Sociodemography and epidemiology of the population attended in a psychological care center in Mexico

Sociodemografía y epidemiología de la población atendida en un centro de atención psicológica en México

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Research article

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Abstract

Objective: It was to analyze the sociodemographic and diagnostic characteristics of the population attending psychotherapy.
Materials and Method: Design was quantitative, descriptive, retrospective and longitudinal of 322 files.
Results: It was found that the majority is male (60%), young (33%), Catholic (81%) and with basic school (26%). Females present more anxiety disorders (56%), related to trauma and stressors (71.4%), personality (75%), primary support group (65%), child neglect (80%), abuse (71.4%) and others related to social environment (62.5%). Males had neurodevelopmental (100%), impulse control/ behavioral (70%) and family upbringing (54.4%) problems. Most frequent problems are the parent-child relationship (14.6%), conflicts with the partner (8.9%) and life phase (6.1%).
Conclusions: Instead of individual problems, most of population (especially women) attended derive from difficulties in their environment (insecurity, poverty) or from the lack of social skills to manage their interpersonal relationships in an assertive manner (parenting styles, resolution of couple problems). Aggressive masculinity is present in many situations, even when patients did not realize it when attending the service.

Keywords: Mental health services; mental disorders; psychotherapy; population characteristics; gender and health

Resumen

Objetivo: Fue analizar las características sociodemográficas y diagnósticas de la población en psicoterapia.
Materiales y Método: Diseño cuantitativo, descriptivo, retrospectivo y longitudinal de 322 expedientes.
Resultados: La mayoría es masculina (60%), joven (33%), católica (81%) y con secundaria (26%). Las mujeres presentan más trastornos de ansiedad (56%), relacionados con traumas y estresores (71,4%), personalidad (75%), grupo de apoyo primario (65%), abandono infantil (80%), abuso (71,4%) y otros relacionados con el entorno social (62,5%). Los varones tenían problemas de neurodesarrollo (100%), control de impulsos/conducta (70%) y educación familiar (54,4%). Los problemas más frecuentes son la relación padre-hijo (14,6%), los conflictos con la pareja (8,9%) y la fase vital (6,1%).
Conclusiones: En lugar de tratarse de problemáticas individuales, la mayoría de los problemas (especialmente para las mujeres) se derivan de las dificultades de su entorno (inseguridad, pobreza) o de la falta de habilidades sociales para manejar sus relaciones interpersonales de manera asertiva (estilos de crianza, resolución de problemas de pareja). La masculinidad agresiva se encuentra presente en muchas de las situaciones atendidas, aún cuando los pacientes no habían tomado conciencia de ello al llegar al servicio.

Palabras clave: Servicios de salud mental, trastornos mentales, psicoterapia, características de la población, género y salud

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Introduction

International statistics indicate that depression is one of the psychopathologies with the highest incidence. The National Household Survey elaborated by the National Institute of Statistics and Geography in Mexico[1] points out that one third of the Mexican population aged 12 years or older, has felt depressed at some point in their lives.

However, what people colloquially refer to as "depression" can easily be confused with emotions of sadness, nostalgia, regret, disappointment, discouragement, among many other similar emotions, which in many cases can be healthy responses to problematic experiences or thoughts.

To strengthen the analysis, the data were compared with those of other Latin American university psychological care centers, which, in turn, showed divergences among themselves. In addition, the data obtained in the first semesters of care for the open population in a university psychological care center in Guanajuato, Mexico appeared to be very distant from government statistics.

Considering that in many countries (Mexico is not the exception) the economic, security, cultural and gender conditions are not optimal and that most people do not have specific training to face the stressful events of daily life, the objective was then set to analyze the incidence of confirmed diagnoses according to the DSM-5 and ICD 10 during five semesters, from January-June 2017 to January-June 2019, in order to have scientific certainty of the sociodemography and epidemiology of the consulting population in the region.

