The Effect of Self-Estem Images on the Well-Being of the Elderly People in Geriatric Homes and a Community Living Elderly

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Abstract: Although living long has been a dream of mankind, people are worried about ageing, as individuals and society, because old age is historically associated with being sick, dependent and face many psychological concerns due to the emotional responses that follow the normal ageing process. As well as, changes in their socio-demographic status, social relationships and the burden of the associated chronic diseases, they experienced. Only few studies have explored the psychological implications of living geriatric homes and psychological distress that most frequently experienced by them, with health perception, life-satisfaction and self-esteem that are correlated with abandoned self-care behaviours and dealt with negative aspects of the late life. The poor self-images of the self-esteem symptoms of excessive self-consciousness, social phobia, nervosa and depression among elderly population enforce the study of these issues, when studying any elderly concerns. This study aimed to assess and compare self-esteem images and associated socio-demographic factors, social effective relationships and the comorbidity status among geriatric home residents and non-institutionalized elderly people.**Methods & Subject:** A cross-sectional study was conducted to study the self-esteem status among a sample of 100 elderly people aged 65 years and more, fifty of them were geriatric home residents and the other half from outpatient clinics attenders. All participants accepted to participate and were cognitively alert. They were selected randomly from non-governmental care homes and outpatients clinics in National Medical Institute of Damanhour at El-Behaira Governorate. Tools: specially designed interview questionnaires were developed and used to collect data for socio-demographic and medical data. Self-esteem scale, according to the Arabic version was utilized to measure individual self-esteem variables. Data were collected in period of a month. The results of the study presented that the mean ± SD age of the studied subjects was 70.0±7.1. More than half (59%) of the respondents were males and nearly half (46%) were widowed. Illiterate and only read & write subjects accounted 64% and those with monetary inadequacy contributed 60% having less than 600 Egyptian pounds monthly. The self-esteem scores of the studied subjects by their socio-demographic factors did not detect any significant difference between socio-demographic studied factors except income source (P=0.03). No significant differences between self-esteem scores and socio-demographic factors among geriatric home residents. For the non-institutionalized participants, both age group and educational level showed significant differences, (P= 0.022 and P= 0.040, respectively). The mean ± SD and median of the self-esteem scores according to pattern of social visits for geriatric home residents were higher for daughters' visits, (20.0±3.2 and median 20.5), while no coming visits were reported. No significant difference for outpatient respondents for self-esteem scores and different patterns of effective social relationships, (P=0.449). There was no significant difference between institutionalized and non-institutionalized studied subject according to the level of self-esteem mean ± SD scores, (P=0.315). The effective support relationships of the geriatric home residents, were from some family members and some non-family members. No one was socially supporting the outpatient clinics participants. Brothers & sisters, children and some neighbours were the stressors, (62%, 40% and 40%, respectively) for the geriatric residents. The dominant associated chronic diseases among the two studied groups were common, namely diabetes mellitus, hypertension, osteoporosis, hepatic diseases and diabetes & hypertension. No significant differences were detected among the two studied groups or even within each group, between self-esteem score and the associated chronic diseases.The findings of this study will be useful for planning interventions to improve self-esteem and life-satisfaction among the elderly population in Egypt. As further studies about self-esteem on a larger number of elderly from different geographical areas are recommended.

1. Introduction:

Throughout the world the elderly population has been increasing both quantitatively and proportionally. Accordingly, it is estimated that current population. Accordingly, it is estimated that current population of over 65-years of age is 390 million and will be doubled in 2025.[1,2,3] Ageing is one of the national phenomena common to all races globally. Elderly individuals are always seen as giving increased burden on families and societies, because most of them are

incapable of performing their activities of daily living independently.[4] As people enter old age, they begin to experience associated changes in their physical, mental and social health. Elderly individuals often develop feelings of loneliness, sullenness, depression and loss of self-confidence.[5] Older adults face many psychological concerns because of the emotional responses that occur as a result of the normal ageing process, acute and chronic diseases, changes in role or status with housing, or problems obtaining medical services. Any of these psychological concerns produce stress and can lead to psychological problems.[6]

Recently psychological Egyptian studies among elderly revealed that most of them experience different degrees of depression, loneliness, life-disaffection and cognitive impairments.[5] From clinical instructors' experience at geriatric homes, it has been observed that aging is associated with poor mental health in some older people, especially the institutionalized persons, where low levels of self-health perception, self-esteem, and depression are major problems.[7]

Study of people aged 50-years or over provides a rich source for exploring issues relating to ageing that are important both for scientific understanding and for policy analysis. It offers a unique opportunity, for the study of a range of topics necessary to understand the economic, social, psychological and health elements of the ageing process and to inform policy in these areas. The increase in life expectancy, as well as, the demographic shift, has raised questions about population trends in disability, the impact on health services, the need for long-term care, trends in the workforce, changes in productive activities after retirement and appropriate pension and other economic arrangements. In many of the socio-demographic aspects analysed, the differences related to education and occupation, marriage was also highly prevalent in cohorts studied and the proportion of people who reported having one child increasing with age.[8] In a study in upper Egypt, explaining the relationship of socio-demographic characteristics, it was found that depression was present among 100% single, 80.9% among divorced and the least was among married (67.4%), where the difference was significant.[9] So, the relationships between biological, social and demographic factors and the presence of a number of chronic conditions considered to be national priority.[10]

Self-esteem is one's opinion of himself. People with healthy self-esteem like themselves and value their achievements. While everyone lacks confidence occasionally, people with low self-esteem feel unhappy or unsatisfied with themselves most of the time. This can be remedied but is takes attention and daily practice to boost self-esteem. Typically, a person with low self-esteem is extremely critical of himself.

