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A MODEL OF DEATH, DEPRESSION, AND TOBACCO USE: THROUGH A PSYCHOLOGICAL STUDY OF BELIEFS IN ELDERLY ADULTS IN MEXICO CITY

Juan Crisóstomo Martínez Berriozabal

Diana Laura Pérez Hernández

Fausto Tomas Pínelo Ávila

José de Jesús Silva Bautista

Abstract: Fishbein and Ajzen (1975) demonstrate the origin of behavior in the beliefs that individuals hold regarding their intention to perform a certain behavior. They define belief as the subjective probability of a relationship between the object of belief and some other object, concept, value, or attribute. López (2015) defines death as the cessation of life. According to the World Health Organization, WHO (2019), depression is considered a mental disorder characterized by a series of symptoms, and it also has a classification related to its degree of severity. WHO (2020). Definition of smoking: smoking at least one cigarette in the last 30 days. This is why the following general approach was developed: What is the relationship between the following variables: beliefs about death, depression, tobacco, tobacco use, religiosity, and sociodemographic variables? (In regression analysis, variables can be used either as IV or DV depending on the researcher's interest.) Data analysis: Frequencies and percentages; Validity (Factor Analysis); Reliability (Cronbach's Alpha); Correlation (Pearson); Descriptive and Inferential Analysis; T-test; ANOVA and Regression Analysis. Some results are mentioned. A general alpha of .870 was achieved. The KMO and Bartlett tests resulted in adequate values of .847 and Sig. of .000.The alphas for each factor (3 in total) were: FACTOR 1. CCT. Beliefs about the consequences of tobacco use .879; FACTOR 2. D T: Depression and tobacco use .802; and FACTOR 3. D M: Depression and death .823. The explanation of variance was 27.739.

Keywords: Smoking; Depression; Death; TAR and TAP and Beliefs

INTRODUCTION

Psychology is one of the sciences that encompasses various areas of application from a different perspective. It is also one of the least developed sciences, but one that raises important questions for a better understanding of human beings and their interactions. Such is the case with social psychology, whose objective is to study the relationship between human beings and their environment, the influence of the society in which they develop as individuals, and how these processes contribute to the modification or establishment of the society in which human beings are immersed.

Before discussing a society with its entire structure, it is important to understand how such a society is formed and emerges. A good starting point would be to understand the groups that make it up, as well as their own socialization process, that is, the constructs that are valid in each group for it to function as such. Social psychology uses these constructs to study the relationship between the individual and society, thus providing us with various categories that generate paradigms, theories, and foundations for expanding existing knowledge. This paper brings together beliefs, death, depression, and tobacco use, which can commonly be found in most groups, as beliefs contribute to the process of socialization betwe , since when they are compatible, a sense of belonging is generated betwe and within the various groups. On the other hand, there is life, which involves its own inevitable processes that occur at a certain moment. These processes may or may not be the consequences of a series of actions, but the reality is that they will have their moment to arise. Among these processes or realities is death, which marks the end of

life. No living being can escape death, and since it is a real and definitive fact, human beings seek to explain it and, in turn, give it meaning. On some occasions, as will be seen later, death is considered a goal, an end for which one must prepare throughout one's entire life. Another section will deal with depression as a result of various factors that negatively affect the environment and the individual's proper balance. Smoking will also be addressed as a practice carried out among individuals and groups for a considerable time now and how this practice is viewed depending on factors such as age, gender, status, among others, that are present in the individual's interaction with the group to which they belong. The study of these categories is considered to be of great relevance since they are present throughout the life of each individual, and interaction with the environment is also fundamental in explaining the occurrence or non-occurrence of such acts, such as consolidating a belief in death and whether such an act has an impact on the decisions that individuals will make throughout their lives.

The first point deals with beliefs as a psychosocial phenomenon among individuals. A theoretical approach is taken, considering the most outstanding works and research in the field of social psychology.

The second point addresses the topic of death from a multidisciplinary perspective. It is important to remember that death can be analyzed from a biological and medical approach, where social aspects such as religion carry the meaning given to it by different religious groups, demonstrating that, although they share similarities regarding the meaning of death, the references or historical background of each religion or group are the guidelines for marking differences and analysis.

The third point addresses depression as a public health issue from a psychological and social perspective, where the relationship between individuals is more relevant than an organic perspective, without neglecting the role played by emotions and the environment in which the individual may suffer from depression.

The fourth point focuses on smoking, addressed as a global problem. Smoking behavior can be viewed from different theoretical models that attempt to explain how the habit of smoking is acquired, what its repercussions are, and the social impact it causes.

Some of the results found indicate that a general alpha of .870 was achieved. The KMO and Bartlett tests yielded adequate values of .847 and Sig. of .000. The alphas for each factor, 3 in total, were FACTOR 1. CCT. Beliefs about the consequences of tobacco use .879; FACTOR 2. D T: Depression and tobacco use .802; and FACTOR 3. D M: Depression and death .823. The explanation of variance was 27.739. The correlation between factors was adequate; all three correlated significantly with each other at the 0.01 level (bilateral). In the T-test, there were differences between F2 and F3 in relation to gender. T-test Smoker or Non-smoker there were differences with F1 and F2. For ANOVA, no significant differences were found in relation to age, marital status, education, religion, and beliefs. This may be due to the homogeneity of older adults in the different variables and their relationship with the beliefs found. Regression of religiosity over two years acts as an independent variable on beliefs about depression and tobacco. R squared .032 is the

most comprehensive explanation. It can also be seen how religiosity over the next two years acts as an independent variable on F1 Beliefs about the consequences of tobacco, which is a dependent variable. Finally, being a smoker or not acts on DV Beliefs about the consequences of tobacco. Consequently, the four hypotheses proposed were generally tested.

I THEORETICAL FRAMEWORK

BELIEFS

Approach to the term belief

Beliefs are a field as extensive as they are relevant within psychology. However, as Pepitone (1991) mentions, the psychosocial literature contains relatively little information about theses and research on the subject of beliefs. Nevertheless, the efforts of various psychosocial researchers to extend the understanding of beliefs continue to accumulate data over time that reaffirm what has already been found, as well as innovations on the subject, which generates motivation to continue investigating the aspects that support what has already been postulated.