According to the report on the Mental Health System in Mexico, conducted by the World Health Organization[2], mental disorders account for approximately 12% of total health conditions in general over a quarter of the life of the sufferer, representing one of the three main causes of death between the ages of 15 and 35 as they are not treated correctly may end in cases of suicide, which have been increasing according to INEGI statistics[1], with 6808 deaths recorded in 2018, the highest figure recorded for a year in the contemporary era.

In addition, according to data reported by CONEVAL[3] in "Poverty measurement 2008-2018, Mexico" at federal level in 2018 it was estimated that 6.9% of the population was considered economically vulnerable by income, 41.9% were in poverty and only 20.2% had access to health services. In this contextual framework, the Center for Psychological Care of the University of Guanajuato Campus Celaya-Salvatierra (CAP-UG by its acronym in Spanish), has been proposed as a non-profit center that has attended economically vulnerable population in the state of Guanajuato, in which 43.4% suffers poverty[3], mainly in the municipality of Celaya, and surrounding areas.

Since the second half of 2016, date in which the CAP-UG was opened, the following functions have been carried out within the centre: a) second-level evidence based psychological care for the general public; b) Research of an epidemiological nature as well as the verification of the usefulness and functionality of different psychological treatments; c) Academic and practical training of pregraduate students of Clinical Psychology at the University of Guanajuato in different professional and clinical basic work skills.

In the 4 years it has been in operation, over 400 cases involving personal, couple and family problems have been treated, with patients aged from 2 to 77 for a wide variety of second-level clinical consultation motives. In this regard, the center has collected some epidemiological information on population which, not having access to efficient health services, do not figure in the mental health statistics reported in Mexico.

In this tenor, there are publications of other university clinics with similar functions to CAP-UG. Within the Latin American context we find clinics affiliated with the University of Costa Rica[4], the University of La Serena in Chile[5] and the University of Manizales in Colombia[6-8].

Within the demographic characteristics of the population with which these clinics worked it can be seen that in both Costa Rica and Colombia more women than men were attended, the difference in Colombia being more pronounced at 16.8%, in addition to this they share as similarity that within their most common age range was "young adult" which they explained by referring to the ease with which students from their respective universities are attached to their clinics. In contrast, in Chile and El Salvador[8], the underage population comprised 86.7% of the total attended, with the "child" population being the most representative with 50.5%, regarding sex differences, the male population outnumbered the female population by 10.8%.

As for the report of the main problems so it is difficult to generalize because these studies gave diagnostic classifications from the DSM-IV or categories based on ICD-10 instead of DSM-5, or taxonomy designed by the researchers themselves in which they grouped the diagnostic impressions and reasons for consultation of their sample.

In Chile, it was reported that the most common clinical picture was "depressive syndrome or disorder" occupying 24.4% of the total diagnoses and "attention deficit disorder" was the most common in the child population with 11.7%, being more prevalent in males.

The Costa Rican study worked with reasons for consultation, indicating that the category "sadness or depression" was the most common, accounting for 11.5% of the total, followed with a difference of 0.8% by "family problems", also distinguishing that

in men "consultations for aggressiveness" and "attention deficit or hyperactivity" were more common, and in women "sadness or depression" and "grief" were more usual. Furthermore, in the range of "young adults" the main reason for consultation was "sadness or depression".

Regarding Colombia in the study conducted by Portilla *et al.*[6] in which they worked with data referring to the period 2011-2014 it was described that from the sample they took to categorize the reasons for consultation "aggressiveness" and "emotional appraisal" obtained the highest percentage with 15.4% respectively in minors, for elderly consultations for "emotional appraisal" represented 27.2%. In the second Colombian study by Narváez & Aguirre[9] focused on analyzing diagnostic impressions within the period 2006 to 2011, they obtained as results that the most common data were "adaptive problems" with 14.6% in which women stood out in quantity over men, "marital problems" with 12.3% leaning towards men and "depressive disorders" with 12.2% where there was a difference between sexes of .5%.

