

REVISTA *apm*

ASOCIACIÓN PSIQUIÁTRICA MEXICANA, A.C.



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Dirección y medios de contacto / Address and contact information. Avenida Periférico Sur 4194, Despacho 104, C.P. 01900, Ciudad de México, México. Tel. (+52) 55 5652 5576, apm@psiquiatriasapm.org.mx, psiquiatriasapm.org.mx, revistaapm@psiquiatriasapm.org.mx. Última actualización el 28 de abril de 2026.

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Asociación Psiquiátrica Mexicana, A.C. · Revista de la APM

Antecedentes

La Asociación Psiquiátrica Mexicana, A.C., constituida en 1966, es la organización médico-psiquiátrica que agrupa al mayor número de miembros con más de tres mil integrantes en todo el país. Su finalidad es promover la unidad en esta rama de la medicina, así como incentivar el desarrollo del conocimiento tanto para sus socios como para el público en general, mediante educación continua en profesionalismo, ética, práctica clínica e investigación en las ciencias de la salud mental. La institución organiza congresos nacionales, reuniones colegiadas y mantiene vínculos de colaboración con organismos nacionales e internacionales, entre ellos la Asociación Mundial de Psiquiatría (WPA) y la Asociación Psiquiátrica de América Latina (APAL).

Visión

Consolidarse como una publicación de referencia en las ciencias de la salud mental en México y Latinoamérica, con impacto internacional, sustentada en la excelencia científica, la ética editorial y la innovación. Aspiramos a ser un espacio transdisciplinario que articule la investigación básica, clínica y psicosocial con la práctica profesional, contribuyendo a mejorar los estándares de atención sanitaria.

Misión

Difundir conocimiento original, riguroso y actualizado en salud mental y disciplinas afines mediante un proceso editorial transparente que garantice la integridad académica. Fomentar el diálogo entre investigadores, clínicos y profesionales, incentivar la formación de nuevas generaciones de investigadores, y promover una comprensión integral de la salud mental en el contexto mexicano y global, respetando la diversidad cultural y las necesidades emergentes de México.

La Revista

La *Revista de la Asociación Psiquiátrica Mexicana, A.C.* es el órgano oficial de difusión de la APM y constituye una publicación cuatrimestral con proceso de revisión por pares doble ciego, conforme a las normas APA 7.^a edición. Publica artículos originales, revisiones sistemáticas, reportes de caso, editoriales y cartas al editor en español e inglés. Todo manuscrito se somete al cumplimiento de los estándares EQUATOR (CONSORT, PRISMA, STROBE, CARE) y a los principios éticos establecidos en la Declaración de Helsinki y las directrices del ICMJE. Desde su relanzamiento digital en 2021, la revista ha consolidado una base de indexación internacional y opera bajo licencia Creative Commons CC BY-NC 4.0.

Background

The Asociación Psiquiátrica Mexicana, A.C., founded in 1966, is the medical-psychiatric organization with the largest membership in the country, comprising more than three thousand members nationwide. Its purpose is to promote unity within this branch of medicine and to foster knowledge development for both members and the general public through continuing education in professionalism, ethics, clinical practice, and research in mental health sciences. The institution organizes national congresses and collegial meetings, and maintains collaborative ties with national and international bodies, including the World Psychiatric Association (WPA) and the Latin American Psychiatric Association (APAL).

Vision

To establish itself as a leading publication in mental health sciences in Mexico and Latin America, with international impact, grounded in scientific excellence, editorial ethics, and innovation. We aspire to be a transdisciplinary space that bridges basic, clinical, and psychosocial research with professional practice, contributing to higher standards of health care.

Mission

To disseminate original, rigorous, and up-to-date knowledge in mental health and related disciplines through a transparent editorial process that guarantees academic integrity. To foster dialogue among researchers, clinicians, and practitioners, nurture new generations of investigators, and promote a comprehensive understanding of mental health in both Mexican and global contexts, respecting cultural diversity and the emerging needs of Mexico.

The Journal

The Revista de la Asociación Psiquiátrica Mexicana, A.C. is the official publication of the APM and a quadrimstral journal with double-blind peer review, following the APA 7th Edition guidelines. It publishes original articles, systematic reviews, case reports, editorials, and letters to the editor in Spanish and English. All manuscripts must comply with EQUATOR reporting standards (CONSORT, PRISMA, STROBE, CARE) and with the ethical principles of the Declaration of Helsinki and ICMJE guidelines. Since its digital relaunch in 2021, the journal has consolidated an international indexing base and operates under a Creative Commons CC BY-NC 4.0 license.

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The Editorial Board was ratified at the beginning of the 2026–2027 term, in accordance with the bylaws of the Asociación Psiquiátrica Mexicana, A.C.

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EDITORIAL

El horizonte histórico de la Asociación Psiquiátrica Mexicana, A.C.

The Historical Horizon of the Asociación Psiquiátrica Mexicana, A.C.

José Carlos Medina-Rodríguez^{1,2,*}

¹ Asociación Psiquiátrica Mexicana, A.C., Álvaro Obregón, Ciudad de México, México. ² Dirección de Enseñanza, Instituto Nacional de Psiquiatría Ramón de la Fuente Muñiz, Ciudad de México, México.

ORCID: <https://orcid.org/0000-0002-0874-3525>. ***Correspondencia:** José Carlos Medina-Rodríguez, Anillo Periférico 4194-104, Jardines del Pedregal, Álvaro Obregón, 01900, Ciudad de México, México; revistaapm@psiquiatriasapm.org.mx.

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Resumen

Este manuscrito analiza la historia, el crecimiento y la influencia de la Asociación Psiquiátrica Mexicana, A.C. en la psiquiatría en México. Se detallan los elementos sociales, culturales, políticos, académicos y científicos que confluieron en el origen del gremio y configuraron su desarrollo a lo largo de las décadas. Se presta especial atención a cómo el *Dasein* mexicano del siglo pasado impactó la reflexión sobre el estado de la salud mental en México. Además de su trayectoria histórica, se examina el contexto contemporáneo de esta asociación civil y los desafíos actuales en su objetivo de contribuir a una psiquiatría mexicana integrativa. Se enfatizan aspectos cardinales, como la formación de nuevos expertos, y se delibera sobre la calidad, el acceso y la pertinencia de los programas de residencia en psiquiatría. Asimismo, se subraya la función del colectivo como entidad en el ámbito público nacional. La relevancia de este artículo historiográfico se sustenta en el uso de documentación de primera, segunda y tercera fuente, proporcionando una perspectiva integral que resalta los aciertos de los últimos bienios.

Palabras clave: Asociación Psiquiátrica Mexicana, A.C.; historia institucional; salud mental; psiquiatría mexicana.

Abstract

This manuscript analyzes the history, growth, and influence of the Asociación Psiquiátrica Mexicana, A.C. on psychiatry in Mexico. Social, cultural, political, academic, and scientific elements that shaped the origin of the professional association and configured its development across the decades are detailed. Particular attention is paid to how the Mexican Dasein of the past century influenced the reflection on mental health in Mexico. Beyond its historical trajectory, the article examines the contemporary context of this civil association and the current challenges it faces in contributing to an integrative Mexican psychiatry. Cardinal aspects—such as the training of new specialists—are emphasized, along with the quality, access, and relevance of residency programs in psychiatry. The role of the collective as a public national entity is likewise underscored. The relevance of this historiographical article is sustained by the use of primary, secondary, and tertiary sources, providing a comprehensive perspective that highlights the achievements of recent biennia.

Keywords: Mexican Psychiatric Association; institutional history; mental health; Mexican psychiatry.

Introducción

El origen de la Asociación Psiquiátrica Mexicana, A.C., constituye un acontecimiento significativo en la historia de la psiquiatría de este país. En consonancia con el progreso de las disciplinas médicas en México, la consolidación de esta institución se asocia con cambios socioculturales, políticos y científicos del siglo XX que favorecieron la colaboración entre expertos en salud mental mexicanos, en un devenir marcado por la carencia de investigación positivista válida y por la falta de respaldo comunitario, a nivel mundial, al gremio psiquiátrico. Por este motivo, el reconocimiento y el respeto hacia quienes padecen trastornos psiquiátricos —hechos jamás olvidados— requirieron del fortalecimiento de nuestros pares en el México vanguardista, de posguerra y delimitado por necesidades poblacionales, a la vez que

de descubrimientos serendipitarios que ofrecían esperanza de una mayor calidad de vida a las personas diagnosticadas.

No es factible evaluar la trascendencia de la Asociación sin repasar el horizonte histórico que condujo a su fundación, así como las acciones en el marco social y político que influyeron en ella. Este estudio se basa en fuentes oficiales, literatura especializada y testimonios de expertos, seleccionados por su enfoque académico y el cuidado con que se presenta la documentación. Asimismo, se busca extender el valor de la deliberación sobre la perspectiva crítica en la interpretación de hechos determinantes para la psiquiatría mexicana, pues el estudio integra datos de la sociedad, la cultura y la medicina de hace aproximadamente ocho décadas. Por otra parte, reconoce el papel de las asociaciones en la construcción de identidades profesionales, así

como la relación entre la salud mental de la población mexicana y la diversidad de determinantes sociales que lo caracterizan.

Antecedentes

Los datos de esta revisión, si bien provienen de registros institucionales y de la literatura especializada, pueden variar en su precisión según la fuente o el testimonio. Para mitigar esta limitación, se recurrió a fuentes primarias y secundarias seleccionadas por su relevancia y fiabilidad en el contexto de la psiquiatría mexicana del siglo pasado. Se dio prioridad a la revisión de archivos institucionales y registros oficiales por su valor histórico y su utilidad para evidenciar transformaciones organizativas y problemáticas sectoriales. También se incluyeron publicaciones académicas y testimonios profesionales que enriquecen las perspectivas.

Ante posibles sesgos derivados de la falta de registros completos o de posiciones institucionales, se complementó la información con diversas fuentes, incluidas publicaciones independientes o críticas cuando fue posible. Entre los documentos principales figuran los archivos del Hospital Psiquiátrico General “La Castañeda” (Archivo General de la Nación, 2022), las estadísticas y los reportes del Instituto Mexicano del Seguro Social y de la Secretaría de Salud, la *Revista de la Asociación Psiquiátrica Mexicana, A.C.* y los informes del Consejo Mexicano de Psiquiatría.

Horizonte histórico

El horizonte histórico, en palabras de Hans-Georg Gadamer (1960/1993), constituye el ámbito situado desde el cual se comprende el pasado: un marco condicionado por la tradición que posibilita la fusión de horizontes entre el intérprete y su objeto de estudio. Lejos de ser un telón de fondo pasivo, el horizonte se despliega como condición de posibilidad del comprender mismo. Desde esta perspectiva hermenéutica puede leerse el devenir de la psiquiatría mexicana.

A finales del siglo XIX y comienzos del XX, se pusieron en marcha las operaciones de instituciones privadas en México, como el Sanatorio Rafael Lavista (1898) y la Casa de la Salud de San Juan de Dios, situada en Zapopan, Jalisco, en 1910 (Asociación Psiquiátrica Mexicana, 2023). Ese mismo año, durante el Centenario de la Independencia, el presidente José de la Cruz Porfirio Díaz Mori inauguró el Hospital Psiquiátrico General “La Castañeda”, con el fin de alinear a México con los estándares galenos eurocentristas y de subsanar la carencia nacional de centros de salud mental en un solo recinto. Este establecimiento, que acogió a miles de personas —pacientes y ciudadanos—, ofreció atención, tratamientos y abordajes, tanto biologicistas como sociológicos, de su época (Archivo General de la Nación, 2022).

