EFFECTIVENESS AND MEANING OF 'LOW-INTENSITY' COGNITIVE BEHAVIOURAL INTERVENTIONS FOR LATIN AMERICAN IMMIGRANTS IN LONDON

JOSE LOPEZ

A thesis submitted in partial fulfilment of the requirements of the School of Psychology, University of East London for the degree of Doctor of Clinical Psychology

May 2012

ABSTRACT

Growing research into the cultural validity of psychotherapeutic models reflects the current interest in the impact of culture on mental healthcare. In the UK, *Low and High Intensity* modalities of Cognitive-Behavioural Therapy (CBT) are offered as cost-effective interventions for anxiety and depression in primary care. Research with Latino migrants in the US highlights the broad suitability of CBT interventions to this culture. However, its findings may not be generalisable to the Latino migrant population in the UK, due to different socio-political circumstances.

This study explores the *effectiveness* and *meaning* of a Low Intensity CBT group intervention for Latino migrants in London using a mixed-methods approach. Participants attended a four-week workshop on anxiety and worry management facilitated in Spanish. Eight participants' pre and post-intervention scores in various outcome measures (CORE-OM, PHQ-9 and GAD-7) were compared using a repeated measures design. Additionally, seven participants gave their views on the intervention in two focus groups, information which was analysed to ascertain the themes underlying the discussions.

Scores showed a trend towards a reduction in anxiety levels, failing to reach statistical significance. However, participants' positive evaluation of the intervention seemed in disagreement with these modest results. Possible reasons for this discrepancy are discussed. Four themes were identified as underlying their discussions: useful CBT-specific elements, useful generic elements, intervention as basic/scope for improvement and Latino community needs. Participants acknowledged the place for Low Intensity CBT interventions, although thought further input was necessary. Therefore, they called for support at a community-level aimed at empowering the Latino community in the UK to tackle socio-political problems affecting them. These results are put in the context of previous research. Potential clinical implications as well as further research necessary on this topic are discussed.

CONTENTS

ACKNOWLEDGEMENTS

I would like to thank my academic supervisor, Dr Maria Castro, for her guidance during analysis and writing-up and her insight into the complexities of working with the Latin American community. Equally, this work would not have been possible without my field supervisor, Dr Melinda Rees, as she suggested the topic initially and supported me during conception of the study, delivery of the intervention and data collection.

I would also like to thank all the voluntary organisations I approached requesting their support with recruitment, premises and equipment for the group (e.g., IRMO, MRC, LAWRS and El Teléfono de la Esperanza). With the enthusiasm and collaboration they showed since the beginning, they demonstrated that they really care about the work they do and the community they serve.

I would also like to extend my gratitude to the participants of this research for the interest they put in attending the intervention and giving their opinion about it. I hope this work will help develop the support they sorely need.

Finally, I would like to thank those more close to me. My family, who, from the distance, have been encouraging me to continue in difficult moments. To friends and flatmates, who have suffered the impact of this thesis and have been flexible and supportive at a time. Thanks in particular to Roger, for his proof reading, and especial thanks to Ilvana, for her selfless understanding during this busy period.

SEARCH STRATEGY

The literature referenced in this work was retrieved from several searches made using a variety of sources. Relevant background literature was gathered in the form of books following recommendations from supervisors (e.g. on topics such as '*culture*', '*mental health*', '*group therapy*' and '*Latino population*'). Additionally, searches were made using Medline and EBSCOhost (primarily *PsycInfo* and *PsycArticles*). Title key words and relevant *Thesaurus* terms were explored, such as '*Psychoeducation', 'Group Psychotherapy', 'Latinos/as', 'Hispanic', 'Cognitive Behavior Therapy'* and *'Minority groups'*. The bulk of the search was made during the period November-December 2010 and August-October 2011. The reference lists of the retrieved material were trawled to identify further relevant material. A further search was made in order to provide a context for results which had not been covered in the original literature review.

INTRODUCTION

This section aims to provide a comprehensive review of the relevant research on the topic. It is structured around two broad themes: the first one covers the links between culture and mental health and how effectively psychological therapies address cultural differences, focusing on Cognitive Behavioural Therapy (CBT). The second part focuses on the Latino culture specifically and how its idiosyncrasies have been, and should be, considered in order to provide effective psychological help. Adopting a *funnel* structure, both sections start broadly and then narrow their focus to Latino migrants in the UK. After identifying the gaps in previous research, this section makes explicit the questions to be addressed.

1. Culture, Mental Health and Psychological Therapies

1.1. Culture

The term *culture* refers to the values, beliefs and practices that pertain to a given ethnocultural group (López & Guarnaccia, 2000). After many years ignoring it, clinicians and researchers have begun to recognise the role of cultural factors in mental health (Marsella & Yamada, 2007). This is in reference to the etiology, expression, manifestation and outcome of all forms of psychopathology and help-seeking attitudes (Lin, Tardiff, Donetz & Goresky, 1978).

Different ontological standpoints inform the developments within cultural mental health. Swartz and Rohleder (2008) identify them as three. Whereas a *universalist approach* argues that psychological concepts (e.g., depression) are found in all cultures, a *relativist position* states that there are different psychological experiences in separate cultures. A *critical approach*, they explain, argues that all contexts have multiple and diverse cultures, and psychological concepts can only be understood with a critical understanding of diversity and how knowledge is produced.

Within the organisational field, Hofstede (2001) identified several constructs that help us distinguish cultures. These are *Power Orientation,* the manner in which

people in a specific culture defer to legitimate authority; *Uncertainty Avoidance,* the extent to which people rely upon, and expects, information to accomplish a task; *Individualism/Collectivism,* or the degree to which a culture emphasizes the well-being of the group over the benefit of the individual; and *Masculinity,* a culture's perspective on the roles that men and women play in society.

From a more clinical angle, Marsella and Yamada (2007) summarise how cultural factors influence and shape 'mental disorders'[1] by determining: types and parameters of psychosocial stressors, coping mechanisms and resources; basic personality patterns; standards of normality and deviance; health attitudes and treatment orientation and patterns of experience and expression of psychopathology.

However, psychiatry's interest in culture, manifested in a vast volume of literature on the topic and the creation of 'culture-bound syndromes' (e.g., susto, ataque de nervios), has caused controversy. Whilst some consider this a step forward, critics see in it distinct racist connotations, as it portrays Western psychiatry as culturally neutral by labelling disorders which do not fit with it as 'culturally-bound' (Fernando, 2010a, p. 40). López and Guarnaccia (2000) argue that no disorder can escape cultural encoding, shaping and presentation and, therefore, all disorders should be regarded as cultural. Mezzich et al. (1999) state that diagnostic classifications, as western cultural documents, carry ontological notions of what constitutes a disorder, epistemological ideas about what counts as scientific evidence and methodological ideas as to how research should be conducted. Equally, exporting western therapeutic models across cultures has been deemed *psychiatric imperialism*, leading to the suppression of indigenous ways of dealing with human suffering, family problems and social disturbance (Fernando, 2010a, p. 113), a further aggrandizement of Western expertise and an increase in pharmaceutical sales (Thomas, Bracken & Yasmeen, 2007).

The provision of mental health services has also been criticised for lacking the cultural and linguistic competence to 'take culture seriously' and respond to growing mental healthcare challenges (Bhui et al., 2007). As a result, evidence in

---

[1] Medical terminology is purposely used throughout this work as a reflection of the dominance of the medical model within the outcome research field. The use of quotations indicates the author's critical stance in this respect.

the US (Sue & Zane, 2009) and the UK (Lawson & Guite, 2005) shows that ethnic minorities have traditionally fared poorly in mental health services (i.e. low representation and higher drop-out rates). Both papers advance the inability of therapists to provide culturally responsive interventions as the most important single explanation. However, the histories of migration to each country differ, which may contribute to the discourses on migration which inform healthcare policies. As a result, whereas some countries develop culture-specific services, others require immigrants to adapt and to use mainstream healthcare (Bhui *et al.*, 2007). In this sense, there have been calls to attenuate the 'excessive accommodation of the needs of ethnic minorities', as it can disempower communities and engender a culture of expectation and entitlement and generate dissatisfaction among the host society (Badat, 2010).

Further warnings have been made about a 'blind' inclusion of culture in mental health. Whilst cultural competence - the professionals' ability to provide services that are culturally acceptable and meaningful to the diverse populations they serve - is essential (Bhui *et al.*, 2007), it should be balanced with awareness of the person's ethnic identity (i.e., extent to which they identify themselves with a specific ethnic group), so that no stereotypical assumptions are made (Marsella & Yamada, 2007). This is especially relevant when working with immigrants, who may vary in their degree of *acculturation* (a process that every individual negotiates differently and influences, among other aspects, the sense they make of mental health models and constructs of the host society) (Nesdale & Mak, 2000).

Finally, López and Guarnaccia (2000) argue that for culture to be fully embraced within mental health, it should include a full social context, including social forces such as class, poverty, and marginality. Culture is important in all aspects of psychopathology research—from the design and translation of instruments, to the conceptual models that guide research, to the interpersonal interaction between researcher and research participants, to the definition and interpretation of symptom and syndromes, to the structure of the social world that surrounds a person's mental health problems.

1.2. The dilemma: Culturally adapted vs. evidence-based interventions

Considering the important role of cultural background in determining 'normal' and 'deviant' functioning (Hwang, Myers, Abe-Kim, & Ting, 2008), the question arises as to how best to include culture in the provision of psychological therapy. Morales and Norcross (2010) regard evidence-based and multicultural psychotherapies as 'strange bedfellows', which, having originated from different traditions and discourses (i.e., clinical science and anthropology), have recently been drawn together sometimes 'in an uncomfortable way'. Culture is included in the definition of evidence-based practice in psychology (EBPP) as 'the integration of the best available research with clinical expertise in the context of the client's characteristics, culture and preferences' (APA, 2006, p. 273).

Wilson et al. (2009) state that most psychologists in the US favour the idea of culturally adapting therapies; however, the extent to which they put it into practice is unclear. The meaning of 'culture' also varies across authors. Whilst some equate it to ethnic origin, others adopt a broader meaning of the term, encompassing a range of aspects, such as values or religious beliefs. Thus, Hays (2009) recommends the ADDRESSING model, including: *A*ge, *D*evelopmental disabilities and acquired *D*isabilities, *R*eligion/spiritual orientation, *E*thnic identity, *S*ocioeconomic status (SES), *S*exual orientation, *I*ndigenous heritage, *N*ational origin and *G*ender. Furthermore, Fernando (2010b) calls for the inclusion of faith-based healing in western models of psychotherapy.

However, critics of multiculturalism often warn that excessive adaptation of EBPP may endanger the notion of therapeutic models, as it could generate such heterogeneity of practice that would make research into its effectiveness impractical. Further concerns include the unknown impact of the adaptation on the efficacy of the intervention and the possibility that modified EBPP loses its 'curative' ingredients (Morales & Norcross, 2010) and its cost-effectiveness (La Roche & Christopher, 2009). Conversely, not adapting the therapy to the particular needs of the person would equate to a 'procrustean fit', which could generate conflict in values, client discomfort and poor engagement, dropout increases and 'treatment' failure (Sue, 2001). There is, therefore, a need for balance when considering adaptations to therapeutic models. Bernal (2009)

states that any adaptation should retain the essence (i.e., key theoretical constructs, theory of change, and basic procedures) of the model; yet the model of adaptation should take into consideration the unique characteristics of the population it is offered to. Possible cultural adaptations include multiple dimensions, for example, language, persons, metaphors, content, concepts, goals, methods and context (Morales & Norcross, 2010).

Griner and Smith's (2006) meta-analytic review of 76 studies provides evidence of the moderately strong benefits of culturally adapting mental health interventions, particularly when these are targeted to a specific ethnic group and are conducted in the client's mother tongue. Morales and Norcross (2010) also emphasise the importance of the therapist's competence in the cultural and linguistic aspects of the client and their experience in integrating these variables in a culturally competent and congruent manner. The systemic stance of 'cultural curiosity' (Grames, 2006) enables the therapist to focus on learning about the client's cultural experience of trauma.

Morales and Norcross (2010) close this debate by asserting that the time has arrived for culturally sensitive EBPP in the US, despite the unavailability of tests of adapted versus standard therapies (Miranda *et al.*, 2005). However, limited progress has been made in this area in the UK and it is important to remain cautious as to how we can generalise the above findings across countries with different ethnic make-up and a whole set of socio-political circumstances.

1.3. Cognitive-Behavioural Therapy (CBT)

1.3.1. Definition and characteristics

In its classical form, CBT is a short-term, structured, problem-solving method by which the person is trained to recognise and modify the maladaptive, conscious thinking and beliefs that are, it is argued, maintaining their problems and distress (Milton, 2008). The model is concerned with conscious mental processes and keeps its focus on the present. However, the expansion it has experienced since its conception, often described as three successive *waves* or paradigmatic shifts (Kaye, 2008), makes it difficult to define. In an attempt to build up its evidence-base, elements from different orientations have been clustered under the

umbrella term of CBT to the point that this label can hardly do justice to its diversity (Clarke, 2008).

Nevertheless, Gilbert (2009) gives a tentative description of CBT as 'an approach that aims to induce changes at a cognitive level which translate into different, more functional behaviour and vice versa. It uses a range of techniques such as Socratic dialogues, guided discovery, behavioural experiments, exposure to the feared and avoided, psycho-education and teaching the skills of self-monitoring, self-reflection and self-change' (p. 400).

In an effort to dissociate themselves from other therapists, CBT practitioners and theorists emphasise a series of characteristics of this approach, namely, a collaborative stance between therapist and client (collaborative empiricism), where both have a more equal role than in other approaches; a focus on conscious processes (drawing on cognitive and behavioural activity and avoidance); a problem-solving approach, focused on specific difficulties the individual experiences; and a focus on the individual and the way they interpret their own circumstances.

A number of critiques have been made to this model (some of which are included below when addressing CBT across cultures and the delivery of CBT in the UK). Another relevant critique when talking about socioeconomically deprived migrants is that an emphasis on alleviating distress through challenging thoughts may be counterproductive, leading to invalidating the context in which distress takes place (Moloney & Kelly, 2008).

1.3.2. Can CBT be used across cultures?

Little attention has been devoted to modifying the CBT model and practice to incorporate an understanding of diverse ethnic, cultural and religious contexts (Rathod & Kingdon, 2009). However, despite this apparent disinterest, Hays (1995) states that there is nothing inherent to this model that would preclude its use across cultures. She makes a balanced analysis of the approach, summarising its potential strengths as an emphasis on the individual's uniqueness and its large range of techniques that provide the tools for such adaptation. Also, CBT can be empowering to the client, by means of teaching skills that can be used without the therapist. Finally, CBT's attention to conscious

processes and specific behaviours may be preferable to other models when therapy is conducted in a client's second language or through an interpreter.

However, a number of aspects of the CBT model limit its validity when used across cultural backgrounds. Firstly, although sometimes presented as culturally neutral, CBT values highly certain stereotypic characteristics of the dominant group that developed it (i.e. highly educated Euro-American men), such as assertiveness, personal independence, verbal ability and change, which may not be congruent with other cultures. Secondly, CBT's individualistic focus may imply placing blame on the individual for problems which are primarily a result of unjust societal conditions (Hagan & Smail, 1997). Equally, focusing on the here-and-now may limit the attention devoted to the client's history. Thirdly, its emphasis on belief-change can come close to undermining the person's philosophy of life or religious convictions, especially when working with people of a different cultural background, e.g. a devout Buddhist (Fernando, 2010a, p. 117). Fourthly, Fernando (2010a, p. 78) criticises western psychology as lacking a sense of spirituality; however, Waller, Trepka, Collerton and Hawkins (2010) argue that the CBT framework lends itself to exploring spirituality issues.

On the basis of this review, the CBT model presents a number of challenges when applied to non-western cultures. Therefore, adaptations to suit the idiosyncrasies of the specific culture may be needed to maximise clients' engagement in therapy.

1.4. The British case

1.4.1. Psychological Therapy Services

The provision of psychological therapy in the UK's National Health Service (NHS) has been traditionally 'limited' and 'patchy' (BACP, 2010). To tackle this situation, the governmental initiative *Improving Access to Psychological Therapies* (IAPT) was launched in 2007. This national programme of investment in England aimed to provide a choice of well-resourced, evidence-based psychological therapies in primary care to those individuals who experience common mental health problems (i.e., 'anxiety' and 'depression') and to support generally their recovery and functioning within employment and society (Turpin *et al.*, 2008). A total

investment of £300m was secured for the development of this framework following an analysis by Layard et al. (2006). Their report highlighted the impact of psychological distress (construed as 'mental ill-health') on the economy and stated that the costs of such investment would be offset by savings in two main ways: reducing absenteeism and returning people to work. However, this work failed to tackle presenteeism.

IAPT has been praised and criticised equally. Among its merits we should highlight that, as the largest investment programme on psychological therapies in the UK, it denotes the Government's commitment to expand their availability (Marzillier & Hall, 2009), shifting the emphasis of service provision away from the purely medical (pharmacotherapy and ECT) and in favour of talking therapy (Clarke, 2008). Whether it was Layard's genuine aim or the *side-effect* of a merely economic drive (Nel, 2009; Pilgrim, 2008), some psychological therapies have become accessible to a wider number of people (Richards & Suckling, 2008).