Below are some of the concepts that have been developed regarding the concept of beliefs:

Developed by Fernández and Besabé (2007), beliefs are addressed as propositions about specific aspects that people express as true. As the authors point out, beliefs are the result of the interaction of specific issues of the person with their environment or society, which together are resolved as true.

Similarly, Palomino (2013) states that beliefs arise from an individual's knowledge of a particular object, which implies a value of truth that is sufficiently solid to support opinions about that object. Following this line of thought, (Sigel, 1985) defines beliefs as "mental constructions of experience, often condensed and integrated into schemas or concepts" (p. 351) that are considered to be true and thus guide behavior.

That said, a given situation must have the necessary impact on the individual to achieve a meaning that is relevant enough to give it truth value, which means that for a belief to exist, it must maintain a state contrary to immobility. As mentioned by Harvey (1986), belief can be taken as an individual situation of reality that has sufficient validity, truth, or credibility to guide thought and behavior.

According to Bain (1868), belief is an active state with varying degrees of strength: it is said to be strong when it drives us like a powerful counter-impulse, or weak when it is overcome by a weak impulse. For his part, De la Pineda (1999) mentions that belief manifests itself as an ordinary experience that cannot be reduced to others; as evidence, an assumption, or a proposition that I cannot rationally or empirically demonstrate to others in a way that compels them to accept it. Given that reality can be subjective, that is, it will depend to a certain degree on the signifiers for each individual, it is a complex task for more than one person to accept another's belief without first being proven. Regarding beliefs and reality, Ramos (2007) states that beliefs represent reality as seen from our perspective and guide our actions. They are very stable ideas that form part of our thinking and have interpretative and evaluative value. They tend

to be limited by the culture in which the individual lives; they are resistant to change, but they are not immutable.

These concepts reveal that, despite the information obtained through years of study on beliefs, it is still not possible to obtain a complete picture that would allow us to define a precise concept around them. Even so, there is no denying the increase in interest and research results on the topics addressed, since the difficulty in defining a concept does not equate to the existence or non-existence of beliefs.

According to Reyes (2007), Fishbein and Ajzen (1975) demonstrate the origin of behavior in the beliefs that individuals hold when intending to perform a certain behavior.

> *(...) they define belief as the subjective probability of a relationship between the object of belief and some other object, concept, value, or attribute. The formation of a belief involves the union between two specific aspects of an individual's world, with the purpose of achieving an understanding of oneself and one's environment. (p.67)*

Function of beliefs

It is an undeniable fact that beliefs contain an important part of each individual's history and experiences. Despite the similarities that we may find between beliefs, each one will have a special and characteristic tinge. The components required to form a belief encompass both internal and external factors. Below are some of the functions of beliefs, because although they contain special information, they have different reasons for arising and persisting despite time and/or circumstances.

According to Diaz, Martinez, Roa & Sanhueza (2010), beliefs have different functions. These functions have emerged through various studies (Barry & Ammon (1996), Goodson & Numan, (2002), Pajares (1992)) dedicated to beliefs, although it is important to note that not all authors agree with what is presented below.

Beliefs are formed early on and tend to perpetuate themselves, either persisting or changing, but the latter is considered more difficult in the face of contradictions caused by time, reason, education, or experience. People develop a belief system that encompasses all those acquired through the process of cultural transmission. The belief system has an adaptive function that helps people define and understand the world and themselves. Knowledge and beliefs are intrinsically related; however, the affective, evaluative, and episodic nature of beliefs makes them a filter through which new phenomena are interpreted. Beliefs are prioritized according to their connections or relationships with other beliefs or other cognitive and affective structures. The earlier a belief is incorporated into the belief structure ( ), the more difficult it is to modify it (Díaz, et al. 2010).

Theory of Reasoned Action and Theory of Planned Action

The Theory of Reasoned Action is a predictor; a probabilistic judgment in which the intention toward behavior can be estimated directly using a probability scale (Reyes, 2007).

Developed by Fishbein (1967), it defines belief as the subjective probability of a relationship between the object of belief and some other object, value, or attribute. The formation of a belief involves the union between two specific aspects of the individual's world, which maintains the purpose of achieving understanding of oneself and one's environment.

In general, the author argued that attitudes are determined by the characteristics that observers associate with an object (beliefs about the object), which establishes the concept of a general attitude. However, it is important to reiterate that this attitude is shaped by the beliefs that precede it and are acquired and probably modified over time based on the subject's experiences. This is why the study of beliefs, among other things, is quite complex but at the same time represents a challenge to advance our knowledge.

Another theoretical model to recognize in order to understand beliefs is the Theory of Planned Action (TPA), which reinforces the previous model. The Theory of Planned Action was also developed jointly by Ajzen and Fishbein (1980). According to Huéscar, Rodríguez-Marín, Cervelló, and Moreno-Murcia (2014), the postulates of PAT suggest that a person's behavior is immediately determined by their intention to perform (or not perform) that behavior. In turn, this intention to perform a behavior is a function of three fundamental elements:

First, the *attitude toward the behavior* as an initial variable, which is determined by the person's beliefs about the results of the intended behavior, by the assessment of those results, and by experience, which translates into a learned way of responding (favorably or unfavorably) to an event in a consistent manner (Ajzen, 1991).

Second, the *subjective norm*, which is the most social component of the model and implies, in turn, the person's belief that there are social pressures exerted on them to perform or not perform the action in question, and the motivation to comply with such pressures.

Thirdly, the *perception of behavioral control* that one has in the situation in which the decision must be made and action taken.

Given the above, the authors' idea of expanding the Theory of Reasoned Action, now including perceived control in this proposal, is demonstrated. (Hogg , Graha, Vaughan, & Morando, 2010) Perceived control is understood as the ease or difficulty of carrying out an action performed by a person, thus giving the possibility of intervening in behavioral intention. All of the above beliefs can lead us to think or act on a concept such as death.