Incluso después de su demolición, los historiadores reconocen el papel de este hospital como cuna de los psiquiatras mexicanos vanguardistas que se formaron con un espíritu galeno y un deber moral. En la década de 1930, “La Castañeda” se encontraba rebasada en su capacidad, por lo que se inició el desarrollo de otros sanatorios, como los de los Dres. Ramírez Moreno y Floresta; en 1942 se creó el Servicio de Psiquiatría del Hospital Español y en 1949 se fundó la Clínica San Rafael —ambos en la Ciudad de México— (Molina-López, 2024). Entre 1940 y 1950, el Estado mexicano consolidó los

hospitales públicos y de seguridad social, formalizando los primeros modelos institucionales de atención médica por parte de la Secretaría de Salud.

En esta etapa de consolidación, en la década de 1950 se fundó el Departamento de Psicología Médica, Psiquiatría y Salud Mental en la Universidad Nacional Autónoma de México, lo cual representó un hito académico (de la Fuente, 1998). Dicho departamento instituyó la psiquiatría como especialidad médica dentro de la medicina interna y promovió la formación de profesionales mediante un programa académico riguroso basado en investigaciones internacionales; la mayoría de los psiquiatras en México se ha formado en este departamento (de la Fuente, 1998). Desde la segunda mitad del siglo XX, en México se establecieron conflictos entre diversas corrientes académicas, al tiempo que surgieron revoluciones neurocientíficas —como el descubrimiento de psicofármacos y avances en neurofisiología y radiología— que aceleraron el desarrollo de la especialidad.

En este contexto, surgieron asociaciones de usuarios y familiares que promovieron el diálogo con los profesionales de la salud mental y colaboraron en una atención cada vez más integral, científica y humanizada. Estas iniciativas se desplegaron hasta llegar a México y, en la Ciudad de México, se concentraron especialistas y recursos que facilitaron la colaboración entre organismos estatales y privados, lo que propició la creación de esta asociación.

Fundación de la Asociación Psiquiátrica Mexicana, A.C.

En aquellas décadas, el número de especialistas en salud mental se situaba entre 400 y 500 (Heinze & Vázquez-Cano, 2019). Un grupo impulsado por el crecimiento disciplinar y la necesidad de cohesión gremial fomentó la consolidación de un grupo selecto de especialistas que convocó a la fundación de la Asociación Psiquiátrica Mexicana, A.C. El acta constitutiva consigna que el 31 de marzo de 1966, en el aula principal del “Manicomio General” de la Ciudad de México, se celebró la asamblea fundacional presidida por Ramón de la Fuente Muñiz, Guillermo Calderón Narváez, Mario Fuentes Pérez (director) y Javier García Diego González (subdirector); juntos sentaron las bases de una asociación que se convertiría en un nodo de formación profesional, defensa de derechos humanos y difusión del saber psiquiátrico.

El crecimiento institucional persiste y se enfrenta a retos derivados de la evolución social y científica del siglo XXI. Entre los desafíos actuales sobresalen las necesidades de fortalecer la formación continua en psiquiatría, en particular a raíz de la contingencia sanitaria por SARS-CoV-2, y de gestionar los recursos públicos y privados ante las crisis presupuestarias que generan barreras de acceso a la salud mental. Si bien el estigma asociado a los trastornos psiquiátricos experimentó un descenso durante el último quinquenio, la lucha por erradicarlo y la integración de los avances científicos en la práctica clínica continúan en curso.

La Asociación Psiquiátrica Mexicana, A.C., se ha adaptado a las circunstancias modernas, ha diseñado estrategias innovadoras que garanticen un acceso cada vez más equitativo a los servicios de salud mental y ha promovido la defensa irrestricta de los derechos humanos.

En bienios recientes, ha desplegado proyectos orientados a la actualización profesional continua mediante preparativos para el examen del Consejo Mexicano de Psiquiatría, seminarios virtuales y presenciales en diversos estados de la República, programas de atención dirigidos a jóvenes en formación médica, y la creación de congresos nacionales de vanguardia.

Cabe mencionar a los expresidentes que, desde el siglo XX, participaron y participan activamente en estos proyectos; en particular, durante el bienio de Jacqueline Cortés Morelos y Alejandro Molina-López se impulsaron iniciativas como las anteriores y se formalizaron la *Revista de la Asociación Psiquiátrica Mexicana, A.C.* y el Comité Editorial de Libros (Molina-López & Medina-Rodríguez, 2023).

Conclusiones

El desarrollo de la Asociación Psiquiátrica Mexicana, A.C., no es un hecho aislado. Está precedido por un mundo y un México complejos, donde esta especialidad, aún novedosa, enfrentó el crecimiento científico, sociocultural y político tanto de forma positiva como negativa. Sin embargo, gracias a la visión vanguardista de profesionales de la época, nació este gremio como referente en la práctica clínica psiquiátrica, con reflexión crítica y académica sobre la salud mental mexicana y global: misión que todos los expresidentes, el presidente electo y el actual sostienen hasta hoy. El bienio actual, presidido por el Dr. David Eduardo Saucedo-Martínez, continúa con los principios fundamentales del gremio —conciencia social, cientificismo, constructivismo pedagógico y renovación institucional—, con la convicción fundada de que este periodo continuará rindiendo frutos para el porvenir de la psiquiatría en México.

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REVIEW ARTICLE

Perinatal Psychiatry Training and Practice in Mexico

Entrenamiento y práctica de la psiquiatría perinatal en México

Lucia Munch-Anguiano¹ Claudia Martínez-Valdovinos¹ Assad Daniel Saad-Manzanera^{1,2,*}

¹ Dirección de Servicios Clínicos, Instituto Nacional de Psiquiatría “Ramón de la Fuente Muñiz”, Ciudad de México, México. ² Dirección de Enseñanza, Instituto Nacional de Psiquiatría “Ramón de la Fuente Muñiz”, Ciudad de México, México. **ORCID:** L.M.A. 0000-0003-4888-4645 · C.M.V. 0009-0009-8649-2109 · A.D.S.M. 0000-0001-6304-5386. ***Correspondence:** Assad Daniel Saad-Manzanera, Dirección de Servicios Clínicos, Instituto Nacional de Psiquiatría “Ramón de la Fuente Muñiz”, Calz. México-Xochimilco 101, Col. San Lorenzo Huipulco, Alcaldía Tlalpan, C.P. 14370, Ciudad de México, México; dr.assdsm@gmail.com. **Acknowledgments.** The authors thank Dr. Iván Arango de Montis, Dr. Juan Jorge Palacios Casados, and Dr. Carlos Sabás Cruz Fuentes for their collaboration and work with the patients of the clinic over the years. **Funding.** None. **Conflicts of interest.** The authors declare no conflicts of interest. **Data availability.** This article does not generate new data.

Resumen

La psiquiatría perinatal es un área en crecimiento en México que requiere formación especializada para atender los trastornos mentales durante el embarazo, el posparto y la lactancia. En los últimos años se han aprobado dos programas de alta especialidad en psiquiatría perinatal por la Universidad Nacional Autónoma de México: uno en el Instituto Nacional de Perinatología y otro en el Instituto Nacional de Psiquiatría “Ramón de la Fuente Muñiz”. Esta editorial describe la experiencia clínica y formativa en este último, incluyendo intervenciones como la Terapia Narrativa de Exposición, el programa Circle of Security-Parenting y el trabajo interdisciplinario con genética médica. Se discuten las necesidades de colaboración interinstitucional e internacional, la implementación de modelos de atención colaborativa y la creación de Unidades de Madre-Bebé en el sector público mexicano.

Palabras clave: psiquiatría perinatal; salud mental perinatal; formación psiquiátrica; posparto; México.

Abstract

Perinatal psychiatry is a growing field in Mexico that requires specialized training to address mental disorders during pregnancy, the postpartum period, and breastfeeding. In recent years, two fellowship programs in perinatal psychiatry have been approved by the Universidad Nacional Autónoma de México: one at the Instituto Nacional de Perinatología and another at the Instituto Nacional de Psiquiatría “Ramón de la Fuente Muñiz.” This editorial describes the clinical and training experience at the latter institution, including interventions such as Narrative Exposure Therapy, the Circle of Security-Parenting program, and interdisciplinary collaboration with medical genetics. The need for inter-institutional and international collaboration, implementation of collaborative care models, and the establishment of Mother–Baby Units in the Mexican public healthcare sector are discussed.

Keywords: *perinatal psychiatry; perinatal mental health; psychiatric training; postpartum; Mexico.*

1. Background

Perinatal psychiatry, a growing and critically important area of psychiatry, has recently been involved in controversies: during an FDA panel focused on the risks of SSRIs during pregnancy (Schneider, 2025) and in the course of US government statements about acetaminophen and autism (Louwen et al., 2025). These events could convey misinformation that may lead to unwarranted fears and confusion in the general population and, particularly, in pregnant women. This is why there is a need for perinatal specialization and training in psychiatry in order to treat patients with perinatal psychiatric disorders; for instance, in Mexico, perinatal depression affects 9–14% of women during pregnancy and 6.6–24.6% in the postpartum period (Lara et al., 2017). This calls for action from specialized professionals, both in health policy and in direct patient care.

In the last decade, many Mexican psychiatrists interested in this area have acquired specialized knowledge and clinical skills by completing stays in the few subspecialized perinatal psychiatry clinics of the

country, but without receiving formal Mexican certification. Other Mexican psychiatrists resorted to foreign in-person or online courses and fellowships for these purposes (e.g., certifications offered by Postpartum Support International, Marcé of North America, Universitat de Barcelona, and Instituto Europeo de Salud Mental Perinatal). In the last two years, two formal perinatal psychiatry fellowships have been approved by the Universidad Nacional Autónoma de México in Mexico City: one at the Instituto Nacional de Perinatología “Isidro Espinosa de los Reyes” (INPER), mainly attending high-risk obstetric and gynecological populations, and more recently another one at the Instituto Nacional de Psiquiatría “Ramón de la Fuente Muñiz” (INPRFM), which primarily treats clinical psychiatric populations (individuals with psychopathology in the preconceptional, prenatal, or postpartum stage, or during breastfeeding). These programs focus on training psychiatrists to understand the nuances and current limits of evidence in the diagnosis and treatment of mental disorders

in the perinatal period, so they can provide evidence-based consultations with women about the known risks of perinatal disorders and specific pharmacological treatments, and collaboratively decide on a treatment plan that is effective and beneficial for each individual dyad. Patients in the perinatal period require substantial social support and interventions focused on the here-and-now balance between finding peace and well-being and being a good-enough mother for the baby.