In Europe, there is a clinic affiliated with the Universitat Autònoma de Barcelona. For their study[10] they collected data from the years 2010 to 2017, it should be noted that in this clinic they only worked with people directly related to the affiliated University, seeing this reflected in that 66.4% of the population were university students. In the results it was described that women outnumbered men by 17.3% and that the age range with the highest representation was between 24 and 30 years with 36.6% of the total population. The most common clinical diagnoses were adjustment disorders with 18.3%, followed by depressive adjustment disorder with 13.5%, bereavement with 9.9%, and phobias with 9%. For university students, anxiety disorders were found to be the most common, representing 34.93% of the total diagnoses. Another diagnostic category in which university students were very representative was "Personality disorders", accounting for 75.56% of the diagnoses in this category[10].

According to the background described above, this study aims to analyze the sociodemographic and epidemiological data recorded in CAP-UG during the 2016-2019 period as a contribution to mental health data in Mexico.

Materials and method

Design

For this study it has been chosen to implement a methodology of quantitative approach with a descriptive, retrospective, and longitudinal scope[11].

Study population

100% of the clinical records from August 2016 to December 2019 were taken into consideration. Considering the inclusion criteria, the sample size was reduced to 322 files (with total population n=352) comprising individual, couple, and family psychotherapy. It should be noted that in the case of the files on couples and family members, they were counted as a single case, since they involved the same diagnosis and problem, even though several people were involved. Thus, the number of 322 is lower than the number of people assisted over the years studied. As a criterion for inclusion, the file was considered to have at least three effective sessions with a recorded diagnosis, since these sessions comprise the minimum diagnostic evaluation period required for confirmation of diagnostic hypotheses. In addition, it was considered to have the informed consent signed by the patient, and in the case of minors or people with cognitive disabilities, the signature of one of the legal guardians.

Instruments

The diagnoses were made based on the DSM-5[12] and considering the ICD10 codes, in addition to having an informed consent for patients. Specific tests were also used for diagnostic confirmation, in accordance with the clinical guidelines of the Mexican Ministry of Health.

Procedure

A data matrix was constructed using the Excel program, where sociodemographic and epidemiological data from the clinical records were recorded. The sociodemographic variables selected for this study were: age, sex, schooling, and religion. Ages were grouped by ranges: 0-12 years (childhood), 13-17 (adolescence), 18-39 years (young adulthood), 40-59 years (middle adulthood), 60 or more (older adult). Clinical diagnoses were based on the Diagnostic and Statistical Manual of Mental Disorders, fifth edition DSM-5, Spanish version[12].

The different disorders and problems presented were placed in groups depending on the diagnostic sections marked by the DSM-5, of which were: "neurodevelopmental disorders" (attention deficit/hyperactivity disorder, autism spectrum disorder, intellectual development disorder, specific learning disorder), "anxiety disorders", "disorders related to trauma and stress factors", "disruptive impulse control and behavioral disorders" (oppositional defiant disorder, intermittent explosive disorder, conduct disorder of infantile onset type, avoidant personality disorder), "personality disorders", "family education" (Parent-child relationship problem, child affected by conflicting parental relationship, parent-child relationship problems and sibling relationship problems), "other problem related to primary support group" (conflictual relationship with spouse, family breakdown due to separation and divorce, uncomplicated bereavement

and high level of emotional expression in the family), "child neglect", "psychological abuse by spouse or partner", "other problems related to social environment" (life phase problems, problems related to living alone, social exclusion or rejection, target of persecution or discrimination, other problem related to social environment).

Results

Sociodemography

The socio-demographic features of the population served during the period 2016- 2019 are broken down in detail in the following table 1.