A low self-esteem can reduce the quality of a person's life in many different ways as, negative feelings, relationship problems, fear of trying, perfectionism, fear of judgment, low resilience, lack of self-care and self-harming behaviors.[11] However, collective self-esteem (CSE) refers to an individual's self-evaluation of his or her social identity. A positive social identity, or high CSE, facilitates accommodation to negative health related circumstances in later life, especially when one feels unable to alter these circumstances directly. Accordingly, CSE would be associated with fewer chronic conditions and greater perceived health for those with low perceived control.[12]

The predominant negative social images can influence the perception that the olders have of themselves, leading to the acceptance of these beliefs and the adoption of behaviours consistent with them.[13,14] This self-acceptance lead to reduce self-esteem, a devaluation of personal skills, and a deterioration of physical and mental health.[15]

Psychological studies of the elderly have been limited to non-institution elderly living at home in the community. Only a few studies have explored the psychological implications of being institutionalized despite the fact that approximately 5% of the elderly 65 years or older reside in nursing homes in united states.[16] For two nursing home residents, in service training to a combination of the educative, two groups were created, group (1) with supportive system of care and behaviour modification. Other group (2) given routine nursing care. After two-week, baseline period nursing, group (1) did significantly more self-care and had significantly higher self-esteem than those of group (2).[17]

The persons whose self-care behaviour style was responsible, formally guided or independent, carried out their daily activities without assistance from others. While those who showed abandoned self-care did not manage their daily activities without help. Life-satisfaction was the highest among the formally guided persons and self-esteem among the responsible ones. Poor life-satisfaction and self-esteem are correlated with abandoned self-care behaviour.[18] Independent self-care is an attempt to maintain the constancy of life. Abandoned self-care is characterized by helplessness and lack of responsibility. It involves bitterness and negative attitude towards ageing. So, abandonment is adhesive to give-up, and self-care is not a separate part of elderly lives, it is associated closely with their past life and with the future. It also, reflects the person's overall attitude towards health care, illness and manner of living.[19]

In the past decade, the positive influence of social relationships on psychological adjustment throughout the human life-span has been fairly well established.[20] Research into different societies, where

both non-traditional culture of marital relationships is developing and where the obligatory family system is maintained will be informative in understanding nonkin contributors as emotional supporters. At present, it is assumed that the proportions of friends versus family members as important figures will vary with cultural-historical, factors, but still the relationship between the patterns of effective relationships and psychological well-being will stay the same.[21] A psychological study among U.S elderly reside in nursing homes, reported that social support significantly correlated with depression, and there was some indications that the type of the institutional setting and frequency of religious participation also interacts with the level of depression.[16] By contrast, a longitudinal study of aging, using structural equation modeling demonstrated that social support reduced depressed affect through an increase in self-confidence and a decrease in self-deprecation, but not by a direct effect on depression. The study suggested the importance of self-esteem improving elements of social support in reducing depressive symptoms,[22] and help to reduce the deleterious effects of stress on emotional disorder primarily by bolstering the self-esteem of older adults and affects psychological well-being only indirectly through self-esteem.[23] However, regardless of how the concept of quality of life is defined, research has consistently demonstrated the importance of social and family relationships in the definition of a good quality of life.[24]

Family members as well as non-family social ties play a role to mediate the link between social support, stress levels and health. The DUSOCS[25] works to capture an individual's perceptions of how supportive or stressful persons' relationship are. Stressful relationships are defined as those that cause problems or make lives more difficult for an individual. It also, allows the identification of one's most supportive and most stressful relationships.[25-27] Several studies reported that individuals with a greater sense of humor (various measures) have higher self-esteem, lower levels of depression, anxiety and perceived stress. Hence, have more positive self-concept, better overall mental and physical health, enhanced ability to cope with stress, and better relationships with other people.[28,29] They appeared to derive greater pleasure and satisfaction from various social experiences and life events and are more mentally tough when stressed.[30,31] Adaptive positive humor style have been associated with higher self-esteem, positive effect and better ability to control anxiety and to initiate social interactions. Whereas, maladaptive negative styles of humor have been associated with lower well-being, higher perceptions of stress and low self-esteem.[32] A readiness to initiate humorous interactions is not on its own a general and positive attribute contributing to

"good" humor, and both self-esteem and initiation competence contribute to use of aggressive humor style.[33]

Illness related variables are associated with poor health, with smaller, but significant contributions from demographic and life style factors. Psychological resources, especially high mastery and self-esteem are also associated with better health in those with chronic conditions or disability.[34] There was a moderate association between short care pervasive depression and the number of life events experienced over the previous years. Personal illness, bereavement and theft were the most salient events.[35] The negative images of ageing affect both social and care treatment given to the elderly population, as well as, the way individuals live their old age.[36] The discrimination against older people is due to abusive generalizations that do not take into account individual characteristics.[37,38] So, the ideas about ageing tend to associate it to physical problems, disability, illness, inter personal changes, such as bad temper, depression, unhappiness, isolation and to cognitive deterioration.[39,40]

However, the clustering of all these can be used to define a large part of the elderly population with a poor quality of life. An important avenue for future research will be, the development and implementation of population intervention strategies designed to address some or all of these major problems among older people in general.[35]

Aim of the study:
The aim of this study:
1- To assess and compare self-esteem images among institutionalized and non-institutionalized elderly people.
2- To assess the association between socio-demographic characteristics and self-esteem of the elderly group of study.
3- To assess the effect of social relationships on the self-esteem of the studied elderly.
4- To assess the effect of associated chronic diseases on the self-esteem of the elderly people.

2. Subjects and Methods:
1- Study setting:
This study was carried out at geriatric homes and outpatient clinics in Damanhour National Institute at El-Behaira Governorate, Egypt Each of the selected settings was visited twice a week for a period of one month, to collect the necessary data during the academic year.

2- Study design:
A cross-sectional study was conducted to study the self-esteem status among in-institution residents and non-institution (outpatients) participants in the selected settings.

3- Target population:

The target population of the study included elderly participants of age of 60 years or more, accepted to participate in the study and being cognitively alert. The study excluded those who refuse to participate and those having any communication problems. (Dar El-Saada, Dar) El-Rabaa, Dar El-AML and Dar El Wafaa).

4- Sample size:

A sample of convenience of 100 aged persons agreed to participate in the study. The age of the studied groups was 60-years and more. Half of studied sample (50 elderly) was residents of geriatric homes. The other half (50 outpatient participants) was from the outpatient clinics attending persons.