2. Perinatal Psychiatry Practice

The perinatal psychiatry clinic at INPRFM receives women and/or men who need psychiatric evaluation and treatment during the pre-conceptional, prenatal, or postpartum period (including the entire duration of breastfeeding). Each period has its own needs and difficulties, with mental health conditions being among the most frequent postpartum complications in the first year (Ke et al., 2025). The earlier the patient is assessed, the better the clinical team can prepare for the well-being of the mother and the child. For example, if symptoms related to previous traumatic events are identified, Narrative Exposure Therapy is offered (Miller et al., 2025), with adaptations for the perinatal period (Serpeloni et al., 2025). To promote healthy attachment and parenting, the Circle of Security-Parenting (COSP) intervention (Powell et al., 2013) is implemented through online groups. Although the evidence around implementing COSP in this population is yet to be clarified (Cassidy et al., 2017; Rosan et al., 2025), studies suggest greater parental reflexivity and sensitivity (Dexter & Wong, 2024), which is aligned with our experience that parents find coherence and better ways to approach parenting and attachment in early infancy. Preliminary analysis from our clinical practice (yet to be published) shows that this intervention can help mothers lower stress related to child-rearing and reduce the propensity for dysregulation episodes. While many other evidence-based interventions exist for this population, there are currently insufficient resources for the holistic treatment that is needed. There is an unmet need for more space and hired specialists that we hope will be addressed in the near future.

Teamwork with medical geneticists is highly valued, as it integrates naturally into this area. Medical geneticists assist patients from the preconceptional period through genetic counseling and play a critical role in the systematic evaluation of newborns to identify congenital anomalies and genetic syndromes. They also provide longitudinal follow-up for up to five years to monitor neurodevelopmental outcomes, facilitate early detection of developmental delays, and ensure timely referral to specialized care and early intervention services when indicated. From a clinical standpoint (based on anecdotal experience), an increase in developmental delays—particularly in the language domain—has been observed since the COVID-19 pandemic, a finding also documented in other studies (O'Connor et al., 2025), including Mexican populations (Villaruel-Ortega et al., 2025). This underscores that both mother and baby should be simultaneously evaluated and considered in every intervention.

3. Future Perspective

These developments underscore the need for collaboration between different professions and institutions, from local to international levels. For example, the first international perinatal mental health congress in Spanish and Portuguese was held in Chile in October 2024 (Madariaga Baeza et al., 2025), highlighting current efforts in the collaboration and development of perinatal mental health in Latin America. Currently, there are not enough perinatal psychiatry specialists available in the public healthcare sector. To expand access to perinatal mental health services and optimize population-level coverage, implementation of collaborative care models may represent a feasible strategy. One such example is the Michigan Clinical Consultation and Care (MC3) program, which integrates psychiatric consultation and capacity-building within primary and obstetric care settings (Muzik et al., 2023). No less importantly, there is an obligation for healthcare professionals and the healthcare system to promote research in this area and to develop adequately resourced clinical infrastructures. At present, there are no specialized Mother–Baby Units within the public healthcare sector in Mexico. Such units allow for the joint inpatient admission of mothers and their infants and have been associated with improved maternal psychiatric outcomes, enhanced mother–infant attachment, and more favorable developmental trajectories in early childhood (Adhikary et al., 2024).

4. Conclusions

Perinatal psychiatry in Mexico has been growing for some years, and that work and effort has now consolidated in the approval of two official fellowship programs, which in the future will lead to better mental healthcare for all women, babies, and their families.

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RECOMENDACIONES DE EXPERTOS

Recomendaciones de expertos mexicanos para el tratamiento de los trastornos de ansiedad

Mexican expert recommendations for the treatment of anxiety disorders across the lifespan

Luis Daniel Alviso de la Serna¹ Laura Elena Jiménez Aquino² Juan Alberto Alcalá Dueñas³ Violeta Erendira Pérez Mejía⁴ Thelma Soraya Sánchez Villanueva⁵

Marisol Cristina Ramírez Abascal⁶ Lorena Rodríguez Bores Ramírez⁷ Sandra Briselda Hernández León⁸ David Eduardo Saucedo Martínez^{3,9,*}

¹ AVALON Vinculación Médica en Salud Mental, CDMX, México. ² Departamento de Neurociencias, Instituto Nacional de Perinatología y Facultad de Medicina, UNAM, CDMX, México. ³ Tecnológico de Monterrey, Monterrey, N.L., México. ⁴ Consultorio privado, Hospital Ángeles Lomas, Huixquilucan, Edo. de México, México. ⁵ SMAG Clínica y DEPREF Clínica, Guadalajara, Jal., México. ⁶ Consultorio privado, Alcaldía Benito Juárez, CDMX, México. ⁷ Coordinación Académica, Asociación Psiquiátrica Mexicana; consultorio privado, CDMX, México. ⁸ Consultorio privado, Colonia Roma, CDMX; Departamento Médico, Schwabe Pharma México, CDMX, México. ⁹ Servicio de Geriatría, Hospital Universitario "José Eleuterio González", Monterrey, N.L., México.

ORCID: L.D.A.S. 0000-0001-8266-5409 · L.E.J.A. 0000-0001-8678-3963 · A.A.D. 0000-0001-7770-7053 · V.E.P.M. 0009-0005-5779-5152 · T.S.S.V. 0009-0005-8796-4447 · M.C.R.A. 0000-0001-6433-2600 · L.R.B.R. 0000-0002-8459-6926 · S.B.H.L. 0009-0008-0102-991X · D.E.S.M. 0000-0003-3458-2005. ***Autor de correspondencia:** David Eduardo Saucedo Martínez, Escuela de Medicina y Ciencias de la Salud, Tecnológico de Monterrey, Av. Morones Prieto #3000, Monterrey, N.L., C.P. 64710, México; david.saucedo@psiquiatriasapm.org.mx.

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Resumen

Antecedentes. Los trastornos de ansiedad son los padecimientos psiquiátricos más frecuentes en México y representan una causa importante de discapacidad; sin embargo, su reconocimiento y tratamiento oportunos siguen siendo insuficientes, especialmente en la atención primaria. **Objetivo.** Formular recomendaciones prácticas y actualizadas para el reconocimiento, la evaluación, el tratamiento y el seguimiento de los trastornos de ansiedad a lo largo del ciclo vital, con énfasis en la atención primaria y en el trastorno de ansiedad generalizada. **Método.** Se realizó una revisión narrativa de la literatura clave en español e inglés. Un panel de nueve psiquiatras mexicanos con experiencia en ansiedad analizó críticamente revisiones sistemáticas, metaanálisis, guías clínicas y estudios originales para identificar evidencia pertinente, áreas de consenso, incertidumbres y prioridades clínicas en el contexto mexicano. **Resultados.** El panel recomienda el tamizaje sistemático con instrumentos validados, en particular la Escala de Trastorno de Ansiedad Generalizada de siete reactivos (GAD-7) en adultos y la Escala de Ansiedad para Niños de Spence (SCAS) en población infantil y adolescente. El abordaje debe incluir un diagnóstico diferencial amplio, la valoración de comorbilidades psiquiátricas y médicas, la estratificación por gravedad y la atención adaptada a poblaciones especiales. En casos leves o subumbrales, se priorizan la psicoeducación, la terapia cognitivo-conductual y los cambios en el estilo de vida. En casos moderados a graves, los inhibidores selectivos de la recaptación de serotonina y los inhibidores de la recaptación de serotonina y noradrenalina constituyen la primera línea farmacológica. Las benzodiacepinas deben restringirse al uso breve y a indicaciones específicas. **Conclusiones.** Estas recomendaciones ofrecen un marco clínico integral para mejorar la detección temprana, individualizar el tratamiento, optimizar la referencia a psiquiatría y favorecer un uso racional de los recursos en México.

Palabras clave: Trastornos de ansiedad, salud mental, trastorno de ansiedad generalizada, ansiedad subumbral, fitomedicamentos.

Abstract

Background. Anxiety disorders are the most prevalent psychiatric conditions in Mexico and a major cause of disability; however, their timely recognition and treatment remain insufficient, particularly in primary care. **Objective.** To develop practical, updated recommendations for recognition, assessment, treatment, and follow-up of anxiety disorders across the lifespan, focused on primary care and generalized anxiety disorder. **Methods.** A narrative review of key Spanish and English literature was conducted. Nine Mexican psychiatrists analyzed systematic reviews, meta-analyses, guidelines, and original studies to identify relevant evidence, consensus areas, and clinical priorities. **Results.** Systematic screening with validated instruments is advised, especially GAD-7 for adults and SCAS for youth. Management should include broad differential diagnosis, comorbidity assessment, severity stratification, and age-adjusted care. Moderate-severe cases: SSRIs/SNRIs first-line. **Conclusions.** These recommendations provide a clinical framework for improving early detection, individualizing care, and optimizing resource use in Mexico.

Keywords: Anxiety disorders, mental health, generalized anxiety disorder, subthreshold anxiety, phytomedicine.

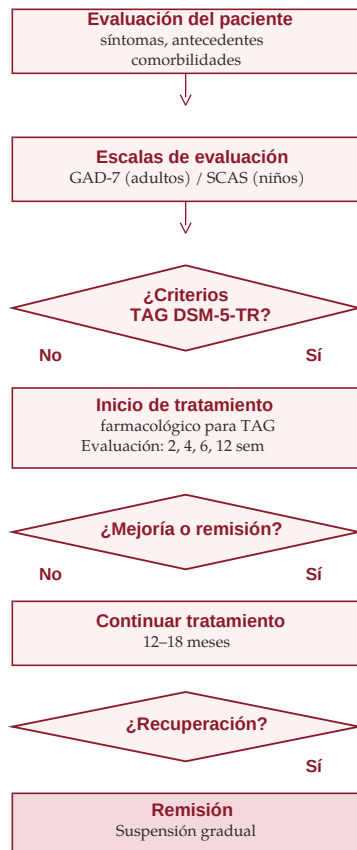


Figura 2. Algoritmo de evaluación y tratamiento del trastorno de ansiedad generalizada en atención primaria.

Nota. TAG = trastorno de ansiedad generalizada; GAD-7 = Escala de Trastorno de Ansiedad Generalizada de 7 reactivos; SCAS = Escala de Ansiedad para Niños de Spence; sem = semanas. Elaboración propia.

secundarias (Medina-Mora et al., 2007). Por ello, el diagnóstico y la intervención tempranos son esenciales (Craske et al., 2017). Además del impacto individual, los trastornos de ansiedad representan una carga económica y social considerable en México. Los costos asociados equivalen al 4 % del producto interno bruto (Carreño García & Medina-Mora, 2018).

Según el estudio *Global Burden of Disease 2021*, los trastornos mentales contribuyen significativamente a los años de discapacidad. Tanto los trastornos depresivos como los de ansiedad figuran entre las principales causas de morbilidad en México (Institute for Health Metrics and Evaluation, s. f.; Medina-Mora et al., 2023). En México, la Norma Oficial Mexicana NOM-035-STPS-2018 establece los elementos para identificar, analizar y prevenir los factores de riesgo psicosociales (Norma Oficial Mexicana NOM-035-STPS-2018, 2018).

El diagnóstico de los trastornos de ansiedad puede retrasarse o dificultarse por factores como la tendencia a no reconocer los síntomas como parte de un trastorno clínico, su frecuente presentación con manifestaciones somáticas o inespecíficas, y las barreras de comunicación asociadas a la vergüenza, la culpa o el temor al estigma (Craske et al., 2017; Medina-Mora et al., 2007). A nivel internacional, México está entre los países con mayor retraso en el inicio del tratamiento (Kessler et al., 2007; Medina-Mora et al., 2007).

