HUMANIDADES E CIÊNCIAS SOCIAIS:

Perspectivas Teóricas, Metodológicas e de Investigação

Luis Fernando González-Beltrán
(organizador)

EDITORA ARTEMIS
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PRÓLOGO

Todos hemos oído la expresión popular “si algo sale bien, hazlo de nuevo”. Y aquí estamos presentando el quinto volumen de “Humanidades e Ciências Sociais: Perspectivas Teóricas, Metodológicas e de Investigação”. En esta ocasión, como lo dice uno de nuestros autores, abordamos los diferentes niveles de análisis, micro o individual, meso o local, y macro o global.

En esta obra, en la que incluimos 21 autores, de procedencias diversas, tanto teóricas, como metodológicas, y hasta disciplinarias, agrupamos los trabajos en cuatro apartados. Iniciamos con 7 capítulos bajo el rubro “Interacción, amor y desviación sexual”.

En primer lugar encontramos las creencias sobre el amor romántico, las relaciones tóxicas, la dominación masculina y la violencia de género. Enseguida encontramos el análisis de la infidelidad y su relación, o falta de ella, con el género y la inteligencia sexual. Tercero, podemos ver como esta infidelidad, que aparece en casi la mitad de los encuestados, genera daño emocional y violencia. A continuación se revisan los factores de riesgo de la violencia en parejas, una “preocupante realidad de millones de adolescentes y adultos jóvenes”. También cómo la autoestima, y su interacción con los padres, les permite tomar decisiones sobre el inicio de su vida sexual. Incluimos también como se cuestionan las músicas populares, los discursos textuales y corporalidades que se entrelazan en ciertas composiciones performativas, para deconstruir aspectos sociales de las masculinidades hegemónicas. Finalizando este apartado con una mirada clínica que intenta, como muchas otras miradas, dar una explicación de los conflictos internos, y la pérdida de contacto con la realidad, que llevan a la violencia y la desviación sexual.

En el segundo apartado nombrado “Cómo nos forjó la historia: Esclavitud, Guerra y Justicia”, tenemos 5 trabajos. Ahí podemos encontrar parte de la historia virreinal, analizando el arte religioso como “agentes con presencia, potencia y acción en la interacción social entre culturas”. Siguiendo con un trabajo que usa la hermenéutica jurídica, para evaluar la justicia y la esclavitud en los afrodescendientes. En los últimos tres capítulos de la sección, se busca resignificar el pasado: primero, interpretando la batalla del Ebro en la memoria colectiva; segundo, analizando la politización de una canción, ejemplo de los diálogos en contra de la dictadura militar y, en el último estudio, se aborda una vanguardia artística vinculada al Modernismo en América Latina, que se reflejó en la figura del indio Caraíba, y la llamamos aquí la jungla identitaria.

La sección “Salud y Sociedad” inicia con un trabajo que muestra que los determinantes sociales de la salud juegan un papel crucial en la aparición y evolución de las enfermedades crónicas. Algo necesario para contraponer con los determinantes comportamentales, el estilo de vida sedentario y la mala alimentación. Así la hipertensión, la osteoporosis y otras enfermedades empeoraron “con el desbalance que generó el

Covid". Sigue un trabajo en la misma línea, que pretende conocer estos determinantes tanto biológicos como psicológicos y hasta sociales, con el fin de poder guiar a los adultos mayores a adaptar y mejorar su estilo de vida. El apartado finaliza con un estudio que considera a los cuidadores de los enfermos, particularmente de Alzheimer, quienes también sufren el cambio en sus rutinas y estilos de vida, para dedicar a sus familiares una labor de 24 horas.

El último apartado "Derecho y Movimientos Sociales", comprende 6 capítulos sobre problemáticas que se analizan en distintos países, Argentina, Perú, Colombia, México, Ecuador, pero que se presentan en toda América Latina. Inicia con la convicción de que los movimientos sociales están en crisis, pero porque la propia sociedad en su conjunto está en crisis. Los gobiernos neoliberales se alternan, mientras se da un paso atrás, al alinearse al Fondo Monetario Internacional y la OCDE. Sigue el análisis del sindicalismo latinoamericano, que transita bajo la paradoja de que a mayores prestaciones a los trabajadores, menor desarrollo económico. A continuación se analizan las políticas públicas del deporte tanto de aficionados como profesionales, que se dictan entre agudas contradicciones en aspectos sociales, económicos y legislativos. Luego se analiza la política fiscal, con la adopción de las nuevas tecnologías, llegando a la conclusión que debe haber colaboración entre los organismos internacionales, los estados y los particulares, en aspectos de seguridad y privacidad, pero siempre a "favor de la dignidad humana antes que a la tecnología". Le sigue una propuesta sobre acuerdos bilaterales, que propone también negociaciones equilibradas que logre integraciones económicas para el desarrollo, tanto en cuestiones ambientales como de infraestructura y en contra del cáncer de la corrupción. El apartado finaliza con los derechos legales e internacionales de los refugiados, y lo mejor, propone recomendaciones prácticas para la protección de estos derechos.

Hemos intentado balancear los temas, las aproximaciones y los diferentes puntos de vista sobre la conjunción de las Humanidades y Ciencias Sociales, para el disfrute del lector que busca estar al día en estas apasionantes materias.

Dr. Luis Fernando González Beltrán
Universidad Nacional Autónoma de México (UNAM)

SUMÁRIO

INTERACCIÓN, AMOR Y DESVIACIÓN SEXUAL

CAPÍTULO 14

COMPREHENSIVE GERIATRIC ASSESSMENT IN INSTITUTIONALIZED OLDER ADULTS

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Claudia Marcela Cantú Sánchez
Profesor de Tiempo Completo
Doctorante en Desarrollo Humano
Departamento de Enfermería y Obstetricia
División de Ciencias de la Vida
Línea de Investigación Prevención y Estados Crónicos del Adulto
Universidad de Guanajuato, México
https://orcid.org/0000-0003-2677-2570

Grever María Avila Sánsores
Profesor de Tiempo Completo
Departamento de Enfermería y Obstetricia de Irapuato
División de Ciencias de la Vida
Línea de Investigación Prevención y Estados Crónicos del Adulto
Universidad de Guanajuato, México
https://orcid.org/0000-0002-2534-7727

Gerardo Ruvalcaba Palacios
Profesor de Tiempo Completo
Departamento de Enfermería y Obstetricia de Irapuato
División de Ciencias de la Vida
Línea de Investigación Prevención y Estados Crónicos del Adulto
Universidad de Guanajuato. México
https://orcid.org/0000-0001-9206-4439

Ma. Gloria Vega Argote
Profesor de Tiempo Completo
Departamento de Enfermería y Obstetricia de Irapuato
División de Ciencias de la Vida
Línea de Investigación Prevención y Estados Crónicos del Adulto
Universidad de Guanajuato. México
https://orcid.org/0000-0003-3206-1791

ABSTRACT: Human aging is a series of gradual and adaptive changes such as biological, psychological, and social, due to genetic changes, lifestyle, environment, and social conditions to which the person has been exposed. For this reason, as healthcare professionals, we must understand the normal morphological and functional changes of physiological aging and guide older adults to adjust and improve their lifestyle. This research aims to assess older adults to determine their health status through comprehensive evaluation. It is a cross-sectional, descriptive study with a convenience sample, as some participants declined evaluation. The total population consists of 62 patients, with a sample size of 29 adults who accepted and signed informed consents.