5- Statistical analysis:

- The collected data were manually coded and tabulated using PC computer. The SPSS for windows version "17" software package was used for social data analysis.
- The probability, $P< 0.05$ is considered significant in all statistical analysis.

6- Technical design:

Tools and description.

For the proper conduction of the present study, structured pre-coded questionnaires were used. They were designed by the investigator to collect the data of:

- Socio-demographic data, that included, personal data as, age, gender, marital status, number of children, educational level, job, income source and monthly income.
- Social relationship data, were collected through 10-items self-administered questionnaire. Respondents rate family members and none-family members on a 4-point Likert scale response format as to the amount of support and stress caused by each relationship. The participant is also asked to indicate the most supportive or the most stressful person, if such relationships exist. Four separate scores, are generated according to (DUSOCS),[25] family support, family stress, non-family support, and non-family stress. As well, data included the visiting patterns for in-institution residents and "living with whom", for non-institutionalized participants.
- The GDS scale, which was tested for content validity,[41] for the study about reliability and validity of the GDS, in a pilot study, using an "Arabic version" which was tested for reliability factor (0.84) with a two week intervals.
- Self-esteem data, were collected using self-esteem scale, which was developed by Rosenberg, 1965,[42] and Sorensen. Self-esteem test.[43] The scale was used to measure individual self-evaluation and self-acceptance. The scale contained, "positive personal self" included in 5-items, and "negative personal self" included in 5-items, that reflect the state of dissatisfaction with oneself. The self-esteem scale (Arabic version) was scored using a 4-point liker scale, ranged from 3=strongly agree (SA), to 0= strongly disagree (SD). While negative items' scores were reversed (0 for SA and 3 for SD). The higher score represented higher self-esteem.

- Medical data sheet was used to collect medical history and type of chronic diseases among the respondents.

7- Operational design:

1- An official permission was obtained to conduct the study, from the managers of the outpatient clinics and geriatric homes, after explanation of the nature and purpose of the study. The informal consent was obtained from elderly participants after complete description of the purpose and natures of the aim of the study.

2- A pilot study was done on 10 elderlies for both geriatric homes and outpatient clinics to assess the tools for their clarity and feasibility.

3- Each elderly was interviewed individually by the researcher after development of the communication and trust relationships. The time of interview differed according to different elderly.

3. Result:

The study examined the self-esteem of elderly people of age 65 years or move among the elderly residents of geriatric homes and elderly patients attending the outpatient clinics, Damanhour, National Medicine Institute. It also detected their self-esteem, status using socio-demographic, social support social stress relationships and associated chronic diseases questionnaires.

Table (1) Illustrates the number and percentage of the studied elderly participants according to their socio-demographic data. It is clear that the age of the participants ranged from 57 to 90 years, where 46% of them their age ranged between 65 to 74 years with mean ± SD of 70.0±7.1. Regarding gender, 59% males were among participants versus 41% of the females. Among them 45% were widowed and 29% were married individuals.

Regarding educational level both illiterate and only read & write contributed by nearly two-third of the study sample valuing 64%, (37% and 27%, respectively). The table also showed that 52% of the studied elders were retired and only 10% were working. Those having no children among those having children was 5.0 with a range of 3 to 10 children. The income source of more than two-third (68%) of the participants was retired fund and the least number of them 3(3%) were depended on their salaries. Among them, 60% had monthly income less than 600 Egyptian pounds, while only 3% were wealthy getting up to 3000 Egyptian pounds monthly.

The mean ± SD of self-esteem scores of the study participants (n=100) by their socio-demographic characteristics are shown on the table (1) it is clear that no significant statistical differences among the age groups of the study, where, (χ^2 = 5.50 and P= 0.065). Similarly, no significant differences according Z-test (Mann Whitney test for two independent groups) for the gender, (Z= 0.17; P= 0.864). No significant differences were detected among the studied elderly people concerning, marital status, having children, educational level, Job and monthly income, where, (χ^2= 4.40; P= 0.226, χ^2= 4.70; P= 0.198, χ^2= 5.0; P= 0.347, χ^2 = 3.50; P= 0.316 and χ^2 = 3.20; P= 0.523, respectively). In contrast, there was a significant difference (χ^2 = 10.70; P= 0.03) regarding income source among the studied groups of elderly people, table (2).

Table (1): Distribution of the study sample by self esteem score of total participants by socio-demographic characteristics

Scio-demographic characteristics	n=100		Self esteem score			χ^2	P
	No	%	Mean	SD	Median		
Age in years							
< 65	27	27.0	16.6	2.2	16.0		
65-74	46	46.0	17.5	1.8	17.0	5.50	0.065
75-90	27	27.0	17.6	2.0	18.0		
Range	57-90						
Mean ± SD	70.0±7.1						
Gender							
Male	59	59.0	17.1	1.9	17.0	Z=0.17	0.864
Female	41	41.0	17.5	2.1	17.0		
Marital status							
Single	13	13.0	17.5	2.3	17.0		
Married	29	29.0	16.9	2.3	17.0	4.40	0.226
Divorced	13	13.0	16.6	1.5	16.0		
Widowed	45	45.0	17.6	1.7	17.0		
Numbers of children							
No child	46	46.0	17.1	2.3	17.0		
3-4	17	17.0	17.9	1.7	18.0		
5-6	21	21.0	17.5	1.7	17.0	4.70	0.198
7-10	16	16.0	16.8	1.4	16.5		
Range	3-10						
Mean ± SD	5.0						
Educational level							
Illiterate	37	37.0	16.7	1.5	17.0		
Read & write	27	27.0	17.8	2.2	17.0		
Primary level	16	16.0	17.0	1.9	16.5	5.00	0.347
Preparatory level	6	6.0	16.8	1.5	16.5		
Secondary level	9	9.0	18.0	2.3	18.0		
University level	5	5.0	18.6	2.9	18.0		
Job							
Not working	20	20.0	17.6	2.0	17.0		
Retired	52	52.0	16.9	1.7	17.0	3.50	0.316
Housewife	18	18.0	18.0	2.2	18.0		
Working	10	10.0	17.2	2.6	17.0		
Income source							
Salary	3	3.0	19.7	2.9	18.0		
Retired fund	68	68.0	17.0	1.9	17.0		
Asset owner	11	11.0	17.8	1.7	17.0	10.70	0.030[*]
Non- governmental charity	6	6.0	16.3	1.0	16.0		
Other sources	12	12.0	18.3	2.2	18.0		
Monthly income							
< 300	24	24.0	17.5	2.1	17.0		
300-600	36	36.0	16.9	1.6	17.0		
600-900	13	13.0	17.2	2.4	16.0	3.20	0.523
900-1500	24	24.0	17.5	1.9	17.5		
1500-3000	3	3.0	19.0	4.0	19.0		

SD= Standard deviation

χ^2 = Kruskal Wallis test for several independent group.