The criticisms of IAPT focus on its underlying principles (i.e., evidence it is built upon) and the way in which it has been implemented. Although Turpin et al.'s definition highlights the word 'choice', IAPT's emphasis on offering 'evidence-based therapies' has resulted in the delivery of cognitive and behavioural therapies, which falls short of the 'choice of therapies' promised. Some authors have cast doubts on this 'one size fits all' assumption (Nel, 2009). Marzillier and Hall (2009) raise concerns about the 'overly optimistic and naïve understanding of the nature of psychological distress and the effectiveness of therapy' (p. 396). They argue it may be dangerous to the therapy industry as it is unlikely that the 'unfunded expectations' made on the effect of IAPT on the economy will be met.

With regards to the evidence upon which IAPT has been set up, it is necessary to refer to the guidelines issued by the *National Institute for Health and Clinical Excellence* (NICE), which makes recommendations on clinical treatments which have shown 'evidence of effectiveness'. Some of the guidelines relevant to Primary Care Psychology provision are specific to diagnostic categories such as Anxiety, Depression, Obsessive Compulsive Disorder and Postraumatic Stress Disorder (NICE, 2004, 2009, 2011, 2005). All these guidelines recommend CBT as a primary intervention or as an adjunct to pharmacological treatment on the

basis of studies which have demonstrated its superiority over other types of intervention.

NICE's approach to mental health has been criticised from different angles (UKCP, 2011). Firstly, it has been challenged on its 'excessive' medical stance, with guidelines based on nosologic categories of contested validity (Boyle, 2007; Pilgrim, 2000). Its use of a hierarchy of evidence which prioritises quantitative methods, especially, randomised controlled trials (RCTs), widely used in physical medicine, has also been questioned as an appropriate methodology for talking therapies (Hemmings, 2008). Critics of the use of the RCT approach to study talking therapies raise concerns about the generalisability of its findings, its ability to operationalise 'relationship effects', the inherent bias of this method, the effects of therapists' allegiance to particular modalities, and cost (UKCP, 2011).

A further criticism has been raised about the allegiance of CBT with the medical establishment (i.e. by adopting medical constructs) and how this has enabled it to be prioritised among alternative approaches (UKCP, 2011). Some authors, however, see this relationship as a positive step, as the 'Trojan horse' of CBT has come to be accepted as an alternative to mere drug-based treatments (Hemmings, 2008, p. 45).

1.4.2. A Stepped Care approach

A central tenet of the IAPT initiative is the delivery of therapy which suits the level of need of the client. *Stepped care* is an organisational principle of delivery of psychological interventions adopted within IAPT characterised by advocating (1) offering clients the least intensive 'treatment' likely to be effective, and (2) using a systematic scheduled review system (i.e. using validated outcome tools) to ensure that the most suitable treatment is actually offered (DoH, 2008). This approach distinguishes five *steps* or levels of intervention, three of which (*1* to *3*) pertain to Primary Care (*appendix 1*).

Low-Intensity (LI) interventions are treatment modalities aimed at increasing access to evidence-based psychological therapies in order to enhance mental health and wellbeing on a community-wide basis, using the minimum level of intervention necessary to create the maximum gain. They have been developed in the context of 'patients' with mild to moderate psychological 'disorders' to

enable *high intensity* interventions to be reserved to 'patients' with severe 'disorders' (Bennett-Levy, Richards & Farrand, 2010). Within IAPT, Low-intensity interventions can adopt different formats: Computerised CBT, Pure self-help (e.g., bibliotherapy with CBT-based material), Guided self-help (facilitated and based on CBT principles), Behavioural activation, Structured exercise and Psychoeducational groups (DoH, 2008).

After reviewing eight studies, Bower, Richards and Lovell (2001) concluded that self-help treatments may have the potential to improve the overal cost-effectiveness of mental health service provision. However, one RCT (Mead *et al.*, 2005) did not find additional benefit to 'patients' on a waiting list for psychological therapy. Khan, Bower and Rogers (2007) synthesised qualitative studies on the experience of receiving self-help interventions, emphasising the need to ensure that the context of primary care is viewed as a suitable location for mental healthcare, supporting the person's active role required in guided self-help, and the importance of actively engaging with the person's own constructions of their difficulties.

Guided self-help interventions have, however, received a number of criticisms. Firstly, its definition (above) denotes a strong medical, individualist and realist approach to psychological distress, which can be easily categorised and measured, and responds to the use of specific cognitive and behavioural techniques. Secondly, by minimising (or even replacing) the therapist's input, these interventions do not take account of the well-established evidence of the importance of the therapeutic relationship (Lambert & Barley, 2001). Thirdly, not being formulation-based interventions renders them standard interventions, of limited adaptation to the person receiving help. Finally, Hemmings (2008) warns about the risks inherent to the use of potent CBT techniques (e.g. downward arrow) by low intensity CBT therapists, without the sensitivity achieved by a more thorough training.

1.4.3. Group Low Intensity CBT interventions

The current approach to mental healthcare delivery and growing pressure to increase throughput at minimum cost has seen Cognitive-Behavioural group therapy (CBGT) as a suitable modality, as it has proven a time-limited, efficient

and cost-effective intervention. CBGT can be deemed a low intensity intervention in that a single therapist can 'treat' up to four times as many 'patients' in the same number of hours compared with individual therapy (Söchting, Wilson, & De Gagné, 2010). Therefore, large group psycho-educational interventions could be increasingly used as a method of delivering low intensity treatments within a stepped care model of the treatment of 'depression' (Dowrick *et al.*, 2000) and 'anxiety disorders' (Houghton & Saxon, 2007).

Low Intensity group interventions are widely used across IAPT sites. However, it is not clear whether its effectiveness is due to specific factors (e.g. psychoeducation and techniques) or nonspecific ones (e.g. group processes, rapport or satisfaction with therapy). A group process is the 'here-and-now' interaction between group members, therapist and group itself (Yalom, 1995). Although some authors distinguish between "structured" (among which CBT is included) and "process" groups, Bieling, McCabe and Anthony (2006) state that group process factors in CBT groups are recognised by 'patients' as important to the therapeutic experience. Oei and Shuttlewood (1997) concluded that specific factors (e.g., automatic thoughts and dysfunctional attitudes) contributed more than non-specific ones (such as satisfaction with therapy or client evaluation of the therapist) to the participants' benefit in a CBT group intervention for 'depression'. However, they did not consider group processes, the impact of which might have been ascribed to the specific factors.

Although group-based LI interventions are just one modality of delivering LI CBT, they are widely used due to their cost-effectiveness and, therefore, likely to be used with non-English speakers. However, this modality presents a number of challenges, such as working with co-morbidity, suitability of 'patients' and expectations about the group. In addition, working across cultures may bring further complexities, as for some cultures privacy and shame may play a large role in their approach to psychological distress (Sochting, Wilson, & De Gagné, 2010). Whilst guidance on working with the Black and Minority Ethnic (BME) population exists within IAPT (DoH, 2009), this is limited to theoretical principles and does not contain practical advice as to required cultural adaptation of interventions.

2. Latinos[2]

2.1. 'Latino culture' and CBT[3]

2.1.1. 'Latino culture': characteristics and views on mental health

It is important to highlight the overgeneralisation inherent in discussing aspects that have been suggested as distinctive of the so-called 'Latino culture'. Latin America is a vast geographical region spanning over half the American continent. Despite remarkable similarities among the countries it comprises (e.g. in history, language, cuisine), its size, ethnic diversity and other idiosyncrasies (e.g. in religious beliefs, traditions, norms) make it difficult to talk about a homogeneous 'Latino culture'. Finally, Latino values, normative behaviours, beliefs and explanatory models of illness vary considerably among individuals. This variation, therefore, will reduce any feature portrayed as characteristic of Latinos to a mere stereotype which may not hold true for many individuals from this collective.

However, previous research has focused on the 'Latino culture' as a cluster of common normative, behavioural and psychological traits among people from these countries in comparison to Western nations, mainly the US. Thus, Hofstede (2001) describes Latinos as characterised by:

- High Uncertainty Avoidance: seeking thorough information before making decisions;
- High Deference to Power: easily deferential to authority, offering little or no resistance;
- High Masculinity: men hold authority;
- Collectivism: valuing the group over their own well-being, which leads Latinos to value cooperation more than competition.

Ardila-Espinel (1982) adds two more defining characteristics of the Latino culture:

---

[2] Following Torres-Rivera (2004), the term *Latino* is used throughout this work as it is an inclusive term used by people of Latin/Hispanic descent to empower themselves. It is also preferred by more liberal, politically correct people as it affirms their native pre-Hispanic identity.

[3] This section draws heavily on research conducted in the US, as it is there where most literature on working with Latinos has been produced.

- Evaluation criteria: being a *person-centred culture*, a sense of belonging and acceptance within the community are prioritised over individual (economic) achievements.
- Concept and use of time: Latinos place emphasis on living and enjoying the present rather than thinking about the future.

Another aspect to consider is the community perception of 'mental illness' among Latinos as it informs discourses on help-seeking behaviour. Much has been written about the predominance of magical and religious explanations for this. Comas-Díaz (2006) gives a throrough account of the diverse healing *knowledges* common among the vast array of people making up the 'Latino culture'. She analyses Latino ethnic psychology, characterised by three elements (i.e., contextualism, interconnectedness and magical realism) which inform their healing practices. In doing so, she focuses on the interplay between spirituality, myths and language in providing an explanation of distress and unusual behaviour. Further to that, research on Latino folk healing depicts the use of herbalists and healers (Zacharias, 2006) and witchcraft (Applewhite, 1995), as common among Latinos.

There is contradictory evidence on the stigma of mental illness among Latinos. Some studies (e.g., Alvidrez, 1999) point at a higher prevalence of negative views on mental illness and a tendency not to disclose it among low-income Latinos. However, Peluso and Blay (2004) found no significant differences in perceptions of mental illness between Latinos and other developed countries. Furthermore, they identified a tendency to share Western medical model values (e.g., physicians and psychologists were recommended and psychological therapy is esteemed, whereas spiritual and religious help is seldom recommended) and few signs of the presence of elements originating from traditional medicine or the magical-religious aspects. Higher levels of education and SES were associated with positive attitudes to 'mental illness'. Interestingly, problems such as depression or alcoholism were not regarded as mental illness.

Lastly, research has shown disproportionate levels of 'psychopathology' among Latino migrants in the US. This has been ascribed to the levels of deprivation in which a large proportion of this population lives (Organista, 2006). The literature describes the 'Latino psychopathology', including both 'universal categories' as

well as specific idioms of distress, such as *ataque de nervios* (nervous attack) or *susto* (scare) (López & Guarnaccia, 2000). Whilst there are concerns about the use of these 'culture-bound syndromes' (above), they tend to describe difficulties this population experiences, using names familiar to them*.*

2.1.2. Latino culture and psychotherapy research

The characteristics above should inform the way in which therapeutic work with Latinos could be carried out as they influence a person's acceptability of a self-management approach: the way they relate to the professionals as people in authority; limitations of change according to culturally sanctioned roles (e.g. gender roles); and their values and appropriate goals to move towards (e.g., assertiveness and family). Equally, the importance of others around the person (and their opinions about them) and Latinos' general present-oriented mind frame may influence the way they think about goals for intervention.

These characteristics, according to Ardila-Espinel (1982), have implications for transcultural psychotherapy. He asserts that when North Americans seek psychological help, they expect to receive information to take their own decisions and clarify behaviour criteria. Conversely, Latinos seek emotional support about already made decisions or behaviours they do not wish to change. The psychologist, therefore, is a source of information for North Americans, but a 'new friend' and source of emotional support for Latinos.

Further Latino values have been identified which should be considered when working therapeutically (Organista & Muñoz, 1996; Torres-Rivera, 2004; Interian & Díaz-Martínez, 2007). Aguilera, Garza and Muñoz (2010) suggest modifications to overcome potential clashes between these and some CBT techniques:

- *Familismo* (familism): strong attachment to and loyalty for one's family, which takes priority over own wellbeing. Therapeutic work needs to respect the importance of one's family (e.g., by scheduling pleasurable activities including them or reframing 'self-care as necessary to care for one's family').
- *Spirituality/religious beliefs*: the presence of religious beliefs and practice is stronger than in Western societies (with Catholicism being the

predominant religion). Religious views need to be included in formulation, as they are deeply entrenched in the Latino culture (e.g., coping strategies, norms and illness models).

- *Fatalismo,* or belief that problems cannot be changed, is a barrier to CBT's problem-solving approach. A clear rationale for behavioural and cognitive techniques is necessary to overcome this obstacle, which, as a strong historico-cultural discourse, will be, however, difficult to surpass.

- *Formalismo* (tendency to use a certain degree of formality) and *respeto* (showing respect for people who are older or in authority) are two values that rule interpersonal interactions among Latinos, which are relevant in terms of engaging the client. The expectation of *simpatía* ("kindness") emphasizes the importance of being polite and pleasant, and supposes a challenge to confrontation in therapy (e.g., limit-setting or cognitive restructuring) which will need to be done subtly.

- An expectation of *desahogo* (relief) makes it necessary to tone down CBT's directive and psychoeducational nature to enable clients to 'get things off their chests'.

- A vast popular wisdom in *refranes* (sayings) should be used as a means of validating CBT techniques, as many are supported by sayings commonly quoted among Latinos. This requires a considerable knowledge of the culture.

- Cognitive techniques present a challenge when working with people with multiple psychosocial stressors and limited educational attainment. Ensuring understanding, validating the client's viewpoint and a tentative approach to change are paramount for a successful outcome.

Due to the deferential attitude common among Latinos, it has been suggested that a *collaborative* approach may need to be replaced by a more directive one, where therapist and client occupy clearly defined roles (Interian & Díaz-Martínez, 2007).

Organista (2006) points out that little CBT outcome research has been conducted including Latino participants in the US. Miranda et al. (2005) summarise several studies with Latinos which have applied the modifications above, yielding positive outcomes. An RCT comparing interpersonal psychotherapy (IPT) and CBT with

Latino adolescents with 'depression' found superiority of the former modality, which might be especially congruent with Latino cultural values (Roselló & Bernal, 1999). Miranda, Azocar, Organista, Dwyer and Areane (2003) compared a CBT group intervention alone and the same therapy supplemented by clinical case management (i.e., support by social worker with housing, employment and recreation difficulties) with impoverished 'patients' in primary care. They found that the enhanced intervention led to a further reduction of depressive symptoms and higher treatment completion rates among Latinos, highlighting the importance of further material support in the engagement in therapy. However, despite this apparent success in culturally adapting mainstream psychotherapy, the individualistic values underlying Western forms of healing do not necessarily translate into healing for collectivistic Latinos (Comas-Díaz, 2006).

Furthermore, whilst a number of studies focus on the effectiveness of CBT with Latinos using quantitative data, no qualitative studies have been conducted on the clients' experience of receiving it. These could inform us of what are the elements that contribute to the effect of these interventions. A review of qualitative work on views on mental health among Latinos in the US (Martínez-Pincay & Guarnaccia, 2007) focused on their views of mental health, specifically on depression, and attitudes towards seeking professional help (preferring talking therapies over medication). However, it did not include reflections on specific therapeutic approaches. Furthermore, Organista (2006) asserts that there is no evidence of superiority of some forms of therapy over others when working with Latinos.

2.2. Latinos in the UK

2.2.1. Evolution of Latino migration to the UK

The migratory landscape between Latino countries and the UK has varied significantly throughout the years. Despite evidence of previous migratory movement, the first significant wave of migration followed the establishment of military dictatorships in Chile and Argentina in the 1960s and 1970s (McIlwaine, 2007). This first wave of political dissidents of the 'elite' of these countries, especially Chile (Bermúdez-Torres, 2003) was followed by people displaced by

conflict, mainly due to the Colombian guerrilla warfare (Carlisle, 2006) in the 1980s. More recently, many migrants have escaped economic crises in countries like Ecuador (1990s) or Argentina and Brazil (after 2000), seeking better opportunities and arriving in the UK as a result of the work permit system, to occupy low paid unskilled jobs. The introduction of the visa system in 1997, limitation in asylum claiming, and further tightening of entry requirements have reduced the volume of asylum applications, although many Latinos are choosing to enter the UK illegally (McIlwaine, 2007). Although the US and Spain have traditionally been the first choice for Latino migrants, changes in American immigration policies following the 9/11 terrorist attacks have diverted Latino migration towards Europe (Carlisle, 2006), where, more recently, the current crisis hitting most countries, especially Spain, has forced higher volumes of people to move to the UK. Finally, the latest changes in immigration policy (i.e., highly skilled migrant scheme) have led to an increase of Latinos coming to the UK to undertake further education (McIlwaine, 2007).

2.2.2. Numbers of Latinos in London

A major obstacle in ascertaining the number of Latinos in the UK is their 'invisibility', as they are not a separate category in ethnic group classifications (Linneker & McIllwaine, 2011). This, together with the high proportion of undocumented Latinos, generates statistics about the size of this population which range widely (Carlisle, 2006). The Foreign and Commonwealth Office (2007) estimates that between 700,000 to 1,000,000 Latinos are visiting or living in the UK at any one time.