KEYWORDS: Aging. Geriatric stay. Older adults. Comprehensive assessment.

EVALUACIÓN GERIATRICA INTEGRAL EN ADULTOS MAYORES INSTITUCIONALIZADOS

RESUMEN: El envejecimiento humano es una serie de cambios graduales y adaptativos como biológicos, psicológico y social debido a cambios genéticos, estilo de vida, ambiente y condiciones sociales a las que ha estado expuesta la persona. Por tal motivo, como profesionales de la salud, debemos de conocer los cambios morfológicos y funcionales normales del envejecimiento fisiológico, y así orientar al adulto mayor para que adecue y mejore su estilo de vida. Con esta investigación se pretende valorar a adultos mayores para determinar su estado de salud a través de una valoración integral, es un estudio transversal, descriptivo, la muestra fue a conveniencia, debido a que algunos participantes se negaron a la evaluación, el universo es de 62 pacientes y la muestra de 29 adultos que aceptaron y firmaron consentimiento informado.
PALABRAS CLAVE: Envejecimiento. Estancia geriátrica. Adulto mayor. Valoración integral.

1 INTRODUCTION

Human aging is a gradual and adaptive process encompassing biological, psychological, and social aspects, resulting from genetically programmed changes, personal history, lifestyle, environment, and social conditions to which the individual has been exposed. Conversely, old age is a stage of life whose onset is defined by society, leading the United Nations to classify individuals aged 60 and above as older adults in developing countries.

This study aims to provide a diagnosis reflecting the current situation of patients in a permanent geriatric residence located in Irapuato, Guanajuato. This institution offers two types of permanent stay: shared and private rooms. The type of accommodation depends on whether the elderly person enters through a free program or pays a monthly fee of $3,000.00 pesos, respectively. Visiting hours are from 9:00 a.m. to 6:00 p.m. The facility provides services for adults with physical disabilities, mental disabilities, or those who are abandoned. Services include supervised meal intake three times daily, daily monitoring of vital signs, therapies, recreational activities, daily hygiene, chapel access, gardens, and provision of wheelchairs as needed.

Understanding these aspects is crucial because aging involves structural and functional changes in various organs and systems. Therefore, as healthcare professionals, it is important to understand the normal morphological and functional changes of physiological aging in order to guide older adults to adapt and improve their lifestyles.

2 BACKGROUND

The current global economy is not adequately prepared for the increasing population of older adults and the corresponding healthcare service demands. Recent gerontology research has identified Older Adults as vulnerable groups in terms of education and societal development, highlighting the need for multidisciplinary collaboration among General Practitioners, Nurses, Psychologists, Social Workers, and Geriatricians to provide comprehensive quality care (Mogollón, 2012).

There is a necessity to educate younger generations about aging through healthy habits from early life stages, viewing individuals holistically to ensure adequate medical attention for future older adults (Navarro, Ojeda, Ortega, Moreno, 2014).

Allevato and Gaviria (2008) assert that aging is not merely a chronological phenomenon but a multifactorial process affecting molecular levels in organs and systems inevitably. Increased life expectancy in the past century, averaging 65 years and older, continues to rise. In low- and middle-income countries, childhood mortality has decreased due to health promotion programs, yet older adults face chronic health issues stemming from unhealthy habits and inadequate healthcare coverage (WHO, 2015). The current challenge related to aging populations is maintaining health and quality of life. Life expectancy has increased by 40 years since the 12th century, with projections that 50% of individuals born in 2000 will live into 2072, though males are expected to have shorter lifespans due to lifestyle factors (Hernández, 2014).

Mexico has experienced rapid demographic growth from the 1930s to 1970, characterized by a broad-based demographic transition. The highest historical growth rate occurred in 1970, with an average fertility rate of seven children per woman, prompting family planning campaigns and increasing female labor force participation (Mendoza, 1998, *in* Ortiz Álvarez and Mendoza, 2008). According to population pyramids, Guanajuato state saw a notable increase in the elderly population, from 6.5% in 2000 to 13.9% in 2015, particularly in industrial areas like León, Irapuato, and Celaya. Common health issues among older adults include diabetes, cancer, pneumonia, depression, hearing impairment, blindness, and age-related unidentified diseases (Navarro, Ojeda, Ortega, Moreno, 2014).

According to the *Diario Oficial de la Federación* (Official Gazette of the Federation), conditions of vulnerability for older adults have intensified due to rapid population growth, increasing demand for supportive services. Effective care improvement is crucial, guided by NOM-167-SSA1-1997 regulations on social assistance for adults and older adults at risk and in vulnerable situations, mandatory nationwide across public, private, and social sectors.

It becomes a problem in the mercantilist and productive society (Gascón 2009), when the individual can no longer work, coupled with a predominant nuclear family system, rejecting adult generations and condemning them to live independently from the rest of the family. Many times, they are economically assisted by their children, losing their authority within the family; sometimes they are admitted to nursing homes that provide necessary care, where they are rarely visited and thus expelled from the family circle. It is more characteristic in urban and rural areas to maintain their place within the family.

According to Novel (2011) the family is the basic unit of society where interactions occur among its members; this is why we can say they function as an open system, playing certain roles in task distribution, which we call family functions. Each member of the family unit is a subsystem, possessing general family characteristics but also interacting with society, adopting its values and beliefs and blending them with their own origins, thereby transmitting them to other members of society. The elderly can be found in an extended family, characteristic of pre-industrial societies, where men and women marry but continue to live with their families of origin, respecting hierarchies among members, unlike the nuclear family, which consists solely of father, mother, and children, with a division of tasks solely among these members.

Therefore, it is intended to apply a model focused primarily on functionality to Mexican older adults, implying paradigm shifts towards healing and focusing on self-care to achieve well-being, ensuring autonomy. Additionally, we must acknowledge the support of the older adult's family, which plays an important role in their well-being through affection, respect, and many of them needing assistance with daily activities such as walking, eating, dressing, and bathing. These groups will continue to undergo a series of biopsychosocial changes. The family is of vital importance to the older adult as their primary caregiver, providing physical, emotional, social, and economic support (Navarro, Ojeda, Ortega, Moreno, 2014).