En la población infantil, el diagnóstico presenta dificultades adicionales. La valoración clínica en esta etapa requiere integrar diversas fuentes de información y considerar el nivel de desarrollo del menor para interpretar adecuadamente la sintomatología ansiosa (Rapee, 2018). Las características diagnósticas de los trastornos de ansiedad se establecen principalmente en el *Manual diagnóstico y estadístico de los trastornos mentales* (DSM-5-TR) y en la *Clasificación Internacional de Enfermedades*, 11.ª revisión (Asociación Americana de Psiquiatría, 2022; ICD-11, 2024).

Existen diversos instrumentos útiles para evaluar el trastorno de ansiedad generalizada y otros trastornos de ansiedad. Entre los más utilizados se encuentran la GAD-7 y la Escala de Hamilton para la Ansiedad (HAM-A) (Julian, 2011; Spitzer et al., 2006). En niñas, niños y adolescentes, el tamizaje puede realizarse con la versión en español de la Escala de Ansiedad para Niños de Spence (SCAS), validada en población mexicana (Hernández-Guzmán et al., 2010). Se aconseja que toda persona con síntomas de ansiedad o con sospecha clínica de trastorno de ansiedad reciba una evaluación sistemática mediante instrumentos estandarizados. Asimismo, se recomienda la referencia a atención especializada cuando la puntuación en la GAD-7 sea de 15 puntos o más, exista comorbilidad psiquiátrica importante o persistan dudas diagnósticas.

3.1. Diagnóstico diferencial y comorbilidades

Las manifestaciones clínicas de los trastornos de ansiedad pueden confundirse o coexistir con otros cuadros médicos y psiquiátricos. El diagnóstico diferencial debe considerar afecciones médicas como enfermedades tiroideas, feocromocitoma, hiperparatiroidismo, síndrome de Cushing, arritmias, enfermedad pulmonar obstructiva crónica, asma y alteraciones neurológicas (DeGeorge et al., 2022; Locke et al., 2015; Ströhle et al., 2018).

También es necesario descartar otros trastornos psiquiátricos, como el trastorno depresivo mayor, el trastorno bipolar y otros trastornos de ansiedad (Craske et al., 2017; Szuhany & Simon, 2022). Además, se debe investigar el consumo de sustancias o fármacos que puedan inducir síntomas ansiosos (Bandelow et al., 2017; DeGeorge et al., 2022; Griffin et al., 2013).

El trastorno de ansiedad generalizada se asocia con frecuencia con otras condiciones psiquiátricas, como el trastorno depresivo mayor, la distimia y los trastornos por uso de sustancias (Arango-Dávila & Rincón-Hoyos, 2018; Szuhany & Simon, 2022). Además, puede acompañarse de ideación suicida e intentos suicidas, por lo que la evaluación del riesgo suicida debe constituir parte fundamental del abordaje inicial y del seguimiento (Li et al., 2022; Szuhany & Simon, 2022).

El tratamiento de los trastornos de ansiedad está indicado cuando la persona presenta malestar clínicamente relevante con repercusión en su vida cotidiana. Se recomienda iniciar tratamiento cuando los síntomas persisten más de dos semanas y afectan negativamente el funcionamiento social, escolar, laboral o familiar; cuando existen síntomas de intensidad moderada a grave; o cuando hay riesgo de desarrollar comorbilidades o complicaciones (Hernández-Guzmán et al., 2010; Spitzer et al., 2006; Szuhany & Simon, 2022).

En casos leves o subumbrales, el abordaje inicial debe centrarse en intervenciones no farmacológicas: psicoeducación, terapia cognitivo-conductual y modificación de estilos de vida. El tratamiento farmacológico está indicado para síntomas moderados o graves, o cuando las estrategias iniciales no resultan efectivas (Rodríguez-Tejada & Torres-Tejera, 2024; Stephenson et al., 2023; Szuhany & Simon, 2022).

Recomendación de los expertos: Se aconseja agendar una consulta de seguimiento en las dos primeras semanas tras iniciar el tratamiento para valorar la respuesta clínica inicial, identificar efectos adversos y evaluar la tolerabilidad (Bandelow et al., 2017; Locke et al., 2015; Szuhany & Simon, 2022).

3.2. Medicamentos de primera línea

Los inhibidores selectivos de la recaptación de serotonina (ISRS) y los inhibidores de la recaptación de serotonina y noradrenalina (IRSN) constituyen el tratamiento farmacológico de primera línea de los trastornos de ansiedad por su eficacia y su perfil de seguridad (Bandelow et al., 2017; Slee et al., 2019). Su utilidad se explica por su capacidad de modular la neurotransmisión serotoninérgica y noradrenérgica (Fagan & Baldwin, 2023).

La selección entre ambos grupos debe basarse en la respuesta esperada, los antecedentes del paciente, la presencia de comorbilidades, el perfil de efectos adversos y el riesgo de interacciones farmacológicas (Bandelow et al., 2022; Slee et al., 2019). La duración mínima del tratamiento es de aproximadamente un año (Bandelow et al., 2017; Secretaría de Salud, 2010; Slee et al., 2019). La suspensión debe realizarse de forma gradual y bajo supervisión médica (Shinfuku et al., 2019).

3.3. Fitomedicamentos

El interés por los medicamentos derivados de plantas ha crecido como alternativa para tratar la ansiedad, especialmente en casos leves y

moderados. Estudios documentan su eficacia ansiolítica y un perfil de seguridad favorable (Jara et al., 2021; Dold et al., 2023). Sin embargo, no todos los productos vegetales son medicamentos; el uso debe basarse en evidencia clínica robusta (Sarris et al., 2022).

Entre los fitomedicamentos utilizados, Silexan[®] emplea como principio activo un derivado de *Lavandula angustifolia*. La evidencia clínica disponible respalda su uso a dosis de 80 a 160 mg/día como adyuvante terapéutico en personas con síntomas de ansiedad (Kasper et al., 2014; Woelk & Schläfke, 2010; Yap et al., 2019; Dold et al., 2023; Möller et al., 2019; von Känel et al., 2021).

Las guías de la *World Federation of Societies of Biological Psychiatry* y de la *Canadian Network for Mood and Anxiety Treatments* otorgan a *Lavandula angustifolia/officinalis* un nivel de evidencia A para el tratamiento de la ansiedad (Sarris et al., 2022).

Nota de transparencia. Los ensayos clínicos citados en esta sección fueron financiados por Dr. Willmar Schwabe GmbH & Co. KG, empresa matriz de Schwabe Pharma México, que aportó el financiamiento para estas recomendaciones. Una coautora (S.B.H.L.) es empleada de Schwabe Pharma México. Véase la sección de conflicto de intereses.

3.4. Poblaciones especiales

El tratamiento debe adaptarse a las características de poblaciones especiales: niñas, niños y adolescentes; personas adultas mayores; mujeres embarazadas o en lactancia; y pacientes con deterioro cognitivo (Alaka et al., 2014; Doyle, 2022; Newton & Hale, 2015).

En la población pediátrica, la primera línea de tratamiento es la terapia cognitivo-conductual. Los ISRS —sertralina, escitalopram y fluoxetina— se consideran opciones con mejor perfil de seguridad (Doyle, 2022; Lorberg et al., 2019; Rapee, 2018). Deben evitarse las benzodiacepinas y los antihistamínicos sedantes (Griffin et al., 2013; Pedrós Cholvi & Arnau de Bolós, 2008).

En mujeres embarazadas, se prefieren ISRS con mayor evidencia de seguridad, como sertralina y escitalopram, y se evita la paroxetina (American College of Obstetricians and Gynecologists, 2023; Vickery, 2023). Es recomendable que la paciente reciba al menos una valoración psiquiátrica durante el embarazo. Durante la lactancia, se recomienda mantener el tratamiento eficaz siempre que sea compatible con la alimentación al seno materno (Newton & Hale, 2015).

3.5. Benzodiacepinas

Las benzodiacepinas actúan como moduladores alostéricos positivos del receptor GABA-A, incrementando la neurotransmisión inhibitoria en el sistema nervioso central (Griffin et al., 2013). Pueden considerarse un recurso terapéutico a corto plazo en situaciones de urgencia o ante síntomas intensos (Bandelow et al., 2017). Sin embargo, se asocian con riesgo de dependencia, tolerancia y abuso (Bandelow et al., 2022; Griffin et al., 2013). La prescripción debe limitarse a periodos breves, con indicación precisa y bajo vigilancia clínica (Bandelow et al., 2017; Bandelow et al., 2022).

3.6. Resistencia al tratamiento

La resistencia al tratamiento farmacológico se establece cuando el paciente no responde a dos esquemas de monoterapia con medicamentos de primera línea de clases farmacológicas diferentes, administrados con dosis y duración adecuadas y con adherencia comprobada (Ansara, 2020; Domschke et al., 2024). Antes de considerar una resistencia verdadera, deben descartarse causas de seudoresistencia como diagnóstico incorrecto, dosis o duración insuficientes, comorbilidades no reconocidas o falta de adherencia.

En los casos de trastorno de ansiedad generalizada resistente, pueden considerarse estrategias de segunda línea o de potenciación, como el uso a corto plazo de benzodiacepinas, gabapentinoides y algunos antipsicóticos en dosis bajas, siempre tras una valoración cuidadosa del perfil riesgo-beneficio y, preferiblemente, bajo supervisión especializada (Ansara, 2020; Domschke et al., 2024).

3.7. Medidas no farmacológicas

Las principales alternativas terapéuticas incluyen la entrevista motivacional, la psicoeducación, la terapia cognitivo-conductual, la psicoterapia breve, los programas de atención plena y las prácticas corporales como el yoga. La terapia cognitivo-conductual cuenta con un sólido respaldo empírico para el tratamiento de la ansiedad, tanto en adultos como en la población pediátrica (Doyle, 2022; Rapee, 2018; Stephenson et al., 2023). La modificación de los estilos de vida es fundamental en el enfoque integral (Rodríguez-Tejada & Torres-Tejera, 2024).

3.8. Referencia a psiquiatría

La referencia a psiquiatría debe considerarse en presencia de riesgo de ideación o conducta suicida, consumo activo de sustancias psicoactivas, uso simultáneo de múltiples fármacos serotoninérgicos, trastorno de ansiedad generalizada con comorbilidades psiquiátricas o médicas relevantes, ausencia de respuesta a dos o más tratamientos farmacológicos administrados correctamente, o en adultos mayores con demencia o enfermedad de Parkinson (American College of Obstetricians and Gynecologists, 2023; Domschke et al., 2024; Li et al., 2022).

4. Discusión

Los trastornos de ansiedad son un foco prioritario de atención en salud pública en México debido a su prevalencia, incidencia e impacto en la funcionalidad global (Medina-Mora et al., 2003; Medina-Mora et al., 2007; Organización Mundial de la Salud, 2024). No obstante, el reconocimiento clínico sigue siendo insuficiente, especialmente en el primer nivel de atención (Kessler et al., 2007; Locke et al., 2015; Medina-Mora et al., 2007).

Una contribución central de estas recomendaciones consiste en subrayar la importancia de la evaluación sistemática desde el primer contacto asistencial. El uso de instrumentos breves y estructurados, como la GAD-7 para adultos y la SCAS para población infantil y adolescente, facilita la detección sistemática y posibilita la toma de decisiones más oportuna en contextos asistenciales con recursos limitados (Hernández-Guzmán et al., 2010; Spitzer et al., 2006).

