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Risks of mental disorders in pre-hospital providers; analysis of 30 years of service

Riesgos de trastornos mentales en atención prehospitalaria; análisis de 30 años de servicio

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ABSTRACT

Everybody has a personal history and most of them mar kit for that. Unpleasant events lived between 4 up 14 years old made an emotional and personal mark changes our behavior (most of them are emotional) and or behavioral character most of them by moral and social alterations and that deviations show it as negative manifestations ways as a conduct (bad social manners) on behavior forms (empathy troubles). Sociology studies and analyses the way that everybody interacts one by one, anthropology supports each personal histories and the behavior way to be, together anthropology and sociology as a complimentary science generates ideas, thoughts, that impact and affect in the psyche make it necessary actives the psychology as a base element to try the understand the way to be and act of everyone. We not see as the other only since one side. We must to see to everybody as a multicultural and transdisciplinary context. In fact, to former, each cluster member of emergency prehospital medical service must attend medical exams on mental health before be admitted at service and at least every six months to determine the mental health actual level and notice how is going in emergency services and prehospitalary life. For that reason, the target of this analysis is raising authority hands for think it about why and what for it could be good (and convenience) to apply mental health medical admittance exam to all the candidates to get in in emergencies institutes.

Keywords: Mental Health; Pathologies; Prehospital Services.

RESUMEN

Todos tenemos una historia personal, y la mayoría estamos marcados por ella. Eventos displacenteros vividos en nuestra etapa de 4-14 años pueden hacer un marcaje emocional y personal repercutiendo en nuestro comportamiento (que casi siempre es de origen emocional) y/o de carácter conductual que en su mayoría es generado por alteraciones morales y sociales y la desviación de éstas darán manifestaciones negativas en forma de conducta (malos comportamientos sociales) y o de comportamiento (problemas de empatía con los demás). La sociología estudia y analiza la forma como interactuamos entre nosotros, la antropología, sustentada en nuestras historias nos brinda la cultura y bases de comportamiento actual y conductual, ambas, la antropología, y la sociología al interactuar entre sí, generan ideas y pensamientos que afectan e inciden en la psique haciendo necesaria la psicología como elemento base para comprender el ser actuar del individuo. No debemos ver al otro solamente desde una postura sino desde un contexto transdisciplinar y multicultural. En relación a lo anterior, cada miembro de los grupos de atención medica prehospitalaria deben llevarse exámenes de salud mental antes de ingresar al cuerpo o al menos cada seis meses para determinar el nivel actual y

cómo va reaccionando ante las emergencias y vida prehospitalaria. Por tal razón, el objetivo del presente trabajo es levantar la mano ante las autoridades y directivos para que consideren el porqué y el para qué sería bueno (y conveniente) aplicar exámenes de admisión a los candidatos a causar alta en las instituciones de emergencia.

Palabras clave: Salud Mental; Patologías; Atención Prehospitalaria.

INTRODUCTION

It was 1990 when we received a call about a shooting at " The Two Sisters " cantina located on Constituyentes Avenue in the city and port of Veracruz, Veracruz, Mexico. The perpetrator had joined the Mexican Red Cross rescue team on January 23, 1988.

We arrived at the scene, and even from outside, we could hear gunfire exchanges between personnel inside. Through the window, we could see a person with a bleeding chest lying face up, moving very slightly, which confirmed that he was still alive. We asked our colleague DB who would go in first, to which he replied, "Whoever gets there last buys the drinks."

Today, almost 34 years later, while pursuing this postdoctoral degree and after a long journey of training in the field of human behavior focused on prehospital medical care, safety, and hygiene, I reflect on a concern that has been troubling us since we were appointed (2020) instructors at the National School of Volunteer Firefighters in Guatemala, where we continue to serve. "There is always talk of the risks (physical, chemical, ergonomic, biological, etc.) faced by prehospital care personnel.[1,2] From our training, first as first responders and then as emergency medical technicians, we talk about pre-hospital care for patients with mental disorders. Still, as far as we know, there is never any mention of personnel who already have mental disorders and wish to join or are already working in pre-hospital services." Is this a risk? Is it a benefit?