McIlwaine, Cock and Linneker (2011) summarise the most comprehensive account (in 2008) of the Latino community in London since the 2001 census, estimating its size as 113,500 (including irregular and second generation immigrants). The largest national groups by country of birth are Brazilians, followed by Colombians and Ecuadorians. Compared to the 2001 Census estimate (Linneker & McIllwaine, 2011), the growth in the Latino population of London has more than tripled over the period to 2008, making it one of the fastest growing migrant groups in the capital. This makes the community a significant part of the city's population, comparable in size to other large migrant and ethnic groups (e.g. Polish and Chinese) and approximately two-thirds the estimated size

of the Bangladeshi and Pakistani ethnic groups (GLA, 2008). A current estimate for the UK Latino population of 186,500 suggests that 61 per cent of the UK Latino population resides in London.

It has been argued that official census figures for Britain have tended to underestimate the number of Spanish-speaking Latinos in London (Block, 2008). Unofficial estimates suggest higher numbers than those presented above, which are corroborated by embassy officials and representatives from migrant organisations (McIlwaine, 2007).

2.2.3. The life of Latinos in London

A sort of vicious circle has been established whereby not being officially monitored (Carlisle, 2006) and the lack of research carried out with the Spanish-speaking Latino population in London (Block, 2008) contribute to keeping them marginalised from public services and mainstream society. In turn, this marginalisation makes it more unlikely that Latinos in London strive to reach positions of influence in society, perpetuating their experiences of deprivation and exclusion.

McIlwaine (2007) identified a poor command of the English language and their illegal status, as the two most commonly cited problems among Latino migrants in London:
- Despite their motivation to learn the language, a number of factors (e.g., costly or low-quality classes, need to work long and fragmented hours and childcare) impede their progress to a fluent level. Socialising with other Latinos was a further obstacle to improving their English. A poor command of the language affects their access to services which do not offer interpreting facilities (McIlwaine, Cock, & Linneker, 2011).
- Their immigration status dominates the lives of many Latinos, curtailing their opportunities for employment and recreation, making it easier to be exploited at work, especially if undocumented. As a result, many people live in a constant state of fear and dependent on rumour (McIlwaine, 2007).

Discrimination was a direct consequence of the difficulties described above. Paradoxically, people reported being discriminated against often by their compatriots, whilst English people treated them well. Almost 40 per cent of

working Latinos experience workplace abuse, including having payments withheld (22 per cent of those working) and verbal abuse (14 per cent). Household incomes substantially below the UK average make them cope with economic vulnerability in a range of ways, including borrowing and saving, and render them more vulnerable to the global financial crisis (McIlwaine, Cock & Linneker, 2011).

Living conditions are a further difficulty many Latinos in London face. Limited access to social housing (16 per cent) due to ineligibility because of their immigration status forces nearly two-thirds to live in private rented accommodation, much of which is low quality or inadequate (45 per cent) (McIlwaine, Cock & Linneker, 2011).

Among women, the threat of deportation, physical abuse and lack of childcare support or benefits combine to create almost insurmountable obstacles to meeting their practical needs and, hence, their strategic interests. Both their immigrant status and their gender make women the target of discrimination (Carlisle, 2006).

Despite these problems, a considerable number of Latinos still migrate to the UK in the knowledge of the opportunities available, in terms of freedom and protection, education and healthcare, which they do not have in their countries of origin. This makes them endure incredibly precarious situations (McIlwaine, 2007).

2.2.4. Limitations of previous research

A considerable volume of research on the use of CBT with Latinos, mostly in the US, suggests that this approach is beneficial to this population. However, no such research has been conducted in the UK, where there is only limited evidence that the BME population find this approach beneficial (Clark *et al.*, 2009) and incipient research into adaptations of the CBT model to suit other ethnic minorities (Naeem, Ayub, Gobbi & Kingdon, 2009). Whilst there are commonalities between Latino migrants in the US and the UK (e.g. low SES, acculturative stress, migration experience, marginalisation), differences also exist which may make these findings non-generalisable. Some of these are: the Latino population size (13 per cent of the American population, but only 0.4 per cent of the British

population); countries of origin (72 per cent of Latinos in the US are from North and Central American countries, whereas the bulk of the Latino population in the UK come from the South American subcontinent); the establishment of the Latino communities in both countries, widely spread throughout the US (where up to 50 per cent of the general population speaks Spanish), but considerably less so in the UK (Organista, 2006). This has had an effect on the provision of statutory services specific to, or adapted to, the needs of this community in the US, but a far less extended initiative in the UK, where most support is provided by voluntary organisations. Other political aspects that should be borne in mind are the existence of a National Health Service in the UK but not in the US, or differences in immigration systems in both countries.

Two further aspects to emphasise are, firstly, that the body of research on CBT and Latinos in the US seems to consider this population as a homogeneous collective, which has led to adaptations based on stereotypical conceptualisations of Latinos. Secondly, there is also a lack of research comparing standard and culturally-adapted CBT interventions with the same group.

2.2.5. Migration

A characteristic that all Latinos in the US and the UK share is migration. Individual experiences vary depending on the circumstances leading to leaving one's country (e.g. political persecution, war, economic hardship). However, the process of international migration usually involves not only leaving social networks behind, but also experiencing at first a sense of loss, dislocation, alienation and isolation, which will lead to a process of acculturation (Bhugra, 2004). Concepts such as *culture shock*, *conflict* and *bereavement* have been used to name reactions to this usually difficult transition (Bhugra, Wojcik & Gupta, 2011).

This acculturative stress, reinforced also by other circumstances (e.g., lack of social support, poverty, poor housing, marginalisation and victimisation) has been conceptualised as 'anxiety' and 'depression' in Latino immigrants (Revollo, Qureshi, Collazos, Valero & Casas, 2011). Different terms have been given to what seems to be a normal reaction to an experience of hardship and helplessness (Pilgrim & Bentall, 1999). In Spain, Achotegui (2008) coined the

term *Ulysses' syndrome* to refer to the 'chronic and multiple stress' commonly experienced by Latino and North-African migrants.

It is important, however, to consider that the beliefs migrants carry with them influence their idioms of distress, how they express 'symptoms' and their help-seeking behaviour (Bhugra, 2004). Inappropriate diagnoses of post-traumatic stress, psychotic and mood disorders have been made in people of non-Western backgrounds when clinicians ignore cultural differences in the expression of grief. The misdiagnosis and subsequent inappropriate treatment will at best not address the issue for the affected person and, at worst, cause harm (Bhugra & Becker, 2005). Help can only be provided to migrant communities by taking into account the culturally sanctioned ways in which they express distress.

3. Anxiety deconstructed

Anxiety is commonly described as the body's adaptive cognitive, behavioural and physiological response to a threatening situation (e.g., Kennerley, 1997). A range of anxiety 'disorders' have been included in psychiatric diagnostic classifications describing different ways in which this response becomes maladaptive generating distress to the individual. These 'disorders' are usually referred to as 'common mental health problems' due to their relatively high prevalence (Krueger, 1999). However, a large volume of literature has been produced questioning the use of psychiatric labels (Pilgrim, 2000), and highlighting their stigmatising effect, especially when working with ethnic minorities (Corrigan, 2007).

Whilst some aspects of emotion are considered human universals, there are several sources of cultural variation in emotion practices. As a result, the expression of anxiety may be mediated by beliefs, values and social practices that support and allow what is moral, imperative and desirable (Varela & Hensley-Maloney, 2009).

As shown above, anxiety amongst migrants occurs in the context of socioeconomic deprivation and inability to exert change in one's situation. Hagan and Smail (1997) formulate how distance to power sources is usually the basis of psychological distress. As a merely descriptive tool, diagnosis decontextualises the individual's distress, failing to account for environmental circumstances

usually generating or maintaining it. Following this argument, it has been contested that, rather than individual interventions, a Community Development (CD) approach should be adopted with disadvantaged people. CD focuses on improving well-being by addressing economic, social and environmental factors, with a commitment to equality and empowerment (Thomas, Bracken & Yasmeen, 2007).

High comorbidity rates between 'anxiety' and 'depression' (Löwe, Spitzer, Williams, Mussell, Schellberg & Kroenke, 2008b) cast doubts about the validity of these categories (Pilgrim & Bentall, 1999). Furthermore, the rigidity imposed by the numerous 'anxiety disorders' has led to the development of a *transdiagnostic* approach within CBT. This approach focuses on the commonalities across the different 'anxiety disorders', i.e., overestimation of threat, heightened physiological arousal, and behavioural avoidance (McManus, Shafran, & Cooper, 2010). There is evidence of the effectiveness of transdiagnostic group interventions on anxiety (Norton, 2008).

Despite this critique, mainstream psychological interventions tend to be diagnostic-specific. There is, therefore, a need to prove whether this is a useful approach to the psychological distress experienced by migrants from different cultural backgrounds.

4. Summary

In recent years cultural factors have been increasingly recognised in mental health research and practice, leading to their inclusion in diagnostic classifications and therapeutic models (Marsella & Yamada, 2007). However, this has been challenged. Arguments have been raised for and against adapting western psychological interventions to make them suitable to people from different cultural backgrounds. Research carried out mainly in the US describes the adaptation of *evidence-based* practices (mainly CBT) to the Latino community, 13 per cent of its population (Organista, 2006).

In the UK, the evidence-based movement has materialised in IAPT, a governmental initiative aimed at delivering evidence-based interventions, especially CBT, in primary care to people experiencing 'common mental health problems' such as anxiety and depression (Clark, Layard, Smithies, Richards,

Suckling, & Wright, 2009). Adopting a stepped care approach, CBT interventions are delivered at *low* and *high intensity*. However, no research has been conducted on the effectiveness of these approaches with people from the different ethnic minorities that make up British society (Rathod & Kingdon, 2009). Such research would enable us to ascertain whether this therapeutic framework is understandable and what modifications are necessary for a better fit.

Despite their similarities, demographic, political and socioeconomic differences between the Latino populations in the US and the UK may limit the generalisability of the research findings obtained in the US.

5. This study

5.1. Justification for this research

It seems important to evaluate whether mainstream psychological interventions offered within the NHS are effective and meaningful to people who may not share the same western values. This research could inform decisions as to the adaptation of the interventions on offer or the delivery of alternative approaches. The absence of previous research in the UK warrants conducting a pilot study which may guide further research in this area.

5.2. Research questions

Because of the limitations of previous research, this study aims to ascertain whether a standard (i.e., non-culturally adapted) 'low intensity' (LI) CBT intervention in group format delivered in Spanish to first generation Latino migrants:
- is effective (i.e., reduces the level of anxiety experienced by the participants, as measured by standardised self-report measures).
- is meaningful to the participants (i.e., fits with their previous understanding), as well as what elements make it beneficial, by means of a focus group discussion at the end of the intervention and individual questions to the participants after each session, respectively.

These two questions warrant adopting a *mixed methods* approach, using both quantitative and qualitative data (Creswell & Plano Clark, 2007, p. 20). Further detail as to how this was implemented follows in the *Method* chapter. The reader

is also referred to page *82*, where the topic of *effective* versus *meaningful* is dealt with.

METHODOLOGY

This section begins by explaining the author's epistemological stance, rationale for and strategy followed in implementing a mixed-methods approach. It continues with a description of the research design and the processes involved in the recruitment of participants, the preparation of material and the delivery of the intervention, data collection and analysis. The chapter concludes giving consideration to the ethical aspects of the research, quality of the instruments used and the rationale for data analysis (both statistical tests and thematic analysis).

6. Epistemological approach and Mixed-methods

6.1. Epistemological stance

Critical realism is an epistemological standpoint that lies between positivism/realism and constructionism (Pilgrim & Bentall, 1999). It acknowledges the contributions of differing perspectives but at the same time recognises these provide only a partial explanation of the object of study, constrained by their individual context and methods (Middleton, 2007). It states that, rather than reality, it is our theories of reality and the methodological priorities we deploy to investigate it that are socially constructed (Pilgrim & Bentall, 1999).

Several reasons make Critical Realism a suitable epistemological standpoint from which to address the present research topic. Firstly, it provides a coherent framework for evaluation research that is based on the understanding of causal mechanisms (McEvoy & Richards, 2003). Secondly, it allows us to acknowledge the material-discursive-intrapsychic concomitants of experiences constructed as distress (e.g., 'anxiety' or 'depression'), without privileging one level of analysis above the other (Ussher, 2010) and conceptualizing them as mediated by culture, language and politics (Bhaskar, 1989). Thirdly, this approach is well suited to frontline services seeking to use evidence-based interventions as it allows a deep understanding of routine clinical practice and adds depth to policy analysis (McEvoy & Richards, 2003), It is, lastly, well suited to research on CBT effectiveness (Harper, 2012).

6.2. Rationale for a mixed-methods approach

Acknowledging an indirect relationship between data and reality, a Critical Realist approach highlights the need for further enquiries, drawing on other types of evidence (Harper, 2012). This makes it fit neatly with a pragmatic standpoint, focused on the consequences of research and the question asked rather than the methods used. This is a pluralistic *worldview*, oriented towards "what works" and practice (Creswell & Plano Clark, 2007, p. 23).

Rather than abiding by previous concerns about untenable combinations of research methods (e.g., Guba & Lincoln, 1988), Pragmatism emphasises that all human inquiry involves imagination and interpretation, intentions and values, but must also be grounded on empirical, embodied experience (Yardley & Bishop, 2008). This stance embraces the use of both qualitative and quantitative data in an attempt to answer questions like the ones in the present study. A mixed-method approach capitalises on the strengths of quantitative and qualitative methods to offset the weaknesses associated with both. Whereas quantitative data produce information generalisable at the cost of the nuances and context of experiences, qualitative research is sensitive to the latter, sacrificing its generalisability (Creswell & Plano Clark, 2007).

Most the research undertaken on the effectiveness of interventions is quantitative, based on the use of standardised questionnaires. Therefore, to compare the results of this study with previous work, it seems appropriate to adopt a similar approach. Additionally, to ascertain how participants make sense of the content facilitated and what elements contribute to the overall effect of the intervention, qualitative evidence should be sought. Therefore, a mixed-methods study seems the most suitable approach as it comprehensively addresses both aims of this study (Creswell & Plano Clark, 2007, p. 33).

6.3. Strategy for implementing a mixed-methods approach

When using mixed-methods, different aspects of the use of both datasets need to be considered. These are timing, weighting and mixing of the information gathered in order to answer the questions posed in a meaningful manner.

Creswell and Plano Clark (2007) categorise mixed-methods designs into different variants according to these considerations.

Following such categorisation, the present study can be conceptualised as a *Triangulation Design.* This describes a one-phase mixed-methods design in which quantitative and qualitative methods are implemented during the same timeframe and with equal weight. Of the four variants of Triangulation Creswell and Plano Clark (2007) suggest, the present study could be categorised as *Convergence* model. This is the traditional model of a mixed-methods triangulation design, in which quantitative and qualitative data are collected and analysed separately and then converged during the interpretation (i.e., compared and contrasted). This model provides a well-substantiated conclusion about the phenomenon under study.

The strengths of the Triangulation design are its intuitive nature and the efficiency of collecting both datasets concurrently and analysing them separately. However, giving equal weight to both types of data at the interpretation stage can be challenging, especially when the results do not coincide. It is important to consider the different sample sizes of both datasets (Creswell and Plano Clark, 2007).

7. Research Design

This pilot study consists of two different elements, a quantitative and a qualitative one, aimed at answering the questions posed about the effectiveness and meaning of the intervention respectively.

The quantitative part aims to draw intrasubject comparisons between the scores obtained during three different stages of their participation:
- *Waitlist/control phase:* participants were recruited leaving a period of up to 4 weeks prior to the beginning of the intervention. During this phase, they were asked to complete several questionnaires (*page 33*) on a weekly basis.
- *Intervention phase:* the intervention took place over a four-week period during which participants re-completed the questionnaires prior to attending their weekly session.

- *Follow-up phase:* participants completed the same questionnaires six weeks after the end of the intervention.

This design enabled every participant to be their own control.

The qualitative part consisted of two focus groups. The participants were invited to attend in order to discuss their views about the workshop. This part also included analysis of the most important elements of the intervention, as highlighted by the participants at the end of each session.

8. Intervention

The author aimed to compile a programme covering transdiagnostic aspects of the constructs of *anxiety* and *worry* (i.e., physiological arousal, behavioural avoidance, cognitive biases)*,* without focusing on specific diagnostic categories. The intervention was facilitated in Spanish to cater for those people who felt their level of English was an obstacle to participating in a conversation on the topic.

Following similar programmes offered by several IAPT services, it was originally decided to devise a schedule of six one-hour sessions. However, in order to maximise attendance at all the sessions, it was subsequently reduced to four 90-minute sessions. Thus, every session was conceived as independent from the rest in order to be understandable despite failure to attend a previous session. The programme was intended to reflect the CBT conceptualisation of anxiety (e.g., Kennerley, 1997) and help participants familiarise themselves with and practise techniques and principles that this model suggests as effective. The focus of the sessions was:

1st session (introduction and CBT model) → definitions of anxiety and worry, physiology of the anxiety response and explanation of the CBT model

2nd session (physiology) → arousal reduction techniques : relaxation techniques (diaphragmatic breathing, visualisation and progressive muscle relaxation).