Table 1. Sociodemographic features

Sociodemographic variable	Description	Percentage
Sex	Male	**60%**
	Female	40%
Age	0 -12	30%
	13 - 17	10%
	18 - 39	**33%**
	40 - 59	20%
	60 or more	7%
Religion	Catholic	**81%**
	Agnostic	3%
	Christian	3%
	Jehovah's Witness	.6%
	Evangelist	.3%
	Atheist	4%
	Holy death	.3%
	Unspecified	8%
Schooling	Out of school	1%
	Preschool	10%
	Primary	21%
	Secondary	**26%**
	High school	17%
	Technical Career	5%
	Engineering	1%
	Degree	15%
	Master	1%
	Unspecified	3%

Source: Psychological files of the Psychological Attention Center CAP-UG, 2020. n=322

The average age of the population was 24 years, with the youngest being 2 years and the oldest 77 years. The age range belonging to children (0-12 years) and young adults (18-39) comprise the largest percentage of the population served, adding up to 63%. In terms of religion, a marked predominance of the Catholic religion was found, and with respect to the level of schooling, secondary education has the highest percentage, representing a quarter of the total sample.

As for the clinical diagnoses, the classifications given by the DSM-5[12] were used for the classification of the 472 clinical diagnoses issued in the sample. Table 2 breaks down the 10 categories with the highest number of recorded cases and their relationship to the age and sex of the sample.

Differences by sex

According to what is recorded in the Center's files, there is a clear difference in the diagnostic categories if we classify by sex.

Thus, for example, in four out of five cases attended with a diagnosis of child neglect, the patient was a woman. In cases of personality disorders the difference is 3 to 1 and in Trauma- and Stressor-Related Disorders, as well as in Spouse or Partner Abuse (Psychological), the difference is approximately 7 women for every 3 men. Regarding other problems related to primary support group and other problems related to the social environment, the difference is smaller, approximately 6 women for every 4 men. Finally, in anxiety disorders, female cases barely outnumber male ones, with a ratio of 56 to 44 for every 100 cases.

The rest of the diagnoses show a mostly male population. The few cases of Neurodevelopmental Disorders were exclusively male. For the diagnoses of Disruptive impulse-control and conduct disorder, there were 7 men for every 3 women, and these were mainly cases in which the children showed behavioral problems and were referred by schools in the surrounding area. Family education was the other case in which men were the majority, with similar themes to the previous one, since it commonly involved children, whose parents were very confused about what to do to reduce conflicts at home, since the minors had attitudes that hindered their educational process, to the point that the atmosphere at home had become tense most of the time.

Differences by age

Regarding the classification of diagnoses recorded by developmental stage, it was found that in infancy (0 to 12 years), as expected, Neurodevelopmental Disorders and Child neglect were significantly more frequent. Similarly, that six out of ten files in which the diagnosis was Disruptive, Impulse-Control, and Conduct Disorders, was also theoretically expected. Consistent with this, of the family education problems, almost half were recorded at this stage. What was striking, however, was that none of the diagnostic characteristics had a higher percentage in the adolescent stage (13 to 17 years).

On the other hand, the young adult stage (18-39) had the highest number of diagnostic categories with higher percentages than other developmental stages. Personality disorders mainly manifested themselves in seven out of ten cases at these ages, with no patients in childhood, adolescence, or older adulthood.

Table 2. Diagnostic categories according to percentage, age and sex.