According to research by Barragán et al.[3], data indicate that prehospital care dates back to 930 BC. These services were provided by a few doctors and mostly apprentices, sorcerers, herbalists, etc. It was not until the 12th century (1797) that Dr. Jean Dominique Larrey (1766-1842), physician to the conqueror Napoleon Bonaparte (1769-1821), designed the prototype ambulance, replacing the then-called Anglo-Saxon hammock, which dated back to 900 BC, using a hut and horses (called light ambulances because they were located near light artillery), giving rise to the French word "ambulant," alluding to walking or wandering. The improved design was proposed by Major John Letterman (1824-1872) in 1862, which included a mounted sergeant and two stretchers inside the hut (Rucker ambulances).

It was during the Battle of Solferino (June 24, 1859) that a Swiss banker named Jean Henry Dunant Colladon (1828-1910) traveled to Italy, where Napoleon's forces were fighting those of Victor Emmanuel II (1820-1878) of Italy (Victor Emmanuel Maria Alberto Eugenio Fernando Tomás de Saboy) and Giuseppe Maria Garibaldi (1807-1882). He witnessed the great slaughter when he was about to meet with the emperor to ask for the lands in Monsjdemila, Algeria, to build granaries and help alleviate the famine ravaging half of Europe. Upon seeing such a horrific scene, in a church in Castiglione, shouting "tutti fratelli" (all brothers), he founded the first first-aid station and, in 1860, the international Red Cross and Red Crescent movement.

After the end of the American Civil War (1861-1865), the Cincinnati Hospital launched the

first regulated ambulance service, followed by Atlanta and New Orleans through the Grady Ambulance Systems.

The entire Mexican Red Cross movement dates back to 1910, when General Porfirio Diaz, then president of the Mexican Republic, was in Paris and witnessed a theater fire. He saw the French Red Cross in action for the first time and decided to create the movement in Mexico, which first arrived in Orizaba (1918) and then in the port of Veracruz (1919). However, since February 2, 1919 (we were instructors in the history of the International and Mexican Red Cross), thanks to the intercession of Mrs. Teresa Viuda de Granés in the port of Veracruz, it became the second delegation in the country after Orizaba. However, in 1920, municipal medical services were created, with the Green Cross being the first to provide pre-hospital care in Guadalajara, Jalisco, Mexico.

Following the efforts of Larrey and De Dunant, the concept of pre-hospital care was born in the United States in 1940 with the country's fire department. In 1960, the National Academy of Sciences established standards and rules for ambulance services, and in 1962, the first training course for emergency medical technicians was established.

Meanwhile, in Mexico, the Rubén Leñero de la Cruz Verde Hospital was created in 1943, with an ambulance service to cover emergencies.

In 1950, the SAMU (emergency medical care system) prototype was developed and is now in operation across Europe. It was thanks to Joseph "Deke" Farrington (1909-1982) and Samuel Banks (1928-2000) that the first pre-hospital care course was created for the Chicago Fire Department. Around 1970, a Mexican official decree created the ERUM rescue and emergency medical squad, which absorbed the Green Cross and developed a pilot program for pre-hospital medical care. After the 1976 earthquake, according to Arreola, Dr. Wilfredo Palma Sacramento and Captain Arturo Espíndola Rivera taught the first training course for personnel in prehospital medical care, serving as instructors for 22 cadets who provided their first service during a tornado that struck the state of Mexico on October 11 of that year.

After a devastating accident in 1975 between a bus and a truck that left many dead and injured, who died due to delays in pre-hospital care, Dr. Gustavo Baz Prada attempted to launch a pre-hospital medical care service project called "latrotecnicos." However, the project was unsuccessful because the authorities did not trust it due to a lack of resources and personnel. In 1981, the SOS group created the first training course for emergency medical technicians, and it was not until 1982 that, through an agreement with CONALEP and ISEM, the first professional certificates were issued. Formal prehospital medical care emerged in Mexico,[4] training competent and qualified personnel, first as doctors and then with a specialty, let's say "officially," after the 1985 earthquake, when in 1987 Dr. Alejandro Grifé Coromina ran the first pre-hospital care course at the Mexican Red Cross to obtain the endorsement of the UNAM (National Autonomous University of Mexico), thus creating the Mexican Red Cross National School of Emergency Medical Technicians.