DEATH

As Oriol (1975) rightly points out, man is the only animal that lives in the presence of death. Unlike irrational animals, humans are aware of their mortality. Another difference proposed by the author is that human beings have a deep reverence for death, ranging from ceremonial centers and funeral rites to dances, songs, and other ideas as a tribute to death itself and to those who have been taken, among other things. However, irrational animals do not engage in any of the aforementioned practices; they simply remain on the path. Oriol himself proposes that the moment of death is considered a bad thought that arises at different

times throughout human life, generating anxiety, that is, the fear of dying in most cases.

Death from a scientific perspective

The scientific study of various aspects of human life has contributed to a better understanding of the various phenomena that occur. Death, of course, could not be left behind, because although it could be understood as the end of an organism's life, the process of dying involves a series of complex events that require more than a simple general review. According to López (2015), death is defined as the *cessation of life.* (p.226) However, there are also various meanings according to a classification scheme of death. Within the same category, López also defines *apparent death* as the "cessation of life indicated by the absence of a heartbeat or breathing." He also mentions the term *brain death*, which, unlike apparent death, is characterized by the complete loss of brain function while the heart continues to beat. Likewise, he mentions the term *assisted death*, which is "a form of euthanasia in which one person helps another to achieve their goal of dying prematurely, either through counseling or by providing them with poison or another lethal instrument." In contrast, he mentions the term *biological death*, which is considered when the event of death is attributed to natural causes.

Death from a social perspective

As human beings grow up, they learn and repeat certain practices that they acquire from the society in which they develop. They learn to identify the practices or rituals performed in each era or on certain dates that have been marked for years, which they can even imagine. In the presence of death, each society or civilization maintains its own rituals, practices, and, consequently, its beliefs about this subject, which undoubtedly continues to be a mystery. Despite the society and culture in which individuals develop, there may be significant differences in how death is conceived, due to various variables such as religion, beliefs, and even experience itself. As mentioned by the philosopher and physicist Bunge (2013).

> *"Death is not a mystery to anyone who knows anything about biology. Death does not frighten an atheist, because he knows that nothing can happen to him after death. The only thing that can frighten him is a slow and painful death, but assisted death frees us from this fear."*

Death from a psychological perspective

Death is highly relevant from a psychological perspective. However, as Russell (1951) mentions, among the important fields of scientific knowledge, psychology is the least advanced of all. In addition to the above, psychology clearly plays an active role in understanding the aforementioned topic of interest.

It is particularly difficult to talk about death: firstly, because we only have the experience of the death of others, which is obviously not a matter of our own experience; but even so, the death of others awakens our awareness of definitive, absolute, unconditional separation (Ulloa, 1997).

It is clear that the experience of death is lived and approached throughout the world, since human beings share certain characteristics that constitute them as such: human beings are biological, psychological, social, and spiritual beings. For the IMT (2011), the Mexican Institute of Thanatology, death in the case of Mexicans is considered taboo.

But what is the relationship between psychology and death? It is difficult to give a concise answer, and even accepting that there is a relationship between the two is not something to be taken lightly. However, psychology as a science has devoted part of its efforts to revealing in a humane and clear way a subject as controversial as death. In the various schools of psychology, we can find concepts surrounding death and how human beings react to it, which can lead to depression or cause them to think or act in a certain way.

DEPRESSION

Definition of Depression

Every day, most people carry out routines, make plans, and perform tasks according to their particular lifestyle, generally hoping that at the end of the day they will have accomplished everything they set out to do or achieved the goals they set for themselves. This is how they go about their daily lives. However, there are various variables or unexpected events that can disrupt plans and even people's lives. What would be expected is that when any kind of unexpected event occurs, people know how to act appropriately to overcome such obstacles or that they have adequate support networks. Such obstacles, in addition to disrupting routines and plans, can also cause emotional imbalance. However, once overcome, people regain a positive state of mind. External agents, i.e., those coming from the environment, and internal agents, which are located in the central nervous system, specifically in the human brain, are involved in this whole process. This is where all the stimuli we receive from the outside world and the reactions that originate from within us converge and are processed. As Pasantes (2017) mentions, we have certain types of emotional systems in the brain that receive stimuli from the outside world, specifically those related to the intensity and success of relationships between individuals. When the imbalance or impact is greater than what a person can assimilate and overcome or recover from, it can give way to what is known as depression. According to the World Health Organization (2019), depression is considered a mental disorder characterized by a series of symptoms. It also has a classification related to the degree of severity. Depression is considered a common mental disorder in the world population. Some of the symptoms that reflect depression are sadness, loss of interest or pleasure, feelings of guilt or low self-esteem, sleep or appetite disorders, fatigue, and lack of concentration. According to the classification established by the WHO (Ibidem), depression can be chronic, which directly affects the performance of the person suffering from it in their daily life. In severe depression, there is a high risk of suicide, whereas mild depression can be treated without medication, unlike moderate depression, where health professionals opt for a medication regimen.

However, there is an exaggeration in the use of the term depression to refer to certain conditions that do not actually meet the criteria mentioned above to be conside-

red the disorder itself. In this regard, Moreno (2008) mentions that due to the abuse of the term depression, one could fall into the error of using depression as a justification for the failures of hedonism, human misery, as well as the confusion between the pathology of feelings and sensory or psychic feelings. "The *vulgarization of the term depression has complicated and expanded the area of affective pathology" (*p. 9). But it is also important to analyze what has been said about the causes of depression.

Causes of Depression

Breton (1996) mentions that, for the causes of any form of depression, three different aspects must be taken into account. First, who is most likely to feel depressed (susceptibility). Second, what will cause them to feel depressed (triggering factor). Third, what causes them to continue feeling depressed (maintenance).