Z= Mann Whitney test for two independent groups; [*]P= < 0.05 (significant)

For examination of mean ± SD and median self-esteem scores among institutionalized residents according to the socio-demographic data, **table (2)**. Indicates that, no significant statistical differences are shown between, the age groups, gender, marital status and number of children, where ($\chi^2 = 0.13$; P= 0.937, Z= 0.46; P= 0.672, $\chi^2 = 1.6$; P= P=0.661, and $\chi^2 = 2.1$; P= 0.365, respectively). As well, no statistical significantly differences were observed regarding educational level, Job, income source and monthly income among the in institution residents concerning their self-esteem scores, valuing, ($\chi^2 = 2.7$, P= 0.440; $\chi^2 = 1.4$, P= 0.711; $\chi^2 = 4.3$, P= 0.362 and $\chi^2 = 2.7$, P= 0.433, respectively).

On the other hand, **table (3)** shows the mean ± SD and median self-esteem scores for the non-institution participants, according to their socio-demographic status. From the table it is observed that the significant differences among the outpatient participants were for age group, ($\chi^2 = 7.00$, P= 0.022) and the educational level, where ($\chi^2 = 8.30$, P= 0.040). While the other socio-demographic items, namely, gender, marital status, number of children, job in come source and monthly income did not show any statistical significant differences, where (Z= 0.76, P= 0.450; $\chi^2 = 3.60$, P= 0.302; $\chi^2 = 0.05$, P= 0.819; $\chi^2 = 3.50$, P= 0.316; $\chi^2 = 8.30$, P= 0.080 and $\chi^2 = 4.90$, P= 0.305, respectively), among the studied outpatient clinics attendants.

Table (2): Self-esteem scores (mean ± SD and median) of socio-demographic characteristics among institutionalized participants (n=50)

Scio-demographic characteristics	Self esteem score			χ^2	P-value
	Mean	SD	Median		
Age in years					
60-64	17.1	1.0	17.0	0.13	0.937
65-74	17.1	1.3	17.0		
75-90	17.0	1.6	17.0		
Gender					
Male	17.2	1.3	17.0	Z=0.46	Z=0.672
Female	16.9	1.1	17.0		
Marital status					
Single	16.5	0.7	16.5	1.6	0.661
Married	16.9	1.5	17.0		
Divorced	16.7	1.2	16.0		
Widowed	17.3	1.2	17.0		
Numbers of children					
No child	17.3	1.1	17.0	2.1	0.365
3-4	16.8	1.3	17.0		
5-6	18.0	1.7	19.0		
7-10	17.0	1.0	17.0		
Educational level					
Illiterate	17.3	1.5	17.0	2.7	0.440
Basic education	16.9	1.3	17.0		
Secondary education	17.3	1.4	17.0		
University or more	17.3	1.1	17.0		
Job					
Not working	17.1	1.3	17.0	1.4	0.711
Retired	17.5	1.0	17.5		
Housewife	17.2	1.2	17.0		
Working	16.8	1.4	16.5		
Income source					
Salary	18.0	0.0	18.0	4.3	0.362
Retired fund	17.0	1.3	17.0		
Asset owner	17.1	0.7	17.0		
Non- governmental charity	16.0	0.0	16.0		
Other sources	17.8	1.5	18.0		
Monthly income					
< 300	16.0	0.0	16.0	2.7	0.433
300-600	17.1	1.3	17.0		
600-900	16.5	0.7	16.5		
900-1500	17.3	1.3	17.0		

χ^2 = Kruskal Wallis test for several independent group.
Z= Mann Whitney test for two independent groups
[*]P= < 0.05 (significant)

Table (3): Self-esteem scores (mean ± SD and median) of socio-demographic characteristics among non-institutionalized participants (n=50)

Scio-demographic characteristics	Self esteem score			χ^2	P-value
	Mean	SD	Median		
Age in years					
60-64	16.3	2.8	16.0	7.60	0.022*
65-74	18.2	2.4	18.0		
75-90	17.9	2.1	18.0		
Gender					
Male	17.1	2.4	17.0	Z= 0.76	Z= 0.450
Female	17.9	2.6	16.5		
Marital status					
Single	17.7	2.4	18.0	3.60	0.302
Married	16.9	3.2	16.0		
Divorced	16.6	1.6	16.0		
Widowed	18.2	2.3	18.0		
Numbers of children					
No child	16.2	1.7	16.0	0.05	0.819
3-4	18.1	2.5	18.0		
5-6	18.0	2.8	18.0		
7-10	19.3	3.8	21.0		
Educational level					
Illiterate	17.6	2.1	17.0	8.30	0.040*
Basic education	17.0	2.3	17.0		
Secondary education	18.7	2.6	19.0		
University or more	17.0	5.2	14.0		
Job					
Not working	17.1	2.6	16.5	3.50	0.316
Retired	18.1	1.9	18.0		
Housewife	18.4	2.9	19.0		
Income source					
Salary	23.0	0.0	23.0	8.30	0.080
Retired fund	17.0	2.4	17.0		
Asset owner	19.0	2.4	19.0		
Non- governmental charity	16.4	1.1	16.0		
Other sources	18.6	2.5	18.0		
Monthly income					
< 300	17.7	2.1	17.5	4.90	0.305
300-600	16.2	2.2	16.0		
600-900	17.3	2.6	16.0		
900-1500	18.4	3.5	18.0		
1500-3000	19.0	4.0	19.0		

χ^2 = Kruskal Wallis test for several independent group.