Otro elemento de este consenso es que promueve un abordaje en función de la edad, las comorbilidades, la etapa del curso vital y el contexto clínico (Bandelow et al., 2017; Secretaría de Salud, 2010). Estas recomendaciones amplían el campo terapéutico al reconocer el valor de los fitomedicamentos con respaldo científico, siempre que se trate de formulaciones estandarizadas (Dold et al., 2023; Kasper et al., 2014; Möller et al., 2019; Sarris et al., 2022).

En los casos de ansiedad resistente al tratamiento, el documento subraya que la falta de respuesta obliga a una reevaluación diagnóstica y terapéutica. Una revisión exhaustiva y la referencia a la psiquiatría permiten distinguir entre resistencia real, seudoresistencia y falla secundaria a factores contextuales o técnicos del tratamiento (Ansara, 2020; Domschke et al., 2024).

5. Conclusiones

Estas recomendaciones constituyen un marco clínico integral para el diagnóstico, tratamiento y seguimiento de los trastornos de ansiedad a lo largo del ciclo vital, con énfasis en la atención primaria. Integran la detección sistemática, la valoración clínica, el abordaje terapéutico y los criterios de referencia en una lógica asistencial alineada con las necesidades del sistema de salud mexicano. El documento enfatiza la identificación oportuna de la ansiedad, el uso de instrumentos estandarizados para la toma de decisiones clínicas, la adaptación del tratamiento según la gravedad y el contexto, así como la combinación de estrategias farmacológicas y no farmacológicas para optimizar los desenlaces. La aplicación de estas recomendaciones puede contribuir a reducir el subdiagnóstico, disminuir la carga de enfermedad, mejorar la calidad de vida y favorecer un uso racional de los recursos sanitarios.

6. Referencias

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ORIGINAL ARTICLE

Emergent mental health training for responders during COVID-19 pandemic: An experience from Mexico

Capacitación emergente en salud mental para respondientes durante la pandemia de COVID-19: una experiencia desde México

Alejandro Molina-López^{1,2,*} Nilson Agustín Contreras Carreto³

María Fátima Moneta Arce⁴ Lorena Rodríguez Bores^{4,5}

Emmeline Lagunes Córdoba⁶

¹ Servicios de Atención Psiquiátrica (SAP), Secretaría de Salud, Ciudad de México, México. ² Departamento de Psiquiatría y Salud Mental, Facultad de Medicina, Universidad Nacional Autónoma de México, Ciudad de México, México. ³ Dirección General de Calidad y Educación en Salud (DGCEs), Secretaría de Salud, Ciudad de México, México. ⁴ Secretariado Técnico del Consejo Nacional de Salud Mental (CONSAME), Secretaría de Salud, Ciudad de México, México. ⁵ Comisión Nacional de Salud Mental y Adicciones (CONASAMA), Ciudad de México, México. ⁶ Division of Psychiatry, University College London, London, United Kingdom.

ORCID: A.M.L. 0000-0003-4509-9174 · N.A.C.C. 0000-0002-4650-9262 · F.M.A. 0009-0004-3381-7006 · L.R.B. 0000-0003-0779-7510 · E.L.C. 0000-0002-1001-4786. ***Correspondence:** Alejandro Molina-López, Servicios de Atención Psiquiátrica, Secretaría de Salud, Av. Paseo de la Reforma 450, Col. Juárez, Alcaldía Cuauhtémoc, C.P. 06600, Ciudad de México, México; doctor.alex.psiquiatria@gmail.com.

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Resumen

Introducción. La pandemia de COVID-19 ha causado problemas de salud mental tanto en la población general como en el personal de salud a nivel mundial. En México, estas problemáticas tenían que comprenderse y atenderse desde su inicio. **Objetivo.** Describir el primer esfuerzo interinstitucional mexicano dirigido a capacitar al personal de salud en respuesta en salud mental durante la pandemia de COVID-19. **Método.** Se diseñó un taller en línea sobre temas básicos de salud mental en el contexto de la pandemia. Los contenidos se videograbaron y quedaron disponibles en *streaming* desde el 10 de abril de 2020. Los datos de inscripción se desglosaron por perfil profesional; las frecuencias acumuladas y tendencias lineales se compararon mediante la pendiente (m) de la línea de inscripción de cada grupo. **Resultados.** Al 5 de octubre de 2020 hubo $n = 243,104$ inscripciones. El personal de enfermería inscribió más (46.54%, $m = 612.99$), seguido por medicina (23.25%, $m = 305.52$), primeros respondientes (16.05%, $m = 220.64$), psicología (4.86%, $m = 55.99$) y trabajo social (2.64%, $m = 35.00$). **Conclusión.** El personal de enfermería mostró el mayor interés, reflejando su compromiso con la educación profesional en campos emergentes de salud mental. Se requieren más estrategias para incluir a psicología y trabajo social en la respuesta a emergencias. Los programas educativos deberían idealmente diseñarse antes de que ocurran las emergencias.

Palabras clave: COVID-19; capacitación en salud mental; personal de salud; enfermería; respuesta ante pandemia; México.

Abstract

Introduction. The COVID-19 pandemic has caused mental health problems in both the general population and healthcare providers worldwide. In Mexico, these issues needed to be understood and addressed from their onset. **Objective.** To describe the first Mexican inter-institutional effort aimed at training healthcare providers in mental health response during the COVID-19 pandemic. **Method.** An online workshop on basic mental health topics during the COVID-19 pandemic was developed for healthcare workers. Contents were videorecorded and available as streaming since April 10, 2020. Enrollment data were broken down by professional profile; cumulative frequencies and linear trends were compared using the slope (m) of each group's enrollment line. **Results.** As of October 5, 2020, there were $n = 243,104$ enrollments. Nurses applied the most (46.54%), with the highest slope ($m = 612.99$), followed by physicians (23.25%, $m = 305.52$), first responders (16.05%, $m = 220.64$), psychologists (4.86%, $m = 55.99$), and social workers (2.64%, $m = 35.00$). **Conclusion.** Nurses showed the highest interest, reflecting their commitment to professional education in emergent mental health fields. More strategies are needed to include psychologists and social workers in emergency responses. Educational programs should ideally be designed before emergencies occur.

Keywords: COVID-19; mental health training; healthcare workers; nurses; pandemic response; Mexico.

1. Introduction

The Coronavirus disease 2019 (SARS-CoV-2 or COVID-19) was first identified in December 2019 in the Wuhan city of China (Wang et al., 2020). However, over the following weeks it started spreading all over the world, and after reaching more than 118,000 cases and over 4,000 deaths in 114 countries, on March 11, 2020, the World Health Organization (WHO, 2020) officially established COVID-19 as a pandemic. By November 2, 2020, there had been 46,403,653 confirmed cases and 1,198,569 deaths worldwide, with more than half of those cases coming from the American continent (WHO, 2020). As of November 8, 2025, there were 7,103,185 deaths due to COVID-19, and still rising (WHO, 2025). The first confirmed case in the United States was reported on January 20, 2020, whereas in Latin America the first case was reported in Brazil on February 25, and in Mexico on February 28 (Rodríguez-Morales et al., 2020).

In Mexico, the COVID-19 outbreak was officially established on March 23, 2020, generating a mandatory lockdown and changes in social and health requirements. By November 2, 2020, Mexico had accumulated 929,932 cases and 91,895 deaths (PAHO, 2020); epidemiologic cross-sectional studies estimated a national incidence of 13.89 per 100,000 inhabitants, with a confirmed case-mortality of 11.1% (Méndez-Domínguez et al., 2020). Although the previous influenza A(H1N1) pandemic in 2009 helped Mexico gain experience on how to manage a pandemic, teaching some lessons on how to prepare for the economic impact and seek international collaboration (Hernández-Ávila & Alpuche-Aranda, 2020), providing mental health support and education was largely overlooked. One of the challenges while facing the COVID-19 pandemic has been addressing the many mental health issues identified in both the general population and healthcare providers, such as stress, stigma, depression, irritability, fear, confusion, anger, violence, and others (Xiong et al., 2020). Because of this, mental health response should focus not only on healthcare systems but also on education and training. Suitable and timely mental health training should be provided to healthcare system leaders, first responders, and healthcare professionals (Pfefferbaum & North, 2020).

Mental health training designed to help people deal with acute stress in Mexico is essential, as natural disasters—to which Mexico is prone—may trigger severe adjustment reactions in the general population, thus increasing the need for training and sensitization of health professionals regarding acute victims of natural disasters (Fresán et al., 2019). However, the COVID-19 pandemic has been longer and more complex than other common emergencies in Mexico, such as earthquakes. The pandemic has continuously led to distress, anxiety, panic, and even violence, not only in the general population but also among healthcare providers and first responders (McCutcheon et al., 2020). Some surveys conducted among the Mexican population during the recent confinement reported that up to 50.3% of respondents rated moderate to severe psychological distress, 15.7% moderate-to-severe depressive symptoms, and 22.6% moderate-to-severe anxiety symptoms (Cortés-Álvarez et al., 2020).

To help address the psychological effects of the pandemic, several interventions have centered on providing mental health training

during the COVID-19 pandemic. These have aimed at mitigating the psychological impact on healthcare workers by protecting and promoting psychological well-being during and after the outbreak (Blake et al., 2020), or by implementing specific topics of mental health preparedness during “peaks” of the “emotional epidemic curve” (Ransing et al., 2020). However, it is necessary to strengthen this kind of knowledge among healthcare providers so they can recognize mental health problems in both themselves and the people they treat. Because of the scarcity of formal training about basic mental health issues in a pandemic context in Mexico, we designed and developed the first inter-institutional training specific for healthcare providers, targeting improved knowledge and awareness regarding the most common psychological problems caused by the COVID-19 pandemic. In this paper we report the inception of this training, its characteristics, and how healthcare providers have responded since its implementation.

2. Method

2.1. Course design and implementation

This initiative was an inter-institutional collaboration between the General Direction of Education and Quality in Health (DGCES, by its Spanish acronym), the Psychiatric Attention Services office (SAP), and the National Secretariat of Mental Health (CONSAME), all organizations part of the Federal Health Ministry of Mexico. Learning objectives addressed two main domains: (a) to understand basic aspects of mental health among patients and healthcare workers during the COVID-19 pandemic; and (b) to learn the basic strategies of psychological first aid and referral to mental health services.

2.2. Procedure

The workshop was developed by three psychiatrists and two psychologists with experience in professional education, and reviewed by a DGCES pedagogic supervisor. Workshop content covered five main aspects of mental health response in the COVID-19 pandemic context: (1) stress management; (2) management of fear and panic; (3) psychological first aid; (4) self-care and prevention of burnout; and (5) mental health screening. The workshop was divided into five sessions, which were recorded and edited by a webmaster from the Pan-American Health Organization (PAHO) office in Mexico City, and then uploaded to the educational platform EDUCADS (DGCES), making them available as 24/7 streaming videoconferences. The workshop was officially launched on April 10, 2020, and was made free and accessible to any applicant who wished to enroll; it remained available for one year after launch.