This establishes the existence of predisposing factors, known in medical terminology, that make some people more prone than others to suffer from certain types of depression. In terms of susceptibility, gender is considered a predisposing factor. According to statistics, women are considered to be more vulnerable to depressive disorders than men. Of every three patients hospitalized for depression, two are women. The reason could be women's awareness of their own hormonal changes and the different periods they go through that are considered critical, such as menstruation, pregnancy, postpartum, and menopause. Another apparent reason could be the way women are treated by society, as well as what is expected of them. Women are considered to be more susceptible to depression if they are unemployed or caring for young children, as this generates depression due to the little time they have for themselves, thus losing their sense of identity. *They see themselves as people whose only function is to attend to the needs of others.* Breton (1996, p. 31) states that this results in a loss of self-esteem and confidence, which in turn generates a common trait of depressive illnesses. This can lead to certain practices that compensate in some way for what is considered unsatisfactory, such as drug use, including tobacco.

SMOKING

Origin of tobacco

The tobacco plant belongs to the Nicotiana genus of the Solanaceae family; it is the only plant in the family capable of synthesizing the powerful alkaloid nicotine, which is still present in its dried leaves. It is native to America, where it was used for ritual and medicinal purposes. Rodrigo de Jerez and Luis de Torres were the first to describe how the natives consumed it, rolling the leaves into a musket shape and inhaling the smoke (Méndez & Flores, 1990; WHO (World Health Organization. WHO, 1997).

According to the University of Murcia (2023), tobacco consumption was introduced among the nobility in France when it was recommended by the French ambassador to Portugal, Jean Nicot (after whom it is named). Nicotine was first isolated by Poseel and Reiman in 1828. In 1843, Mathieu Orfila began the first pharmacological experiments with it. At the beginning of the 18th century, tobacco was consumed in pipes and in the form of snuff. The industrial production of cigarettes began in the mid-19th century, and the first factory was located in Seville.

Today, industrial cigarette production is becoming increasingly sophisticated in order to reconcile the demands of manufacturers on the one hand and international health organizations on the other to reduce health risks. The aim is to lower tar and nicotine levels and to replace their effect on the palate with multiple chemical substances (around 500). Since it is during the combustion process that the greatest amount of toxins for the body are produced, the production of "smokeless" "eco-friendly cigarettes," or "clean cigarettes" (including chewing tobacco) has increased in recent years, and more recently, electronic cigarettes, which are still under debate due to their high toxicity and the high level of dependence they cause. However, although they appear to be less harmful to the individual and the environment, they are still equally dangerous to health.

Overview of smoking in Mexico

According to the Mexican Council Against Smoking (CMCT, 2011), there were 11 million smokers in Mexico. If the country fails to reverse this trend, half of them will die from tobacco-related diseases. In addition, 72% of current smokers want to quit, but only 10% have succeeded in doing so. According to the 2008 National Addiction Survey (ENA), published in part in 2009, nearly 11 million Mexicans who have never smoked (23.3% of the population) are exposed to secondhand smoke. As a result, 60,000 people die each year in Mexico from causes attributable to tobacco, representing 165 deaths per day. According to Ahued (2011), up to 46% of the capital's residents smoke, resulting in 65,000 deaths per year and costs of 100 million pesos annually.

According to ENA (2008), the results show that, in the Federal District, the consumption of medical and illegal drugs in general is higher than the national average, especially marijuana. The percentage of people dependent on drug use is 0.5%, which is similar to the national average of 0.6%. This points to an increase in substance use in the Federal District, especially cocaine and marijuana.

The Global Youth Tobacco Survey (GYTS, 2011) reports that between 2003 and 2005, the prevalence of smokers among the student population in general was 19.6% (95% CI 18.1-21.8) (Valdés-Salgado, 2006).

Other data indicate the following. In Mexico, the total prevalence is 14.6%; for men it is 15.8% and for women 12.9%. In addition, the Youth Smoking Survey (ETJ, 2003)

In the National Health Surveys in Mexico, the prevalence among adults in 2000 and 2006 was 12.9% (95% CI: 11.8 to 14.1) and 13.3% (95% CI: 12.8 to 13.8) among daily smokers and 9.4% (95% CI: 8.9 to 9.9) and 5.6% (95% CI: 5.3 to 6.0) among non-smokers. (Villalobos & Rojas 2007).

Susceptibility to smoking is highest among women in Puebla, at 37.3%, followed by Zacatecas, at 37.1%, and Pachuca, at 31.7%. In Mexico City, it is 27.8%. Among men, San Luis Potosí ranks first with 31.2%, followed by Tlaxcala with 30.2%, and Mexico City ranks third with 29%.

For the GATS (2023) Global Adult Tobacco Survey, the following data are the most current.

Between 2009 and 2023, the number of adult smokers who received counseling from health professionals to quit smoking increased from 17.3% to 42.3%. This does not necessarily imply an increase in smokers, because it may be that confidence in seeking help has increased.

The Global Adult Tobacco Survey (GATS) is the result of efforts by various agencies of the Ministry of Health, in particular the National Institute of Public Health (INSP) and the National Commission on Mental Health and Addictions (CONASAMA), in conjunction with the Pan American Health Organization (PAHO).

The GATS is a global instrument that systematically monitors tobacco use in people over the age of 15 and tracks tobacco control indicators. The INSP (National Institute of Public Health) conducted the survey in 2009, 2015, and now in 2023, with the coordination of the National Council for Mental Health and Addictions.

It was reported that the current prevalence of tobacco use among adults **"remained unchanged from 2009 to 2023."** Currently, 14.3 million people (15.3 percent of the population) smoke tobacco; of these, 71.9 percent plan to quit smoking, and 42.3 percent of smokers who visited health services in the last 12 months received advice to quit.

Between 2009 and 2023, there was a significant decrease in exposure to tobacco smoke in homes and public spaces such as workplaces, public transportation, and government buildings. However, exposure remains high in bars/nightclubs at 70.3 percent.

In January of this year, Mexico's General Law for Tobacco Control came into effect, prohibiting all forms of tobacco advertising, promotion, and sponsorship, including the direct and indirect display of tobacco products at points of sale, as well as requiring 100 percent smoke-free and emission-free spaces in all workplaces and public gathering places such as plazas, parks, beaches, and stadiums.

In this regard, 90.5 percent of the population supports laws that prohibit smoking in enclosed public places and workplaces, while 82.5 percent supports laws that completely ban the advertising of tobacco products.