3rd session (behaviour) → graded exposure and behavioural activation, sleep hygiene and community services offering relevant activities/support.

4th session (cognition) → worry management and thought challenging.

In addition, every session ended with a suggested *homework task* aimed at putting the principles discussed into practice. These were:

1st session: identifying behavioural, cognitive and emotional aspects of a case example of panic attack.

2nd session: practising a relaxation technique using the CD given.

3rd session: identifying an area of avoidance the participant wants to work on and building an exposure hierarchy.

4th session: completing a 'thought record' focusing on cognitive biases as shown during the session.

8.1. Material

8.1.1. Development of the material

The intervention comprised audiovisual and printed material. This was based on self-help booklets accessible online (e.g., Northumberland Tyne & Wear Mental Health Foundation Trust, n.d.), in printed format (Dugas & Robichaud, 2007; Williams, 2003) and material gathered from four IAPT services offering group interventions on anxiety and stress management, which kindly shared their programmes for the purpose of this study. This material was translated into Spanish and formatted as a Microsoft Powerpoint presentation. Further material in Spanish (e.g., on relaxation script and principles of exposure) was accessed online from different sites and used as handouts for the participants. Additionally, a 20-minute relaxation CD was recorded with a Spanish script of progressive muscle relaxation read with New Age music and beach sounds as background. Copies of this recording were given to the participants after the session. Further audiovisual material was used as part of the sessions (e.g., online video on attentional biases).

8.1.2. Validity of the material

Once the material for the intervention had been developed, an outline in English (*appendix 2*) was sent to four qualified LI CBT therapists. Their views were requested about the length and structure of the programme, whether it reflected a 'guided self-help' approach and to highlight any lacking or irrelevant aspects. Feedback was received from three of the people approached, which confirmed the validity of the material as a LI intervention and suggested modifications in length and focus, which were made accordingly.

8.2. Facilitation

The intervention was facilitated by the author, a former LI CBT Therapist (Postgraduate Certificate in Primary Care Mental Health) with previous experience facilitating individual and group support at this level.

To cater for those interested in participating, two slots were arranged on two different days and times (i.e., a weekday afternoon and a weekend morning). Participants' availability and limited access to a suitable room were considered when deciding these. Participants were assigned to the groups, which did not exceed ten people each. Both groups were facilitated by the author in order to provide a homogenous intervention.

The sessions took place in the premises of a well-established collaborating organisation catering for Latinos and based in an area of South London with a large Latino population.

The sessions aimed to strike a balance between theory and practice, encouraging group and pair discussion and practical exercises. Participants followed the discussion helped by the overhead presentation, of which they were given handouts (*appendix 3*).

Using Spanish as vehicular language, participants' difficulty to complete the suggested inter-session tasks and other adjustments made (e.g., using Spanish/Latino sayings) made it difficult to ensure that the workshop was a legitimate LI intervention. Following the programme, which had been structured following other LI group interventions and self-help material and evaluated by a number of qualified LI therapists (as discussed in page 28) was the best way to ensure the LI nature of this intervention.

9. Participants

9.1. Recruitment

It was felt that recruiting participants from statutory services would incur a bias as people accessing these services are likely to be more able to communicate in English and might have spent more time in the UK than those using community-specific organisations. Therefore, participants in this study were recruited from the voluntary sector.

Recruitment took place over a six-week period in May-June 2011. A range of London-based organisations catering for Latinos and for migrants in general were contacted and sent information about the project in order to consider whether they could help to recruit participants. The Latino-specific charities contacted included those providing generic support (e.g. legal, housing and employment advice) and more specific ones (e.g. health awareness, spiritual/religious care or women-specific organisations). Some organisations agreed to support the project by promoting it among their service users with posters (*appendix 4*) and discussing it with people interested.

Other organisations agreed for the researcher himself to promote the intervention among the attendees at their activities and courses. The researcher attended some activities provided at one of the organisations on different days and times (e.g., English classes, groups for mothers and children) to maximise the range and number of possible participants.

Participants constituted a convenience sample formed by people who responded to the promotion of the intervention. This was by contacting the researcher on the phone or in person at the organisation or leaving their contact details with the collaborating agencies' staff. Efforts were made to recruit a diverse group of people (in terms of age and gender). Those interested were contacted and invited to attend an initial meeting with the researcher (see *consent* section for details of this meeting).

In excess of 20 people were initially approached to arrange two groups of up to 10 participants each as an attempt to minimise an excessive dropout that endangered the validity of the pre-post comparisons.

9.2. Inclusion/exclusion criteria

Participants were:

- first generation adult (18 years and above) Latino migrants currently residing in London who had lived in Latin America a minimum of 10 years; and
- Currently experiencing or with past experience of high levels of anxiety, and/or were interested in learning techniques to manage it; and

- Interested in participating in a group programme and able to attend all sessions.

People were not included if:

- they expressed self-harm ideation, in which case they were signposted to more suitable services; or,
- they were unwilling to participate in a group intervention and were seeking individual support; or,
- currently receiving therapy.

10. Ethical approval

Ethical approval was obtained from the University of East London School of Psychology (see *appendix* 5). No further approval was deemed necessary (e.g. NHS Ethics Committee) as no participants were recruited via the NHS.

11. Ethical issues

11.1. Consent

An individual session was arranged with people interested in participating. During this session details of the intervention, intended benefits for the Latino community (i.e., improving the care offered to them) and expected impact on individual participants were discussed. The concerns of those interested were discussed as well as the expectation of their active involvement in the intervention (e.g. inter-session tasks).

Researcher and potential participants reviewed the *Participant Information Sheet* (*appendix 6*), and discussed participants' concerns. Those willing to take part were asked to sign the *Informed Consent Form* (*appendix 7*). The forms comprised information about both parts of the study (i.e., questionnaire completion and attendance at focus group), following the National Research Ethics Service's (2009) recommendations. It was emphasised, however, that participants could withdraw at any time without giving reasons to do so and this would not affect the attention they received from their referring organisations.

11.2. Confidentiality

Participants were assured anonymity. A unique code was assigned to each participant, which was used throughout their involvement in the study. All identifying information was kept in paper format during data collection and separate from the rest of the data gathered. Participants' names were used during the intervention and focus group sessions; however, these were replaced by the participants' codes when these sessions were transcribed. Both internal and field supervisors and examiners were provided with access to anonymised questionnaire data and interview transcripts.

Raw questionnaire data and transcripts were securely stored in a locked cabinet and on an encrypted portable USB and laptop, where they will be kept for five years, in accordance with the Data Protection Act (UK Parliament, 1998). Participants were informed that audio-recordings of the sessions would be kept until the thesis is successfully completed.

11.3. Procedure for managing distress and psychological aftercare

The likelihood that participation in this study would directly cause distress to participants was judged by the author to be low. However, they were informed they could withdraw at any time.

Participants were also reminded at the beginning of each session that they alone would decide what they wanted to share with the group. Whilst relevant self-disclosure was welcome, it was emphasised that this was not a requirement.

Should any participant have experienced any emotional distress during the intervention or the focus group, this was to be managed by the researcher or they had the option of a referral to local Primary Care Clinical Psychology Service or other relevant services. This measure did not prove necessary.

12. Clinical supervision

Whilst facilitating the intervention, the author received regular supervision from his field research supervisor. This consisted of five weekly sessions where a range of clinical and research-related topics were discussed. Namely:

- the author's concerns about managing individual participants' needs (e.g., unwittingly reinforcing participants' dependency);

- group processes and boundaries as a LI therapist;

- attrition management and contact with people dropping out, and

- aspects to explore during qualitative enquiry.

This support proved invaluable during the facilitation of the groups and in thinking about the management of the research project. It also added validity to the intervention by ensuring that it was kept within the limits of Low Intensity interventions despite the modifications introduced (i.e., being facilitated in Spanish).

13. Quantitative data collection and analysis

13.1. Selection of questionnaires and standardised measures

Questionnaire selection was guided by a series of considerations. Firstly, in order to provide data comparable to previous literature on the effectiveness of CBT interventions, some of the questionnaires routinely used within the IAPT framework were used (e.g., PHQ-9 and GAD-7). Additionally, more comprehensive instruments were used, such as CORE-OM. Secondly, to overcome the language barrier, only instruments validated in Spanish were used. Thirdly, instruments covering issues relevant to the question to be answered were included (e.g., acculturation scale). Finally, efforts were made to keep the numbers and length of questionnaires to be completed to a minimum in order not to interfere with the therapeutic nature of the intervention.

13.1.1. Patient Health Questionnaire 9 (PHQ-9)

The PHQ-9 (*appendix* 8) is a short, self-administered 'depression' module of the Primary Care Evaluation of Mental Disorders, PRIME-MD (Spitzer, Kroenke & Williams, 1999). Its nine items reflect the diagnostic criteria for major depressive disorder in the Diagnostic and Statistical Manual Fourth Edition (DSM-IV). Its score ranges from zero (no depression) to 27 (severe depression). Its developers claim that this instrument allows the clinician to assess symptoms in order to make a tentative 'depression' diagnosis and derive a severity score to help select and monitor treatment. They considered it a reliable (internal consistency α=.89) and valid measure of 'depression', with good sensitivity (84 per cent) and specificity (72 per cent) (Kroenke, Spitzer & Williams, 2001).

However, Williams et al. (2009) highlight concerns about its psychometric properties, mainly due to its double-barrelled items and non-exhaustive rating scale categories. Two further criticisms of this scale are, firstly, as reported by Healy (1990), the excessive weight it gives to physical symptoms, which renders it vulnerable to reflect changes other than variation in affect. Secondly, due to its decontextualising nature (i.e., does not consider the person's circumstances), this instrument may fail to discriminate 'depression' from adjustment to adverse life events, leading to unduly diagnosing a 'psychiatric disorder'.

Various studies confirm the validity of the Spanish version of the PHQ-9 as a measure of 'depression'. Diez-Quevedo et al. (2001) used it with Spanish general hospital inpatients, concluding that its diagnostic validity in that population is comparable to the English version in primary care. Wulsin, Somoza and Heck (2002) deemed the Spanish version of the PHQ-9 valid to measure 'depression' with primary care population in Honduras. Furthermore, Huang et al. (2006) used the Spanish version of the PHQ-9 in a study with primary care 'patients' from Latino and other ethnic backgrounds. They concluded that it measures a common concept of depression and is effective for the detection and monitoring of 'depression'.

13.1.2. Generalised Anxiety Disorder 7-item (GAD-7) Scale

The GAD-7 (*appendix* 9) is a brief, self-administered 'anxiety' scale. This instrument covers the construct of 'generalised anxiety disorder' as defined by DSM-IV, of which it has been claimed to be a valid and efficient screening tool. It shows good reliability, as well as criterion, construct and factorial validity. A cut-off point has been identified that optimizes sensitivity (89 per cent) and specificity (82 per cent) (Spitzer, Kroenke, Williams & Löwe, 2006). Its seven items yield a score range from zero ('no anxiety') to 21 ('severe anxiety'). Like the PHQ-9, its depression forerunner, the GAD-7 was conceived to offer a means to make a tentative 'anxiety' diagnosis and derive a severity score to help monitor treatment (Löwe *et al.*, 2008).

The above criticism about the PHQ-9's non-exhaustive rating categories also applies to the GAD-7. Also, its focus on a specific anxiety disorder makes it of limited value in assessing other anxiety presentations. Furthermore, using two

different scales to measure 'anxiety' and 'depression' reflects the widespread yet controversial understanding of these constructs as two independent *realities* (Pilgrim & Bentall, 1999). The high comorbidity between both constructs in Löwe's study (2008b), also manifest in this work, pose a challenge to this *dichotomic* conception.

Two papers based on the same sample were identified which have attempted to validate the Spanish version of the GAD-7. García-Campayo et al. (2010) completed a thorough cultural adaptation of the instrument to a Spanish population and subsequently assessed its psychometric properties by administering it to 212 'primary care patients'. They concluded that the scale was one-dimensional through factor analysis (explained variance= 72 per cent), and showed adequate values of sensitivity (86.8 per cent) and specificity (93.4 per cent) and satisfactory concurrent validity. Furthermore, Ruiz et al. (2011) concluded that it correlates highly with 'specific anxiety disorders' and with disability measures.

13.1.3. Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE-OM)

The CORE-OM (*appendix 10*) is a self-administered scale comprising 34 items which address domains of subjective *well-being*, *symptoms*, *functioning* and *risk*. Within the *symptoms* domain 'item clusters' address *anxiety*, *depression*, *physical problems* and *trauma*. The *functioning* domain item clusters address *general functioning*, *close relationships* and *social relationships*. Items are scored on a five-point scale from zero ('not at all') to four ('all the time'). Half the items focus on low-intensity problems (e.g. 'I feel anxious/nervous') and half focus on high-intensity problems (e.g. 'I feel panic/terror') (Barkham, Gilbert, Connell, Marshall & Twigg, 2005).

Evans et al. (2002) report that the scale has shown satisfactory psychometric properties across a range of settings, including primary care services. It shows good internal and test-retest reliability (0.75-0.95), and convergent validity with seven other instruments. Its sensitivity to 'both low intensity and high intensity ranges of distress' (Evans, Mellor-Clark, Barkham & Mothersole, 2006) makes this instrument suitable to measure primary care practice, where clients show a considerable variation in their range of distress.

The only study identified which has used the Spanish version of the CORE-OM is Botella's (2006), which reflects on the use of this instrument as a routine outcome measure within a psychotherapeutic department.

13.1.4. Short Acculturation Scale for Hispanics (SASH)

The SASH allows researchers to quickly and reliably identify Hispanics who are low or high in acculturation. The original scale included 12 items related to three factors: *Language Use*, *Media* and *Ethnic Social Relations*.

It has been used with respondents from a variety of Hispanic subgroups. The SASH shows a high reliability, with an overall coefficient alpha of .92. It has good construct validity, correlating highly with the respondents' generation (r = .65), the length of residence in the United States (r = .70), ethnic self-identification (r = .76), and the age at arrival (r = –.69) (Marín, Sabogal, VanOss Marín, Otero-Sabogal & Pérez-Stable, 1987).

The authors claim that the scale can be reduced to four items (covering 'language use') without sacrificing its predictive value, validity or reliability. This shortened version (*appendix 11*) was used to minimise the demands on the participants during first contact.

13.1.5. Demographic questionnaire

A form was compiled to collect participants' demographic data relevant to the study (*appendix 12*). This form was completed during the first meeting with the participants. It enquired about participants' age, level of education, occupation, time residing in the UK, country of origin, use of psychotropic medication and history of psychological therapy.

13.2. Use of the questionnaires by the participants

Participants were requested to complete questionnaires at different stages of their involvement in the study. During the initial conversation, when different aspects of the study were discussed and consent to taking part was given, participants completed the demographic and acculturation questionnaires. This was also the first time they completed the PHQ-9, GAD-7 and CORE-OM, on which they were supported as required (i.e., by explaining items when necessary). These scores were used as the initial baseline.

Participants were asked to complete a PHQ-9 and GAD-7 on a weekly basis between registration and first intervention session. These questionnaires were handed to the facilitator in a sealed envelope. These scores showed participants' progression during the control period.

Prior to the first session, clients completed the CORE-OM, PHQ-9 and GAD-7 forms, completing the latter two thereafter at the start of every session. The scores obtained in the first session were used as the intervention baseline. Prior to the focus group session, participants were asked to complete all three questionnaires in order to compare these scores to those obtained during the first session.

Participants were also given a stamped self-addressed envelope and a further set of three questionnaires, identified with their unique code, which they were requested to complete and post back to the facilitator six weeks after the group had been completed. Text message reminders were sent to maximise questionnaire completion. These scores were used as follow-up data.

13.3. Analysis of questionnaire data

Quantitative data gathered from the PHQ-9, GAD-7 and CORE-OM forms completed by the participants was analysed using the statistical software package SPSS/PASW v.18.

The analysis consisted of comparing participants' scores to ascertain their variation during the control and the intervention phases. *Wilcoxon Signed Rank Test* was used as the analysis involved repeated measures with a small sample and outcome measures were not assumed to be normally distributed.

In addition, and in order to avoid the common mistake of inappropriately using the asymptotic Z when working with very small samples (Mundry & Fischer, 1998), *Exact procedures* were run, as the sample was lower than 15 participants (Siegel & Castellan, 1988). *Exact* tests provide an accurate significance level when the data do not meet the assumptions of the asymptotic method (i.e., normality, large sample). Exact non-parametric methods remain valid for very small sample sizes, as well as for data that are sparse, skewed, or heavily tied (Narayanan & Watts, 1996).

Further comparisons were not drawn (e.g., between questionnaires completed sessionally or between CORE-OM's subscale scores). Whilst this could have resulted in a more comprehensive analysis of the effect of the intervention, multiple comparisons could have generated undue significant results. The low number of participants completing the programme also prevented ascertaining the influence of factors likely to mediate the outcome (e.g., acculturation level and length of residence in the UK).

Attrition was studied by comparing the demographic details of the participants withdrawing from with those completing the intervention. *Exact Kruskal Wallis* test was used to ascertain potential differences explaining their engagement.