Z= Mann Whitney test for two independent groups; *P= < 0.05 (significant)

Self-esteem status among the studied groups.

The study looked into the self-esteem of the institutionalized elders according the social visits and different patterns of affective relationships for non-institutionalized participants. As well as the self-esteem variables of the total study group (n=100).

The mean ± SD and median of the self-esteem scores by the pattern of social visits for the institutionalized residents (n=50) was higher to out visits to their daughters with mean ± SD valued (20.0±3.2 and median 20.5). There was highly statistical significantly difference for the answer to "who you go out to visit" among the patterns of out visits, scoring (χ^2=11.1; P= 0.001). In contrast there was no significant difference, (χ^2=1.9; P=0.757), for the coming visitors for answer of "who visits you in the institution", according to patterns of social visitors, **table (4)**.

Table (5) shows the self-esteem among the outpatient clinics participants, regarding the different patterns of affective relationships, who the participants living with. The results showed no significant difference concerning the mean ± SD and median self-esteem scores, (χ^2= 3.60, P= 0.449).

The number of the total participants of the study reliability to self-esteem variables, shown in **table (6)** illustrated that positive images and attitudes accounted high scores of strongly agree, ranging from 76 to 95, while the only dominant negative attitude was for the variable "all in all, lam inclined to feel that lam a failure" with 57.0 disagree score. The reliability of the participants to the self-esteem variables, recorded, 0.627, according to Rosenberg self-esteem score.

Table (7) summarized the self-esteem levels and mean ± SD scores among the institutionalized residents and non-institutionalized outpatient clinics attenders, where there was no significant statistical difference, (t=1.10, P= 0.315) between the self-esteem levels and mean ± SD scores.

Table (4):Mean ± SD self-esteem scores by the pattern of social visits for institutionalized elders (n=50)

Patterns of social visits	Self-esteem score			χ^2	P-value
	Mean	SD	Median		
Who you go out to visit					
My daughters	20.0	3.2	20.5		
Family	15.0	0.9	15.0	11.1	0.001*
Friends	17.0	1.6	17.0		
No one	17.7	2.4	18.0		
Who visits you in the institution					
My sons	17.0	0.0	17.0		
My daughters	17.6	2.9	18.0		
Family	18.1	2.6	18.0	1.9	0.757
Friends	17.0	1.4	16.5		
No one	16.9	2.5	16.0		

χ^2 = Kruskal Wallis test.   *P= < 0.05 (significant)

Table (5):Self-esteem scores (mean ± SD and median) among different patterns of affective relationships for outpatient participants. (n=50)

Patterns of affective relationship (living with)	Self esteem score			χ^2	P-value
	Mean	SD	Median		
Family	16.9	1.3	17.0		
Son	18.0	1.2	18.0		
Daughter	17.2	1.6	17.0	3.6	0.449
Siblings	17.3	1.5	17.0		
Alone	17.0	0.9	17.0		

χ^2 = Kruskal Wallis test.   *P= < 0.05 (significant)

Table (6): The number of participants according to their reliability to the self-esteem variables for the study elderly (n=100)

Self-esteem variables	Reliability	SA	A	D	SD
On the whole lam satisfied with myself		76.0	24.0	0.0	0.0
*At times, I think I am no good at all		17.0	53.0	30.0	0.0
I feel that I have a number of good qualities		89.0	11.0	0.0	0.0
I am able to do things as well as most other people		85.0	10.0	0.0	5.0
*I feel I do not have much to be proud of	0.627	7.0	64.0	27.0	2.0
*I feel really I am of no use sometimes		7.0	62.0	28.0	3.0
I feel that I am a person of worth, at least on an equal plane with others		78.0	14.0	0.0	8.0
*I wish I could have respect for myself		12.0	79.0	9.0	0.0
*All in All, I am inclined to feed that I am a failure		11.0	24.0	57.0	8.0
I take a positive attitude towards myself		95.0	4.0	0.0	1.0

SA = strongly agree, A= Agree, D= Disagree, SD= strongly disagree.
Scoring: SA=3, A= 2, D= 1, SD= 0, items with asterisk are reverse scored.

Table (7):Self-esteem level and mean ± SD scores among institution residents and non-institution participants

Study sample groups (n=100)	Self esteem level and mean score			t	P
	Minimum	Maximum	Mean ± SD		
Institutions	15	20	17.1±1.3	1.1	0.315
Non-institutions	13	23	17.5±2.5		

t: Independent samples t-test
*: P<0.05 (significant)

Social supportive and social stressing people relationships.

The present study showed that the percentages of the participants by pattern of affective support relationships, as well as the patterns of stressing people relationships among institutionalized residents and non-institutionalized individuals. **Table (8)** protrudes that some of the family members of the first 6 items and some of the non-family

members of three of the last four items scored higher percentages for the institutionalized residents. On the opposite, the non-institutionalized participants had no one of the family members or non-family members support, where. "no one" of the ten items scored the highest percentages. For the religious men, "no one" of the, supporters recorded, 38% for institutionalized residents and 62.8% for the outpatient community participants. The significant differences between the all items of social relationships of the two study groups are based on Mont Carlo exact probability for p-value <0.05 (significant).

