian culture and translated to Portuguese by Dini, Quaresma, and Ferreira (2004).

The SRI is a self-reported survey to classify the social status of a person. The items analyzed to determine social status included age, years of study, marital status, number of children, religion, participation in religious meetings in church, and practice of leisure activities. These last two items were included by Trapé (2012) in the instrument with the aim to measure pleasant activities linked to personal satisfaction, without functional or utilitarian aims. In this study, we considered leisure activities as all activities considered as pleasurable practices by the women.

According to premises of critical epidemiology, the ways to work (WW) and the ways to live (WL) influence the social status of people. In this sense, four subitems related to WW were included in the SRI: occupational qualification, availability of job training, occupation, and professional status of the main person responsible for the financial support of the family. The subitems used to classify WL were the responses (yes or no) to seven questions: owner of the residence, existence of public sewage service, existence of light and treated water in the residence, payment of official public taxes, quantity of rooms used exclusively to sleep, participation in religious meetings in the church, and practice of leisure activities (Trapé, 2012). The religious and leisure practices are important characteristics of a sociocultural group (Dumazedier, 2001; Melo & Alves, 2003).

In the SRI instrument, the jobs are according to the Brazilian Classification of Occupations (BCO; Brazil, Ministry of Work and Job, 2002),

which classifies, recognizes, nominates, and codifies headings and contents of the national work market occupations (Pierantoni & Varella, 2002). The items of the BCO include industry, commerce, agriculture, administrative services, cleaning services, technical and scientific occupations, teachers, media workers, lawyers, directors, and managers (Brazil, Ministry of Work and Job, 2002). Women who declared themselves as "housewives," "unemployed," and "retired" were classified separately.

To determine the woman's social status, we used the SRI's instrument. We have added the points attributed to each item of the WW and the WL. The result of this equation permitted us to classify a woman as being of one of the four possible social status group. Group one (G1) is composed of people with higher social status and group four (G4) of people with lower social status. Group two (G2) and group three (G3) were the intermediate groups in terms of social status.

The Rosenberg SES is a self-reported scale used to classify an individual's SE. It is one of the most studied constructs in psychology. The RSES is composed of 10 affirmations, and to each of them is attributed a score between 1 (*strongly agree*) and 4 (*strongly disagree*). Five phrases are related to positive feelings and the other five to negative feelings. The level of SE of a person can be classified as satisfactory (higher than 30 points), medium (20 to 30 points), or unsatisfactory (lower than 20 points) (Dini et al., 2004; Rosenberg et al., 1989).

In our study, the dependent variable was the women's SE mean score. We considered as independent variables the following sociodemographic characteristics of women: age, years of study, marital status, number of children, occupation, religion, participation in religious meetings in the church (yes/no), and practice of leisure activities (yes/no). The other independent variable was the women's social status (G1, G2, G3, or G4).

Data Analysis

We analyzed the data using SPSS® for Windows (Version 16.0). Number, proportion, mean, median, and standard deviation were used to analyze demographic data. We used ANOVA to compare SE means and independent variables. We considered statistical significance when the p value was less than .05. We did multiple linear regression through backward stepwise considering variables with $p < .05$. The final model was reached when all variables were statistically significant.

Ethical Considerations

We obtained authorization from the Ethics Committee of the Municipal Health Office of São Paulo City (register number 0117.0.196.162-11) before data collection. All women signed the Informed Consent Form.

RESULTS

Women's sociodemographic characteristics are shown in Table 1.

Women's mean age was 39.4 years ($SD = 10.5$). Almost half (58.3%) reported 8 years or less of schooling. None had received university education. The major proportion (72.5%) were legally married or were living together (according to Brazilian legislation, couples who live together have the same rights as legally married couples), and 89.2% had children. The most common occupation was housewife (41.0%), and 31.6% were employed.