Diagnostic category	Percentage	Sex		Age				
				Child	Adolescent	Young Adult	Middle Adult	Older Adult
		Male	Female	0-12	13-17	18-39	40-59	60 or more
Neurodevelopmental Disorders	2.97%	**100%**	0%	**75%**	25%	-	-	-
Anxiety Disorders	5.30%	44%	**56%**	32%	16%	**36%**	16%	-
Trauma-and Stressor-Related Disorders	5.93%	28.6%	**71.4%**	14.3%	-	**39.3%**	**39.3%**	7.1%
Disruptive, Impulse-Control, and Conduct Disorders	2.12%	**70%**	30%	**60%**	10%	20%	10%	-
Personality Disorders	4.24%	25%	**75%**	-	-	**70%**	30%	-
Family education	20.97%	**54.5%**	45.5%	**48.5%**	17.2%	16.2%	16.2%	2%
Other Problems Related to Primary Support Group	17.2%	35%	**65%**	11.2%	6.12%	**36.7%**	32.7%	12.3%
Child Neglect	2.1%	20%	**80%**	**60%**	20%	10%	10%	-
Spouse or Partner Abuse, Psychological	3.6%	28.6%	**71.4%**	5%	15%	**35%**	**35%**	10%
Other Problems Related to the Social Environment	8.69%	37.5%	**62.5%**	30%	5%	**37.5%**	12.5%	15%

Source: Psychological files of the Psychological Attention Center CAP-UG, 2020. n=322

Anxiety Disorders, Trauma-and Stressor-Related Disorders, Other Problems Related to Primary Support Group, Spouse or Partner Abuse (Psychological) and Other Problems Related to the Social Environment accounted for between 35% and 40% of the population attended.

For the middle adult age range of 40 to 59 years, the Trauma-and Stressor-Related Disorders category was repeated, with a percentage of 39.3%, identical to that found for persons aged 18 to 39 years. The other category that was found mostly in this stage was Spouse or Partner Abuse (Psychological), which again had a percentage identical to that of the previous stage, with 35% of the cases recorded.

Finally, the older adult stage generally had very few records, to the point that in five categories there were no records at all. Only two categories exceeded 10% of cases, Other Problems Related to Primary Support Group (12.3%) and Other Problems Related to the Social Environment (15%).

Common disorders

Table 3 shows that the most common problems for which a person is treated at the Center are Parent-child relational problem, Conflicting relationship with spouse or partner and Phase of life problem. Interestingly, all these diagnoses belong to the DSM-5 section "Other Conditions That May Be a Focus of Clinical Attention".

Approximately one in five cases received were related to parent-child problems. It should be noted that this item does not include Disruptive, Impulse-Control, and Conduct Disorders, so it is to be remarkable that so many cases of parent-child problems were presented. Generally, these were young boys who disobeyed their parents or refused to comply with their school or domestic obligations, which generated significant discomfort in the parents and gave rise to continuous arguments and conflicts at home.

Table 3. Most common clinical diagnoses in CAP-UG from 2016 to 2019

Diagnosis	N	Percentage of total records	Percentage by sex	Most frequent age range	Category (DSM-5)
			Male - Female		
Parent-child relational problem	69	**21.42**	**59.2** – 40.8	Childhood (50.7%)	Family education
Conflicting relationship with spouse or partner	42	13.04	42 - **58**	Middle adult (39.6%)	Other problems related to primary support group
Phase of life problem	29	9.00	**70**-30	Childhood (23.3%)	Other problems related to the social environment

Source: Psychological files of the Psychological Attention Center CAP-UG, 2020. n=322

Discussion

When confronting the results of this study with similar university clinics, it can be noticed that the data by age are similar to those reported in El Salvador, Costa Rica, Spain and Colombia, with a majority of young adults, as opposed to Chile, where the majority were children aged 0 to 12 years old. The discrepancy can be understood since the Psychological Care Center of the University of La Serena in Chile is focused precisely on child and adolescent care, according to its own data[5]. It can be stated, then, that there is a general tendency to request psychological care in late adolescence and early adulthood. This may be assumed to be the result of the fact that the care centers reported in this study are physically located in university facilities, whose students are either users or refer to family members or acquaintances, as was the case in Costa Rica, Colombia and Spain. However, this last statement is refuted when considering that the highest percentage of attendance in our study was in secondary education, with 1 out of every 4 patients, followed by 1 out of every 5 in elementary school.