Table (8): Percentage of participants by pattern of affective relationships among institutionalized and community dwellers

Pattern of affective relationships	Study sample (n=100)				MCP
	Institutions		Non-institution		
	No	%	No	%	
Spouse					
No one	2	4.0	34	81	
Some	28	56	4	9.5	0.000*
Several	7	14	1	2.4	
Not one of them	13	26	3	7.1	
Children/ grand children					
No one	2	4.0	33	68.8	
Some	39	78	13	27.1	0.000*
Several	4	8.0	0	0.0	
Not one of them	5	10	2	4.2	
Parents/ grand parents					
No one	22	44	35	81.4	
Several	19	38	5	11.6	0.001*
Not one of them	9	18	3	7.0	
Brothers/ sisters					
No one	5	10	25	58.1	
Some	41	82	17	39.5	0.000*
Several	2	4.0	0	0.0	
Not one of them	2	4.0	1	2.3	
Relatives by blood					
No one	8	16	22	51.2	
Some	36	72	17	39.5	0.004*
Several	2	4.0	2	4.7	
Not one of them	4	8.0	2	4.7	
Relatives by marriage					
No one	8	16.3	24	57.1	
Some	36	73.5	5	11.9	0.000*
Several	1	2.0	11	26.2	
Not one of them	4	8.2	2	4.8	
Neighbours					
No one	8	16	23	53.5	
Some	39	78	4	9.3	0.000*
Several	1	2.0	14	32.6	
Not one of them	2	4.0	2	4.7	
Co-workers					
No one	18	36	27	62.8	
Some	23	46	0	0.0	0.000*
Several	1	2.0	9	20.9	
Not one of them	8	16	7	16.3	
Religions men					
No one	19	38	27	62.8	
Some	17	34	3	7.0	0.002*
Several	0	0.0	3	7.0	
Not one of them	14	28	10	23.3	
Other friends					
No one	16	32	24	54.5	
Some	28	56	6	13.6	0.000*
Several	0	0.0	5	11.4	
Not one of them	6	12	9	20.5	

MCP: P-value based on Mont Carlo exact probability.

* : P < 0.05 (significant)

Table (9) Illustrates the percentages of participants by pattern of stressing people relationships among institutionalized residents, (n=50) and non-institutionalized participants, (n=50). The results showed that no one of the family members or non-family members exerted stress on the geriatric home residents, except some children, brothers/ sisters and some neighbours scoring high percentages, (40%, 62% and 40%, respectively). In contrast no stress was practiced upon the outpatient clinics participants, where "no one" of the all ten items scored higher percentages. There were highly statistically significant differences according to the patterns of stressing people relationships, between the two groups of the study, according to p-value of Mont Carlo exact probability, (P< 0.05).

Table (9): Percentage of participants by pattern of stressing people relationships among institutionalized and non-institutionalized individuals

Pattern of stressing people relationships	Study sample (n=100)				MCP
	Institutions		**Non-institution**		
	No	**%**	**No**	**%**	
Spouse					
No one	15	30.0	47	94.0	0.000*
Some	9	18.0	2	4.0	
Not one of them	26	52.0	1	2.0	
Children/ grand children					
No one	12	24.0	45	90.0	0.000*
Some	20	40.0	5	10.0	
Not one of them	18	36.0	0	0.0	
Parents/ grand parents					
No one	21	42.9	48	96.0	0.000*
Some	2	4.1	1	2.0	
Not one of them	26	53.1	1	2.0	
Brothers/ sisters					
No one	13	26.0	37	74.0	
Some	31	62.0	13	26.0	0.000*
Several	1	2.0	0	0.0	
Not one of them	5	10.0	0	0.0	
Relatives by blood					
No one	18	36.0	34	68.0	0.000*
Some	4	8.0	16	32.0	
Not one of them	28	56.0	0	0.0	
Relatives by marriage					
No one	15	30.0	33	66.0	
Some	10	20.0	8	16.0	0.000*
Several	1	2.0	8	16.0	
Not one of them	2.4	48.0	1	2.0	
Neighbours					
No one	12	24.0	33	66.0	
Some	20	40.0	1	2.0	0.000*
Several	2	4.0	14	28.0	
Not one of them	16	32.0	2	4.0	
Co-workers					
No one	17	34.0	35	71.43	
Some	4	8.0	1	2.04	0.000*
Several	1	2.0	6	12.24	
Not one of them	28	56.0	7	14.29	
Religions men					
No one	20	40.0	40	80.0	0.000*
Several	0	0.0	1	2.0	
Not one of them	30	60.0	9	18.0	
Other friends					
No one	20	40.0	40	80.0	
Some	0	0.0	1	2.0	0.000*
Several	0	0.0	1	2.0	
Not one of them	30	60.0	8	16.0	

MCP: P-value based on Mont Carlo exact probability.   * : P < 0.05 (significant)

Table (10) summarizes the patterns of social affective (social support and social stress) scores according to Duke Social Scale (DUSOCS) for both in-institution residents and non-institution participants as follows: family support, non-family support and social support scores of (57.14, 21.43 and 50.0 DUSCOS, respectively) for institutionalized resident social support, versus (20.0, 0.0, and 9.10 DUSOCS, respectively) for the non-institutionalized participants. Regarding the social stress, family stress, non-family stress and social stress scores, of (28.6, 10.0 and 22.73 DUSCOCS, respectively), for the geriatric home residents, versus (14.3, 0.0, and 9.10 DUSCOCS, respectively) for the outpatient community participants. For both social support and social stress (the most supportive and the most stress persons) were brother/ sister of family members.

Table (10): Summary of patterns of social affective (social support and social stress) scores according to Duke Social Scale (DUSOCS) for in-institution residents and non-institution outpatients

Patterns of social affective	In-institution (n=50)	Non-institution (n=50)
	DUSOCS	DUSOCS
1- Social support:⊗		
Family support score	57.14	20.0
Non-family support score	21.43	0.0
Social support score	50.0	9.10
2- Social stress:⊗		
Family support score	28.6	14.3
Non-family support score	10.0	0.0
Social support score	22.73	9.10

⊗ :For both social support and stress (the most supportive and most stress persons) were brothers/sisters of family members.

Self-esteem scores according to associated chronic diseases.

Table (11) presents the mean ± SD and median self-esteem scores according to associated chronic diseases among institutionalized residents and non-institutionalized elderly participants. From the table diabetes mellitus, hypertension, osteoporosis, hepatic diseases and diabetes & hypertension combined are the common associated chronic diseases among both studied groups. No significant differences, according to self-esteem mean ± SD and median scores were detected by Z-test (Mann Whitney test) scoring, (Z= 0.49, P= 0.06214, Z= 0.21, P= 0.837, Z=0.20; P= 0.40, Z= 0.79; P= 0.427, and Z= 0.57; P= 0.567, respectively), between the studied two groups. Similarly, there was no significant difference (χ^2= 3.9; P= 0.550) between the associated chronic diseases according to the self-esteem scores within the group of geriatric home residents. As well, there was no significant difference among the same diseases regarding self-esteem scores of the outpatient participants, where (χ^2= 2.3; P= 0h.892).