2.3. Enrollment and professional profile of applicants

To enroll, applicants were asked to fill a brief application form, which included personal and professional information such as name, occupation, academic degree, and institution of employment. To ensure acquisition of knowledge and receive a continuing professional development certificate endorsed by the DGCES Director, enrolled students had to answer an evaluation questionnaire, scoring at least 20 out of 25 items at the final evaluation. In the very first days after

launching the workshop, we received a very high number of applicants. Indeed, the platform was quickly overcrowded as many tried to take the training at the same time, resulting in technical difficulties accessing the course during the first two weeks. Since its launch, the DGCES periodically reported the cumulative frequencies of enrollment, breaking them down by professional profile and sociodemographic characteristics. We described and analyzed the DGCES reports of enrollments from start (April 10, 2020) to the last cutoff point (October 5, 2020).

2.4. Cumulative and linear frequencies of enrollments

To estimate and compare the patterns of enrollment increase through time and calculate the cumulative frequencies and linear trends of enrollment among applicants, we graphed five frequency curves of enrollments, broken down by the most frequent professional profiles. The groups included nurses, physicians, first responders, psychologists, and social workers. We calculated a linear pattern of each professional's cumulative frequency curve using a linear regression algorithm in Microsoft Excel®. From each linear pattern, we then calculated the slope (*m*) of a straight line, as in the equation $y = mx + b$, where *m* represents the slope, gradient, or incline of a straight line, and *b* represents the y-intercept (not relevant for this study). Therefore, the more positive the value of *m*, the higher the incline and the higher the linear increase of enrollments. Slope values of linear trends have been previously used as a measure of changes in epidemiological studies, e.g., changes in cancer rates through time (Levesque et al., 2001).

3. Results

3.1. General frequencies of enrollments

As of October 5, 2020, there had been a total of $n = 243,104$ people enrolled in the course, of whom $n = 171,586$ (70.54%) were female. Regarding state of origin, most participants were from the State of Mexico ($n = 49,095$; 20.19%), Chiapas ($n = 20,669$; 8.50%), Mexico City ($n = 17,655$; 7.26%), and Guanajuato ($n = 13,586$; 5.59%). Regarding professional profile, nurses represented almost half of all course participants ($n = 113,148$; 46.54%), followed by physicians ($n = 56,530$; 23.25%) and first responders ($n = 39,007$; 16.05%). Registration from other healthcare professionals such as psychologists ($n = 11,811$; 4.86%) and social workers ($n = 6,410$; 2.64%) had much lower frequencies, while other professional profiles represented less than 2% of all applicants. The majority of applicants were from public institutions (69.06%), especially from community healthcare services. Among public enrollees ($n = 167,888$), the largest share came from the Secretaría de Salud (SSA; 135,318; 80.6%), followed by IMSS (13,750; 8.2%), ISSSTE (7,142; 4.3%), and SEDENA (6,181; 3.7%).

By level of care, community services accounted for the majority (102,027; 60.8%), followed by general hospitals (20,089; 12.0%) and specialized facilities (2,819; 1.7%). Geographically, the central region concentrated most enrollments (134,788; 55.4%), followed by the south (50,585; 20.8%), northwest (30,232; 12.4%), and north (17,226; 7.1%). The average number of enrollments across

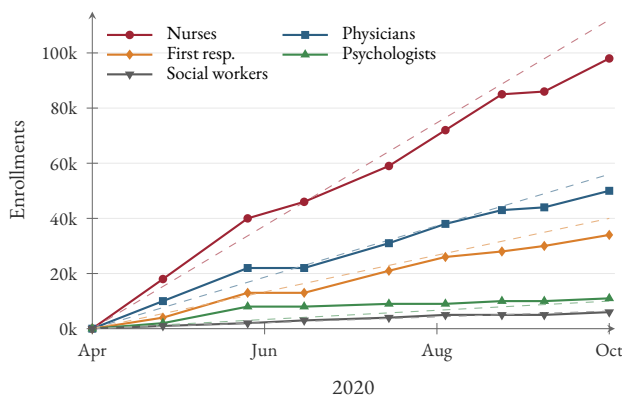


Figure 1. Cumulative enrollments and linear trends by professional profile (Apr–Oct 2020). *m*: Nurses 613; Physicians 306; First resp. 221; Psychol. 56; Social w. 35.

all cutoff points from April to October 2020 was highest among nurses ($M = 45,739.8$; $SD = 18,357.13$), followed by physicians ($M = 24,572.7$; $SD = 9,869.9$) and first responders ($M = 15,028.5$; $SD = 7,125.41$). Psychologists showed fewer enrollments ($M = 7,591.3$; $SD = 1,772.5$), and social workers showed the fewest ($M = 2,398.8$; $SD = 983.4$).

3.2. Cumulative frequency curves and lines of enrollment

We found clear differences between groups of applicants at all cutoff points throughout the course, showing highest patterns of enrollment among nurses. Lower patterns of increase on cumulative frequency curves of enrollments were observed among physicians, first responders, psychologists, and social workers (Figure 1, solid lines). Linear trends of applications were clearer for understanding that nurses were not only the professionals who applied the most, but also the group showing the highest increase of new enrollments over time. This was especially consistent when comparing each group's slope value *m*. We found that nurses showed the highest slope ($m = 612.99$), whereas physicians showed a middle value ($m = 305.52$). First responders showed a higher slope ($m = 220.64$) than psychologists ($m = 55.99$) and social workers ($m = 35.00$). Figure 1 (dashed lines) shows the linear trends of enrollments broken down by professional profile.

4. Discussion

To our knowledge, this was the first online training addressing the mental health aspects of the COVID-19 pandemic developed for first responders and healthcare providers in Mexico. Although the recent earthquakes of 2017 gave Mexico great experience in responding to acute mental health problems in disasters (Álvarez-Icaza & Medina-Mora, 2018; Ulloa & Sarmiento, 2020), there was no specific preparedness for mental health response in a pandemic context. Similar to what happened in other countries, many emergent responses had to be developed while the COVID-19 pandemic was affecting both the general population and healthcare systems. However, training directed at responding to the psychological effects of a natural disaster, such as this pandemic, should be developed before rather than after disasters occur in the first place (Hansoti et al., 2016).

A remarkable outcome of this course was the highly variant frequency of enrollments between different healthcare providers, with nurses being the most interested in taking this training, while psychologists and social workers were the least interested. Nurses' interest in enrolling may be explained because they are often the first contact of healthcare systems (Cadena-Estrada et al., 2020). Furthermore, nurses have demonstrated more resilience and employed more coping skills during disasters (Turner, 2015). This may explain the highest linear growth of nurses' enrollment over time, which may also reflect a rapid spread of interest and commitment to mental health training among this profession, and the need for implementing more of these educational activities.

Physicians and first responders were groups with middle frequencies of enrollment, which might be a good indicator that mental health has gradually been perceived as a priority regarding clinical aspects of basic and advanced healthcare responses. Challenges for medical education in Mexico during COVID-19 include defining proportional exposure risk according to the level of training and establishing measures to preserve people's mental health (Barajas-Ochoa et al., 2020).

Opposite to nurses and physicians, psychologists and social workers showed less interest in enrolling, which may be attributed to the social perception that reconversion activities are considered exclusive medical activities, leading psychological and psychosocial interventions to be considered as "complementary" protocols. This might have discouraged many professionals from actively providing psychosocial response, which could have brought valuable and integrative contributions to many mental health issues, such as online death notification and remote crisis intervention (Landa-Ramírez et al., 2020).

Despite its relative success in reaching many healthcare workers, this course had some limitations. First, implementing a training course during rather than before the onset of the pandemic might not have been completely suitable for pedagogic and training purposes. The rapid spread of the virus made it difficult to be proactive regarding educational interventions. Nevertheless, we consider the implementation of an emergent training centered on mental health "first aid" is better than other strategies such as self-assessment, which is reported to be flawed when applied in isolation (Wolff et al., 2017). Second, our reports do not reflect the actual educational and clinical skills acquired by applicants after taking this training, so it is necessary to develop more integrative learning activities that could allow for meaningful follow-ups.

5. Conclusion

Timely preparedness for facing and coping with disasters are ideal objectives for any government or healthcare organization. Emergent educational activities developed alongside clinical responses are unlikely to be the best strategies to cope with an emergency, but they might give us a valuable lesson for developing better training to cope with future emergencies. Overall, our experience with this pandemic might have helped us realize that implementing mental health training for healthcare providers is as important as providing training in

physical conditions, so we need to remind healthcare organizations and service providers that there is no health without mental health.

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ORIGINAL ARTICLE

Inventory of Callous-Unemotional Traits: Positively Worded Version for Mexican Adolescents: Validity and Reliability

Validez y confiabilidad del Inventario de Callo Emocional con redacción en positivo: versión para adolescentes mexicanos

Francisco R. de la Peña Olvera¹ Sebastián Totxo Guerrero²
Javan Guillermo Segovia Aguirre³ Assad Daniel Saad-Manzanera¹
Marcos Francisco Rosetti Sciuotto⁴ Alexa Bazúa Gerez¹
Luis Santana Arellano¹ José Carlos Medina-Rodríguez^{1*}

¹ Unidad de Fomento a la Investigación, Instituto Nacional de Psiquiatría Ramón de la Fuente Muñiz, Ciudad de México, México. ² Clínica de Adolescentes, Instituto Nacional de Psiquiatría Ramón de la Fuente Muñiz, Ciudad de México, México. ³ Centro de Investigaciones en Salud Mental Global, Instituto Nacional de Psiquiatría Ramón de la Fuente Muñiz, Ciudad de México, México. ⁴ Instituto de Investigaciones Biomédicas, Universidad Nacional Autónoma de México, Ciudad de México, México.

ORCID: F.R.P. 0000-0001-5421-2744 · S.T.G. 0000-0003-1966-0503 · J.S. 0009-0000-9263-0023 · A.S. 0000-0001-6304-5386 · M.F.R. 0000-0002-4607-8984 · A.B.G. 0009-0006-7360-7710 · L.S.A. 0009-0007-1648-9591 · J.C.M.R. 0000-0002-0874-3525. ***Correspondence:** Dr. José Carlos Medina-Rodríguez, Unidad de Fomento a la Investigación, Instituto Nacional de Psiquiatría Ramón de la Fuente Muñiz, Calzada México-Xochimilco 101, Tlalpan, C.P. 14370, Ciudad de México, México. Tel. (+52) 55 4443 8609; jcmédinar@inprf.gob.mx.

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Resumen

Introducción. Los rasgos de callo emocional (CE) fueron incluidos en el DSM-5 como el especificador de emociones prosociales limitadas (EPL). El *Inventory of Callous Unemotional Traits* (ICU) es el instrumento más utilizado para evaluar el especificador EPL. El ICU usa reactivos redactados tanto de forma positiva como negativa, siendo posible que estos últimos influyan en sus propiedades psicométricas. **Objetivos.** Crear una versión del ICU exclusivamente con redacción positiva, adaptada al español para niños y adolescentes (ICU-A); evaluar su consistencia interna, validez de constructo y validez convergente; y determinar su correlación con psicopatología dimensional. **Métodos.** Participaron niños y adolescentes reclutados de una clínica ambulatoria. Los datos clínicos se obtuvieron mediante las entrevistas estructuradas K-SADS-PL-5 y BPRS-CA-29. La muestra constituyó 163 adolescentes con edad promedio de 15.24 años ($DE = 1.40$, rango 13–17), siendo 74 participantes mujeres (45.4 %). **Resultados.** Los adolescentes con y sin especificador EPL presentaron puntuaciones promedio en el ICU-A de 35.03 y 25.55, respectivamente ($t = 6.455$, $p = 0.001$). La consistencia interna fue excelente ($\alpha = 0.86$). El análisis factorial exploratorio reveló tres factores; el análisis factorial confirmatorio indicó que un modelo de tres factores con estructura unifactorial fue el mejor ajustado a los datos. Las correlaciones del ICU-A con las entrevistas clínicas semiestructuradas para EPL fueron superiores a 0.30, y la correlación entre ICU-A y la psicopatología externalizada fue moderada ($r = 0.49$). **Conclusiones.** La versión del ICU-A con redacción positiva mostró excelente consistencia interna, validez de constructo moderada, validez externa media y correlaciones moderadas con psicopatología externalizada en población clínica adolescente mexicana.