A large proportion of women (46.7%) classified themselves as Catholic, and 40.8% did not mention adherence to a specific religion. The majority of women (61.0%), however, indicated participation in religious meetings

TABLE 1 Women's Sociodemographic Characteristics ($N = 120$)

Characteristic	*N*	%
Age (years)		
18–24	12	10.0
25–30	15	12.5
31–40	41	34.2
41–59	52	43.3
Schooling (years)		
Less than 8	70	58.3
8–11	50	41.7
Marital status		
Single	20	16.7
Married	54	45.0
Divorced	5	4.1
Stable union	33	27.5
Widow	8	6.7
Number of children		
No	13	10.8
1–2	66	55.0
3 or more	41	34.2
Occupation		
Administrative services or commerce	14	11.7
Cleaning services and similar	38	31.7
Housewives	50	41.7
Unemployed	13	11.6
Retired	4	3.3
Religion		
Catholic	56	46.7
Spiritualist	11	9.1
Protestant	4	3.4
No religion	49	40.8
Participation in religious meetings in the church		
Yes	73	60.8
No	47	39.2
Practice of leisure activities		
Yes	82	68.3
No	38	31.7

TABLE 2 SE Mean Score According to Women's Social Status ($N = 120$)

Social status	*N*	SE	*SD*
Group 1	16	32.6	6.5
Group 2	63	30.7	4.7
Group 3	08	31.7	4.1
Group 4	33	29.0	3.7

in the church. The practice of leisure activities was reported by 68.2% of women. About women's social status, 52.5% were from G2 (intermediate with tendency to higher), 27.5% from G4 (lower social status), 13.3% from G1 (higher social status), and 6.7% from G3 (intermediate social status with tendency to lower). Therefore, most (59.2%) women were from intermediate social status.

Women's SE mean value was 30.6 ($SD = 10.8$), considered satisfactory (Dini et al., 2004; Rosenberg et al., 1989). In Table 2, the association between SE mean score and social status is reported.

No statistical association was found between the SE mean score and the women's social status ($p = .087$).

Women's SE mean score according to their personal characteristics are presented in Table 3.

TABLE 3 SE Mean Score and Women's Characteristics ($N = 120$)

Variable	*N*	Score	*SD*
Years of age ($p = .253$)			
18–24	12	32.3	3.7
25–30	15	31.2	3.0
31–40	41	31.0	5.0
41–59	52	29.7	5.2
Years of study ($p = .025$)			
8 or less	70	29.4	5.1
8—11	50	32.2	5.9
Marital status ($p = .566$)			
Single	20	29.8	5.4
Married	54	31.2	4.3
Divorced	33	30.5	4.2
Stable union	5	29.0	6.5
Widow	8	29.0	7.7
Religion ($p = .065$)			
Without religion	11	29.4	4.6
Catholic	49	29.5	4.1
Protestant	56	31.3	5.1
Spiritist	4	34.7	5.1
Participation in religious meetings in the church ($p = .022$)			
No	47	29.0	4.8
Yes	73	31.5	4.5
Practice of leisure activities ($p < .001$)			
No	38	28.1	4.3
Yes	82	31.7	4.6

TABLE 4 Multiple Regression Model for SE Level ($N = 120$)

Parameter	B	p	Confidence interval (95%)	
			Lower bound	Upper bound
Intercept	34.07	<.000	32.65	35.48
Higher schooling	2.46	.002	.89	4.03
Participation in religious meetings in the church	2.57	.001	1.00	4.14
Practice of leisure activities	3.29	<.000	1.63	4.95

We have not found statistically meaningful association between SE mean score and women's social status. We found significant associations, however, between SE mean score and higher levels of schooling, participation in religious meeting in the church, and practice of leisure activities. From multiple linear regression, we found that high schooling, participation in religious meetings in the church, and practice of leisure activities improved SE level 2.46, 2.57, and 3.29 points on average, respectively. Women who showed higher schooling, were participating in religious meetings in the church, and were practicing leisure activities showed an SE level of 42.39 on average. So, the SE level for women with low schooling, who did not participate in meetings in church orpractice leisure activities was of 34.07 (Table 4).