Therefore, we must invest in education, particularly for older adults, starting from childhood to improve our quality of life with productive expectations. Several goals have been achieved in basic, middle, and higher education. There are some economic problems in countries leading to long-term unemployment, especially since jobs for young people are of low quality. There is talk of overeducation due to excessive competencies acquired by the youth compared to undereducation. Young people take a long time, up to six years, to settle into formal employment, often resorting to temporary jobs. All these conditions contrast sharply with those of older adults, who are usually retired, or at least that was the ideal in past generations. Now we see that the unemployment rate is among the severest in recent years.

If we ground these changes in Mexico, it caused a significant drop in production and therefore in employment. There were adjustments in the labor market favoring informal employment, affecting manufacturing exports, a crisis that has not been overcome to this day. Additionally, coupled with the migration of young people seeking a better quality of life in another country, leaving these elderly parents without the close support they need, something the government must address is economic growth focusing on the most vulnerable sectors of our country.

According to Lugo et al. (2014), it is expected that by the year 2020 the number of older adults will increase. Therefore, there should be the creation of businesses focused on their care, leading to growth in areas such as nursing, optometry, dentistry, and medical specialties for older adults. This could involve nursing homes, retirement homes, or day centers for older adults acting as daycare facilities but also providing recreational activities for their health care. The staff responsible must have scientific and human knowledge for optimal care with quality and warmth. In this globalized world, this could be one of the best options for generating employment.

2.1 LIFESTYLE OF OLDER ADULTS

A sedentary lifestyle and poor physical condition mean that many older individuals are subjected to high demands during their daily activities. For them, even a small decrease in physical activity levels can lead from a state of functional independence to a state where they are unable to carry out their daily activities, requiring external assistance or help. Physical activity is a very effective means to prevent and delay the inevitable decline in functional capacity in older individuals. The level of physical fitness determines a person's ability to live autonomously and have a full and independent life. Assessing the capacities that support physical fitness through tests should be considered a fundamental aspect in determining the functional capacity of older individuals.

2.2 ASSESSMENT OF FUNCTIONAL PHYSICAL CONDITION - COMPONENTS THAT MUST BE MEASURED

The measurement of functional capacities is a fundamental component in the evaluation of older adults. By function, we understand the ability to autonomously perform those more or less complex actions that make up our daily activities in a desired manner, both individually and socially. When referring to functional physical condition in older subjects, we do not identify it with performance, but rather with the capacity to carry out normal daily activities without fatigue and in a safe and independent manner. The degree of

physical condition a person possesses determines their ability to function independently, participate in social activities, travel, use the services offered by society, and ultimately lead a full and independent life without being a burden to those around them.

2.2.1 Sarcopenia

Sarcopenia (from the Greek sarx, flesh, and penia, poverty) is the involuntary loss of skeletal muscle mass that occurs with advanced age. Muscle mass declines approximately 3-8% per decade starting from age 30, and this rate accelerates after age 60. This decrease in muscle mass leads to a reduction in strength and muscle function, which are involved in elderly disability. Sarcopenia increases the risk of falls, fractures, and vulnerability to injuries, consequently leading to functional dependence and disability in the elderly. Sarcopenia is part of the frailty syndrome in the elderly, being one of the main risk factors for disability and death in this population. Additionally, the decrease in muscle mass is accompanied by other changes in body composition, such as a progressive increase in fat mass. These changes have been associated with increased insulin resistance in the elderly, implicated in the etiopathogenesis of type 2 diabetes mellitus, obesity, hyperlipidemia, and arterial hypertension in genetically susceptible populations.

2.2.2 Pressure ulcers

The prevalence of pressure ulcers in institutionalized elderly is a concerning issue in the development of nursing care plans. Pressure ulcers result from a combination of factors: prolonged bed rest, reduced mobility, malnutrition, physiological alterations, incontinence, etc. Wound care is undoubtedly one of the most common actions in healthcare and socio-health activities carried out by healthcare professionals in various care settings. The interplay between old age and incontinence, as stated by Martínez E. (2002) clearly and significantly facilitates the appearance and development of these lesions. In Martínez et al.'s study on urinary incontinence, it is affirmed that among institutionalized patients over 65 years old, the percentage of urinary incontinence ranges from 40% to 60%[1].

Nix D (2004) mentions that there is not much data available on the incidence of fecal and mixed incontinence, although it is estimated to affect around 2% of the population with an increased risk in institutionalized patients. According to Ersser S (2005), experiencing fecal incontinence represents a 22% increase in the risk of developing pressure ulcers. Doreen Norton developed the first pressure ulcer assessment scale (EVRUPP) in 1962, which included incontinence as an important factor

in developing these lesions. All subsequent scales derived from Norton's work have included urinary and fecal incontinence as risk factors (Norton D, 1962, and Ek A, 1982). Since the studies conducted by Jordan et al. and Jordan and Clark, numerous studies have been conducted on the location and stages of pressure ulcers. According to these authors, the most frequent locations are: sacrum (40%) and heels (20%), followed by ischial tuberosities (15%) and trochanters (10%), although lesions can appear anywhere on the body (Barbenel JC, 1997).

2.2.3 Risk of Falls

Falls, defined by the World Health Organization as "the consequence of any event that causes a person to come to rest inadvertently on the ground or floor" (Quevedo, 2018), are recognized as a global public health problem in various contexts, including institutional hospital and outpatient settings, as well as in the community. However, while the institutional context focuses on patient safety for institutionalized patients, in the community setting, attention is drawn to the significant repercussions that a fall can have on older adults, with the most serious being hip fractures. Falls, due to their high frequency and the elevated risk of associated secondary injuries, constitute a highly significant negative phenomenon in the elderly[1,2]. They are one of the main causes of injuries, disability, institutionalization, and even death in older individuals, thus they are considered a marker of frailty in the elderly and perhaps the most characteristic prototype of so-called geriatric syndromes (M. Lázaro, 2009).

Approximately one third of older adults living in the community fall each year. In institutionalized individuals, the incidence and prevalence of falls are even higher (Tinetti, 1988). It is important to note that these percentages could be higher, as the true incidence of falls is often difficult to ascertain because falls are frequently considered "normal for age" and not reported, and sometimes patients themselves do not disclose falls out of fear of restrictions. It has also been noted that between 13–32% of older adults do not recall falls they experienced in previous months (M. Lázaro, 2009). Any fall in an elderly person during daily activities is a vital sign indicating an unidentified medical problem or an unresolved need and should be properly evaluated.

2.2.4 Sleep and Rest

Modern society is aware of the significant impact sleep has on people's lives. The effects of sleep extend beyond the individual's body and affect their development and normal functioning in society (work or school performance, interpersonal relationships,

road safety, etc.; Sierra, 2005). Sleep disorders in elderly patients are common, multifactorial, and may contribute to increased healthcare utilization (Vizcarra, 2003, and Halter J, 2009). The Primary Care Guidelines of the Pan American Health Organization (PAHO) emphasize that adequate nocturnal sleep allows older adults to maintain an active and healthy life (PAHO, 2002).