Palabras clave: Psiquiatría infantil y del adolescente; evaluación psicométrica; Inventario de Callo Emocional.

Abstract

Introduction. Callous-unemotional (CU) traits were included in the DSM-5 as a limited prosocial emotion (LPE) specifier. The *Inventory of Callous Unemotional Traits* (ICU) is the most used instrument for evaluating LPE. The ICU utilizes positively and negatively worded items; negatively worded items may influence its psychometric properties. **Objectives.** To create a positively worded Spanish version of the ICU child/adolescent version (ICU-A); to assess its internal consistency, construct and convergent validity; and to determine its correlation with dimensional psychopathology. **Methods.** Participants were children and adolescents recruited from an outpatient clinic. Clinical data were collected through the K-SADS-PL-5 and BPRS-CA-29. **Results.** One hundred sixty-three adolescents participated, with a mean age of 15.24 ($SD = 1.40$, range 13–17), and 74 (45.4 %) were female. Adolescents with and without LPE had mean ICU-A scores of 35.03 and 25.55, respectively ($t = 6.455$, $p = 0.001$). Internal consistency was $\alpha = 0.86$. An exploratory factor analysis revealed three factors; confirmatory factor analysis indicated that a three-factor unifactorial model was the best fit. Correlations between ICU-A and LPE with semi-structured interviews were $r > 0.30$; the correlation between ICU-A and externalizing psychopathology was $r = 0.49$. **Conclusions.** We found excellent internal consistency, moderate construct validity, medium external validity, and moderate correlations with externalizing psychopathology for the positively worded version of the ICU-A.

Keywords: Child and Adolescent Psychiatry; Psychometric Assessment; Inventory of Callous Unemotional Traits.

1. Introduction

Callous-unemotional (CU) traits represent a set of characteristics linked to disruptive behavioral disorders (DBDs) in children and adolescents. These traits are associated with a subgroup of children exhibiting severe aggressive behavior (Frick et al., 2014; Frick & Ray, 2015) and an earlier onset of delinquency (Neo & Kimonis, 2021). Furthermore, CU traits are correlated with the presence of psychopathy in adults (Viding & McCrory, 2018). Recently, CU traits have been redefined as limited prosocial emotions (LPE) to mitigate the associated stigma and have been included in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5; American Psychiatric Association, 2013) as a specifier of conduct disorder. LPE characteristics are also listed in the *International Classification of Diseases, Eleventh Edition* (ICD-11), serving as a specifier for conduct disorder and oppositional defiant disorder (World Health Organization, 2019). According to both, the LPE specifier is present when at least two of the following traits persistently manifest over a minimum of 12 months and across multiple relationships and settings: lack of remorse or guilt, callousness or lack of empathy, lack of concern about performance, and shallow or deficient affect (American Psychiatric Association, 2013; World Health Organization, 2019).

The Inventory of Callous-Unemotional Traits (ICU), developed by Frick (2004), provides a rational assessment for identifying CU traits in youth. The ICU consists of a 24-item questionnaire rated on a 4-point Likert scale, as a self-report (ICU-A) or completed by parents (ICU-P) or teachers. This version includes positively and negatively worded items, with three positive and three negative items for each of the four CU traits (Frick, 2004). The ICU is one of the most widely used instruments for evaluating the construct of LPE (Morales-Vives et al., 2019).

Negatively worded items in this instrument have a significant impact. Ray et al. (2016) stated that “positively worded items were more likely to receive ratings in the lower response categories, demonstrated higher difficulty levels in Item Response Theory analyses, and showed a stronger correlation with measures of antisocial and aggressive behavior.” Some authors suggest combining negatively oriented and positively worded items (Cole et al., 2021). Recent studies have provided evidence that wording can affect construct validity. For instance, Dodeen (2023) indicated that using negatively worded items reduces the reliability of psychosocial scales and adversely impacts the factor structure. For these reasons, we modified ICU-A into a positively worded version.

The ICU is available in over 20 languages, and two meta-analyses support its validity and reliability in adolescent samples. Deng et al. (2019) reported mean alpha (α) values ranging from 0.70 (unemotional subscale) to 0.81 (total score). Ray and Frick (2020) reported omega (ω) values of 0.80 for ICU-A. Additionally, factor analysis indicated that the structure of the ICU aligns with the criteria for LPE specifiers in the DSM-5, as shown in a multinational adolescent sample (Kemp et al., 2022). The French version of the ICU-P also exhibited adequate internal consistency ($\alpha = 0.85$) in preschool children (Payot et al., 2022). However, there is a gap in research regarding the adolescent age group, especially within the Spanish-speaking

population. Most versions contain both positive and negative wording; therefore, we decided to explore the validity of an exclusively positively worded ICU-A.

2. Objectives

The goals of this study were: (1) to create a positively worded Spanish version of the ICU-A; and (2) to evaluate the internal consistency, construct validity, and convergent validity of the positively worded Spanish version of the ICU-A in a clinical sample of Mexican adolescents.

3. Methods

3.1. Clarity and Accessibility of Data

The ICU-A was modified to use exclusively positive wording. Data analyses were conducted in R Studio (R Studio Core Team, 2023).

3.2. Internal Consistency

The internal consistency of the positively worded ICU-A version was assessed using Cronbach's α , with targets over 0.80 to confirm adequate consistency.

3.3. Construct Validity

Using Varimax rotation, construct validity was assessed through exploratory factor analysis (EFA). Items with factor loadings lower than 0.35 were removed from the confirmatory factor analysis (CFA), which was conducted to evaluate the best fit of the identified factor structures.

3.4. Model Fit Evaluation

Fit indices from the CFA, including chi-square (χ^2), degrees of freedom (df), chi-square to degrees of freedom ratio (χ^2/df), root-mean-square residual (RMR), goodness of fit index (GFI), adjusted goodness of fit index (AGFI), and normed fit index (NFI), were used to assess model fit. Lower values of χ^2 , RMR, and χ^2/df nearing one, along with GFI, AGFI, and NFI values approaching one, indicated a better fit of the model to the data.

3.5. Convergent Validity

Correlating ICU-A scores with relevant items from the BPRS-CA-29 and the K-SADS-PL-5 subscale for LPE determined convergent validity.

3.6. Correlation Analysis

Pearson correlations were calculated to assess the relationships between ICU-A scores and scores from the BPRS-CA-29 psychopathology dimensions: externalizing disorders (ED), internalizing disorders (ID), neurodevelopmental disorders (ND), and abuse (AB). Specific correlations were reported to evaluate associations between CU traits and these psychopathological dimensions. Additionally, percentile-based analyses were conducted to explore correlations at different levels of ICU-A scores, specifically at the 75th and 90th percentiles. This approach provides insights into how these traits vary with increasing severity.

4. Results

4.1. Sociodemographic and Clinical Characteristics

The sample consisted of 163 adolescents, with a mean age of 15.24 years ($SD = 1.40$, range 13–17). Among these participants, 74 (45.4 %) were female and significantly older than males (mean age 15.58, $SD = 1.30$ versus 14.96, $SD = 1.42$; $t(161) = -2.92$; $p = 0.004$). In 148 (90.7 %), the participating parent was the mother. At the time of evaluation, 139 participants (85 %) regularly attended school.

Clinical data were collected from 147 of the 163 participants using the BPRS-CA-29 interview. The ID dimension had a mean score of 9.19 (22.42 %) out of a maximum possible score of 45 (100 %). The ED dimension had a mean score of 5.1 (24.28 %) from a maximum possible score of 21 (100 %). The ND dimension had a mean score of 3.06 (17 %) from a maximum possible score of 18 (100 %). The AB dimension had a mean score of 0.32 (10.66 %) from a maximum possible score of three (100 %). The mean total score for the ICU-A was 29.45 ($SD = 10.23$). Regarding sex differences, the mean ICU-A score for males was 29.56 ($SD = 10.82$), while for females it was 29.31 ($SD = 9.75$). ICU-A total mean score with and without LPE showed a significant difference, 35.03 with LPE and 25.55 without LPE ($t = 6.455$, $p = 0.001$).

4.2. Internal Consistency

The ICU-A reported an $\alpha = 0.86$.

4.3. Construct Validity

The EFA for ICU-A revealed three factors, all with eigenvalues greater than one (see **Table 1**). The EFA was adjusted by eliminating items with a low factorial load: items 2, 7, and 10. This analysis showed modest fit indices for a three-factor unifactorial model in the CFA. The values are presented in **Table 2**.

4.4. Convergent Validity

Moderate correlations were found with the BPRS-CA-29 items and the K-SADS-PL-5 subscale for the LPE specifier. The correlations were as follows: ICU-A and BPRS-CA-29 ($r = 0.30$, $p < 0.001$); ICU-A and K-SADS-PL-5 ($r = 0.48$, $p < 0.001$).

Pearson's correlations were computed between the mean ICU-A score and the scores for the ED, ID, ND, and AB dimensions. The correlation between ICU-A and ED was $r = 0.49$, $p < 0.001$; for ID, $r = 0.18$, $p = 0.03$; for ND, $r = 0.07$, $p = 0.40$; and for AB, $r = 0.02$, $p = 0.55$. When excluding item 29 from the ED dimension, which directly measures LPE, the correlation for ICU-A became $r = 0.42$, $p = 0.001$. Percentile-based analyses indicated that at the 75th percentile, the mean ICU-A total score was 35.0. The correlations at this percentile between ICU-A and ID, ED, ND, and AB were $r = 0.14$, $p = 0.073$; $r = 0.45$, $p < 0.001$; $r = 0.08$, $p = 0.291$; and $r = 0.19$, $p = 0.015$, respectively. At the 90th percentile, the mean ICU-A score was 42.0, and the correlations between ICU-A and ID, ED, ND, and AB were $r = 0.14$, $p = 0.064$; $r = 0.41$, $p < 0.001$; $r = 0.03$, $p = 0.735$; and $r = 0.14$, $p = 0.067$, respectively.

5. Discussion

5.1. Main Findings

Results showed excellent internal consistency, moderate construct validity, medium external validity, and high concurrent validity for the positively worded Spanish version of the ICU-A.

5.2. Sociodemographic Characteristics

The sociodemographic characteristics indicated a balanced sex distribution, although females were significantly older than males. Nearly all participants regularly attended school, suggesting a good functional level regardless of psychopathology. This differs from other ICU-A validity studies that included incarcerated populations (Kemp et al., 2022; Payot et al., 2022). Therefore, sociodemographic characteristics may influence the variance in factorial load distribution.