Table (11): Self-esteem score (Mean ± SD and median) according to associated chronic diseases among institutionalized residents and non-institutionalized participants

Associated chronic diseases	Study sample participants (n=100)						Z-test	P-value
	In institutions (n=50)			Non-institution (n=50)				
	Mean	SD	Median	Mean	SD	Median		
Diabetes mellitus	17.6	2.8	17.5	17.0	1.2	17.0	0.49	0.624
Hypertension	17.3	2.8	17.0	17.0	0.9	17.0	0.21	0.837
Osteoporosis	17.0	1.7	18.0	18.5	0.7	18.5	0.20	0.400
Hepatic diseases	16.7	1.2	16.0	17.6	1.8	17.0	0.79	0.427
Diabetes mellitus and hypertension	18.0	2.8	17.5	17.0	1.2	17.0	0.57	0.567
χ^2 (P-value)	3.9(0.550)			2.3(0.892)				

Z= Mann Whitney test. χ^2 = Kruskal Wallis test.   P= < 0.05 (for significant)

4. Discussion

Sample of the current study consisted of fifty geriatric care home residents and fifty individuals those attended the outpatient clinics. Both groups' members elderly aged 60 years or more, who met the inclusion criteria of selection and agreed to participate in the study. This study gives an overview of the selected groups, such as, age and gender, as well as, other socio-demographic variables, including marital status, number of children, educational level, job,

income source and monthly income. It also, looked into self-esteem status, social effective relationships and associated chronic diseases. The results presented the percentages of the respondents according to their socio-demographic data, that nearly half of the studied subjects ages ranged between 65 ± 0.74 years. Similar, range of ages was reported among non-governmental geriatric care home residents in Egypt.[5] This range was more broad among geriatric patients newly admitted to a large traditional nursing home.[44] In

contrast, a range of (55-64 years) was reported among Australian men over 55 years.[10]

The present study, showed that more than half of the subjects were males versus only 41% females, whereas widowed subjects counted 45% versus only 29% for married elderly respondents. In contrast to these findings, many investigators mentioned that dominancy of females,[5,8] were most of them related that to females longevity than males.[5,8,45] For widowed elderly similar percentages were reported for widows elderly living in rural England.[46]

This study reports nearly two-third of the studied subjects was literacy subjects, and those having no children contributed by nearly half (46%). More than two-third of them (68%) receive their income from state pension. Who earns monthly income (less than 600 Egyptian pounds) accounted 60% of the elderly subjects. In agreement to these results, a cross-sectional study found high level of literacy,[47] and low monthly income among 44% of Nigerian elderly.[48] Similar, observation was reported by Amal et al.,and Sidhu et al.,.[49,50] In England, nearly half of pensioner couples and nearly three quarter of single pensioners get their income from the state pensions and benefits.[51] Inconsistent, to the study findings, 72% of the over 65-years elderly in England said they were satisfied with their future monetary securing.[52]

Regarding self-esteem scores of study subjects (n=100) concerning their socio-demographic factors, only income source, showed significant difference (P=0.03). Socio-demographic factors among geriatric home residents and self-esteem scores, showed no significant differences. While the study found significant differences for age group (P=0.022) and educational level (P=0.04), among non-institution participants. In match to these findings, a correlational study to investigate the relationships among depression, social support, self-esteem and selected socio-demographic variables of the studied subjects, found no significant effect on their feeling of self-esteem or depression.[16] A cross-sectional study focused a weaken association between socio-demographic characteristics, depression and life events among handicap subjects.[35] It was also established that in elderly people, mobility was affected by socio-demographic factors, such as, age, gender and chronic diseases while, life-satisfaction was related to age, education level and health perception level.[53]

Self-esteem status among the in institution residents, according to pattern of social visits, showed high mean ± SD and median, for parents visited their daughters than visiting other family members, with significant difference, (P=0.001). No visitors to all studied subjects (n=50) in their care homes. For outpatient clinic respondents, no significant differences among the self-esteem scores (mean ± SD, median) for effective social relationships "who they like with", (P=0.449). These results are in accordance with four psychological well-being scores of spruce, child, friend and lone-wolf, for psychological adjustment scores, where self-esteem and life-satisfaction showed significant effects on effective relationship patterns. Self-esteem scored the highest significant difference among effective relationship patterns (P<0.001), and lone-wolf. Participants scored significant lower than those in the reaming three patterns, (P<0.001).[21] In the context, a longitudinal study of ageing, demonstrated that social support reduced depression effect through an increase in self-confidence and a decrease in self-deprecation.[16,22] In the contrast, social support did not show a direct effect on depressed effect. This finding suggested the importance of self-esteem improving elements of social support in reducing depressive symptoms.[22]

The present study reported a considerable reliability, (0.627), according to **Rosenberg, 1965,[42]** for the total (n=100) study subjects, towards the self-esteem variables, with the self-perceptions. The percentages of strongly agree (SA), for positive perceptive items were the highest, versus the negative self-perceptive items. No significant difference between self-esteem levels and mean ± SD & median among institutionalized elderly and non-institutionalized participants, (P=0.315). A comparable correlation study findings of a two-week test-retest quantitative reliability of family support, stress and personal functional health status, reported 0.76 for family support, obtained from a sample of ambulatory patients.[25]

The social supportive relationships among the geriatric home residents and the effective social relationship, were from some of family members and some of non-family members. While no social support was dominant among outpatient clinic attenders. There was a highly significant difference between the two studied groups, for both family and non-family members relationship. The study also showed that persons who exert stress on geriatric home residents, were some children, brothers/ sisters and some neighbours, (40%, 62% and 40%, respectively). No stress was practiced upon the other group of study. There were significant differences between the different patterns of stressing social relationships between the two studied elderly populations. The findings according to DUSOCS scale showed that, social support and social stress scores were higher for the institution subjects, (50.0 and 22.73, respectively) versus (9.10 and 9.10) for non-institution respondents. The mentioned findings highlight the importance of social relationships, this is in agreement to the opinion expressed by the report of the International