In a study conducted at a primary care center in Lima, Peru, it was found that 33% of elderly patients had some difficulty sleeping, and only 16% consulted a doctor for this reason (Rey, 2005). Older adults often take longer to fall asleep and experience more frequent nocturnal awakenings. More than 50% of older adults reported at least one chronic sleep complaint, with the most common problem being difficulty falling asleep (Harrington J, 2006). The prevalence of poor sleep quality in our setting is 63.8% (Alcorta, 2003). Sleep problems in the geriatric population are related to both aging and associated comorbidities (Pando, 2001). Between 50% to 90% of patients with chronic pain report poor sleep quality (Vizcarra, 2008).

Insomnia is the most common sleep complaint among older adults, with its prevalence in this age group estimated between 20% and 40%, and an annual incidence of approximately 5% (Halter, 2009). Inappropriate use of hypnotic sedatives for managing insomnia in older adults leads to daytime drowsiness and increases the risk of accidents and falls. Healthcare professionals should educate and promote healthy lifestyles among older adults as part of appropriate insomnia treatment (Vizcarra, 2003, and AASM, 2005). The high prevalence of insomnia in the elderly may be associated with several interacting factors, including a higher prevalence of affective disorders such as depression, and organic mental disorders such as dementia, which are associated with sleep difficulties. The most common causes of insomnia are associated with poor sleep hygiene (Petit, 2003).

Sleep hygiene encompasses habits and behaviors that facilitate sleep while avoiding factors that interfere with it. Inadequate sleep hygiene, as defined in the International Classification of Sleep Disorders, refers to sleep disorders secondary to daily life activities that are inconsistent with maintaining good sleep quality and daytime alertness (Stepnowsky C, 2008). Sleep quality is influenced by various environmental factors (light, noise, temperature, etc.) and health-related factors (nutrition, physical exercise, and consumption of certain substances). Exposure to noise or extreme temperatures has negative effects on sleep architecture. Nutrition also affects sleep quality; for example, vitamin B, calcium, and tryptophan promote sleep, while alcohol, caffeine, and nicotine disrupt sleep architecture, as do many hypnotics, barbiturates, and benzodiazepines (Lomelí, 2008).

2.2.5 Pain in Older Adults

Pain, according to Ferral (1991), is one of the main reasons for consultation among elderly patients. Therefore, it is important to understand its behavior and variations in relation to other patients. In fact, patients often wait for pain to become severe or intolerable before consulting a healthcare professional. Pain can be a symptom or consequence of injury, illness, or surgery. One definition is the perception of an unpleasant sensation and the emotional experience associated with actual or potential tissue damage.

Pain can be classified in several ways. Acute pain is of recent onset, generally with a demonstrable cause, although not always, and may persist from minutes to days. Pain lasting longer than 72 hours is termed subacute, while chronic pain can last from months to years, although its definition varies. Chronic pain is commonly considered to persist for more than three months, but this limit is quite arbitrary. Others define chronic pain as any pain that lasts longer than expected for the resolution of a problem. With this definition, the time allowed to classify it as chronic varies[4]. Pain can be referred to a distant site from its origin and is common in conditions of internal organs or viscera such as kidneys, colon, uterus, and rectum, which can refer pain to the lumbosacral region. The anatomical basis of referred pain lies in somatic and visceral tissues innervated by afferent fibers from the same segment of the spinal root. Primary nociceptive pathways interconnect with other spinal segments, allowing the perception of pain to be located in a place distant from the actual site of the disease. Nociceptive stimulation can produce hyperexcitability in spinal cord nerve cells, which can refer pain to related tissues[4]. Pain can radiate from its origin and produce a large painful area. Some speculate that when it radiates to a large area, it indicates a particularly severe injury that will localize more as the problem resolves (Maestre, 2022).

2.2.6 Family Functioning

The family is a self-correcting system governed by rules that develop over time through trials and errors. The central idea of this hypothesis is that each natural group with a history, of which the family is fundamental (but which could also be a work team, a spontaneous community, a business group, etc.), is formed over time through a series of trials, exchanges, and corrective feedback, experiencing what is and is not allowed in the relationship until it becomes a unique systemic unit sustained by peculiar rules (Kozier, 1993).

3 PROBLEM STATEMENT

Until the 1970s, Mexico lacked a defined public policy addressing the issue of older adults. During the colonial era, the Reform and the Revolutionary and post-revolutionary Mexico, old age was conceived as a natural and individual condition of human beings, whose care corresponded to the private family sphere, where assistance institutions, especially religious ones, were involved only in cases of extreme vulnerability, abandonment, and helplessness. In this sense, the social response, rather than governmental, was based on the commandments of faith and charity. From the Porfiriato era onwards, history records the efforts of the State to take care of dependent populations (elderly, minors, disabled)[1]. Thus, care for the elderly became the responsibility of the *Beneficencia Pública* (Public Charity).

The National System for the Integral Development of the Family, DIF, became a specialized, autonomous, and decentralized arm of the health sector, and the National System for Social Assistance was formed, which, in addition to traditionally served sectors such as children and women, added young people and the elderly (Youth Integration Centers, National Institute for the Elderly) and created branches throughout the country at the state and municipal levels, with their own management of resources. Social assistance became a complex system with commitments, strategies, laws, and agreements.

Therefore, the following question arises: **What was the health status of the elderly in a permanent geriatric stay in November 2022?**

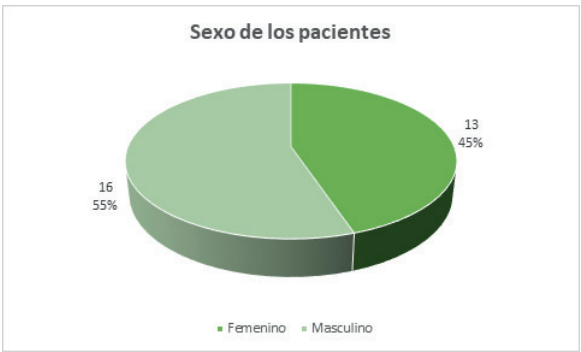
4 METHODS AND METHODOLOGY

It is intended to work with geriatric patients aged 45-90 years, divided into Pre-senile 45-60 years, Gradual senility 60-70 years, Declared old age 70-90 years, and long-lived over 90 years, who are patients residing in the Casa Hogar La Paz nursing home, to determine the nutritional status of the elderly using 7 Likert-type scales: Braden for pressure ulcers, SARC-F for sarcopenia, Mini Nutritional Assessment MNA SF, and a scale with a stadiometer already present in the institution to determine the nutritional status of the elderly. The Morse scale will be used to assess the risk of falls, and the IHS-AM scale for sleep assessment, as well as the pain Visual Analog Scale (VAS). Family functioning was assessed using the Mini-Mental State Examination (MMSE), Mini-Cog, Yesavage Depression Scale, Katz Index, Lawton Scale, and Morse Scale. Subsequently, the data was graphed in Excel to show demographic and health status data. Informed consent forms were provided to participants in this study.