Regarding anti-smoking warnings, 61.4 percent of adults saw smoking prevention information on radio and television programs; 45.3 percent on social media or the internet, while 34.6 percent of current smokers considered quitting due to health warnings.

Regarding electronic cigarettes, 12.9 percent of the population (12 million), 16.8 percent of men, and 9.1 percent of women have used them at some point; and currently, 2.1 percent use them. On the other hand, 0.2 percent are users of heated tobacco products.

In terms of economics, 47.7 percent of current manufactured cigarette smokers last purchased loose cigarettes (by the unit), with an average monthly expenditure of 474.9 pesos.

Due to all of the above, such as beliefs, death, depression, and smoking, the following instrumental part was reached.

METHODOLOGY

1. Statement of the problem

What is the relationship between beliefs, death, depression, tobacco use, and religiosity?

2. Research questions

1. What is the relationship between different types of beliefs?

2. What is the relationship between different types of beliefs and sociodemographic variables such as gender, marital status, education, age, and tobacco use?

3. What is the relationship between different types of beliefs and degree of religiosity and religiosity in the next two years?

4. What is the relationship between smoking or not smoking and beliefs?

3. Hypothesis

General hypothesis.

If there is a relationship between beliefs, death, depression, tobacco use, and religiosity

Specific hypotheses

1. Is there a relationship between different types of beliefs?

2. Is there a relationship between different types of beliefs and sociodemographic variables such as gender, marital status, education, age, and tobacco use?

3. Is there a relationship between different types of beliefs and degree of religiosity and religiosity in the next two years?

4. Is there a relationship between smoking or not smoking and r beliefs?

4. Research variables

Independent Variables (IV). Sociodemographic variables are: gender (male/female), age, marital status (widowed/married), education, religion, smoker or non-smoker.

Dependent variables (DV) are beliefs about death and depression.

Beliefs about their degree of religiosity

Beliefs about future increase or decrease in religiosity.

(In the case of regression analysis, the variables can be used either as IV or DV depending on the researcher's interest.)

5. Type of research and design

Type of research: descriptive, correlational, and explanatory.

Ex-post-facto, intragroup, and multivariate design

6. Population and sample

The research was carried out with a sample of 300 older adults, comprising 150 older men residing in Mexico City and 150 older women residing in Mexico City.

7. Measurement instrument

Composed of three parts: sociodemographic variables, belief scale, and variables of religion, degree of religiosity, and future religiosity.

8. Procedure

The subjects were approached and asked to please complete the instrument if they agreed to participate. Once submitted, it was checked to ensure that everything had

been answered; if not, they were asked to complete it and finally thanked.

9. Data Analysis

Descriptive analysis; frequencies and percentages; reliability and validity of the instrument; correlation between different types of beliefs and also with religiosity; inferential analysis, T-test, ANOVA, and multiple regression.

RESULTS

Cronbach's alpha

It was decided not to eliminate any items, maintaining the initial 52 items with a general reliability of **.870**, and exploratory factor analysis was therefore performed.

Exploratory Factor Analysis. This presents adequate values for the KMO and Bartlett tests. (see Table 2 below).

The results obtained from the exploratory factor analysis indicate a total of 3 factors, with a total of 19 items and an overall Cronbach's alpha of .870 and an overall explained variance of 46.705 (see Table 3 below).

Pearson Correlation Analysis between Factors

Hypothesis Test 1 relationship between different types of beliefs

The purpose of Pearson's correlation is to determine the strength of association between two or more variables, taking into account the characteristics of each variable and the degree of interaction between them. The following describes the relationship between the three factors found, highlighting the significance of all factors in terms of the responses of older adults living in Mexico City regarding their beliefs about death, depression, and tobacco use.

F1, Beliefs about the consequences of tobacco; F2, Depression and tobacco; F3, Depression and death. The three factors interact significantly, which indicates that this part of the instrument is well integrated (see Table 4 below).

Correlation between belief factors and degree, increase, decrease in religiosity

Hypothesis 3 test: relationship between beliefs and religiosity

As can be seen, there is a significant relationship between degree and the possibility of an increase or decrease in religiosity. F1 CreeConseTaba with Religiosity in two years; F2 Depre and tobacco; with degree and next 2 years; F3 is not significant. The three factors in terms of their correlation have already been explained above. Although the type of relationship, whether as VI or VD variables, remains to be determined, this will be done later with the regression analysis. (See Table 5), below.

Inferential Analysis, T-test, ANOVA, and Regression

6.1 T-test Hypothesis 2 Test: Relationship between beliefs and gender

Here we present two factors that show significant differences in relation to beliefs: F2 women would agree more with the sequence depression and tobacco. As for F3,

	Sociodemographic Variable	Frequency	Percentage %
EDUCATION	None	48	16
	Basic	134	44.7
	Upper Secondary	47	15.7
	Higher	71	23.7
MARITAL STATUS	Married	253	84.3
	Single	20	6.7
	Widowed	27	9
GENDER	Male	150	50
	Female	150	50
AGE	60 to 65	184	61.3
	66 to 71	74	24.7
	72 to 77	42	14.0
SMOKER	Yes	177	59
	No	123	41%
RELIGION	Catholic	198	66
	Christian	48	16
	Other	54	18%

TABLE 1. Frequency analysis of sociodemographic variables.

Kaiser-Meyer-Olkin measure of sampling adequacy		.847
Bartlett's sphericity test	Approx. Chi-square	6996.779
	Gl	1326
	Sig.	.000

Table 2. KMO and Bartlett's test.