Conference Population Ageing: issues and challenges, which stated that social changes in the context of an ageing population have exerted pressures on the family institution and existing social protection schemes.[54] A research work also demonstrated the importance of social and family relationships in the definition of good quality of life.[24] Reports are mentioned a stronger graded relationship between the social support deficits and depression as an indicator of self-esteem.[35]

It is assumed that the proportions of friends versus family members as an important supportive figures will vary with cultural-historical factors.[21] Regarding the social stress relationship/ presented by this study, cope the general concepts of many investigators, who sorted stressors as secondary and primary stressors, which again categorize as the strains experienced in roles and activities outside of care giving and intrapsychic strain, involving the diminishment of self-concepts-social support can be potentially intervene at multiple points along the stress process.[55] The findings also matched with a suggestion of people in geriatric homes cannot cope with stressful life events and individuals' mental well-being is associated with low social support. Such social factors are also common in many African countries.[29,56] Similarly, the social stress scores reported by the study are almost in accordance to previous reported scores (0.68) for non-family stress and (0.40) for family member stress.[25-27]

The present study appeared that the dominant associated chronic diseases for the two studied groups of elderly people, were common, namely, diabetes mellitus, hypertension, osteoporosis, hepatic diseases and a combination of diabetes mellitus & hypertension. There were no differences statistically for self-esteem scores, regarding the associated chronic diseases between the two studied groups, or even within each group. These findings are confirmed by a study results of a community-based sample of persons aged 55-85 years, with different chronic diseases, where string linear associations were found between the number of chronic diseases and depressive symptoms, and anxiety indicating that psychological distress among elderly people is more apparent in the presence of more diseases.[57] In accordance to the results, a multiple regression analysis, showed that both self-related oral health and self-related health, independently explained a significant amount of variance in concurrent rating of self-esteem and life-satisfaction.[58] These variations are explained by psychological distress is the most frequently experienced by patients with osteoarthritis, rheumatoid arthritis and stroke, where as diabetes and cardiac patients appear to be least psychologically distressed. These differences in disease characteristics

may partly explain the observed psychological differences across diseases.[57] Also, Cott et al., reported that psychological resources, especially high mastery and self-esteem are associated with better health in those with chronic conditions.[34] In regard to hypertension, Awobusuji et al.,found to be the most prevalent non communicable disease in Nigeria in general outpatient department.[47] In agreement to our findings, Mukadder et al., in Turkey, found that examined life-satisfaction in elderly living in nursing home, showed that mobility and self-esteem are affected by chronic diseases and life-satisfaction is related to health perception level.[53] Rugulies reported that the depression, as a sign of self-esteem, is associated with chronic disorders, such as, diabetes mellitus, arthritis and strongly with cardiovascular diseases in late life.[59]

Conclusion

Among the elderly people ageing is associated with poor mental health, especially for the institutionalized residents of geriatric care homes, and for those living alone in the community. Where low level of life-satisfaction and self-esteem are major problems. As well, the social relationships that are swings between supportive and stressing social affective relations. In addition, the comorbid attenuation, lack of self-care abilities, and socio-demographic shifts at their late life.

This study demonstrated that the ages of the 46% of study elderly respondents, ranged between 65 to 74 years, where 45% of them were widowed versus 29% married individuals. About two-third (64%) of the studied group (n=100) were illiterate and only read & write who were actually at the margins of illiteracy. Monetary inadequacy counted (60%) with less than 600 Egyptian pounds monthly earning, where (68%) were pensioners.

Self-esteem had no significant effect of the studied elderly group (n=100), regarding age, gender, marital status, educational level, job or monthly income. Similarly, self-esteem scores of the geriatric home residents did not show any significant differences according to their socio-demographic characteristics. While self-esteem of the non-institutionalized participants affect significantly according to age group (P= 0.022) and educational level, (P=0.04). The self-esteem status among geriatric home residents, according to the patterns of social visits scored high mean (20.0±3.2) for visiting their daughters, with significant difference (χ^2= 11.10; P=0.001). No visits from family or non-family members were reported for the elderly in the geriatric care home, with no significant difference, (χ^2= 1.9; P= 0.747). The self-esteem scores among the different patterns of effective relationships, who they like to

stay with for outpatient respondents, did not show any significant statistical difference, (χ^2= 3.6; P= 0.449). There was a considerable reliability, (0.627) to self-esteem variables according to Rosenberg 1965, with positive self-perception. There was no significant differences, between the self-esteem levels and the mean scores of the institutionalized geriatric home residents and those living in the community, (P=0.315).

The social supportive relationships among the geriatric home residents, for the affective persons, were from some family members and some non-family members. No social support was dominant among non-institutionalized respondents from family or non-family members. There was a highly significant social supportive relationships. Concerning social stress relationships, there was no stress practiced upon the outpatient clinic attenders. While the exerted stresses on the geriatric home residents, were from some children, sisters & brothers and some neighbours, scoring (40%, 62% and 40%, respectively).

The findings of this study, according to the DUSOCS scale, for social support and stress, showed that family social support and stress scores, were higher than non-family support and stress, (57.14 and 28.6, respectively) versus (21.43 and 10.0, respectively) for the geriatric home residents. Similarly, social support score (50.0) and social stress score, (22.73) for the geriatric home residents were higher than those (9.10 and 9.10) of the community living participants. The most supportive and most stressing persons, for social support and social stress, were brothers & sisters of family members.

It was found that the dominant associated chronic diseases for the dominant associated chronic diseases for the two studied groups were common, namely, diabetes mellitus, hypertension, osteoporosis, hepatic diseases and a combination of diabetes mellitus and hypertension. No significant differences were observed for self-esteem mean and median scores, regarding the associated chronic diseases, between the two studied groups, according to (Z) Mann Whitney test, or even within each group, (χ^2= 3.9; P= 0.550), for geriatric home residents and (χ^2= 2.3; P= 0.892), for non-institutionalized participants.

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