14. Qualitative data collection and analysis

14.1. Focus groups

A focus group is a "carefully planned series of discussions designed to obtain perceptions on a defined area of interest in a permissive, non-threatening environment" (Krueger & Casey, 2009, p. 5). Several reasons led to the choice of focus groups over individual interviews: (1) it enables capitalising on group dynamics as data generated through the social interaction of the group are often deeper and richer; (2) it offers a more 'natural' environment, more similar to the intervention setting, thus enabling the participants to 'talk in a group about a group experience', and (3) it is a time-efficient alternative to individual interviews.

The uniqueness of a focus group is its ability to generate data based on the synergy of the group interaction (Willig, 2008, p. 30). Efforts were made to minimise changes to the membership of the groups, so that participants felt comfortable with each other. However, two members had to swap groups as they could not attend their originally assigned session.

The focus groups were moderated by the facilitator of the intervention. The reason for this was the difficulty in identifying an alternative Spanish-speaking facilitator with knowledge of the topic and previous experience moderating a focus group. Whilst this is likely to have introduced a bias in the discussion, it might have also enhanced the discussion about the intervention, due to the rapport already established and the facilitator's knowledge of the subject matter. To minimise the *desirability bias* inherent in this arrangement the importance of

constructive criticism was emphasised as a means of improving the intervention delivered. The scope for improvement was stressed by informing the participants that it was the first time that the group format was used with Latino migrants in London.

14.2. Running the focus group

14.2.1. Participants

Rabiee (2004) suggests that participants in a focus group should be selected because they are a purposive, although not necessarily a representative, sampling of a specific population. In this study, all participants who completed the intervention (i.e., ten people) were invited to take part in a further session 'to give their views about the programme they had completed'. Out of the nine who agreed to participate, three and four people took part in the two sessions respectively. The participants were six females and one male, of ages ranging from 23 to 76. Following Willig's (2008, p. 31) classification, the sample participating in the focus groups was *homogeneous* (on the basis of the reasons for recruitment), *pre-existing* (the groups had been established during the intervention phase) and *concerned* (having shown their commitment to the topic by attending the intervention sessions).

14.2.2. Preparation for the focus group

Participants able to attend the focus group were handed a sheet with some pointers (*appendix 13*) to reflect on a week prior to the interview. This was aimed at encouraging a critical evaluation of the different aspects identified by the author as relevant to include in the discussion.

14.2.3. Focus group agenda – a systemic approach

An interview agenda was developed in order to steer the interview towards a discussion that generated data relevant to address the research question (Willig, 2008, p. 27). This consisted of several questions to prompt discussion among the group about issues that, from the author's viewpoint, needed to be covered. These (*appendix 14*) were identified by the author in consultation with his field supervisor.

However, effort was made to avoid biasing the discussion excessively towards topics potentially irrelevant to the participants when posing them pre-defined questions. Instead, a *systemic* stance was adopted whereby participants were asked at the beginning of the session *"what would we have to talk about today for you to feel that you have discussed fully your experience of and feelings about attending the group?".* Groups' answers to this question were used as pointers for the subsequent discussion. Once these pointers had been sufficiently explored, further questioning was guided by the interview schedule developed prior to the session.

14.3. 'Most Important Event' (MIE) question

A range of therapeutic factors (Yalom, 1995) other than the information facilitated are at play in a LI Group intervention. The MIE question is aimed at ascertaining the impact of these factors as perceived by the participants. It consists of asking all participants at the end of each session to state what they think was the most important event they witnessed or experienced during that session. It was originally used by Bloch et al. (1979), and subsequent research has shown that both patients and therapists attach most importance to self-understanding, self-disclosure and learning from interpersonal actions (Bloch & Reibstein, 1980).

The wording used in this study was "*If you had to name the most important thing that has happened in this session, just one thing that you take home with you today, what would that be?".* This question was read out and visually presented with the overhead projector to the participants, who took turns to answer it.

14.4. Apparatus and resources for qualitative data collection and analysis

A digital voice recorder was used for the focus groups. Participants' consent to being recorded was requested during recruitment.

14.5. Transcription

The author transcribed the interviews verbatim, following a simple notation system adapted from Banister, Burman, Parker, Taylor and Tindall (1994). Attention was focused on the content of the interview and, therefore, non-linguistic aspects of the sessions were not transcribed. However, efforts were made to remain faithful to the recording, including incomplete sentences,

laughter, false starts and repetition of words. The transcripts were checked against the tapes for accuracy.

14.6. Analysis of interview data

Thematic analysis is a method for identifying, analysing and reporting patterns (themes) within the data. It minimally organizes and describes the data set in (rich) detail. However, it frequently goes further than this, and interprets various aspects of the research topic (Braun & Clarke, 2006).

One of the advantages of thematic analysis is its versatility, as it is not wedded to any pre-existing theoretical framework. Thus, it can be characterised by theories, such as Critical Realism, which acknowledge the ways individuals make meaning of their experience, and, in turn, the ways the broader social context impinges on those meanings, while retaining focus on the material and other limits of reality (Braun & Clarke, 2006). It is, therefore, a method that works both to reflect reality and to unpick or unravel the surface of reality.

It should be noted that no analysis took place before both focus group interviews had been facilitated and the data transcribed. Therefore, both interviews were independent of each other.

The transcriptions of the focus group interviews and the answers to the MIE questions were analysed following the stages described by Braun and Clarke (2006). Namely:

Phase 1. Familiarisation with the data: the author read the material up to three times following the transcription work in order to familiarise himself with it, starting preliminary work on coding by marking and taking notes.

Phase 2. Generating initial codes: codes were generated for the entirety of the two interviews.

Phase 3. Searching for themes: codes were collated into potential themes and sub-themes by means of visual mind-maps.

Phase 4. Reviewing themes: provisional themes were scrutinised to refine the thematic map, focusing on internal homogeneity and external heterogeneity among themes.

Phase 5. Defining and naming themes: a further review of the proposed themes was carried out to ensure they were named in a way that reflected their content.

Phase 6. Producing the report: a narrative was developed linking the identified themes and illustrating it with data extracts (see *Results* section).

Following recommendations from previous cross-language research (Temple, Edwards & Alexander, 2006), original transcriptions (in Spanish) were used in order to ensure a faithful analysis of the data. Discussion about the findings was possible in Spanish due to the fluency of both author and main supervisor.

RESULTS

This section sets out the results from both the quantitative and qualitative parts of the study. It begins by summarising the quantitative results, covering the sample's demographics, the outcome data from the different stages of the study and an analysis of the attrition observed. The qualitative section presents the results of the thematic analysis completed on the data gathered during the focus groups as well as an analysis of the participants' responses to the MIE questions posed to them at the end of each session.

15. Quantitative analysis

15.1. Sample's demographics

Approximately 40 people showed interest in participating in the study of whom 18 people became registered (the reasons for this will be covered on pg. *69*). *Table 1* summarises the demographic characteristics of the participants registered.

Table 1. Participants' demographics

Gender	Age	Country	Education	Time in UK	Participated	Completed intervention
Female	56	Colombia	High School	6 years	Yes	**Yes**
Male	39	Bolivia	University	3 years	Yes	**Yes**
Female	61	Colombia	-	21 years	Yes	**Yes**
Female	40	Peru	University	8 years	Yes	**Yes**
Female	26	Bolivia	University	3 years	No	No
Female	43	Ecuador	University	9 months	Yes	**Yes**
Female	76	Peru	University	12 years	Yes	**Yes**
Female	32	Ecuador	High School	6 years	Yes	No
Female	41	Ecuador	High School	2 months	No	No
Female	27	Colombia	University	2 years	Yes	No
Female	29	Colombia	High School	-	Yes	No
Male	51	Colombia	University	1 month	No	No
Female	51	Mexico	High School	1 month	Yes	No
Female	24	Ecuador	University	15 years	Yes	**Yes**
Female	42	Bolivia	University	1 year	Yes	No
Female	43	Colombia	University	8 years	Yes	**Yes**
Female	40	Colombia	High school	6 months	Yes	**Yes**
Male	45	Colombia	-	-	Yes	**Yes**

Out of the 18 participants originally recruited, 15 (83 per cent) participated in the first session, of whom 10 (67 per cent) people completed the intervention. Of these, 8 (44 per cent) attended a minimum of 3 sessions (75 per cent of the intervention) and completed questionnaires at registration, first session and focus group (one week after the last session). Therefore, only the outcomes of these 8 participants are reported below.

The average age of these 8 participants was 50, ranging between 39 and 76. Seven of them (88 per cent) were female. They had spent an average of 7.5 years in the UK, ranging between 6 months and 22 years. Their level of education varied between secondary education (3), bachelor's degree (2) and master's level (3). Despite a relatively high educational attainment, most participants were seeking employment or working in rather low-paid jobs (e.g., social care and catering/cleaning industry). Half of them had previous contact with psychiatric services (in the UK or abroad) and had received various types of psychological therapy (but none at the time of the study).

Table 2 shows how participants vary considerably in the scores obtained in the outcome measures they completed at the registration stage, with people covering all the range from 'no caseness' to 'severe' difficulties.

Table 2. Participants' mean scores in outcome measures at registration stage

	N	Minimum	Maximum	Mean	Std. Deviation
CORE_Reg	8	.71	2.79	1.4375	.67624
PHQ_Reg	8	3.00	26.00	9.2500	7.64853
GAD_Reg	8	3.00	21.00	8.5000	5.39841
Valid N (listwise)	8				

15.2. Outcome data

15.2.1. Progression during the control phase

A Wilcoxon Signed-ranks test was performed with PHQ-9, GAD-7 and CORE-OM scores obtained by all 8 participants during registration and at the start of the first intervention session. It showed non-significant reductions:

-   CORE-OM scores decreased by 1.3 standard deviations (Z=-1.26, p=.23);

- PHQ-9 scores showed a 1.2 standard deviations reduction (Z=-1.19, p=.31), and
- GAD-7 scores decreased by 0.4 standard deviations (Z=-.39, p=.78).

Although scores tended to decrease over the up to 4-week control phase, this variation did not reach conventional levels of statistical significance.

Graphs 1 to *3* represent the progression of average scores obtained in all three outcome measures. They show a subtle decrease during the *control phase* (e.g., between registration and prior to first session).

15.2.2. Progression during intervention phase

A Wilcoxon Signed-ranks test comparing scores obtained at the beginning and end of the intervention showed a somewhat larger variation than during control phase:

- CORE-OM scores decreased by nearly 2 standard deviations (Z=-1.99, p=.06);
- PHQ-9 scores decreased by 1.5 standard deviations (Z=-1.53, p=.17), and
- GAD-7 scores showed a reduction of 2 standard deviations (Z=-3.03, p=.06).

Whilst all three instruments failed to reach conventional levels of statistical significance, CORE-OM and GAD-7 were close to the significance threshold. *Graphs 1* to *3* show a more noticeable drop in scores of all three measures between first session and focus group (one week after the fourth session) than between registration and first session.

Graph 1. CORE-OM scores
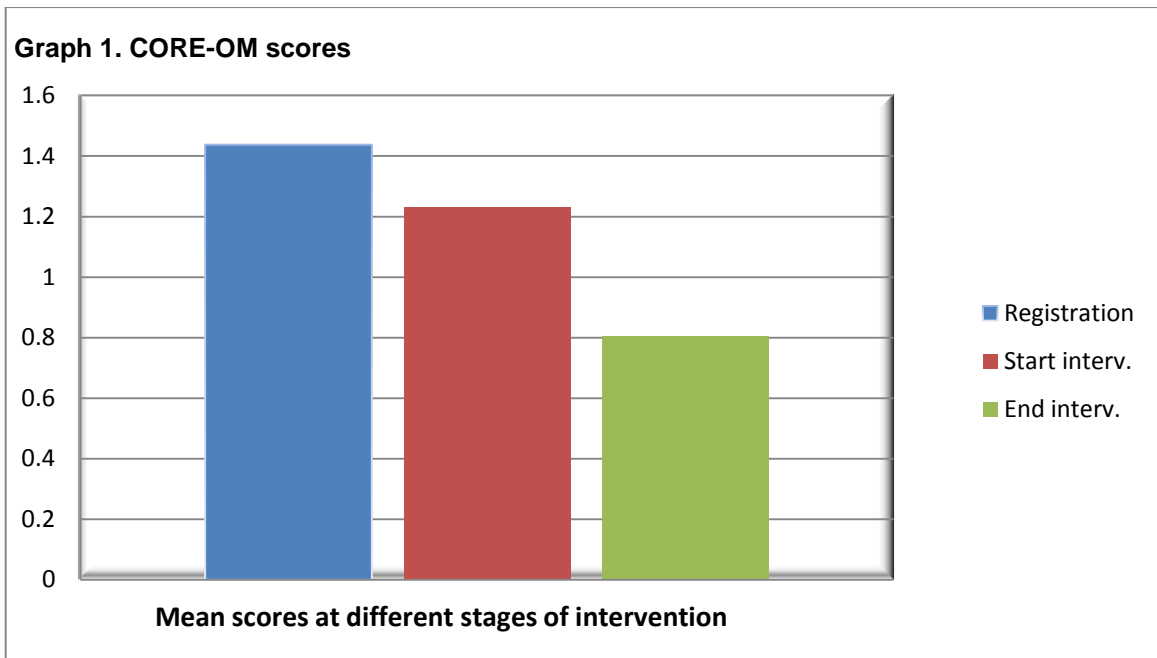
CORE-OM scores decreased from *clinical population* range (i.e., *M*(1.86), *SD* (0.75)) to *non-clinical* range (*M*(0.76), *SD*(0.59)) (CORE IMS, 2010).

Graph 2. PHQ-9 scores
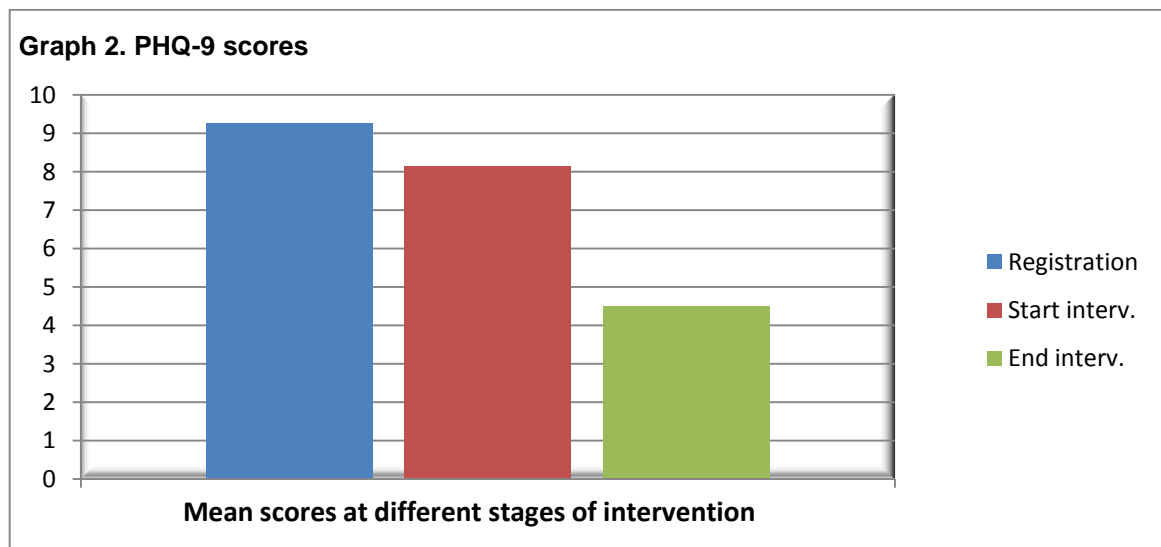
Mean PHQ-9 scores moved from 9.2 (higher end of *mild depression* range) to 4.5 (lower end of the same range).

Graph 3. GAD-7 scores

Mean scores at different stages of intervention

Legend: Registration, Start interv., End interv.
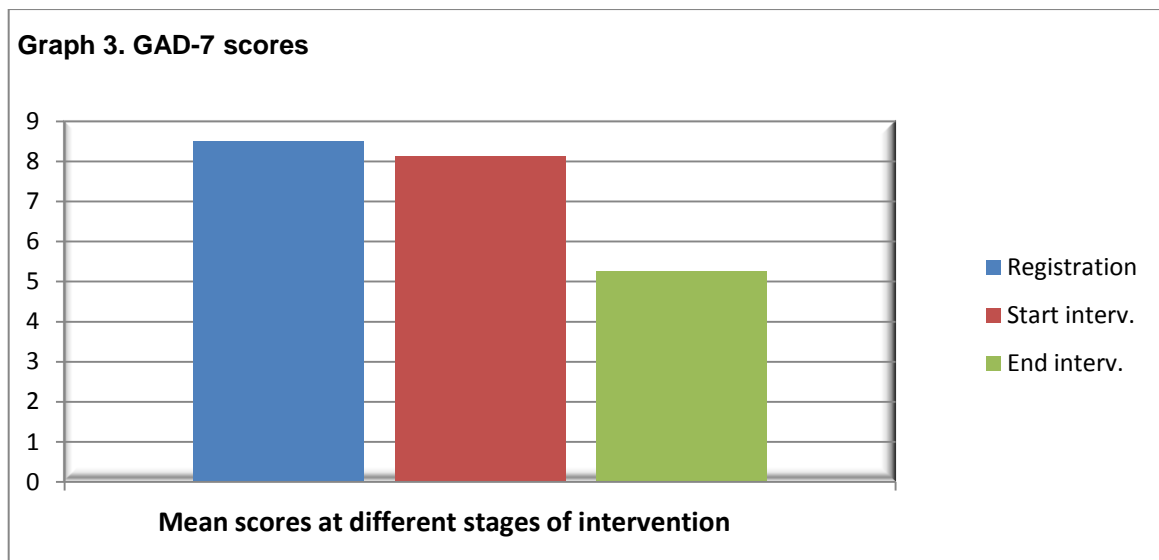
Mean GAD-7 scores also decreased from 8.5 (higher end of *mild anxiety* range) to 5.2 (lower end of the same range).