Factors	Alpha Cronbach	Number of Items	% explained variance	Cumulative variance	M	SD
FACTOR 1. CCT. Beliefs about the consequences of tobacco use	.879	6	11,617	11,617	2.65	.987
FACTOR 2. D T: Depression and Tobacco	.802	6	8.743	20,360	2.53	.849
FACTOR 3. D M: Depression and Death	.823	7	7.379	27,739	2.94	.882

TABLE 3. Alpha, quantity, explained variance, cumulative variance, mean, and standard deviation for each factor

	F1 BelieveConseTaba	F2 Depr and Tobacco	F3 Depr and Death
F1 CreateConseTaba	1	.	
F2 Depre and tobacco	.392**	1	
F3 Depression and death	.373**	.445**	1

** The correlation is significant at the 0.01 level (bilateral)

Table 4. Factor analysis corresponding to the results of Pearson's correlation

	My degree of religiosity is	I believe that my religiosity will increase or decrease in the next two years	F1 CreeConseTaba	F2 Depression and tobacco	F3 Depression and death
My level of religiosity is	1				
I believe that my religiosity will increase or decrease over the next two years.	.111	1			
F1 BelieveAdvise	-.102	**-.123***	1		
F2 Depression and tobacco	-.125*	-.141*	.392**	1	
F3 Depression and death	-.056	-.090	**.373****	**.445****	**1**

The correlation is significant at the 0.05 level (two-tailed).*

The correlation is significant at the 0.01 level (two-tailed).**

Table 5 Correlation between belief factors and degree, increase, decrease in religiosity

	Gender	N	Average	t	gl	Bilateral
F2 Depression and tobacco	Male	150	2.6411	2,253	298	.025
	Women	150	2,4089			
F3 Depression and Death	Male	150	3.0611	2,029	298	.043
	Women	150	2,852			

Table 6 T-test for gender with the two belief factors

women also show greater sensitivity with regard to depression and death**.** (See Table 6 above).

In the following case, Hypothesis 2 is tested: the relationship between beliefs and being a smoker or non-smoker.

In this case, the differences in the factors were analyzed. Based on whether or not the respondent was a smoker, significant differences were found in F1 and F2. In the first case, non-smokers believed more in the consequences of smoking; similarly, in the second factor, non-smokers believed more in the relationship between depression and tobacco. (See Table 7 below).

ANOVA

No significant differences were found in relation to age, marital status, education, religion, and beliefs (as factors). This may be due to the homogeneity of the older adults in this case, for this sample studied.

Regression

The tables will be presented in order of importance, from highest to lowest, based on R-squared explanation of the phenomenon.

Hypothesis 3 test: relationship between religiosity and beliefs

In the following table, religiosity over two years acts as an independent variable on F2, beliefs about depression and tobacco. (See Table 8 below). R-squared .032, the most comprehensive explanation.

The following table shows how religiosity in the next two years acts as V1 on F1 Beliefs Consequences of Tobacco, which is DV see (Table 8) below.

Continuing with: Hypothesis 4 test: relationship between smoking yes or no and beliefs

Here, being a smoker or not would act as a DV on the VD beliefs, which in this case would be on F2, beliefs about depression and tobacco. (See Table 9, below).

Table 9 regression of smoking yes or no with beliefs about depression and tobacco.

In Table 10 below, being a smoker or not affects VD F1 Beliefs about the consequences of tobacco.

Table 10 Regression of smoking yes or no with F2 Beliefs about depression and tobacco.

Based on the above, the following model proposal was generated.

FIG. 1. PROPOSED MODEL OF DEATH, DEPRESSION, AND TOBACCO USE: BASED ON BELIEFS IN OLDER ADULTS. (PMMDCTSCEAM)

As can be seen, the variable that explains the most is the Degree of Religiosity; on F2 Beliefs Depression and Tobacco; followed by F1 Beliefs Consequences of Tobacco; While the variable of Smoking or Non-Smoking Behavior influences F2 Beliefs Depression and Tobacco in the first instance; then on F1 Beliefs Consequences of Tobacco, and finally the degree of religiosity, suggesting further research for this case of older adults.

	Smoker	N	Mean	T	gl	Sig. (bilateral)
F1 CreateConseTaba	Yes	177	2.7853	2,030	298	.043
	No	123	2,5407			
F2 Depre and tobacco	Yes	177	2.6356	2.581	298	.010
	No	123	2,365.9			

Table 7 Independent Samples T-test Smoker or Non-smoker.

		Unstandardized coefficients		Standardized coefficients		
Model		B	Std. Dev.	Beta	t	Sig
1	(Constant)	3,534	.349		10,127	.000
	I believe that my religiosity in the next two years will Increase Remain the same Decrease	-.239	.107	-.129	-2.239	***.026***

a. Dependent variable: F2 Depression and tobacco

Table 8 Coefficients. R squared .032

Model		Unstandardized coefficients		Standardized coefficients	T	Sig.
		B	Std. Error	Beta		
1 Predictors	(Constant)	3.659	.403		9,091	.000
	I believe that my religiosity in the next two years will be	-.242	.123	-.113	-1,967	.050

a. Dependent variable: F1 BelieveAdvice

Table 8 Coefficients. R squared .023

Model		Unstandardized coefficients		Standardized coefficients	T	Sig.
		B	Std. Dev.	Beta		
1	(Constant)	2.905	.156		18,613	.000
	VI Smoker	-.270	.105	-.148	-2,581	.010