5.3. Positive Wording

Ray et al. (2016) reported that positively worded items tended to score lower or present higher difficulty levels in comprehension, suggesting better discrimination at higher CU trait levels. This indicates that the psychometric properties of the ICU can be effectively assessed and refined using Item Response Theory, particularly in future studies focusing on linguistic aspects (Cole et al., 2021). For instance, Ray et al.'s (2016) shortened 10-item ICU version retained similar psychometric qualities as the full version, maintaining negatively and positively worded items. Some authors recommend avoiding negative items because of the additional cognitive effort they require, which leads to increased processing time and potential confusion (Swain et al., 2008; Koutsogiorgi & Michaelides, 2022). Swain et al. (2008) suggested that using antonyms can preserve the benefits of mixing positively and negatively worded items while avoiding the risks of negation. In our version, items that include antonyms with precise positive wording were designed to enhance these psychometric properties further.

5.4. Internal Consistency

Our version demonstrated excellent internal consistency, similar to previous research that included positively and negatively worded items. This suggests that items in each version reliably measure the same underlying construct (Deng et al., 2019; Ray & Frick, 2020; Essau et al., 2006; Kimonis et al., 2008). These findings indicate that modifying items to use positive wording did not significantly affect this parameter.

5.5. Factor Analysis

We included only items with loadings ≥ 0.35 . This approach led to the removal of items 2, 7, and 10 for confirmatory factor analysis. It is essential to note that items 7 and 10 were positively worded; however, most validation studies using the mixed wording version also excluded these two items, which may suggest their low contribution to the ICU construct (Kimonis et al., 2008).

Our findings demonstrated that while items 6, 8, 13, 16, 17, 20, and 24 loaded differently compared to other research, items 2, 3, 4, 5, 7, 9, 10, 11, 12, 14, 15, 18, 19, 21, and 23 loaded similarly (Willoughby et al.,

Table 1. Inventory of Callous-Unemotional Traits — Adolescent Version: Items, their factorial loads and eigenvalues.

#	Item (English / Spanish)	Factor I Callous.	Factor II Unemot.	Factor III Uncaring
1	I express my feelings openly. <i>Expreso abiertamente mis sentimientos.</i>	-0.05	0.35	0.01
2*	What I think is “right” and “wrong” differs from what others think. <i>Lo que yo conozco como bueno o malo es diferente a lo que otras personas piensan.</i>	0.25	-0.04	0.05
3	I care about how well I do at school or work. <i>Me importa qué tan bueno soy en la escuela o en el trabajo.</i>	0.10	0.21	0.74
4	I can hurt someone to get what I want. <i>Puedo lastimar a alguien para conseguir lo que quiero.</i>	0.60	-0.11	0.11
5	I feel bad or guilty when I do something wrong. <i>Me siento mal o culpable cuando hago algo mal.</i>	0.06	0.42	0.52
6	I hide my emotions from others. <i>Oculto mis emociones a los demás.</i>	0.51	0.22	-0.18
7*	I care little about being on time. <i>Me importa poco llegar a tiempo.</i>	0.34	-0.11	0.15
8	I am concerned about the feelings of others. <i>Me interesan o preocupan los sentimientos de otras personas.</i>	0.10	0.65	0.34
9	I care little about getting in trouble. <i>Me importa poco si me meto en problemas.</i>	0.51	-0.05	0.10
10*	I prevent my feelings from controlling me. <i>Impido que mis sentimientos me controlen.</i>	-0.04	0.16	-0.02
11	I care little about doing things right. <i>Me importa poco tener que hacer las cosas bien.</i>	0.51	-0.06	0.05
12	I seem cold and uncaring to others. <i>Me comporto emocionalmente frío e indiferente hacia los demás.</i>	0.62	0.14	-0.23
13	I readily admit to being wrong. <i>Con facilidad admito mis errores.</i>	-0.05	0.40	0.06
14	It is easy for others to tell how I am feeling. <i>Los demás saben fácilmente cómo me siento.</i>	0.02	0.37	0.02
15	I always try my best. <i>Siempre intento dar lo mejor de mí.</i>	0.07	0.23	0.70
16	I apologize to people I hurt. <i>Me disculpo con las personas a las que lastimé.</i>	0.11	0.65	0.30
17	I avoid hurting the feelings of others. <i>Evito lastimar los sentimientos de los demás.</i>	0.04	0.65	0.30
18	When I do wrong, I live free from regret. <i>Cuando hago mal vivo sin arrepentimiento.</i>	0.62	-0.18	0.12
19	I am very expressive and emotional. <i>Soy muy expresivo y emocional.</i>	-0.06	0.35	0.18
20	I dislike dedicating time to things so that they are right. <i>Me disgusta dedicarle tiempo a las cosas para que queden bien.</i>	0.35	0.04	0.80
21	The feelings of others are unimportant to me. <i>Me importan poco los sentimientos de los demás.</i>	0.67	0.00	-0.09
22	I hide my feelings from others. <i>Escondo mis emociones con los demás personas.</i>	0.50	0.27	-0.27
23	I work hard on everything I do. <i>Trabajo mucho en todo lo que hago.</i>	0.04	0.18	0.43
24	I do things to make others feel good. <i>Hago cosas para hacer sentir bien a los demás.</i>	-0.06	0.65	0.29
Eigenvalue		3.89	2.67	2.20

Note. English wording is in regular font; positive Spanish wording is in italic font. Bolded loadings indicate the primary factor for each item. An asterisk (*) marks items discarded due to low factorial loads (items 2, 7, 10).

Table 2. Fit indices for Inventory of Callous-Unemotional Traits — Adolescent Version: confirmatory factor analysis models.

Model	χ^2	df	χ^2/df	RMR	GFI	AGFI	NFI
One-factor	658.88	180	3.66	0.071	0.864	0.835	0.803
Two-factor	200.41	170	1.18	0.053	0.912	0.895	0.874
Three-factor	95.00	170	0.56	0.046	0.936	0.910	0.894

Note. χ^2 evaluates model fit (lower is better); df = degrees of freedom; χ^2/df near 1 = good fit; lower RMR = better fit; GFI, AGFI, NFI near 1 = better fit. The three-factor model best fits the data.

2015). Considering the differences associated with positive wording, items 6, 17, and 20 loaded into different factors than those identified in prior research (World Health Organization, 2019; Kimonis et al., 2008). Another example is item 20, which had the highest factor loading in our study and was integrated into the uncaring factor. Interestingly, other positively worded items (4, 9, 11, 18) aligned with the callousness factor, consistent with previous studies (Ray & Frick, 2020). This suggests that positive wording may alter item distribution across factors without disrupting the original three-factor model proposed by Frick et al. (2000) and confirmed in subsequent studies (Fanti et al., 2009; Roose et al., 2010; Kimonis et al., 2014).

Interestingly, some studies have found that positively worded items score higher on CU traits, fall into lower response categories, and better discriminate at higher CU trait levels (Ray et al., 2016). Although

the three-factor model (callousness, uncaring, unemotional) remains consistent with Frick et al.’s (2000) original framework and has been validated across various cultural contexts (Fanti et al., 2009; Roose et al., 2010; Kimonis et al., 2014), some studies propose adding a fourth factor, carelessness, which was not observed in our EFA (Kimonis et al., 2014; Kliem et al., 2019).

Comparatively, Payot et al. (2022) found that a three-factor model was most suitable for younger populations. Similarly, earlier Mexican adaptations of the ICU-P, known as INCA, also identified three factors: unemotional, callousness, and uncaring/antisocial behavior (Morales-Vives et al., 2020).

On the other hand, limited evidence has supported a one-factor or two-factor model for the ICU-P, with fit statistics often ranging from poor to unacceptable (Wang et al., 2017; Allen et al., 2021). However, research involving positively and negatively worded items has found that a two-factor model comprising callousness and uncaring dimensions provides the best fit and consistency across sexes in school-attending youth from the United Kingdom and China (Allen et al., 2021).

Kliem et al. (2019) also utilized Item Response Theory to evaluate the ICU’s factor structure in a substantial sample of about 3,878 ninth-grade students from Germany. While their analysis indicated that a four-factor model was the most suitable fit, we conclude that

positively worded items affect the goodness of fit parameters of the CFA models.

5.6. Convergent Validity

Prior research has demonstrated that ICU scores are significantly associated with other measures of DBD symptoms and antisocial behavior (Pardini et al., 2003; Hawes & Dadds, 2007). Convergent validity was established with aggressive and delinquent behaviors in detained youth, revealing small to medium significant correlations (Kimonis et al., 2008). Only one study has examined the convergent validity between the ICU-A and the Hare Psychopathy Checklist (PCL), showing no significant correlations (Feilhauer et al., 2012). Morales-Vives et al. (2020) demonstrated convergent validity between INCA and ICU ($r = 0.19-0.55$), aligning with our findings. Neo et al. examined the convergent validity of a new instrument (CAPE) with ICU through ANCOVA, obtaining similar effect sizes (Neo & Kimonis, 2021).

5.7. Correlation Analysis

Clinical psychopathology was assessed across four dimensions: internalizing disorders (ID), externalizing disorders (ED), neurodevelopmental disorders (ND), and abuse (AB), similar to a recent meta-analysis conceptualizing diagnoses dimensionally (World Health Organization, 2019). ED and ID were present in nearly one-fourth and one-fifth of participants, respectively; ND in approximately one-sixth, and AB in one-tenth. According to the same meta-analysis, ICU's correlation with ED was higher than with ID, mirroring our results in this clinical population. This suggests LPE characteristics are more prominent in ED. Interestingly, LPE characteristics may also be associated with ID and ND, supporting the ongoing debate regarding their conceptualization as transdiagnostic specifiers for several diagnostic groups (de la Peña et al., 2024).

ND, including autism spectrum disorder (ASD) and attention-deficit/hyperactivity disorder (ADHD), have been linked to lower prosocial functioning. ASD primarily associates with deficits in cognitive empathy (Blair, 2005; Bons et al., 2013), while children with ADHD demonstrate global empathy deficits (Maoz et al., 2019; Davis, 1980). Low executive and empathic functioning in ADHD appears to be influenced by aggressive behaviors (Cristofani et al., 2020). Childhood interpersonal trauma negatively associates with prosocial behavior (Coulombe, 2021; Music, 2011). Music (2011) found that following abuse and neglect, youth show diminished capacity for care. Given our sample's abuse prevalence, examining the relationship between abuse and LPE is crucial, particularly regarding primary and secondary CU variants (Craig et al., 2021).

5.8. Strengths and Limitations

The study's key strengths include its innovative use of positively worded items in the ICU-A. A limitation is the lack of direct comparison between positively and negatively worded ICU versions; this comparison could clarify how item wording affects the ICU's psychometric properties. Furthermore, some studies suggest cultural factors may

influence CU trait expression, impacting ICU development, stability, and validity across populations (Frick & Ray, 2015; Wang et al., 2017).

6. Conclusions

This research demonstrated excellent internal consistency, moderate construct validity, and moderate external validity for the positively worded version of the ICU-A in a Mexican Spanish-speaking adolescent population. The study underscored the significance of including positively worded items in developing psychometric assessments to capture the complete spectrum of CU traits better.

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