15.2.3. Follow-up

Due to the poor completion rate of follow-up questionnaires (i.e., 4 participants' questionnaires were received fully completed), these results cannot be reported.

15.3. Attrition analysis

Ten participants completed the intervention attending 90 per cent of the sessions (with 7 participants attending all sessions). Five dropped out during the intervention. Reasons for attrition could not be thoroughly ascertained due to ethical limitations (i.e., contacting people after dropping out was not contemplated in the application for Ethics approval). Those who informed the facilitator about their withdrawal from the study put forward unexpected changes in circumstances (e.g., work or family) and unavailability (e.g., sudden trip abroad).

No further factors differentiate the participants who completed the intervention from those who, after registering, did not start it or dropped out. *Table 2* shows the results of the Kruskal-Wallis test performed. Neither age nor educational attainment explain the participants' attendance. Acculturation (as measured by the SASH and years of residence in the UK) is not associated with attendance. Severity of distress at registration (as measured by all three outcome measures) does not explain their engagement.

Table 3. Association between demographic factors and attendance[a,b]

	Chi-square	df	Asymp. Sig.	Exact Sig.	Point Probability
Age	3.117	2	.210	.222	.001
Education	.447	2	.800	.799	.008
Years_UK	3.614	2	.164	.169	.001
Acculturat	2.976	2	.226	.236	.001
CORE_Reg	1.432	2	.489	.514	.001
PHQ_Reg	2.107	2	.349	.368	.001
GAD_Reg	2.196	2	.334	.354	.001

a. Kruskal Wallis Test

b. Grouping Variable: Attendance

16. Qualitative analysis

The analysis of the qualitative information gathered comprises mostly the thematic analysis of the focus groups conducted with the participants. Additionally, an account of the participants' responses to the MIE question posed to them at the end of every therapy session is added as further evidence for the thematic structure suggested below.

16.1. Sample's demographics

Seven participants attended the focus groups: three females attended one of the sessions and three females and a male the other one. Five out of the seven participants had attended all four intervention sessions with the other two attending three. Their mean age was 48 years ranging between 24 and 76. They were originally from Colombia (two), Peru (two), Ecuador (two) and Bolivia (one), and had lived in the UK between three months and 22 years with an average of 7.5 years.

16.2. Thematic structure

The findings from the thematic analysis of the focus group discussions are represented as themes and sub-themes, which were identified from participants' descriptions of their experience of attending the intervention. The final stage of the analysis produced 4 broad themes, which collectively encapsulate 13 subthemes, that give structure and coherence to the *candidate themes*. Following

Braun and Clarke (2006), a review of the themes was conducted to ascertain whether the thematic map reflected the data set. As a result, a candidate theme was split into two and some subthemes were omitted from the analysis. The theme split into two was considered too large and comprised quite divergent subthemes. Equally, the omitted subthemes were thought not to fit in or not to be relevant to the research questions. *Table 4* provides a summary of final set of themes and subthemes, which is discussed below in further detail. Additional information can be found in the appendices:

Appendix 15 gives details of the reviewing process of a preliminary thematic structure and the audit trail, which demonstrates the different stages worked through by the researcher during thematic analysis (Wolf, 2003).

Appendix 16 includes a diagrammatic representation of the thematic structure and the relationship among the different themes and subthemes.

Table 4. Themes and subthemes of thematic analysis

Themes	Subthemes
Specific LI CBT elements useful	"Knowing what to do" – CBT techniques for anxiety/worry
	"Knowing what it is" – CBT conceptualisation of anxiety/worry
	"When is it really a problem?" – questionnaires
	"Putting it into practice" – intersession tasks
Generic aspects of the intervention	*"I appreciate your professional stance"* - Facilitator's role/approach
	"It's so important to have information in your own language" - Intervention in Spanish
	"We are all in the same boat" - Group factors
Intervention as limited/scope for improvement	*"We did the basic [level] and now we go for the second one"* - Intervention as starting point
	"Things you might want to change - Practical changes
	"We expect different things" –homogeneity and timeliness of the intervention
Latino community needs	*"No, here you have to wise up!"* - Attitudes towards migration
	"... that's the Latino mentality" - 'Latino' cultural values
	"How we can solve our own problems as a community" - Other more suitable support for the Latino Community

Most participants in both groups expressed positive views about the intervention as a whole. The comments below illustrate how participants showed their appreciation of the programme: by being 'grateful' for the opportunity to take part in the current one, coupled with a 'wish to pay back' and showing interest in participating in further workshops. Participants also regretted that others had dropped out and stated their intentions of sharing their newly acquired knowledge with others:

> *"please, don't forget about the next workshop, as I'd love to participate"* (participant 5, line 1326);
>
> *"I was sad that that little girl left because she needed it"* (p.2, 1094-95);
>
> *"we should have been the ones bringing cake and a bottle of wine"* (p.3, 666);
>
> *"I'm happy to photocopy the material [for others] and say 'look, read this, it's very good'"* (p.1, 527-8).

An analysis of what participants thought was helpful about the intervention yielded the first two themes, describing both CBT-specific and non-specific factors. Further questioning led to a discussion of aspects that could be improved. Throughout the discussions, participants referred to wider, contextual issues which seemed relevant to their views on the intervention. These were issues common to the Latino community in the UK (e.g., immigration, cultural values) and further support they thought was necessary for their community.

16.2.1. Specific LI CBT elements seen as useful

In answer to the question about helpful aspects of the intervention, participants highlighted the importance of combining 'theory and practice' (i.e., conceptualisation and coping strategies) of anxiety management and stressed the link between both elements:

> *"I think the relationship between concept and practice was really useful..."* (p.7, 310).
>
> *"So knowledge is very important. With it one can use the techniques and avoid further mistakes"* (p.4, 249).

16.2.1.1. 'Knowing what to do'. CBT techniques for anxiety/worry

Participants stressed the importance of the techniques to reduce their excessive physical arousal and worry during both focus groups and in answer to the MIE questions posed at the end of every session. Some participants emphasised the *priority* of learning techniques to manage anxiety over more conceptual issues (e.g., diagnostic categories). They stated the constructive approach of the sessions and the importance of 'knowing what to do' about 'anxiety' and 'excessive worry' as primary elements:

> *"... many times at the moment of anxiety, you don't think about the concept, but of 'how I get out of this one'"* (p.7, 312-12);
>
> *"because this hasn't been like going to the psychologist to cry […] and the psychologist keeps quiet. It's been very constructive. We've been given techniques […]",* (p.2, 194-6).

The elements participants paid most attention to were *relaxation, worry management* and *exposure techniques*:

> *"[...] and the most interesting is your CD... really good. It's worked really well for me"* (p.5, 211-6);
>
> *"To me the breathing techniques have been phenomenal because I came here with horrible anxiety attacks"* (p.1, 372-5);
>
> *"And the other bit was the topic of worry [...] To discern, to use the 'sieve'... Since we talked about it, I've been managing it well... And giving time to worries was also helpful"* (p.6, 189-95);
>
> *"After overcoming this (anxiety difficulties), now I understand and say 'God, never avoidance: you have to confront it!'"* (p.4, 274-5).

Participants with previous experience of anxiety difficulties linked these techniques to favourable outcomes, such as better sleep and feeling calmer:

> *"I've realised that since a couple of weeks I'm calmer"* (p.6, 197);
>
> *"I'm grateful since at least sleep is something I can now manage"* (p.5, 795-7).

Those with no previous experience of severe anxiety talked about the preventative effect of anxiety awareness and 'enthusiasm'. This was possibly due to feeling empowered by new techniques to manage their anxiety and, therefore,

freer to go about their daily life. This sense of empowerment linked to being 'one's own therapist' was also described by another participant:

> *"It's good because we share things that can happen to one in the future. It's like you have an idea of how to overcome these things"* (p.7. 418-20);
>
> *"This experience has helped me to have more enthusiasm for everything"* (p.3, 406-7);
>
> *"These workshops help you because you are the one that has to work on yourself. In that moment, you are your own psychologist"* (p.1, 1184-87).

16.2.1.2. 'Knowing what it is'. Conceptualisation of anxiety/worry

Although not as important as the techniques, a clear CBT conceptualisation of anxiety difficulties was also quoted by participants during focus groups and in response to the MIE questions. Some highlighted the importance of gaining a clear understanding of the concept of anxiety. One described this succinctly, emphasising that this knowledge had to be *professional* and *scientific* and leading to effective techniques to control the 'symptoms':

> *"To me, the most important (aspect) has been to know exactly what anxiety is [...] At a professional, scientific level, not from third persons. [...] It gives you clear guidelines and techniques which are effective"* (p.4, 235-242).

Lack of this knowledge was identified as a contributing factor to anxiety crises and linked to previous experiences of distress:

> *"it's lacking this information that makes someone fall into a crisis"*, (p.4, 244-245);
>
> *"Had I known all this earlier, [my crisis] would have been more bearable"* (p.4, 290-293).

Gaining an understanding of the concept of anxiety was possible due to what one participant repeatedly described as 'accessible and comprehensive' material and the open dialogue format in which it was facilitated:

> *"If we go to a GP or psychologist, we won't have what we've had here. The explanation is very accessible. We had the chance to participate and discuss"* (p.1, 235-7).

Participants talked specifically about the CBT model of anxiety, presented as a '*hot cross bun*' (Padesky & Mooney, 1990). They stated that it was *"the most*

important aspect" and *"the main foundation of the workshop"* (p.1, 1010, 1021). They emphasised its comprehensiveness and its capacity to provide an articulate description of one's experience:

> *"All is related, interconnected: there isn't one without the other one [...]. The thought generates a physiological sensation; this one, a behaviour, and so on"* (p.4, 1267-78)
>
> *"With this we can name every state we are in"* (p.1, 1014-15).

When asked whether the model left aspects of their experience of anxiety unexplained, participants stated it did not.

16.2.1.3. 'When is it really a problem?' – questionnaires

Following from the previous sub-theme, conceptualising anxiety as graded and, therefore, more or less helpful depending on its degree resonated with some participants:

> *"I realise that anxiety is positive when it pushes you to improve [...] In my case, following an accident, I started to experience a negative anxiety..."* (p.4, 264-8).

However, this led one participant to wonder when they could regard themselves as having a 'problem' warranting professional help:

> *"I'd like to know when we should consider we have a problem so serious that we need to go to the doctor"* (p.6, 138-9).

This conversation progressed onto the sessional use of outcome measures, which some participants talked about in positive terms:

> *"[Completing the questionnaires] is good to know in what state you are, where you started…"* (p.1, 543-4).
>
> *"For me it's like looking at my own statistics. Like having a scale and weighing myself. It's been helpful: I've seen myself as in my own mirror"* (p.2, 571-3).
>
> *"… and more than anything, it's your own assessment. You are assessing yourself"* (p.1, 582-3).

16.2.1.4. 'Need to put it into practice' – intersession tasks

Participants stated the importance of practising regularly their newly learnt techniques in order to become familiarised with them and reduce their levels of anxiety, stating their awareness of the chronic nature of their difficulties:

> *"But now it's our turn to continue practising, reading and not just filing it away"* (p.1, 522-3)*.*

> *"... although you know that these things don't get cured overnight"* (p.1, 521-2)*.*

In this sense, it was felt that the intersession tasks suggested were relevant and important to complete. Regular practice was also discussed as a commitment participants had acquired with the facilitator and a means of expressing their gratitude:

> *"This thing of the homework tasks is very important. For me it's like an exam"* (p.1, 1412)*.*

> *"There you can see the gratitude for what he [facilitator] has done"* (p.1, 1416-20).

Some participants requested that the facilitator suggest further material in Spanish for further individual work:

> *" […] Possibly at the end of the programme you might want to make it more theoretical, with books to read or related topics to give continuity… guidelines, manuals"* (p.7, 942-5)*.*

> *"[…] a specific book, when you see that a person is unwell"* (p.6, 947)*.*

16.2.2. Generic aspects of the intervention

Participants discussed aspects of the intervention which are not specific to the CBT model. These included the facilitator's role and style, an intervention delivered in Spanish, and different group processes taking place during the intervention.

16.2.2.1. "I appreciate your professional stance" - Facilitator's role

The figure of the facilitator was repeatedly brought into the conversation. He was portrayed as a 'role model' of calmness by one participant:

> *"and I see you, with total calmness"* (p.6, 202).

Further facilitator's characteristics stressed as conducive to participants' engagement were his *kindness* and *professional manner*, which one participant construed as *love*:

> *"you are very kind, not drastic [...] We don't feel forced or intimidated here"* (p.2, 253-55);
>
> *"I appreciate your professional qualities"* (p.2, 323-24);
>
> *"With that love you are 'stealing' people [from other services]"* (p.2, 908).

The facilitator's style during the first contact was discussed in both groups as essential to participants' decision to enrol in the intervention:

> *"I thought it was a warm invite, I thought the initiative would be great […]"* (p.7, 743-44).
>
> *"Above all, the way you invited her to the workshop"* (p.1, 334-336).

However, one participant warned the facilitator to tone down his 'kindness' as it might have led people to not value the workshop enough:

> *"You should not be that kind in that first conversation"* (p.2, 628).
>
> *"If you are, people go 'ah, I'm at home, can't be bothered' [attending the group today]"* (p.2, 813-14).

One participant emphasised the importance of a *shared culture* between participants and facilitator. However, she also speculated that more cultural similarity (e.g., sharing nationality) could have been counterproductive:

> *"if you were English, you wouldn't have facilitated it like this, because an English person doesn't understand our culture, our ways"* (p.2, 252-53).
>
> *"if you were Colombian, you would have been more drastic, harsher"* (p.2, 1047-49).

16.2.2.2. "It's so important to have information in your own language when abroad" - Intervention in Spanish

Participants in both groups referred repeatedly to the language barrier the average Latino experiences in non-Spanish-speaking countries, which led to the importance of using one's mother tongue when discussing abstract and complex topics:

"Latinos in the UK, due to the language issue, can't express themselves clearly nor say what they experience or what's happening to them" (p.4, 328-31).

"I think it'd be ideal if a Spanish-speaking person was there [at a GP practice] to enhance the conversation, to understand people who get into a state… because that also causes depression" (p.5, 355-358).

One participant shared her positive experience when being supported by a Spanish interpreter in a health setting. However, others voiced their concern about the limitations of working through interpreters and the restriction of this support in a climate of budget cuts. This awareness led the participants to describe having information delivered in Spanish by a professional as a privilege:

"my GP had a Spanish-speaking person and thanks to them I could manage my problem" (p.5, 381-87);

"if you have an interpreter, it helps, but the message transmitted is not the same" (p.7, 392-93);

"because having an interpreter or someone in each NHS service with all that is going on and cuts and all... is not going to happen" (p.7, 1164-67);

"few people have access to professional information in one's language [...] It opens a world of possibilities" (p.4, 1316-20).

16.2.2.3. *"We are all in the same boat" - Group factors*

Participants' comments about the workshop as a group intervention emphasised both its *positive* aspects as well as its *not ideal* nature. Among the positive elements of a group intervention, people in both groups talked about the group as a *source of relief* resulting from sharing experiences:

"It works as a group to be able to share experiences" (p.7, 886-87);

"people need to externalise in the group" (p.4, 523).

Participants gave considerable importance to the *normalising* and *liberating* effect of being surrendered by others with similar difficulties:

"Here I don't feel I am the only one with my problem" (p.2, 293);

"you are surrounded by people here who have lots of problems" (p.6, 204-05).

The workshop was described as an *opportunity for exposure* and a chance of meeting like-minded and supportive individuals

> *"Individual attention works as it is direct, but if you push that person into the swimming pool, you are giving him a technique to socialise. [...]. The group has been that swimming pool"* (p.4, 870-76);
>
> *"you get to share experiences, but at the same time you sit with people whom you can become friends with outside and can be helpful in the long term"* (p.7, 877-80).

Several participants emphasised the importance that this support extends beyond the sessions and keep in contact after the end of the workshop:

> *"and you start to create a network... but with people who genuinely want to contribute and learn"* (p.5, 1213-16)
>
> *"I'd love to have everyone's phone numbers and arrange to meet for a coffee"* (p.5, 1210-11).