In 2004, the official Mexican standard NOM-237-SSA-2004 was created, which is mandatory in our country. It was supplemented nine years later to regulate the training and performance processes of individuals and entities that provide pre-hospital medical care.

For this paper, we will refer to what we have observed in more than 30 years of service in

emergencies and pre-hospital care in the locations and countries where we have experience.

DEVELOPMENT

We have already discussed some historical stages in the training of emergency medical technicians and prehospital medical care services. Still, we did not address the training foundations, as this is not the aim of this report. We therefore wish to focus on the fact that the author, in his more than thirty years of prehospital care in two countries, professional studies in mental health sciences (diploma in psychoanalytic theory and practice, expert in psychosomatic disorders, master's degree in psychology of emergencies, catastrophes, and personal loss, master's degree in clinical psychology, psychopathology, and psychotherapy, and a doctorate in knowledge sciences, for which we studied sociology, anthropology, psychiatry, and psychology, as well as courses totaling more than sixty hours, not counting subjects within the heuristic matrix such as psychosocial intervention in disasters within the doctoral program in catastrophe, which would exceed 1,500 hours of training) 2001-2019 providing psychotherapy on board ambulances to patients suffering from illnesses or accidents has allowed us to realize that under the guise of volunteerism, the need to cover services and have competent personnel, the Mexican Red Cross delegations until 2019, when we stopped providing services in the area of training, limiting ourselves to the operational part, did not apply at least in Mexico and Guatemala (except in Guatemala, where there was evidence of continuity, but no evidence of continuity was found). We provided services to the municipal association of departmental firefighters in the 82nd company in Quetzal City and in the 100th volunteer fire station in that country from 2017 to 2018. We have been instructors in mental health since 2020 and have also collaborated with ASOMET (Guatemalan Occupational Medicine Association). Therefore, the objective is to assess the prevalence of potential mental health conditions among pre-hospital care providers.

As mentioned at the beginning of this text, we joined the Veracruz branch of the Mexican Red Cross on January 23, 1988. As first responders, we co-founded the local first aid school in 196 together with Dr. Luis Enrique Martínez Bazavilvazo. In 1994, we raised the level of training at the school for basic emergency medical technicians together with Dr. Víctor Ramón Vela Rangel, where we served as deputy director from 1996 to 1998 and then as academic director from 1998 to 2000. There, we realized that 90 % of illnesses had an emotional origin, and since in Mexico, as in TUMS, we cannot administer drugs, we opted to study the mind and its conditions.

When we were state coordinators (2001) for the federal entity of Veracruz, we proposed adaptations such as reviewing the mental status of staff at least every six months (by then we had completed a first diploma course in mental health areas, which was in theory and psychoanalytic clinic at the University of the Gulf of Mexico, Orizaba campus), as well as medical-legal considerations and the use of disposable gloves for services.

Pinet[5] identifies two central prehospital medical care systems (they are not the only ones, but they are the most commonly referred to) with their variants: the Anglo-American system, which includes the first responder TUM-B, TUM-I, TUM-A with their multiple variants/combinations, and the Franco-German system (TUM-B, TUM-D, Nurse(o), TUM-A, emergency physician, etc.). Both describe the profiles that service providers should have, emphasizing physical and cognitive academic skills (in Mexico, at least a high school diploma is required to train as an emergency medical technician). To save the reader time, we will refer to prehospital service providers as TUM/TEM/TSUM. Pinet[5] reviews the overall structure, in which the profiles and admission and discharge criteria are mentioned, but none of them mention psychological

or mental testing. Some types of services and the evaluation of the system's performance are mentioned, but not the mental repercussions of the elements.

The Official Mexican Standard NOM-034-SSA3-2013.[6] Regulation of health services. Prehospital medical care. Refers in section 4.1.12 to the prehospital medical care technician as:

"Pre-hospital medical care technician, personnel specifically trained at the technical level of pre-hospital medical care or, where appropriate, trained and authorized by the competent educational authority to apply the knowledge, skills, abilities, and attitudes acquired during their training, regardless of their academic designation. Emergency medical technicians, pre-hospital medical care technicians, and other similar professionals are equivalent for this standard. They may have a basic, intermediate, advanced, or higher university level of technical training."