INTERPRETATION AND DISCUSSION

We found a meaningful association between SE mean score and higher levels of schooling, participation in religious meetings in church, and practice of leisure activities. This finding shows the need for a comprehensive approach to women's lifestyle for activities aiming to improve their SE.

We did not find associations between social status and SE levels. In fact, family socioeconomic characteristics, if analyzed as an isolated variable, did not affect women's SE significantly, only marginally (Elliott, 1996; McMullin & Cairney, 2004). Findings presented by other researchers have demonstrated the effects of social status on women's SE levels. These researchers have described that the aging Canadian women from lower social status showed lower SE scores. These researchers highlighted the assumption that class, age, and gender interact within social life. Adopting the interpretive and feminist perspective, some researchers argued that people with less power have few chances to make changes in their life (McMullin & Cairney, 2004). Therefore, health care providers should approach all aspects of women's social life during HP activities.

In this study, with participation of women from 18 to 59 years of age, we have not found a statistical association between SE mean score and women's age. Elliot (1996) reported the existence of associations among age, SE, and

employment status in a study focused on low-income White adult women living in the United States of America. Younger women who were employed experienced higher SE, regardless of parental status. This researcher concluded that the financial independence of the employed women and the recent transition to adulthood, a period characterized by the consolidation and growth of SE, can have contributed to their higher SE (Elliot, 1996). The differences observed in the findings of these studies show the need for deeper study of the relationship between SE and age.

Gecas and Seff (1990) reported an association between the ways SE is influenced and the ways women perceive their own work and life. The ways a woman establishes relationships with others, perceives herself and the world, as well as the importance attributed to these questions were reported (Gecas & Seff, 1990). Lower SE found amongwomen below 40 years of age can be related to changing social roles (Josephs et al., 1992). As mothers, women can be influenced by the loss of defined family and social roles (Elliot, 1996). Additionally, body image is a major contributor to SE scores in women. Specifically in Brazilian culture, there is an idealized body image strongly influenced by the mass media ideal of femininity (Chedraui et al., 2010).

We found a statistical association between SE score and education. Women with higher levels of schooling exhibited a higher SE mean score. The existence of this association was also reported by researchers from diverse sociocultural settings (Elliott, 1996; Gecas & Seffa, 1990; Maçola, Vale, & Carmona, 2010; McMullin & Cairney, 2004; Mirowsky & Ross, 1996). Women who were working in advanced occupations and were involved in challenging and creative work showed higher SE scores when compared with those employed in less advanced occupations. This difference was particularly noticeable among women who were performing repetitive activities (Gecas & Seffa, 1990).

We observed a meaningful association between the SE mean score and participation in religious meetings in the church. Among Brazilians without a declared religion, many were participating regularly in meetings of diverse spiritual backgrounds (Almeida & Monteiro, 2001). The desire to find a place to feel better may explain the adoption of this type of behavior (Rodrigues, 2007).

Santa-Bárbara (1999) found associations between higher SE scores and the participation of Spanish university students in community groups, including religious activities. The findings reported by this researcher corroborate the premise that affirms spirituality as an important element of social support. Valla (2006) concluded that when a person felt socially supported, having close relationships with neighbors or participating in religious activities, her health condition is improved. Brazilian researchers Silva, Ronzani, Furtado, Aliane, and Almeida (2010) reported that people with higher participation in religious meetings showed better psychological well-being,

demonstrating that religiosity is an important aspect of health protection. Baungart and Amattuzzi (2007) also reported that the religious experience, closely attached to changes in personal subjectivity, provokes meaningful changes in daily behaviors. These changes contributed to an improvement of quality of life.