Some people, however, perceived the group as a context where sharing personal experiences can be positive. This was closely linked to some participants' conviction about the importance of self-disclosure as a means to *recovery:*

> *"So, if there are people like Elsa*, willing to listen, it's interesting"* (p.4, 560-64)
>
> *"People need to externalise"* (p.4, 523);
>
> *"many times other people wanted to open up a bit more and have more chance to discuss"* (p.2, 1086-87),

In addition, participants in one of the groups shared a great deal of mutual encouragement (*"Isabel*, it's you and not God that is doing the 'miracle'. Your wish to overcome it..."*, p.1, 788) and acknowledged witnessing how other members had shown a remarkable improvement (*"Teresa* flew and she flew high"*, p.1, 736). However, witnessing others improve, whilst highlighted as meaningful (possibly as an inspiring event), was not regarded as helpful or certainly less important than the actual content of the sessions:

---

* Fictitious names

> *Moderator:*   *so, has seeing her as a different person on session 4 helped you personally?*
>
> *p.1.*   *No, not personally. Personally it's your workshop that has helped me (p.1, 369-72).*

Among the negative aspects, some participants talked about their apprehension to be part of a group due to concerns about confidentiality:

> *"When I came here I thought 'Oh God, everyone will comment outside on what I say and it will be gossip'"* (p.2, 305-06);
>
> *"In the group people will say 'we have compassion', but outside the person may think 'they won't talk to me because I tried to kill myself'"* (p.7, 650-53).

The concerns above led some people to consider alternative support (i.e., individual therapy):

> *"I wanted to have a private conversation as I didn't feel prepared to share with others something very personal"* (p.5, 721-27).

Imparting of information and *Universality* were the only group therapeutic factors identified by the participants in their answers to the MIE question, following Yalom's (1995) classification. They emphasised the relief they experienced being part of the group due to the realisation that other participants acknowledged similar difficulties to the ones they were experiencing. Interestingly, some aspects of the group dynamics, which could be catalogued as group factors were not mentioned by the participants. The progressive 'gelling' among some (*group cohesiveness*), *altruism* and peer support and instances of imitative behaviour among participants were (un)consciously omitted from the discussion.

16.2.3. Intervention as limited / Scope for improvement

Despite the positive comments summarised above, participants also identified limitations in the intervention and suggested potential ways to improve it. They talked about it as a good 'first step' to be complemented with further input. Practical changes were suggested, together with possible ways in which participants should be selected to make the intervention more relevant to them.

16.2.3.1. "We completed the basic [level] and now we go for the second one" – LI Intervention as starting point.

Positive remarks on the intervention were followed in both groups by the participants' recognition of its 'basic' nature and their interest in attending further workshops:

> *"I think you won't finish with this basic project: a second and a third one will follow"*, p.2, 131-3;

> *"And I hope that maybe this is not the only workshop, but more workshops follow with more people"*, p.7, 1310-12).

> *"If you did more workshops gradually, and we, first patients attending, had the opportunity of coming to the next step... Because we don't stop here. Look, I've been at a very low level, and now I'm feeling better"*, p.2, 779-83.

Exploring the participants' expectations of further input resulted in different ideas: some suggested more workshops covering the same material more in depth whereas others requested more intensive input considerably different from a LI CBT approach and moving towards group psychotherapy:

> *"If you had the opportunity to offer another course more extensive about all that we are discussing, it would be great"*, p.5, 591-6);

> *"Then you should say to the people: 'what do you think about confronting the issues, touching the wounds? Because touching the wounds frequently cures us"*, p.2, 996-8).

However, gathering further detail about the group's expectations on further input proved challenging as participants' descriptions seemed too metaphoric. This 'sitting on the fence' and relying on the facilitator to design *what he knows is the most appropriate* could be due to a genuine lack of knowledge about what works. Alternatively, it could also be the manifestation of a *magical realist* approach to a reality over which the person does not think they have much control:

> *Moderator: In the second [workshop], what would we cover?*

> *p.4:   Yes, because we already saw this; we need to give a further step.*

> *Moderator: Yes, and what would that step be? After covering avoidance, relaxation, cognitive biases, what would 'level 2' be?*

> *p.4:*   *When we arrived here we were stuck, we were... and we can't...*
>   *And you were telling us how... not because we are stupid, but*
>   *because we are unblocking ourselves psychologically. Now, it's the*
>   *next step, with more confidence [...] With more self-assurance and*
>   *motivation, looking up to the horizon... And perhaps a third one to*
>   *look at victory (p.2, 1243-54).*

16.2.3.2. "Things you might want to change" - Practical changes

Time constraints were the main concern repeatedly voiced by most participants in both groups. All participants stated that time restrictions proved an obstacle to the inclusion of elements they deemed central to the effectiveness of the intervention, such as disclosing difficulties to the group:

> *"Too short because there are things you left to be read at home [...] and I haven't read because of lack of time" (p.5, 360-3);*
> *"... because actually it's been very short time" (p.1, 379).*

> *Moderator:*   *It seems that it's important to leave time for people to express*
>   *what has brought them to the session, experiences they've*
>   *had [...]. Do you think that the workshop as it's been facilitated*
>   *has allowed for that to happen?*
> *p.4:*   *No*
> *p.5:*   *No, it's been too short [...].*

A series of changes were suggested in both the format and the content of the sessions. They comprised practical changes to the sessions to enhance participants' engagement and understanding of the content discussed, such as including *warm-up* activities or a follow-up/recapping on previous sessions

> *"to start each session with a short exercise to relax [...] Something related to the topic we are discussing. As a way of engaging the person..." (p.6, 813-29);*
> *"[...] we didn't have something half-way through to discuss 'did you understand it?'" (p.7, 756-8).*

One participant's emphasis on the importance of 'celebrating the ending' (*"Let's make a good 'ending meditation'"*, p.1, 610-11) and facilitating the group in a relaxed manner was widely backed by others in the group:

> *"for it not to be too monotonous, having more time and half-way through the session, something relaxing, a little story"* (p.1, 926-9).

A variety of social activities were suggested aimed at maximising the interactive nature of the group, e.g., a group meal in the park (*"as these things are good for our body"*, p.1, 1350-2). Participants' engagement in suggesting practical and format ideas was in stark contrast with their difficulties in suggesting changes in the content facilitated (as described above).

Participants' suggestions to improve engagement included a more compassionate and a harsher approach. Whilst they suggested offering individual support at the beginning of the workshop to those ambivalent about taking part, they also discussed introducing a *punishment* system:

> *"for those without the confidence to express things in public, you should have a specific day or time"* (p.6, 706-8);
> *"those who don't attend should pay 50p"* (p.1, 607).

Further suggestions included making the material *alive and real*. This was closely related to the importance of self-disclosure (discussed above) and the use of 'real' case examples. This could denote some difficulty in *translating* psychological jargon into concrete and observable behaviours and sensations:

> *"More practice, not just theory [...] Then, people understand as they have the theory and also the practice"* (p.4, 596-605).
> *"It would be ideal that for every topic you present a real case that someone tells you and you bring to the group anonymously"* (p.5, 906-9).

16.2.3.3. "We expect different things" –importance of an homogenous audience

Both groups suggested the need for homogeneity among attendees on different aspects: severity of anxiety and age.

Whilst some participants stated that *everyone needed the intervention*, they also recognised that distress levels varied among individuals (*"Although we all needed this workshop, each of us has a different burden: ones heavier and others lighter"*, p.1, 343-6). This led some to suggest making the groups more homogenous, by selecting people on the basis of the difficulties they had experienced to tailor the intervention to their needs. However, this was contested

by some, who felt that, despite these differences, *mutual benefit* was possible, as long as there was *willingness to learn from each other:*

> *"[...] if I have experienced it and the other person hasn't, there are two different levels what we both expect to receive"* (p.7, 440-42);
>
> *"there needs to be a mixture [...] A time comes when you have to share with people who have a broader mind"* (p.4, 558-64).

Some participants reflected on the severity of the problem amenable to the intervention. They emphasised the preventative nature of the intervention, suggesting that the techniques discussed could be applied in everyday life and specified that they can help prevent a crisis. However, once this has occurred, further, more intensive treatment is necessary:

> *"I think that these concepts can be applied everyday"* (p.7, 307-9);
>
> *"this can be suitable to those who have had a mild crisis but when they have gone through a major crisis, they need more intensive help [...] More individualised and of a higher degree. Don't know... Psychotherapy, psychiatry…"* (p.4, 298-304).

During one of the groups there was some reflection on younger people who had dropped out and discussed how age difference should be addressed. People perceived that *"youngsters don't show much interest; they don't feel anything but older people are more interested"* (p.3, 878-80). This led them to suggest making the workshops age-specific because *"one has to understand young people [...] You may have to change your approach when working with them"* (p.2, 833-37). However, no age was suggested as a cut-off point. Participants explicitly stated that other characteristics (e.g., gender) were not *an issue* requiring separation:

> *Moderator:*   *In terms of age, gender or what?*
>
> *p.1:*   *In terms of age. Not gender.*
>
> *p.5:*   *No, age.*
>
> *p.1:*   *Gender doesn't matter to me.*

16.2.4. Latino community characteristics and needs

Participants referred to a series of aspects which affect the Latino community and set the context to the discussion on the effectiveness of the intervention provided. Among these, they mentioned *migratory grief* and the style of acculturation to a

new country, including a reflection on different attitudes among migrants about their relationship with the host society. This was intrinsically connected to two other sub-themes; namely, *cultural values* and a discussion on *alternative/more comprehensive support to the Latino community*.

16.2.4.1. No, here you have to wise up!" - Attitudes towards migration

Participants talked about their experience of migration and adaptation to the host culture as a difficult process, plagued with limitation and disempowerment:

> *"Here you are more limited in many ways. Here there is no happiness, you don't have that freedom..."* (p.1, 1173-75);
>
> *"If you are alone in this country and the winter comes, and work and problems and everything..."* (p.2, 1131-33).

This was closely related to the *lack of realism* that some participants identified among Latinos migrating to the UK:

> *"the gravy train came to an end. People come here to give, not to take"* (p.1, 1163-64);
>
> *"Often people come and realise that this is not what they thought, and then emotional problems appear"* (p.2, 1126-28).

Some participants stated the importance of *toughening up* as a means of survival, opposed to what they described as a Latino tendency to get sympathy from others:

> *"because we, South Americans, tend to make others feel pity for us... And that the other person feels like 'poor him!' No. Here you have to wise up!"* (p.6, 1073-75);
>
> *"One has to get up and overcome tragedies. Stand up or die!"*, (p.2, 1125-26).

Different views were expressed about negotiating cultural clashes when adapting to a different culture: whilst some were adamant that Latinos had to accept the host culture in order to prevent undue distress (and had adopted this posture themselves by rejecting some Latino characteristics), others thought this was a matter of mutual adaptation:

> *"I can't come here to impose my conditions. I can't tell Britons 'you have to adapt to me' [...] One should know how to adapt and I think they would suffer less"* (p.2, 115-122);
>
> *"I applaud European mentality, because I don't like the Latino one at all. I totally reject that way of being, thinking and behaving. It's not all Latinos but most of them"* (p.5, 1053-1056);
>
> *"both parties should change"* (p.4, 1142).

Some of the observations made by the participants during the focus groups and therapy sessions bore remarkable parallelism with their views on the process of migration and how they talked about their daily life as immigrants. Whilst this was not verbalised as a theme, it seemed a salient element when analysing the discussion. The situation of disempowerment described by some participants in relation to the host society seemed to mimic their stance in relation to the facilitator (e.g., lack of critical views). One member stressed the importance of rebelling against entrenched behaviour patterns (e.g., *excessive* submission and fear). However, this submissive attitude may have underlain the lack of disagreement during the sessions and the repeated comparisons some made of therapy with other power-imbalanced relationships (e.g., teacher-students or father-children). The 'need to adapt to the host society' seemed to resonate among participants, and was intrinsically related to their acceptance of the help available, as expressed by one participant (*"We are the ones who need to change"*, p.6, 1043).

16.2.4.2. *"That's the Latino mentality" - 'Latino' cultural values*

A number of experiences described by the participants denoted values of the Latino community supported by previous research. Participants also talked about *seeking help* and expectations about the support received.

Among 'Latino values', one participant described her exasperation at the appearance of a former therapist she was referred to (*"When I arrived, the man was with his shirt opened till here, that looked unprofessional... a bit punky. I said 'a person like that should not do that job'"*, p.2, 468-71), which reflected the widely documented values of formalism and respect. She also praised feeling accepted *despite her age* (*"being as old as I am, you treat me so well"*, p.2, 858).

This might reflect personal experiences of feeling disrespected or negative societal attitudes towards old age.

However, respect was also negatively construed, as a value enacted by Latinos:

"since children had been taught to be afraid and, when growing up, any small thing... Because we are afraid of speaking in public, of saying to the teacher that they are wrong" (p.1, 729-732).

Familism was an aspect on which participants seemed to have discrepant views. Whilst some stated it as a core Latino value, others stated individual differences among Latinos:

"Latinos are much more familiar, their context is more familiar, unlike Europeans" (p.4, 1085-87)

"it depends on how you've been brought up, what principles and values come from one's family [...] because there is so much selfishness among Latinos" (p.5, 1104-07).

Some explained this detachment as a strategy to protect oneself as a migrant and talked about distance from relatives in their countries as a source of distress

"So, one becomes distant from the community to avoid that danger" (p.2, 306-08);

"This is not such a problem for Spaniards, as you are so close by... you have a problem and buy a flight to be with your family" (p.2, 1137-41).

This community/family spirit was also manifested in some participants' reason for attending the intervention:

"This gives me a tool to transmit to relatives or friends at the edge of a crisis" (p.4, 324).

Some participants emphasised different aspects of seeking help for psychological distress. Some stated that mental health is not a priority (*"regrettably people attend when they're already in a crisis"*, p.4, 319) and stated its taboo nature and the effects of this:

"That [referring to taboo comment] is very important, it's the Latino mentality. But if you talk with Europeans, they say 'I've cut my veins but I don't care if David Cameron knows it" (p.4, 1003-1007)

> *"We come here with a wrong mentality, the 'what will they say?', which limits us when expressing ourselves, say what we think"* (p.5, 1020-1022).

Religion/spirituality was portrayed as a more culturally attuned source of support than mainstream mental health services by one participant (*"the psychiatrist discharged me. But I still had problems [...]. Then I said 'now I'm going to look for a church'"*, p.4, 459-462). Others responded to this by stressing the importance that the person themselves takes the initiative when seeking the type of help they find most suitable to them:

> *"Each of us seeks help where their heart or instinct takes them"* (p.1, 722-723).

Expectations from therapy varied among participants. Whilst some valued *desahogo* (relief) as a core aspect, most participants highlighted their preference for specific techniques and advice on how to manage difficulties over a more counselling-like approach:

> *"I think your [psychologists'] motto should be 'say anything you feel'"* (p.4, 543);

> *"If you go to [known mental health charity] and you talk and cry and the other person doesn't say anything [...] Then, when I go there, I leave empty"* (p.2, 266-267).

16.2.4.3. How we can solve our own poblems as a community - Other more suitable support for the Latino Community

Both focus group discussions seemed to move from an individual to a group/community focus. Both sessions ended emphasising the importance of maintaining contact with other attendees and taking further the principles learnt:
"I'd love to have everyone's phone numbers and call each other and gather somewhere..." (p.5, 1210-1211).

A participant in one of the groups led the discussion towards the situation of the Latino community within the UK ethnocultural landscape. She described the disadvantage this community experiences when compared to other ethnic minorities (*"I think that the Latino community is lagging behind other communities... although it's a relatively new community"*, p.7, 1291-1294). This

reflection led to discussing common experiences generating distress in Latinos, among which migration issues were highlighted, e.g., migratory grief:

> *"I think something addressed to the Latino community like migration, migratory grief or things happening at that specific time, like a new migration wave... I think all those things bring about anxiety"* (p.7, 1156-1160).

Elaborating on the above common experiences among Latino migrants, participants stated the need to empower the community to help them manage their own difficulties and bridge limitations in service provision for Latinos due to language barriers (*"I'd like to suggest ideas about how we can solve our own problems as a community, to help each other"*, p.7, 1167-1168). This observation seemed to resonate among other members of the group, who ratified this need:

> *"We need these types of things that go to our specific needs: what we need, what works for us. These types of things are needed"* (p.5, 1243-1245).

'Empowering the community to solve their own difficulties' struck as a core element of Community Psychology practice (Duffy & Wong, 2003). It was suggested that the community takes the initiative in identifying topics they required help with and seeking professional support to satisfy this need:

> *"maybe among us there is an issue that attracts our attention and we need help with to elaborate and analyse it... maybe we need to invite other people"* (p.7, 1370-1372).

This was, however, in stark contrast with the prominent role some participants gave to the facilitator, whose position was stated as central to the development of this approach:

> *"... knowing that we have a professional before us, but a community which seeks help and knows which is the connection point"* (p.7, 1196-1198); *"You are the link"* (p.4, 1323).

These grand plans were made from a realistic standpoint: *"Anyway, everything takes its time. We can't do anything overnight. It takes time to progressively join..."* (p.7, 1357-1359).

The integration between Latinos and of the Latino community within the UK landscape was suggested as a further aim of this suggested community-level approach:

"This could be in the future a connection point between the community and a professional... and not just among Spanish-speaking people but also English-speakers" (p.7, 1198-1200).

17. Summary

A mismatch seems to exist between the quantitative and qualitative results of this study. Whilst the former merely indicates a trend towards a positive impact of the intervention, the latter is rich in praise for the intervention, highlighting both CBT-specific and generic aspects of the intervention. To a lesser extent, participants raised concerns about the limitations of this approach and alternative ways in which their needs should be met. This will be discussed further and linked to previous research in the *Discussion* section.