Once again, the issue of profile is addressed, but the mental profile is not specified. Item 7 of the aforementioned standard specifies the scope according to the level of training. Within, the admission requirements for applicants to the Red Cross National School of Emergency Medical Technicians mention: *For excellent performance, applicants must have:*

- Logical, analytical, critical, and reflective thinking.
- Have upper-secondary-level knowledge of health sciences.
- Skills. Abstract verbal reasoning, accuracy and speed of response, biopsychosocial adaptation, independent judgment, proper management of interpersonal relationships, observation skills, concentration and retention, interest and initiative in research, physical development required for this type of service, and physical integrity, courage, and boldness to face emergencies.
- Attitudes. Initiative, vocational interest in the career, ethical and humanistic values, emotional stability, discipline, sensitivity to understand human behavior, firm criteria for decision-making, interest and willingness to work in interdisciplinary and multidisciplinary teams, acceptance and respect for the institution's regulations, organization, and commitment.
- Interests. Human, scientific, academic, continuous training, helping the population, and perseverance in study.
- Skills. Effective communication and teamwork.

Admission Requirements

To enter the Emergency Medical Technician program, the following is required:

- Proof of upper secondary education in the National Education System or its equivalent.
- Availability of time and mobility for travel to complete any required internships.
- Minimum age of 18 years old.
- Meet the requirements of the call for applications.

However, no mental health examination or equivalent is required.

SCHOOL REGULATIONS OF THE SAME INSTITUTION PROGRAM: BASIC TECHNICAL TRAINING IN MEDICAL EMERGENCIES[7] LEVELS I AND II RVOE: D-006/2004 (RVOE means officially valid educational registration) quote: *Referred to the participant profile :*

A) All applicants for Basic Technician in Medical Emergencies Levels I and II must be between 18 and 40 years of age.

B) Have the appropriate skills and aptitudes to perform the tasks and acquire

the knowledge necessary for Prehospital Care (logical reasoning, verbal and written comprehension and expression, spatial reasoning, mental concentration, analytical ability, synthesis ability, distributed attention, physical ability, and inference).

C) Have a minimum of a high school diploma or equivalent.

D) Pass the admission exams.

E) Verify current professional activities (letter of employment or proof of current studies).

F) Complete the application form.

However, it does not mention any mental evaluation.

Continuing with the Mexican Red Cross regulations for Emergency Medical Technician applicants, the national training coordination mentions in Article 2.

A) All applicants for Basic Emergency Medical Technician must be between 18 and 45 years of age. Persons over the age limit will be considered for admission after an interview with the school.

B) Not have any physical impairment or chronic degenerative disease, except in special situations that the campus authorities will consider

C) Have a minimum level of education equivalent to high school or higher.

D) Applicants must provide proof of current professional activities.

E) Complete the application form.

Only Article 3, concerning the participant selection process, mentions that psychometric tests must be taken, but it does not mention the criteria for rejection or approval.

For this study, the general health law[8] was not considered, as it does not cover paramedics or emergency medical technicians. This law only covers medical assistants, who may be any person whose activities are related to those of a doctor, and this service is only considered within the hospital, not outside it.

GUATEMALA

In Guatemala, we found that Ministerial Agreement[9] No. 221-2015 *Technical Standard for Mobile Prehospital Care Centers*, in Article 9, specifies the characteristics of the operator and personnel, limiting them to competencies.

The 2019 manual of standards and procedures for the transport of patients by ambulance in Guatemala, in item C, only indicates that the crew boards, with clothing being specified in item C7, which determines the levels of competence that should be highlighted, referring only to medical and nursing personnel and not mentioning emergency medical technicians or any equivalent.

Heroic volunteer fire department

The Organic Law of Guatemala 10Decree 81-87 *Organic Law of the Meritorious Volunteer Fire Department of Guatemala* does mention the basic requirements for admission to the National School of Volunteer Firefighters:

1. Be of legal age and under forty (40) years of age.
2. Be a Guatemalan citizen or foreign resident.
3. Pass the National Firefighters School entrance exam.
4. Be in good mental and physical health and have no physical impairments.

5. Have a respectable occupation.
6. Have no criminal or police record.

To demonstrate good mental health, applicants are required to take tests only to enter the academy as first-time entrants. The battery of assessments consists solely of psychological and physical fitness tests. The advantage is that the academic director is a psychologist who administers the tests to the applicants and grades them. In 2023, there was only one rejection, and over the last five years, we know of three rejections.