Regarding the overall differences by sex, results agree with those found in Chile[5], with a distribution of 6 men per 4 women. In Colombia[7], El Salvador[8] and Costa Rica[4] the population is almost equally distributed. Therefore, it can be asserted that there are no significant differences between men and women in terms of how many requests psychotherapy services. The only case that is different is that of Spain, where the population attended is around 7 women for every 3 men, although most of the population is from the university itself, so it should be asked whether this may have had some impact on their particular data or whether it is a difference that can be explained by the cultural differences between the two continents.

However, although the number of individuals is similar, the problems presented by men and women do have clear differences. For example, aggressive behaviors related to impulse control, conduct disorders or oppositional defiant behaviors are mostly presented by men. In the case presented here, the ratio is 7 to 3, approaching the 4 to 1 according to data from Costa Rica[4] Chile[5] Colombia[7]. Although for the cases contrasted here from university clinics, El Salvador and Spain do not present diagnoses classified by sex, the results are consistent with what is normally expected in terms of the predominance of the male sex in the DSM-5[12].

It would also be worth considering that for the case presented herein, the higher male frequency may have been derived from the links with the basic education system, since CAP-UG is a referral center that received many underage students who showed behavioral problems and that on many occasions, are not attended by the Mexican public health system (which is mainly hospital-based) since they deal mostly with mood, anxiety, or personality disorders. Similarly, Neurodevelopmental Disorders such as ADHD, language disorders, autism spectrum disorders or intellectual disabilities, among others, were also in line with worldwide statistics, showing a higher frequency in males[12]. It is noteworthy that with only these two sections and the coding of family education problems (Z62.820), it was enough for males to account for 60% of the total population attended in the overall data of our study.

In cases where the patient was a woman, the results directly resemble those found in Costa Rica[4] and Colombia[7] and indirectly those found in El Salvador[8] and Chile[5]. Again, the case of Spain[10] differs from the Latin American data, where there are no significant sex differences. Both the university centers in Costa Rica and Colombia found that women attended more for emotional problems related to anxiety and sadness, as well as problems related to family, parenting, and the environment.

The statement that indirectly El Salvador and Chile also show similarities is that although they do not make an in-depth breakdown of diagnoses by sex, in all these cases it is concluded that the social role of women is negatively marked by adverse psychosocial and poor housing conditions or socioeconomic and partner difficulties (they repeatedly suffer psychological violence).

Thus, the results of this study reinforce the assertion that women (at least Latin American women) seek therapeutic help on more occasions because of everyday suffering and not because of an individual disorder. This would also help to understand why men seek help on fewer occasions: their problems tend to be of control of their own behavior, so they do not find it so urgent to ask for help. Even if we recall the data presented previously, the male record could be discussed in terms of whether it is a female teacher or the mother herself who is requesting support for a boy who is presenting Disruptive, Impulse-Control, and Conduct Disorders.

Conclusions

According to the above, it can be observed that, in the sociodemographic characteristics, Mexico and Chile have a larger male population attended compared to Costa Rica, Colombia and Spain, where most of the cases were female. There is also a significant contrast in terms of age and schooling of the population, since in Costa Rica, Colombia and Spain, more young adults were attended, being their highest schooling the bachelor's degree, however in Mexico, although the largest age group attended was young adulthood, this did not match the university schooling, being secondary and primary the highest percentage obtained from the population attended, which may be due to the second highest age group, which was in childhood or because of the rates of urbanism in the region.

Regarding clinical diagnoses, a considerable difference can be seen in terms of the most frequent diagnostic categories, since, in Chile, Costa Rica, Colombia and Spain, they share similarities in the frequency of "depressive disorders", "anxiety disorders" and problems of "aggressiveness" and "attention deficit and/or hyperactivity disorder", which were the most frequent in those studies, compared to the results obtained in Mexico, where "parent-child relationship problems" were presented, "These problems were mostly caused by interpersonal relationships and the environment, triggering depressive and anxious symptoms, which generated discomfort in the population served due to poor interaction between family members and the transition from one life stage to another, for example from childhood to adolescence and from middle adulthood to older adulthood, which represented the highest percentages of age in the clinical diagnoses of the aforementioned categories. It can be observed that in countries such as Costa Rica and Colombia, where "family problems," "adaptive problems" and "marital problems" were present, they only appeared in lower percentages and always below "depressive disorders".