5 DISCUSSION

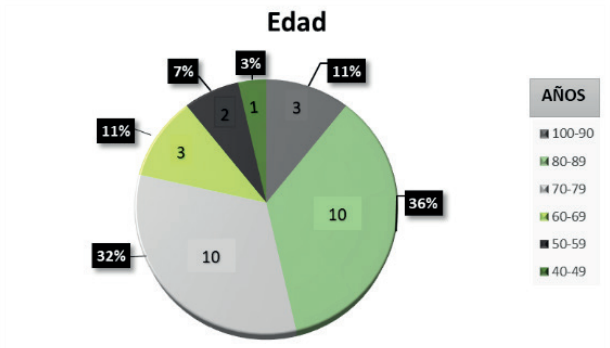
5.1 SEX OF PATIENTS

Of the evaluated patients, there is a higher prevalence of men, comprising 55%, compared to 32% of women at Casa Hogar La Paz.



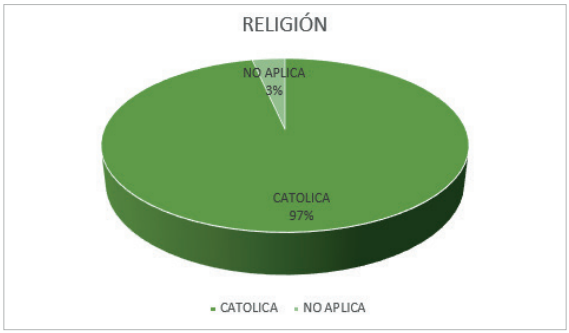
5.2 AGE

Based on the age distribution of the patients, it can be observed that there is a greater population in the age group of 80 to 89 years, with 10 patients in this age range. This is followed by the age group of 70 to 79 years, which has 9 patients, and then the age groups of 90 to 99 and 60 to 69 years, each with 3 patients. Next is the age group of 50 to 59 years, with 2 patients, and finally, the age group of 40 to 49 years, which has 1 person.



5.3 RELIGIOUS FAITH

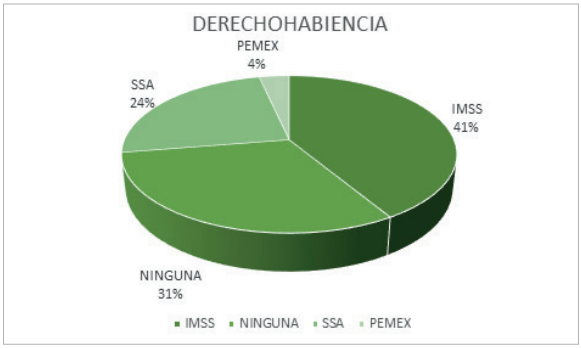
Regarding the religion of the elderly adults, 97% of them (28 individuals) are Catholics.



5.4 HEALTH COVERAGE ("*DERECHOHABIENCIA*[1]")

According to their health coverage, out of the total 29 patients in the facility:

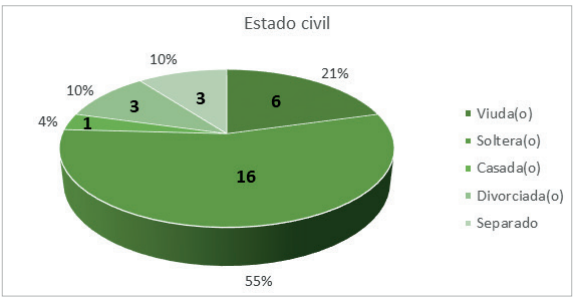
- 41% (12) belong to IMSS (Mexican Social Security Institute).
- 31% (9) do not have any health service coverage.
- 24% (7) are affiliated with SSA (Secretaría de Salud, Ministry of Health).
- Only 3% (1) is affiliated with PEMEX (Petróleos Mexicanos).



5.5 MARITAL STATUS

Out of 100% (29) of the older adults, 55% (16) are single, 21% (6) are widowed, 10% (3) are separated, 10% (3) are divorced, and 4% (1) are married.

[1] Derechohabiencia is a term used in Mexico to refer to the entitlement of individuals to receive health services through various public or private institutions. It specifies a person's affiliation to a healthcare system, such as IMSS (Mexican Social Security Institute), ISSSTE (Institute for Social Security and Services for State Workers), SSA (Ministry of Health), PEMEX (Mexican Petroleum), among others.

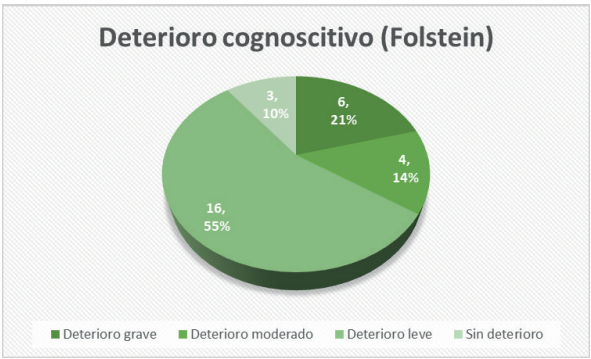


5.6 MINI-MENTAL

The Mini-Mental State Examination (MMSE) is the most commonly used test to assess symptoms related to cognitive impairment, memory problems, or dementia, especially in older adults. It evaluates issues such as temporal and spatial orientation, attention and calculation, reading, writing, memory, drawing, among others, with a scoring range from 0 to 30 points.

The Mini-Mental test by Folstein can be divided into two parts. Part A contains a total of 21 points, while Part B requires paper and pencil, with a total score of 9 points.

It is recommended to administer the Mini-Mental test in a comfortable and distraction-free environment. It should be conducted individually, without setting time limits for each response. Before starting the test, it is important for the evaluator to gather some information such as: name, age, level of education, whether the person wears glasses, and if they have noticed any recent memory problems.