When they enter the Emergency Medical Technician (EMT) program, no evaluation is done. It is understood that they are already firefighters and are opting for a specialization.

In 2017, a project was launched at Station 100 with two psychologists so that interested personnel could meet with them. Still, the lack of understanding of the cultural dimension of psychosocial risks meant the project stalled and was abandoned after two months.

ASOMBOMD

Within the municipal association of municipal firefighters, ASOMBOMD, among the requirements[11] for admission, we find:

GENERAL REQUIREMENTS FOR ENROLLMENT IN THE COURSE FOR ASPIRING THIRD-CLASS PROFESSIONAL MUNICIPAL FIREFIGHTERS:

- Age between 17 and 45 years old.
- Complete photocopy of ID card.
- Health card.
- Three letters of recommendation.
- Proof of completion of the last degree, minimum sixth grade.
- General medical certificate (can be obtained at any health center).
- ID-sized photograph.
- No criminal or police record.
- No physical disabilities.
- Complete the admission form.
- Fill out the liability waiver letter.

No mental health examination required.

Continuing with ASOMBOMD, reviewing its ADMINISTRATIVE PROCEDURES MANUAL[11] on its personnel hiring procedure (ASOMBOMD is municipal or departmental with a salary, unlike volunteers, whose two bodies, together with the Guatemalan Red Cross, cover pre-hospital and emergency services in that country).

To hire the technical-administrative services of a person and to guarantee equal opportunities for all those who wish to apply for a position within the institution, the following stages of the personnel hiring procedure must be followed:

1. Creation of the administrative department.
2. Creation of the duties to be performed within the administrative position and creation of the professional profile that must be filled to apply for the administrative position.
3. Approval of the creation of the administrative department, the duties to be

performed within the administrative position, and the professional profile by the Board of Directors; a certificate of approval will be issued.

4. Call for applications and establishment of salary range.
5. Appointments for interviews with interested parties.
6. Conducting interviews by General Management (interested parties must bring their respective resumes).
7. Recruitment of individuals who meet the required professional profile.
8. Presentation of the recruitment list to the Board of Directors for the selection of the person who will fill the position.
9. Selection by the Board of Directors of the person who will fill the administrative position, based on the recruitment list presented.
10. The relevant department will notify the person selected for the position and arrange a meeting to agree on the amount of fees, the conditions of service provision, benefits, and obligations that will serve as the basis for drafting the contract for the provision of technical-administrative services.
11. Signing the contract.

No requirement for mental health examinations for personnel.

The Guatemalan Red Cross[12] requests that its volunteer staff.

Of legal age:

- Fill out the registration form
- Submit a photocopy of ID
- Photocopy of criminal and police records (current)
- Submit two letters of recommendation
- Submit proof of current National Sex Offender Registry status
- Complete the Induction Course for the International Red Cross and Red Crescent Movement

Of the two countries where we provide services (which are highly regulated), only two consider applying mental health exams: the Mexican Red Cross in its Regulations for Emergency Medical Technician Applicants and the Meritorious Volunteer Fire Department of Guatemala.

Now let's look at the mental health context, according to the report from Mexico City[13] (CDMEX), SEDESA, and public health services from 2020 (at the time of writing, we have not found any updates to this report on its official website), which reveals that the primary mental disorders affecting the population in Mexico City alone are:

- Depression
- Autism
- Anxiety disorders
- Stress
- Panic attacks
- Agoraphobia
- Claustrophobia
- Social phobia
- Eating disorders
- Anorexia nervosa
- Bulimia nervosa

- Attention deficit hyperactivity disorder (ADHD)

In developed countries, according to DSM V[14] Diagnostic and Statistical Manual of Mental Disorders Published by the American Psychiatric Association in 2013 and ICD 11[15] International Classification of Diseases-Tenth Revision, which is the European classification used by the WHO,[16] the ten leading causes of loss of healthy life years between the ages of 15 and 44 are:

1. Major depressive disorder;
2. Alcohol use;
3. Traffic accidents;
4. Schizophrenia;
5. Self-harm;
6. Bipolar disorder;
7. Psychoactive drug use;
8. Obsessive-compulsive disorder;
9. Osteoarthritis;
10. Violence