It was observed at CAP-UG that problematic responses in their affective dimension, with symptoms related to sadness are mistaken for disorders by most of the consultants, which can result in false positive diagnoses, while a more in-depth professional evaluation from Clinical Psychology allows us to locate many cases in which negative emotions are an expected response to triggering events or thoughts of high frustrating or stressful content, particularly for women, since men present more problems of aggression and women of trauma related, at least in this geographical region. Of course, in most cases there are negative emotions or similar symptoms, but frequently derived from difficulties present in their environment (insecurity, poverty) or lacking social skills to manage their interpersonal relationships in a non-conflictual way and with better life skills (parenting styles, couple problem solving).

Great care should be taken as health personnel not to establish diagnoses in a single session with the patient, without the correct in-depth evaluation of the case (biomarkers, specific tests, and sequential integrative analysis). It is recommended, for administrative purposes, to use "provisional", "risk diagnosis" or some other similar administrative coding instead.

Mental health constitutes a priority issue within the field of public health; this is confirmed by the different epidemiological studies that account for the contribution of mental disorders to the global burden of disease in the world[13] and in each region. In accordance with the recommendations of the WHO[14] regarding health promotion as an emerging field dedicated to care through various models, it is important to highlight the role of clinical psychology in the public health of collectives, specifically when it performs its work through clinics open to the community. Psychologists then should turn to consider more work outside the consulting room in one-on-one sessions, a more communitarian, social work, and for Mexico, on preventing aggressive maleness. Perhaps then we will stop pathologizing emotions that fulfill their natural function of mobilizing the individual in search of a different, less stressful reality.

Finally, this would lead to consider if the "Other Conditions That May Be a Focus of Clinical Attention" section in the DSM should be expanded to develop more specifically (even regionally) diagnostic and differential criteria, which are extensively described in the disorders of the previous sections. And of course, it would also lead to a reconsideration of the evaluation and sociodemographic data of depressive and anxiety disorders. In all the Latin American clinics reviewed, including the Mexican clinic, the data pointed to a shift towards the study of relational and contextual problems over anxiety or mood disorders, especially with attention to those who request the service the most: Latin American women.

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Conflict of interest

There is no conflict of interest between authors.

Authors' contribution

Conceptualization and design: J.A.G.S.; Methods: E.M.P., M.J.J.G.; Data collection and software: F.C.J.M.; Data analysis: J.A.G.S., M.J.J.G., E.M.P.; Principal Investigator: J.A.G.S.; Research: J.A.G.S., F.C.J.M.; Manuscript preparation: F.C.J.M., I.M.G.; Manuscript revision and editing: J.A.G.S., E.M.P.; Visualization: M.J.J.G.; Supervision: J.A.G.S., F.C.J.M.; Financing: J.A.G.S., E.M.P., F.C.J.M., M.J.J.G.

References

1. Instituto Nacional de Estadística y Geografía [INEGI]. Salud mental [Mental health]. Available from: https://www.inegi.org.mx/temas/salud/default.html#Informacion_general

2. World Health Organization [WHO]. Informe sobre sistema de salud mental en México. Informe de la evaluación del sistema de salud mental en México utilizando el Instrumento de Evaluación para Sistemas de Salud Mental de la Organización Mundial de la Salud (IESM-OMS). [Report on the mental health system in Mexico. Report of the assessment of the mental health system in Mexico using the World Health Organization Assessment Instrument for Mental Health Systems (WHO-IMHIS)] Available from: http://www.who.int/mental_health/who_aims_country_reports/who_aims_report_mexico_es.pdf