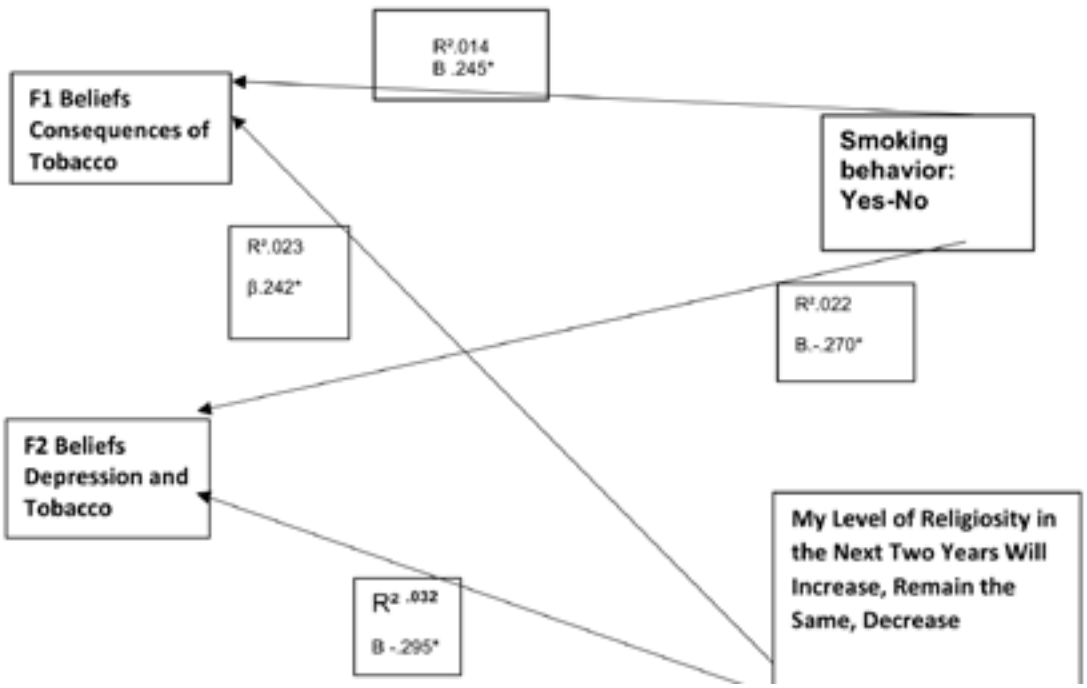
a. Dependent variable: F2 Depre and tobacco.

Table 9 Coefficients. R squared .022

Model		Unstandardized coefficients		Standardized coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	3.030	.180		16,832	.000
	VI Smoker	-.245	.121	-.117	-2,030	.043

a. Dependent variable: F1 CreeConseTaba.

Table 10. Coefficients. Rsquared .014



R^2 = R squared

Beta = β example .41…etc.

Significance: * =.01; ** = .001; *** = .000

Figure 1.

Discussion and Conclusions

Hypothesis 1 relationship between different types of beliefs (correlation).

F1, Beliefs about the consequences of smoking; F2, Depression and smoking; F3, Depression and death. The three factors interact significantly, which indicates that this part of the instrument is well integrated. Beliefs are a field as extensive as they are relevant within psychology. However, as Pepitone (1991) mentions, the psychosocial literature contains relatively little information about theses and research on the subject of beliefs. Palomino (2013) states that beliefs arise from an individual's knowledge of a particular object, which implies a value of truth that is sufficiently solid to support opinions about that object. Following this line of thought, Sigel (1985) defines the concept of beliefs as "mental constructions of experience, often condensed and integrated into schemas or concepts" (p. 351) that are considered true and thus guide behavior. A theoretical model to be recognized in order to understand beliefs is the Theory of Planned Action (TPA), which comes from the (TAR) and reinforces the above. The Theory of Planned Action was developed in the same way by Fishbein and Ajzen in 1985. According to Huéscar, Rodríguez-Marín, Cervelló & Moreno-Murcia (2014), the postulates of PAT suggest that a person's behavior is immediately determined by their intention to perform (or not perform) that behavior. In turn, this intention to perform a behavior is a function of three elements: norms, intentions, and motives.

One of the most important conclusions of the study of smoking is that it depends on beliefs for it to occur or is closely related, as has been demonstrated, to a series of behaviors such as depression, or phenomena related to death. The scientific study of various aspects of human life has contributed to a better understanding of the various phenomena that occur. Death, of course, could not be left behind, because although it could be understood as the end of an organism's life, the process of dying involves a series of complex events that require more than a simple general review. According to López (2015), death is defined as the *cessation of life* (p. 226). As Pasantes (2017) mentions, we have certain types of emotional systems in the brain that receive stimuli from the outside world, specifically those related to the intensity and success of relationships between individuals. When the imbalance or impact is greater than what a person can assimilate and overcome or recover from, it can give way to what is known as depression. According to the World Health Organization (WHO, 2019), depression is considered a mental disorder characterized by a series of symptoms. It also has a classification related to the degree of severity. Depression is considered a common mental disorder in the world population. Some of the symptoms that reflect depression are sadness, loss of interest or pleasure, feelings of guilt or low self-esteem, sleep or appetite disorders, fatigue, and lack of concentration.

In relation to smoking and death, according to the World Health Organization (WHO, 2019) and the Pan American Health Organization (PAHO, 2019), smoking kills about 8 million people each year. In addition, tobacco is the only legal consumer product that kills up to half of its users when used as intended by the manufacturer. Ultimately, half of all long-term smokers will die

from a tobacco-related disease, losing around 10 to 15 years of their lives.

According to the WHO (2011), tobacco remains the leading cause of preventable deaths worldwide and causes economic losses of hundreds of billions of dollars globally. Most of these deaths occur in low- and middle-income countries, and this disparity is expected to continue to increase in the coming decades. If current trends continue, by 2030 tobacco will kill more than 8 million people a year, with 80% of these premature deaths occurring in low- and middle-income countries. Without urgent action, tobacco could kill 1 billion people or more in the 21st century.

Regarding beliefs and smoking, Valdés et al. (2006) reported that 73.8% of respondents believed that secondhand smoke was harmful to them, and 46.9% thought that smoking in public places should be prohibited. In another study (Kim, Yu, Chen, Kim, Brintnall, & Vance, 2000), when respondents were asked, "What would you do if someone were smoking in a public place and there were no rules against it?", 58% of non-smokers and 48% of former smokers responded that they would leave.

Hypothesis 2: Relationship between beliefs and gender (T-test)

The data closest to the previous hypothesis are presented below. According to Reynales-Shigematsu, Vázquez-Grameix & Lazcano-Ponce (2007), they comment on the Global Health Professions Student Survey (GHPSS, 2006). In Mexico, third-year dental students were surveyed at on the use of cigarettes and other tobacco products. The sample consisted of 15 dental schools in 2006. The school response rate was 86.7%, and a total of 1,301 students participated

Prevalence: 83.2% had ever smoked cigarettes (men = 86.1%, women = 81.8%); 42.8% currently smoke cigarettes (men = 48.0%, women = 40.5%). 14.8% have ever used tobacco in forms other than cigarettes (males = 30.0%, females = 7.9%); 3.9% currently use tobacco in forms other than cigarettes (males = 8.6%, females = 1.7%).