Diagnoses that mental health professionals must make include:

Diagnoses on five axes

- Axis I: includes psychiatric disorders.
- Axis II: includes personality disorders and intellectual disability.
- Axis III: includes medical conditions.
- Axis IV: psychosocial and environmental problems.
- Axis V: current functioning

Let us remember that mental disorders have a psychological cause and mental illnesses have an organic cause. Since we are not psychiatrists, based on more than thirty years of observation, we have ruled out the axes proposed by psychiatry due to a lack of competence. Assessment and diagnostic methods help us rule out medical illnesses and those related to current functionality because they are not visible. We observe that we can only deduce psychiatric personality disorders and psychosocial problems from behavioral patterns; accordingly, based on Guyton's physiology manual, we will recall the physiological bases of neurological development in the individual.

A mental disorder is characterized by a clinically significant alteration in an individual's cognition, emotion regulation, or behavior. According to the DSM-5,[14] specifically, it is "a syndrome characterized by a clinically significant disturbance in an individual's cognitive state, emotional regulation, or behavior, reflecting a dysfunction of the psychological, biological, or developmental processes underlying their mental functioning.

An individual's brain structures begin to connect from an early age, so that between the ages of four and seven, which is the most crucial emotional stage, according to the theory of the three brains, children under the age of two are governed by the reptilian system, which makes them impulsive and instinctive, obeying these impulses if we compare it to Maslow's pyramid[17] attempts to meet the primary needs of protection from cold, heat, hunger, thirst, etc. On the second level of Maslow's pyramid, we find primary needs that are already linked to the emotional side, where the individual's needs are no longer just about eating but also about feeling loved and cherished. Between the ages of 4 and 7, the limbic brain begins to imitate and

associate with the individual who suffers contempt or has to fight to be and feel loved. Loved and desired. This will have an impact on how they relate to the world.

From ages 7 to 14, the individual adopts behavior guided by the limbic brain, with nuances of an attempt to control the neocortex, which already links to higher-level understanding and reasoning.

Behavior is the result of linking the environment with memories that may be one's own or acquired, conscious or unconscious, that emit emotions and sensations, which manifest themselves physically as behavior. Thus, if a child experienced emotional abuse, they will grow up to be a dysfunctional adult with problems being accepted, doing everything possible to be accepted, loved, and validated.

On the other hand, a child who experienced contempt, humiliation, etc., between the ages of 7 and 14 will likely grow up with resentment, anger, etc.

That is why any negative condition or experience can lead to the formation of narcissists, people with bipolar disorder, avoidant disorder, and eating disorders. If the exposure is prolonged and the child is very young, morphological or biochemical alterations may occur, such as amygdala growth in male patients with schizoid or sociopathic tendencies, but this is exclusively the domain of a psychiatrist.

And that is where we might have the hero child syndrome, people who are afraid of nothing and who often obey that desire/need for validation.

The prevailing, foul-mouthed, loud element who had a difficult childhood, where he was yelled at, and now treats others as he was treated.

Another profile could be that of the child of a narcissist who castrated him in such a way that he developed low self-esteem and is unable to make decisions for himself.

The cases we observe within our areas of service, understanding and accepting that we are not competent to make a judgment of a mental disorder nature, are based on the MADFOCS mnemonic[18] used to identify patients with possible mental disorders, but for everyday life, finding that most cases corresponded to males whose ages ranged from 19 to 24 years old, where those mentioned presented observable characteristics similar to mood or affective disorders, and to a lesser extent, elements suggestive of neurotic disorders.

The author of this article enjoyed making observations comparing traits and aspects of conduct and behavior based on this mnemonic device, which proposes to relate elements that influence behavioral changes, without ruling out elements such as alcohol, previous medical conditions such as head injuries, blood glucose alterations, and/or drugs as etiological agents that can alter or modify behavior (DSM V)[14] are:

1. The highly self-absorbed element has two aspects: consciously competent or unconsciously incompetent.

The traits observed by the author in his work in emergencies suggest personalities with presumably narcissistic traits, low self-esteem, and a great need for validation.