3. National Council for the Evaluation of Social Development Policy [CONEVAL]. Medición de la pobreza [Measuring poverty] Available from: https://www.coneval.org.mx/Medicion/Paginas/PobrezaInicio.aspx

4. Maroto, A., Molina, L. & Prado., J. Características sociodemográficas y motivos de consulta de personas atendidas en el Centro de Atención Psicológica de la Universidad de Costa Rica (2004-2013) [Sociodemographic characteristics and reasons for consultation of people attended at the Psychological Care Center of the University of Costa Rica]. Revista Costarricense de Psicología. 2017; 36 (1), 23-44. Available from: https://doi.org/10.22544/rcps.v36i01.02

5. Muñoz, M.G. & Robledo, V. Síndromes y trastornos clínicos diagnosticados en un centro universitario de atención psicológica 2013-2016 [Clinical syndromes and disorders diagnosed in a university psychological care center]. UCMaule. 2017; (52), 9-24. Available from: http://doi.org/10.29035/ucmaule.52.9

6. López, M., Montoya. & D. Dussán, C. Caracterización de los asistentes al centro de atención psicológica de la Universidad de Manizales, 2006-2010. [Characterization of the attendees of the psychological care center of the University of Manizales] Hacia la promoción de la salud. 2016; 21(2), 127-141. Available from: https://www.redalyc.org/pdf/3091/309126826011.pdf

7. Obando, D., Romero, J., Trujillo, A. & Prada, M. Estudio epidemiológico de salud mental en población clínica de un centro de atención psicológica. [Epidemiological study of mental health in clinical population of a psychological care center] Psychologia. 2017; 11 (1), 85-96. Available from: https://doi.org/10.21500/19002386.3104

8. Chacón, E., Hasbún, S. & Membreño, C. Estudio de buenas prácticas en Clínica de Psicología. Caso UTEC [Study of good practices in Psychology Clinic. UTEC case] Entorno, 2015; 59, 49-68. Available from: https://doi.org/10.5377/entorno.v0i59.6182

9. Narváez, M. & Aguirre, H. Análisis de las impresiones diagnósticas en consultantes de un Centro de Atención Psicológica Universitario. [Analysis of diagnostic impressions in consultants of a University Psychological Care Center] Informes psicológicos. 2016; 16(2), 87-101. Available from: http://dx.doi.org/10.18566/infpsicv16n2a06

10. Tejedo, A. Condicionantes del diagnóstico en la demanda de ayuda psicológica en una unidad de atención psicológica en un campus universitario. [Diagnostic conditions in the demand for psychological help in a psychological care unit on a university campus] Revista de psicoterapia. 2019; 30(113), 213-237. Available from: https://doi.org/10.33898/rdp.v30i113.279

11. Hernández, R., Fernández, C. & Baptista, M. Metodología de la investigación [Research methodology]. D.F, México: McGraw Hill Education; 2014.

12. American Psychiatric Association [APA]. Manual Diagnóstico y Estadístico de los Trastornos Mentales DSM-5 [Diagnostic and Statistical Manual of Mental Disorders DSM-5] Arlington, VA: Médica Panamericana; 2014.

13. Restrepo, D. & Jaramillo, C. Concepciones de salud mental en el campo de la salud pública. [Conceptions of mental health in the field of public health] Revista Facultad Nacional de Salud Pública. 2012; 30(2): 202-211. Available from: http://www.scielo.org.co/pdf/rfnsp/v30n2/v30n2a09.pdf

14. World Health Organization [WHO]. Promoción de la salud mental: conceptos, evidencia emergente y práctica. [Mental health promotion: concepts, emerging evidence, and practice.] Available from: https://www.who.int/mental_health/evidence/promocion_de_la_salud_mental.pdf