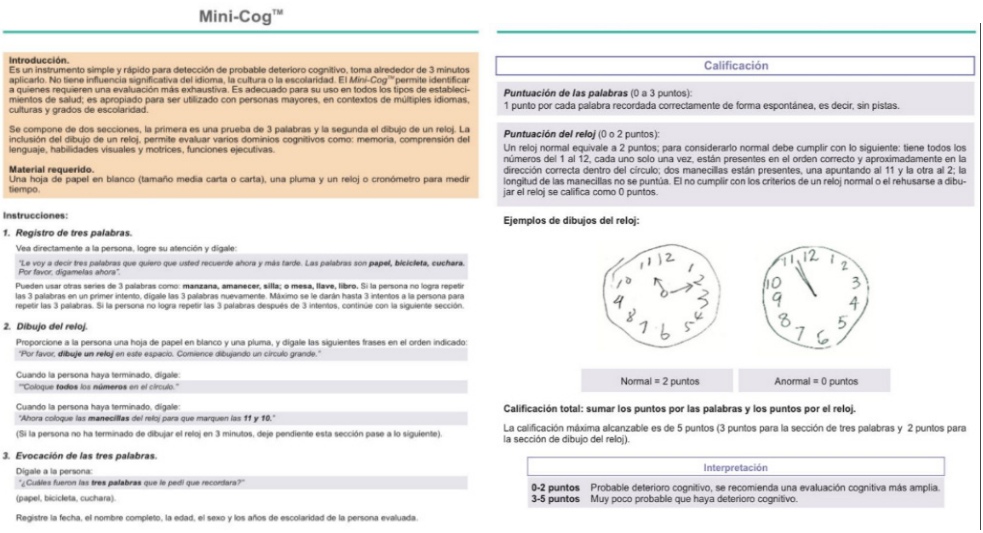
It was found that out of the 29 patients:

- Only 3 (10%) do not have cognitive impairment.
- 16 (55%) have mild cognitive impairment.
- 4 (14%) have moderate cognitive impairment.
- 6 (21%) have severe cognitive impairment.

5.7 THE MINI-COG

Is a simple and quick tool used for detecting possible cognitive impairment, taking approximately 3 minutes to administer. It is not significantly influenced by language, culture, or level of education. The Mini-CogTM helps identify individuals who may need a more thorough evaluation and is suitable for use in all types of healthcare settings, including diverse linguistic, cultural, and educational backgrounds.

It consists of two parts: the first part involves a 3-word recall test, and the second part requires the person to draw a clock. The inclusion of the clock-drawing task allows for the assessment of various cognitive domains such as memory, language comprehension, visual and motor skills, and executive functions.



Mini-Cog™

Introducción.
Es un instrumento simple y rápido para detección de probable deterioro cognitivo, toma alrededor de 3 minutos aplicarlo. No tiene influencia significativa del idioma, la cultura o la escolaridad. El *Mini-Cog™* permite identificar a quienes requieren una evaluación más exhaustiva. Es adecuado para su uso en todos los tipos de establecimientos de salud; es apropiado para ser utilizado con personas mayores, en contextos de múltiples idiomas, culturas y grados de escolaridad.

Se compone de dos secciones, la primera es una prueba de 3 palabras y la segunda el dibujo de un reloj. La inclusión del dibujo de un reloj, permite evaluar varios dominios cognitivos como: memoria, comprensión del lenguaje, habilidades visuales y motrices, funciones ejecutivas.

Material requerido.
Una hoja de papel en blanco (tamaño media carta o carta), una pluma y un reloj o cronómetro para medir tiempo.

Instrucciones:

1. ***Registro de tres palabras.***
Vea directamente a la persona, logre su atención y dígale:
"Le voy a decir tres palabras que quiero que usted recuerde ahora y más tarde. Las palabras son ***papel, bicicleta, cuchara.*** *Por favor, dígamelas ahora".*
Pueden usar otras series de 3 palabras como: **manzana, amanecer, silla; o mesa, llave, libro.** Si la persona no logra repetir las 3 palabras en un primer intento, dígale las 3 palabras nuevamente. Máximo se le darán hasta 3 intentos a la persona para repetir las 3 palabras. Si la persona no logra repetir las 3 palabras después de 3 intentos, continúe con la siguiente sección.
2. ***Dibujo del reloj.***
Proporcione a la persona una hoja de papel en blanco y una pluma, y dígale las siguientes frases en el orden indicado:
"Por favor, ***dibuje un reloj*** *en este espacio. Comience dibujando un círculo grande."*
Cuando la persona haya terminado, dígale:
"Coloque ***todos*** *los* ***números*** *en el círculo."*
Cuando la persona haya terminado, dígale:
"Ahora coloque las ***manecillas*** *del reloj para que marquen las* ***11 y 10.***"
(Si la persona no ha terminado de dibujar el reloj en 3 minutos, deje pendiente esta sección pase a lo siguiente).
3. ***Evocación de las tres palabras.***
Dígale a la persona:
"¿Cuáles fueron las ***tres palabras*** *que le pedí que recordara?"*
(papel, bicicleta, cuchara).
Registre la fecha, el nombre completo, la edad, el sexo y los años de escolaridad de la persona evaluada.

Calificación

Puntuación de las palabras (0 a 3 puntos):
1 punto por cada palabra recordada correctamente de forma espontánea, es decir, sin pistas.

Puntuación del reloj (0 o 2 puntos):
Un reloj normal equivale a 2 puntos; para considerarlo normal debe cumplir con lo siguiente: tiene todos los números del 1 al 12, cada uno solo una vez, están presentes en el orden correcto y aproximadamente en la dirección correcta dentro del círculo; dos manecillas están presentes, una apuntando al 11 y la otra al 2; la longitud de las manecillas no se puntúa. El no cumplir con los criterios de un reloj normal o el rehusarse a dibujar el reloj se califica como 0 puntos.

Ejemplos de dibujos del reloj:

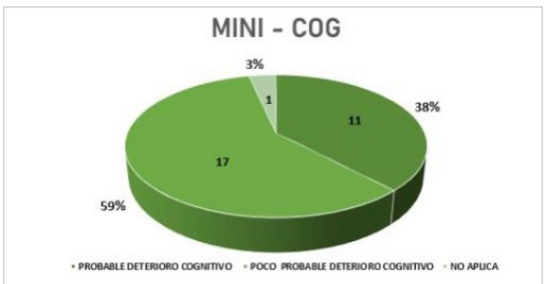
Normal = 2 puntos | Anormal = 0 puntos

Calificación total: sumar los puntos por las palabras y los puntos por el reloj.
La calificación máxima alcanzable es de 5 puntos (3 puntos para la sección de tres palabras y 2 puntos para la sección de dibujo del reloj).

Interpretación	
0-2 puntos	Probable deterioro cognitivo, se recomienda una evaluación cognitiva más amplia.
3-5 puntos	Muy poco probable que haya deterioro cognitivo.

Upon applying the Mini-Cog test, it was determined that out of the total population of 29 patients:

- 59% (17 patients) have a low probability of cognitive impairment.
- 38% (11 patients) have probable cognitive impairment.
- 3% (1 patient) did not apply to this test.

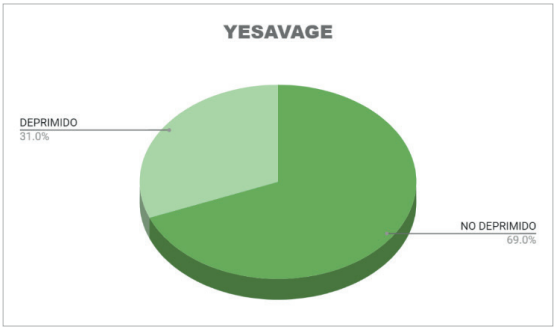


5.8 YESAVAGE

The Yesavage Geriatric Depression Scale is a widely used tool for screening depression, consisting of 15 questions to enhance ease of administration. A score of 5 or more positive responses suggests depression, with a sensitivity and specificity ranging from 80-95% depending on the studied population.