2. The submissive element

3. The brave element
4. The heartthrob
5. The one who does not like to obey or follow orders
6. The one who does not respect the rules and looks for shortcuts
7. The element that lives apart from everyone else and does not socialize, only appearing when there is a service to be done
8. The boisterous, talkative, cheerful one
9. The fatalist who always thinks the worst possible scenario and gets stressed about everything
10. The one who likes rules to be followed and respected, even if they don't always follow them themselves
11. The eternally depressed
12. The anxious one
13. The one who is happy today and unhappy tomorrow
14. The person who seeks to please and serve
15. The person who knows everything (or at least thinks they do) but wants to be the center of attention
16. The person who likes everything to be done perfectly
17. The element that is always in a bad mood

I omitted personalities whose traits are highly compatible with society, whose way of interacting is engaging, respectful, and highly social.

The findings observed, combined with the AMIR psychiatry manual[19] that we use in our doctorate in science, led us to correlate them in the following table deliberately.

Table 9.1. Identified disorders

Psychotic disorders	Some colleagues had delusions of grandeur that showed a certain disconnect from reality. 1, 15
Mood disorders	2, 7, 8, 10, 11, 12, 13
Anxiety disorders	7, 9, 10, 12, 16
Somatization disorders	Unidentified
Dissociative disorders	2
Factitious and malingering disorders	15
Impulse control disorders	1, 3, 5, 6, 12
Eating disorders	12, 13, 14
Substance abuse disorder	The observable was alcohol 1, 3, 4
Personality disorders	1, 2, 3, 4

Comparative table of findings observed in emergency and prehospital care personnel in Mexico and Guatemala over more than 30 years, compiled by the author with support from the AMIR psychiatry manual,[19] and their probable correlation with what was observed.

DISCUSSION

We do not intend to turn this document into a psychiatric or psychological debate, as we

are far from being experts in the field. The objective of this document is to identify patterns of behavior to help colleagues and avoid complex situations within the population.

Many mental disorders or illnesses are not isolated; it seems that some colleagues have more than one simultaneous pathology. The table presented above seeks only to point out that we are failing to do something in terms of the pre-selection of candidates for admission to our emergency institutions, which, if we were to strengthen the filters, would result in:

A) that the candidate may not have known they had a pathology and, thanks to the examination, can seek help and avoid a fatal outcome, and improve their quality of life.

B) Protecting the public from someone who is potentially unstable and could, after a trigger event, commit a felony.

If we consider all the elements mentioned above and take into account that we live in a society (Mexico) with high tendencies toward stress and depression, whose traits and patterns we now see in candidates to be part of emergency groups who are between 16 and 28 years of age, a life of stress and suffering at their young age could cause behavioral patterns that may be visible daily or lie dormant in the subconscious and, when triggered, emerge as behaviors that mark the candidate for life.

In fact, candidates may have experienced, as in the case of COVID, the loss of their job, loved ones, home, city, pet, and/or family members, placing them in situations of unresolved grief and loss, generating a situation of post-traumatic stress that lies dormant in the subconscious.

That is, the candidate may display common behavioral traits and, when faced with a stressful situation, relive a traumatic event, causing their normal behavior to shift into a form of inappropriate acting out.

Talking about mental illness invites us to remember that it can have a significant genetic component, such that if someone in the candidate's family exhibited unusual behavioral traits, disregarding all morality, ethics, and emotional control, they most likely had a mental illness, and the candidate, as a relative, has a high probability of inheriting the genetic predisposition for these characteristics. The second determining factor is a concomitant factor, i.e., one that occurs during the same period, and the third is a triggering factor, such as divorce, the death of a loved one, etc.

CONCLUSIONS

Since we are not psychiatrists, we suggest following prehospital care guidelines to identify patients with psychiatric disorders, and applying them not only to patients but also to candidates until formal guidelines for the general public are available.

Assume that every member has a personal life history; never assume that we are all healthy. On the contrary, believe that we all have a life history that, even if we don't think so, most likely has some impact on our subconscious.

If this manuscript reaches authorities and public figures, it would be ideal to review the legislation to include mental health examinations for admission. Given that prehospital medical personnel are exposed to high levels of cortisol, this leads to high levels of stress among members, with the well-known emotional and health alterations that can lead to cerebrovascular events, heart attacks, strokes, etc.

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