Current smokers and former smokers are 80% more likely to suffer from depression than non-smokers. In addition, current smokers (men and women) who consume more than one pack a day are three times more likely to suffer from depression than non-smokers. (Benjet, Wagner, Borges Medina–Mora, 2004).

Arillo-Santillán, Thrasher, Rodríguez-Bolaños, Chávez-Ayala, Ruiz-Velasco, & Lazcano-Ponce, (2007) mention that a person addicted to tobacco and suffering from depression shows a higher risk of suicide compared to someone who only has one of these conditions.

According to Mental Health (2018), people living with depression or anxiety are twice as likely to smoke cigarettes as people without these health conditions, and they die 25 years earlier than other people in general.

Depression is one of the most common mental disorders in the United States. Its symptoms range from mild to severe and can affect a person's ability to function.

While it is common to think that smoking relieves stress, this is not actually true. Any short-term relief felt from smoking is soon replaced by the stress of nicotine withdrawal. In fact, quitting smoking decreases stress levels as well as symptoms of

depression. What types of health problems can occur because I smoke and have depression or anxiety? Smoking can increase your feelings of stress and anxiety, as well as symptoms of depression. Certain medications used to treat depression and anxiety disorders do not work as well when you smoke. You are more likely to think about or attempt suicide. People with mental health disorders who smoke are more likely to die from cancer, cardiovascular disease, and respiratory disease than people who do not smoke and live with that disorder. How will my health improve if I quit smoking? Although quitting smoking can be challenging, studies have shown that veterans with anxiety or depression can successfully quit. Studies have also found that quitting smoking can decrease feelings of depression, anxiety, and stress and improve your mood and quality of life. Quitting smoking will not jeopardize your mental health treatment or increase your chances of having suicidal thoughts or needing psychiatric hospitalization. The physical benefits of quitting smoking include reducing your risk of getting and dying from conditions such as tobacco-related cancer, heart disease, and respiratory disease. If you have depression and use alcohol, you may drink less after quitting smoking.

Hypothesis 2: relationship between beliefs and sociodemographic variables (ANOVA)

No significant differences were found in relation to age, marital status, education, religion, and beliefs. This may be because the elderly population is fairly homogeneous in terms of their beliefs in relation to the variables mentioned.

Hypothesis 3: Relationship between religiosity and beliefs (regression)

Religiosity over two years acts as an independent variable on beliefs about depression and tobacco. R squared .032 is the most comprehensive explanation.

It can be seen how the independent variable religiosity in the next two years acts on the dependent variable F1 Beliefs. R-squared .023

Hypothesis 4: Relationship between smoking and beliefs (Regression)

Here, being a smoker or not would affect VD beliefs, which in this case would be beliefs about depression and tobacco. R squared .022

Whether or not one is a smoker influences VD beliefs about the consequences of tobacco. R squared .014

The explanations of regression were addressed from a greater explanation of R squared to a lesser one, with religiosity at two years being the greatest weight in explaining beliefs about depression and tobacco and the consequences of tobacco.

Being a smoker or not acts as an independent variable on the dependent variable Depression and tobacco and Consequences of tobacco. It is important to mention here that, contrary to expectations, beliefs as an independent variable to explain smoking behavior and, consequently, modify it in this case, is not the case. This could perhaps be explained by the fact that the population is elderly. However, the question remains as to what can be done in the case of smoking for people of this age. One alternative could

be to use religiosity as a variable in treating smoking, since in this study it proved important to analyze smoking through religiosity, which is ultimately a belief similar to what happens in other cases, with some differences, and only as an exploratory measure, when alcoholics make vows to quit smoking. New questions arise from other research with this type of population. There is little information on smoking and religion; here are some of them.

At the beginning of the month, alarm bells rang in Turkey when the results of a report on the 185 industrial uses of pork were released. According to this Dutch report, **cigarette filters contained porcine hemoglobin, i.e., pig's blood.** Turkish religious groups quickly expressed their dismay, and Turkish smokers understood this to be a divine sign to quit smoking. However, the Ministry of Health was quick to deny this, stating that **there are no traces of pork in cigarettes sold in Turkey.** (El Mundo newspaper, 2010)

What is the Christian view on smoking? Is smoking a sin?

For GotQuestions.org Spanish. (SD). The Bible never directly mentions smoking. However, there are a couple of principles that definitely apply to smoking. First, the Bible commands us not to allow our bodies to be "dominated" by anything. 1 Corinthians 6:12 says, "Everything is permissible for me, but not everything is beneficial. But I will not be dominated by anything." Smoking is undeniably a strong addiction. Later in the same passage, we are told, "Do you not know that your body is a temple of the Holy Spirit within you, which you have from God? You are not your own, for you were bought with a price. So glorify God in your body." (1 Corinthians 6:19-20). Undoubtedly, smoking is very bad for your health. It has been proven that smoking damages the lungs and often the heart, among other things. So it is not forbidden, but the body belongs to God and you must take care of it.

CONCLUSIONS

It is clear that a review of the research literature has found a relationship between beliefs about tobacco, depression, death, and religiosity.

As for the relationship between beliefs about tobacco and gender, it can be said that the male population exceeded expectations, as around 90% of men smoke, compared to around 30% of women. If we compare this with smoking populations of other ages, the average is 44% overall.

Regarding religiosity, which ultimately is a belief, it affects smoking in terms of its consequences and depression-tobacco, so it is envisaged, as mentioned above, to use beliefs about religion as a way of influencing smoking among older adults, although in this case it might not be considered total cessation, but rather reflecting on how they can support young people in avoiding it and, where appropriate, reducing it.

It is clear that smokers know that smoking will lead to depression and other consequences. However, they seem resigned to this and do not see any alternatives or are unaware of them, naturally assuming that only those who request support will receive it.

Recently, programs have been developed to prevent young people from taking up smoking or to help them quit, leaving aside older adults who are also worthy of mention and treatment. The possibility of working with older adults remains up in the air, not only in terms of smoking but in all their problems.

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