Within Casa Hogar La Paz, it was found that out of the total population (29 patients):

- 31% (9 patients) are in a depressive state.
- The remaining 69% (20 patients) are not depressed.



5.9 THE KATZ INDEX

The Katz Index is a caregiver-administered questionnaire with 6 items, dichotomously scored. It assesses functional independence across six areas:

- Bathing
- Dressing
- Toileting
- Transferring
- Continence
- Feeding

It categorizes individuals into eight potential levels of function:

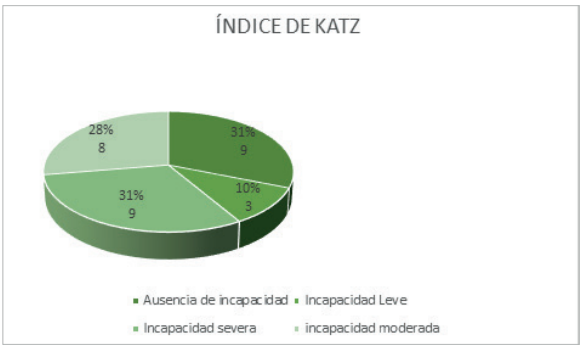
- A: Independent in all functions
- B: Independent in all functions except one
- C: Independent in all functions except bathing and one other
- D: Independent in all functions except bathing, dressing, and one other
- E: Independent in all functions except bathing, dressing, toileting, and one other

- F: Independent in all functions except bathing, dressing, toileting, transferring, and one other
- G: Dependent in all functions
- H: Dependent in at least two functions, but not classifiable as C, D, E, or F

The conventional classification based on scores is as follows:

- Grades A-B or 0-1 points: Absence of disability or mild disability
- Grades C-D or 2-3 points: Moderate disability
- Grades E-G or 4-6 points: Severe disability

With the assessment of activities of daily living, 10% corresponding to 3 individuals have mild disability, 28% (8 patients) have moderate disability, 31% (9 patients) have severe disability, and the remaining 31% (9 patients) have no disability.

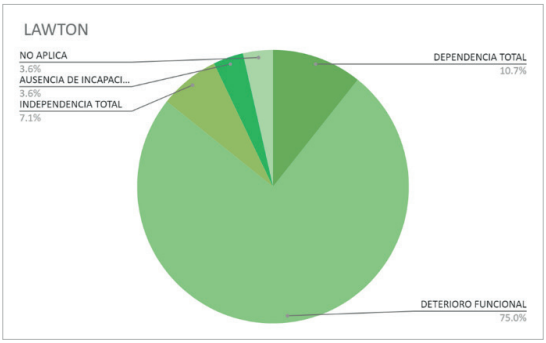


5.10 LAWTON

Assesses functional capacity through 8 items: ability to use the telephone, shop, prepare meals, do housework, do laundry, use transportation, handle medications, and manage finances.

Of the 29 patients in Casa Hogar La Paz, it was found that:

- 22 (75.0%) have Functional Impairment,
- 3 (10.7%) have Total Dependence,
- 2 (7.1%) have Total Independence,
- 1 (3.6%) have No Disability, and
- 2 (3.6%) are Not Applicable.

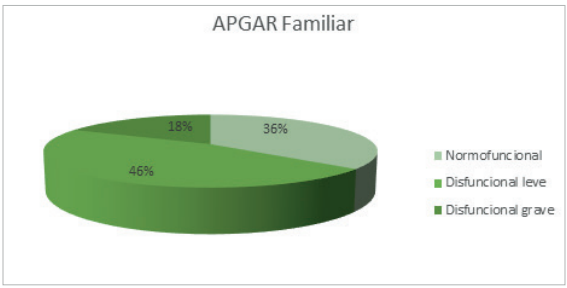


5.11 APGAR FAMILIAL

The APGAR Familial is an instrument that shows how family members perceive the overall functioning level of the family unit, including children as it is applicable to the pediatric population. It is useful for highlighting how a person perceives their family's functioning at a given moment.

It was found that out of the 29 patients:

- 10 patients (35.7%) have a normally functional family,
- 13 patients (46.4%) have a mildly dysfunctional family, and
- 5 patients (17.8%) have a severely dysfunctional family.



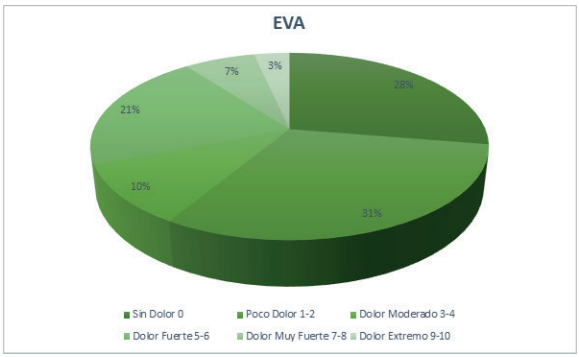
5.12 EVA (VISUAL ANALOG SCALE)

EVA is a tool used to help a person assess the intensity of certain sensations and feelings, such as pain. The visual analog scale for pain is a straight line where one end signifies no pain at all and the other end signifies the worst pain imaginable. The patient marks a point on the line that corresponds to the amount of pain they are feeling. It can be used to choose the correct dose of an analgesic. It is also called a visual analog scale.

Out of the 29 patients evaluated using the EVA scale:

- 8 patients (28%) reported no pain at all,
- 9 patients (31%) reported mild pain,

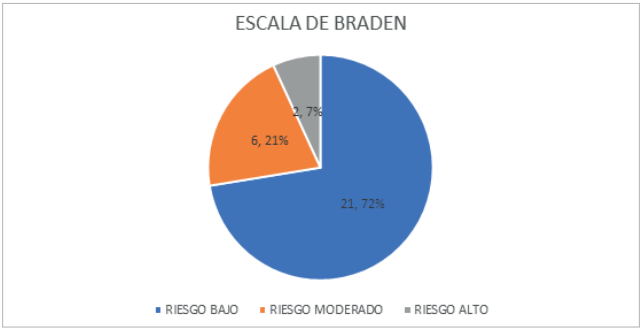
- 3 patients (10%) reported moderate pain,
- 6 patients (21%) reported severe pain,
- 2 patients (7%) reported very severe pain, and
- 1 patient (3%) reported extreme pain.



5.13 BRADEN SCALE

When evaluating the Braden Scale in older adults, the results showed:

- 21 patients (72%) are at Low Risk,
- 6 patients (21%) are at Moderate Risk,
- 2 patients (7%) are at High Risk.