These researchers are demonstrating the importance of spirituality for the human being. Spirituality that includes the capacity to live the religious experience can mobilize forces and influence the women's daily attitudes (Baier & Wampler, 2008). Health care providers need to be prepared to offer adequate support to patients who turn to religion to overcome illness (Salgado, Rocha, & Carvalho, 2007). Holistic health care requires a comprehensive approach personal backgrounds, including spirituality (Heliker, 1992; Salgado et al., 2007). Typically, there are not enough opportunities to discuss, in a judicious and unprejudiced way, the religious perspectives involved in the provision of health care (Salgado et al., 2007). Nevertheless, health care providers should be prepared to better support their patients' spiritual needs (The American Holistic Nurses Association, 2012).

We observed that women who were practicing leisure activities showed a higher SE mean score than women who did not. Such findings reiterate the benefits of leisure activities in several dimensions of life. Other researchers demonstrated that women actively engaged in cultural, recreational, and civic activities lived years longer when compared with people who participated moderately in such activities. Women not involved in any leisure activity died earlier (Hyyppa, Maki, Impivaara, & Aromaa, 2005). Older adult women who were practicing leisure activities showed higher SE and self-confidence scores. Therefore, health status and well-being can be promoted through practice of leisure activities (Son, Kerstetter, Yarnal, & Baker, 2007). Recreational activities, in addition to other factors, are essential for relaxing and for physical and mental wellness (Ohtsu et al., 2012).

Our research findings and those from other studies underscore the importance of recreational activities to the well-being of the community. Opportunities to discuss preoccupations, to participate actively in the decision -making process, and to choose the preferred activities are also important elements in improving the effectiveness of leisure activities on HP. When these aspects of health care are focused on by care providers, the patient's self-confidence and SE are similarly improved. Consequently, people can feel healthier and motivated to pursue additional leisure activities, constituting a virtuous circle (Strachan, Wright, & Hancock, 2007).

IMPLICATIONS FOR HEALTH PROMOTION

Our study showed the importance of a comprehensive approach of women who are participating in HP activities, considering participation in religious

meetings in the church and the incorporation of leisure activities in daily life as factors that determine the increase of SE scores, adjusted by schooling. In our study, no difference in the mean SE score was found among women from different social statuses. This finding shows that women from diverse social status living in a determined primary health care facility area can be included in the same group, when the purpose is the promotion of SE levels.

Women with higher SE scores feel psychologically stronger and better able to face their health problems. These women also have more resources to confront the difficulties experienced daily. Interventions designed to improve SE scores, therefore, should be adopted because this score directly influences women's well-being (Forthofer, Janz, Dodge, & Clark, 2001). Creating opportunities for women to participate in a variety of experiences to foster emotional relationships was also recommended. These opportunities, which can enhance the relationships among people, can promote the identification of daily life difficulties influencing SE (Coelho, 2005).

Issues relevant to women's needs include their perceptions and expectations regarding health care and the importance of their engagement in health services and their social support network to improve SE. Stimulus to participate in religious meetings in church and incorporation of leisure activities in daily life can contribute to improving women's SE. We confirm these as important elements of the promotion of women's health.

In this sense, health care and educational facilities should provide more opportunities for women to take part in recreational activities, especially in peripheral areas of the cities, where usually these kinds of resources are scarce. Primary health care facilities have already incorporated into their routine handicrafts skills courses, recyclables materials usage, physical activities such as walking in groups, and other social support free of costs in order to promote women's health status. Because of its importance in women's health, improvement in SE levels should be achieved through many other initiatives that are far beyond simply clinical treatments or health educational activities.

LIMITATIONS OF THIS STUDY AND RECOMMENDATIONS FOR FURTHER STUDIES

In this study, we found only women with 11 or fewer years of study. Considering that the level of schooling is associated with SE levels, women who studied more than 11 years can have higher SE levels. Their SE can also depend on other aspects of daily life, extrapolating the presence in religious meetings in the church or the practice of leisure activities. Further studies can include women with a higher degree of schooling, especially women who have a university degree, in order to verify if their SE levels are also higher and are associated with the frequency of attending religious meetings in the church or practicing leisure activities.

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