5.14 MORSE SCALE

The Morse Scale was applied to 29 patients, yielding the following results:

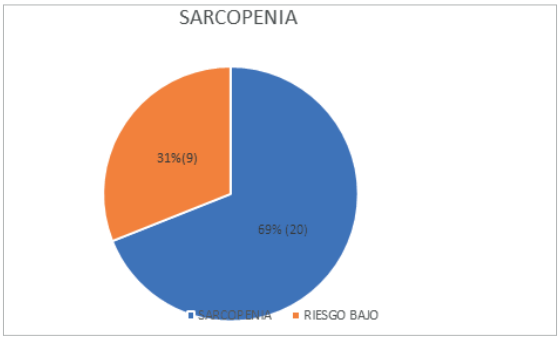
- 8 patients (27.59%) have a High Fall Risk,
- 18 patients (62.07%) have a Low Fall Risk,
- 3 patients (10.34%) have No Risk.

5.15 SARCOPENIA

Sarcopenia, a condition associated with aging, involves loss of muscle mass, leading to muscle weakness, reduced mobility, and increased risk of falls, fractures, and frailty.

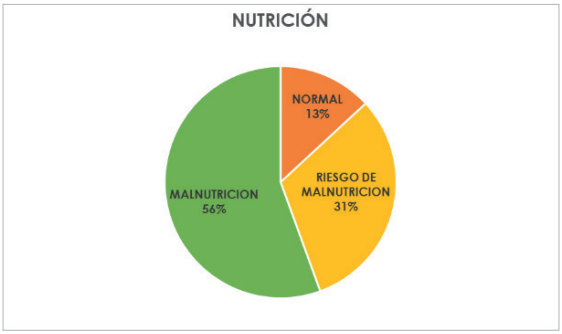
The SARC-F tool assesses muscle strength through a scoring system where patients rate their ability in 5 parameters: strength, ability to walk, rise from a chair, climb stairs, and frequency of falls. Each component is scored 0, 1, or 2 points (0 indicates no difficulty, 1 indicates some difficulty, and 2 indicates much difficulty or inability).

The total score ranges from 0 to 10, with patients scoring 4 points or fewer considered to have sarcopenia. SARC-F has been developed as an alternative to imaging tests and physical exams commonly used to measure muscle strength.



5.16 NUTRITIONAL SCALE

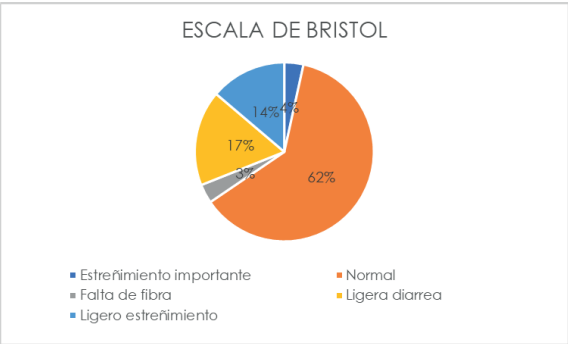
During the assessment of nutritional status at Casa Hogar La Paz, it was found that 56% of the population is malnourished, 31% are at risk of malnutrition, and 13% are in a normal nutritional state.



5.17 BRISTOL SCALE

Upon evaluating the graph displaying the results of the Bristol Scale, it is observed that the normal disorder predominates with a percentage of 62% in the population. This is

followed by mild diarrhea disorder (17%), then mild constipation disorder (14%), with less prevalence being significant constipation (4%), and finally, with a lesser percentage but not less significant, fiber deficiency disorder (3%).



6 CONCLUSIONS

It was found that older adults suffer significantly from health problems, which through a comprehensive assessment can be identified, enabling responsible personnel to develop plans and programs aimed at improving their quality of life through trained personnel.

6.1 ETHICAL CONSIDERATIONS

The research was considered “low-risk” according to the Regulations of the General Health Law on Health Research, 25, applicable at the time of the study, as no interventions were made on participants’ physiological or psychological variables, nor was sensitive information collected, thus participants were not required to provide written informed consent.

7 FUNDING

This research was funded by “Semillas Hibridas de Irapuato,” which provided resources for the collection of scales.

8 CONFLICT OF INTEREST

None of the authors report conflicts of interest.

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SOBRE O ORGANIZADOR

Luis Fernando González-Beltrán- Doctorado en Psicología. Profesor Asociado de la Facultad de Estudios Superiores Iztacala (FESI) UNAM, Miembro de la Asociación Internacional de Análisis Conductual. (ABAI). de la Sociedad Mexicana de Análisis de la Conducta, del Sistema Mexicano de Investigación en Psicología, y de La Asociación Mexicana de Comportamiento y Salud. Consejero Propietario perteneciente al Consejo Interno de Posgrado para el programa de Psicología 1994-1999. Jefe de Sección Académica de la Carrera de Psicología. ENEPI, UNAM, de 9 de Marzo de 1999 a Febrero 2003. Secretario Académico de la Secretaría General de la Facultad de Psicología 2012. Con 40 años de Docencia en licenciatura en Psicología, en 4 diferentes Planes de estudios, con 18 asignaturas diferentes, y 10 asignaturas diferentes en el Posgrado, en la FESI y la Facultad de Psicología. Cursos en Especialidad en Psicología de la Salud y de Maestría en Psicología de la Salud en CENHIES Pachuca, Hidalgo. Con Tutorías en el Programa Alta Exigencia Académica, PRONABES, Sistema Institucional de Tutorías. Comité Tutoral en el Programa de Maestría en Psicología, Universidad Autónoma del Estado de Morelos. En investigación 28 Artículos en revistas especializadas, Coautor de un libro especializado, 12 Capítulos de Libro especializado, Dictaminador de libros y artículos especializados, evaluador de proyectos del CONACYT, con más de 100 Ponencias en Eventos Especializados Nacionales, y más de 20 en Eventos Internacionales, 13 Conferencia en Eventos Académicos, Organizador de 17 eventos y congresos, con Participación en elaboración de planes de estudio, Responsable de Proyectos de Investigación apoyados por DGAPA de la UNAM y por CONACYT. Evaluador de ponencias en el Congreso Internacional de Innovación Educativa del Tecnológico de Monterrey; Revisor de libros del Comité Editorial FESI, UNAM; del Comité editorial Facultad de Psicología, UNAM y del Cuerpo Editorial Artemis Editora. Revisor de las revistas “Itinerario de las miradas: Serie de divulgación de Avances de Investigación”. FES Acatlán; “Lecturas de Economía”, Universidad de Antioquía, Medellín, Colombia, Revista Latinoamericana de Ciencia Psicológica (PSIENCIA). Buenos Aires, Revista “Advances in Research”; Revista “Current Journal of Applied Science and Technology”; Revista “Asian Journal of Education and Social Studies”; y Revista “Journal of Pharmaceutical Research International”.

https://orcid.org/0000-0002-3492-1145

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