DISCUSSION

This section aims to critically discuss the results presented above and the methodology used. It does so by summarising the most salient results and comparing them with existing literature, highlighting agreements and discrepancies. It then addresses the limitations of the study and makes suggestions for future research. Finally, the clinical implications of these findings are discussed and conclusions are drawn.

18. Current findings in the context of previous literature

This study was aimed at ascertaining whether the LI CBT therapies offered within the NHS at primary care level are effective and meaningful when delivered in group format to first generation Latino migrants. Different types of evidence are integrated in an attempt to answer the research questions. Using a triangulation design, it merges qualitative/personal and quantitative/general evidence, following Upshur et al.'s classification (2001). Reviews of studies in the US (Organista, 2006; Carter, Mitchell & Sbrocco, 2012), where most research with Latino migrants has been done, fail to identify similar studies on the management of anxiety using a transdiagnostic approach with Latinos.

Ten people attended a standardised programme focused on anxiety and worry management delivered in their native language, Spanish. Participants completed several self-report scales during a 4-week period before (i.e., control phase) and sessionally throughout the programme (i.e., intervention phase) in order to monitor its impact on their anxiety difficulties. The 'effectiveness' of the intervention was judged quantitatively by comparing the outcome measures completed by participants pre and post intervention.

People who completed the intervention were invited to participate in two focus group interviews where they discussed their experience giving their opinions as to how to make the programme more suitable to them. The 'meaning' of the intervention was explored through a thematic analysis of the discussion generated among the participants during the focus groups. This was complemented with the analysis of the participants' responses to the *MIE question* posed to them at the end of each session. From a critical realist position, this data was analysed focusing on participants' reflections and,

simultaneously, drawing on underlying factors such as politics, culture and language, which affect their experience.

The main findings of this study are discussed and contrasted below with previous research on the topic. Due to the lack of studies on group interventions with Latinos on anxiety management identified by previous reviews (Miranda *et al.*, 2005), these results will be compared with interventions focused on 'depression'.

18.1. Participation

Approximately 45 per cent of those showing interest in participating in the study actually became registered. Thirty per cent of them did not meet the inclusion criteria. Possible factors explaining why the remaining people who were originally interested but never registered (despite attempts to contact them) are other commitments, life events, poor motivation or reticence to participating in a group intervention. A 67 per cent completion rate among those registered compares favourably with similar studies with Latinos focused on depression (e.g., Organista *et al.*,1994). This discrepancy could reflect differences in anhedonia and hopelessness, which characterise people diagnosed with 'depression' and might not necessarily be present in those with 'anxiety' difficulties. Comparison of severity of 'depression' was not possible as measures differed across studies. This moderately high attendance may have been possible due to the facilitator's reminders via text messages, as has been found in the literature (Aguilera *et al.*, 2010).

Conversely, there was a noticeably poor completion of follow-up measures. This might be due to a myriad of factors, from letters going astray in the post to participants' re-evaluating their involvement in the intervention and deciding to discontinue their participation, or other life matters taking priority.

Seventy per cent of those finishing the intervention attended the focus groups. Participants showed willingness to share their views, as this was requested as 'a means of improving future interventions for the Latino community'. Attendees showed an active involvement, with those with past experience of anxiety difficulties being more participative in the conversation.

18.2. Effectiveness of LI CBT interventions

Although qualitative methods can be used to measure therapeutic effectiveness, a quantitative approach was chosen as it allowed a direct comparison of the outcomes of this study with those routinely gathered in mainstream services (i.e., IAPT sites).

The importance of cautiousness in the interpretation of the quantitative results reported above cannot be overemphasised. The small number of people filling out all the questionnaires did not allow further comparisons (e.g., sessional progression, comparison of CORE-OM's subscales) which could have provided a more accurate understanding of the impact of the intervention on the participants' management of their anxiety and worry. The comparisons made, whilst not showing statistically significant differences, indicate that participants' scores did not change during the control period but did improve during the intervention phase, reaching levels close to those conventionally accepted as statistically significant in two of the scales completed (i.e., $p=.06$ for both CORE-OM and GAD-7). However, to avoid obtaining spurious significant differences due to the small sample size, no further comparisons were established.

Demographic characteristics of participants who completed and those who withdrew from the intervention were compared, identifying no factors as a potential explanation of their engagement. Whilst the low number of participants may have prevented obtaining significant differences, this could also mean that factors other than those explored played a role in their engagement (e.g., from internal factors, such as motivation, to more external ones such as competing commitments).

18.3. Meaning of LI CBT interventions

Overall, qualitative verbal feedback on the intervention was positive, as participants elaborated on what they thought were the positive aspects of the intervention. The different aspects brought up by the participants in the focus groups were analysed and synthesised in a thematic structure consistent in four themes, each comprising between three and four subthemes. These are discussed and linked to previous research below.

18.2.1. Specific LI CBT elements considered useful

Participants highlighted a number of aspects intrinsic to LI CBT-based interventions as facilitated within the NHS (Richards & Whyte, 2008). Among these, they emphasised the importance of some coping strategies presented and the *psychoeducational* element on the constructs of anxiety and worry provided during the sessions. They also reflected on the role of sessional outcome measure completion and the importance of the inter-session tasks suggested as a means to establish regular practice.

Anxiety coping techniques

Participants' endorsement of the importance of techniques to manage anxiety and worry over more conceptual elements of the intervention may reflect a pragmatic approach to life, where, rather than a deep understanding, knowing *what to do* empowers oneself to confront life's vicissitudes. Other reasons for this prioritisation might be an inadvertent emphasis given by the author to this element or the more demanding nature of the conceptual material. This finding concurs with literature which identifies CBT's emphasis on education as suitable to Latinos, who view life as an instructive experience (Comas-Díaz, 2006). The immediate benefits and ease of use of the techniques discussed by some participants -and reported in previous literature (Hays, 1996) - might be an important reason for their prioritising these over conceptual knowledge.

CBT conceptualisation of anxiety/worry

Conversely, people appreciated the importance of gaining a *comprehensive* understanding of the inner workings of anxiety and worry, which they stated gave them the rationale for some techniques they found useful. The CBT conceptualisation of anxiety seemed to be readily understood and to provide a logical explanation of experiences that most participants could relate to. Furthermore, participants explicitly stated that, whilst it was new knowledge for most, it posed no challenges to their understanding of distress. The medical slant (with a heavy physiological component part, e.g., fight-or-flight response) given to the explanation of anxiety may have made this model more suited to a culture with high prevalence of somatisation (Escobar, 1995). *Professional and scientific* knowledge was highlighted, as opposed to less reliable information derived from practices other than those of the medical institution. This assertion reflected

participants' endorsement of the medical model, where the professional possesses the knowledge, for example, on how to lead healthy lives, avoiding excessive stress leading to a crisis (Peluso & Blay, 2004). This stance contrasts with literature on Latino folk healing, which stresses the prevalence of witchcraft (Applewhite, 1995), herbalists and healers (Zacharias, 2006) and other forms of spiritual healing (Comas-Díaz, 2006).

Intersession tasks

Whilst verbally acknowledging the importance of intersession tasks to familiarise themselves with their newly learnt techniques, participants failed mostly to regularly complete these. This discrepancy between a verbalised positive attitude and failed completion of the tasks is apparent in other studies. Aguilera et al. (2010) describe that participants in previous intakes of the intervention emphasised the importance of these tasks to new members in the group, despite their own irregular completion rate. Apart from genuine practical difficulties to complete the tasks (e.g., due to lack of time), this might reflect their position in relation to the facilitator (respect for his authority) or the approach (reverence of scientific knowledge). This would also link to their emphasis on their gratitude towards the facilitator as a reason for implementing them.

Questionnaires

Sessional completion of the standardised questionnaires as a means of mood monitoring was perceived by the participants in one focus group as a useful element of the intervention. Some saw it as a helpful element as it provided an objective measure of the way they felt, allowing them to monitor their progress. This is an element also highlighted by researchers in similar group interventions with Latinos (e.g., Aguilera *et al.*, 2010). Although it was not explicitly acknowledged, this might reflect their expectation that their mood improve during the intervention. This is despite them recognising the long-term nature of distress and need for practising regularly newly learnt techniques and strategies, as stated by the participants.

18.2.2. Generic aspects of the intervention

In discussing the aspects of the intervention they found beneficial, participants also talked about the facilitator's style as conducive to their engagement. Their

74

answers to the *MIE question* identified also some group factors held as therapeutic in the literature (Yalom, 1995). Finally, they also praised the opportunity to participate in an intervention in their native language.

Facilitator's role

The facilitator's role was repeatedly commended as a factor contributing to the effectiveness of the intervention. Being listened to during the individual registration session as well as his *soft* manner were stressed as positive. Hence, these results point out the importance of the relationship with the therapist, as illustrated in the CBT literature (Hardy, Cahill & Barkham, 2009). However, similar studies on depression state that client evaluation of the therapist was not as strong as other specific factors to predict positive outcomes in a group CBT intervention with non-Latino participants (Oei & Shuttlewood, 1997).

Participants stressed the cultural features shared with the therapist and his knowledge of their culture. This was in line with research conducted on the advantages of ethnic matching in therapy (Griner & Smith, 2006). However, whilst a good therapeutic relationship was established with some participants, the emphasis made on this factor may be a bias generated by the double role of the researcher/facilitator. It is also possible that some positive comments on the facilitator's performance may be actually due to a feature of the model (i.e., participants tended to praise the facilitator's clear explanations instead of the clarity of the model). The dynamics within the focus groups (e.g., three middle-aged and older females and a considerably younger male researcher in one of them) may have been conducive to a possible overemphasis on the relationship, somewhat less prominent in the other focus group. Lastly, the emphasis on personal relations and affectionate nature common among Latinos (López & Katz, 2001, p. 16) may have also contributed to emphasise this element.

Intervention in Spanish

Participants' appreciation of an intervention delivered in Spanish has also been reported in previous literature. Torres-Rivera (2004) emphasises the importance of conducting assessment and intervention in Spanish due to the likelihood that Latino migrants' earlier experiences and traumatic events will be associated with their mother tongue. In their meta-analytic review, Griner and Smith's (2006) report that studies where therapist and client were matched based on language

had outcomes twice as effective as studies where they were not. The opportunity to use one's mother tongue might improve outcomes by allowing people to express rather abstract ideas, even for those with fluent English. Using Spanish may have allowed participants to engage more in discussion. Studies comparing interactions of Latino and non-Latino 'patients' with Latino and non-Latino physicians show that sharing a language allows for more information to be provided to the patient. Equally, it shows that Latinos were less likely to request information not given to them (Miranda *et al.*, 2006).

Group factors

Bieling, McCabe and Anthony (2006) describe the curative factors identified by Yalom (1995) as active ingredients of CBT group interventions. In this study, participants' comments were consistent with the factors of 'imparting information' and 'universality'. The emphasis on the former concords with Oei and Shuttlewood's (1997) study, in which specific CBT factors seemed to be more associated with reduction of depression than non-specific ones. In a similar vein, Aguilera et al. (2010) emphasise the role of mood-management methods as having a longer impact than the support of the group as the latter ends with the intervention whereas participants can use the techniques at any time.

Whilst people noticed improvements in fellow participants, this was not explicitly described as helpful. No further factors were acknowledged, despite these being observed by the researcher. A possible explanation for this 'overlooking' group factors could be the participants' genuine failure to notice the group dynamics. It could also be a result of their (un)consciously giving more weight to other elements of the intervention (i.e., psychoeducation, facilitator's role) to the point of dismissing the role of group factors. A further reason might be related to the socio-historical context of fights among South American countries and rivalry among participants of different nationalities.

18.2.3. Intervention as limited/scope for improvement

Together with the positive elements discussed above, participants identified some limitations of the intervention and aspects that should be changed in order to improve it.

Intervention as 'basic'

Participants talked about the intervention as a *commendable* initiative likely to benefit the Latino community. However, it was also perceived as limited in its scope and 'basic'. This feedback coincides with other qualitative studies on LI CBT interventions (Khan *et al.*, 2007; Macdonald *et al.*, 2007), which depict this level of input as helpful support *whilst awaiting* more intensive interventions. Participants' taking for granted that the intervention would be continued can be interpreted as *wishful thinking* and manifestation of the need they have for support in their native language. This links with a realistic view on the complex nature of distress in the context of their volatile circumstances, which requires more intensive or longer interventions. Another possible reason for regarding it as a 'basic' intervention might be its focus on the individual, leaving aside relational complexities, in line with previous research (Comas-Díaz, 2006).

The varying suggestions for further intervention made by the participants indicate the different expectations with which they approach help offered to them, which in turn shape their experience (Macdonald *et al.*, 2007). Some participants' difficulty describing the support expected (e.g., using metaphorical language) may denote an excessive reliance on professional judgement, consistent with the *high power orientation* by which Hofstede (2001) describes the Latino culture. It could also be a manifestation of their magical realist understanding of life, common among Latinos (especially among Colombians), who have grown helpless and discouraged from attempting to exert control over external circumstances in the midst of rife political scandals, corruption, crime and terrorism (Haste, 2007). The blending of reality with fantasy which magical realism involves (Comas-Díaz, 2006) allows escaping from a world of uncertainty and danger which engenders mistrust and fear to a sometimes safe retreat of idealistic features (e.g., 'looking up to the horizon, to the victory').

Suggestions for improvement

The most frequently voiced concern was that material was covered in a rushed manner due to time constraints. Time restriction was the main obstacle to participants experiencing *desahogo* (relief), reported as one of the main elements sought by Latinos in therapy (Ardila-Espinel, 1982; Organista & Muñoz, 1996; Guarnaccia & Martinez, 2003). This calls for striking a better balance between the

psychoeducational component and open space for discussion, as previously suggested (Interian & Diaz-Martinez, 2006). Further modifications suggested to the format of the sessions, aimed at enhancing participants' engagement and understanding, reflect other 'Latino characteristics' documented in the literature. For example, the emphasis on including group activities reflects the Latino's *personalism*, or tendency to seek personal contact (Interian & Díaz-Martínez, 2007); similarly, using *tales* and bringing case examples that framed new information into a story may also reflect their preference for narrative style as an educative approach (Comas-Díaz, 2006). Interestingly, whilst suggestions were made about the format, none was made about the content of the sessions, which may reflect a position of inferiority with respect to the authority of *scientific knowledge*.

Need for homogeneity

Participant homogeneity was stressed as a factor likely to allow tailoring the intervention to their specific needs. Among the criteria considered to homogenise the audience were their age and the severity of the difficulties experienced. Age was suggested as a criterion by older participants. The reason given for this suggestion was the need for a different style to engage young people. However, it is likely that the value of *respect* and how it should be shown to people of different ages is the basis of such thinking. Seeking an age homogeneous audience may obey to norms shared among Latinos and strongly held by those who are less acculturised to the host society, who tend to be older people (Gloria, Ruiz & Castillo, 2004).

The severity of the difficulties experienced was a further criterion to consider in establishing a more homogeneous audience. This concurs with literature on screening criteria for LI interventions among the general population (Gega *et al.*, 2005).

18.2.4. Latino community needs

Throughout the discussions about the intervention facilitated, participants included topics which they considered intrinsically related to or underlying their experiences of distress and, therefore, relevant when discussing psychological interventions for the Latino community. These comprised reflections on their

experience of migration and how people dealt with the distress this generated. There was interplay between the vicissitudes related to their migrant status and some values deemed inherent to their Latino background, and both influenced each other. Finally, some participants identified alternative foci and approaches to support the Latino community by enhancing their integration and empowering them to solve their own difficulties.

Migration/acculturation

Migration (mostly due to economic betterment) and the disadvantage it involves was repeatedly alluded to as underlying the distress experienced. This has been documented in the literature on Latino migrants both in the US (Torres-Rivera, 2004) and the UK (McIlwaine, 2007), particularly among women (Carlisle, 2006), who made up most the sample. Difficulties discussed by the participants fit with vicissitudes experienced roughly across different communities when migrating into countries with a different language, in which they find themselves at disadvantage (Bhugra, 2004).

The discussion among participants showed different views on the process of acculturation, which seemed to gravitate between the poles of *assimilation* (i.e., no wish to maintain one's own cultural roots) and *integration* (i.e., can see positives in keeping own cultural identity, hence, change should be from both sides), following Berry's (2001) classification. A third pole defined by Berry and latent to participants' descriptions although less voiced, was that of *separation*, which describes the isolation experienced by some Latinos, avoidant of interaction with others. Interest in receiving support conducive to further integration of the Latino community within the UK social landscape was also expressed. This is in line with Phinney et al. (2001), who link *integration* to higher levels of well-being, acknowledging, however, that acculturation styles depend on individual preferences, official policies and prevailing attitudes in one's immediate surroundings.

Participants' discrepant views on whether *familism* is a defining value of Latino migrants and how family relationships change with their migrant status shows the variation existing among Latinos, largely ignored in the literature. However, it could also illustrate what Torres-Rivera reports as 'a struggle among many

Latinos to understand how discrimination and immigration affect and change them' (2004, p. 220).

'Latino' values

The above mentioned familism and allocentrism were referred to as distinctive Latino values when compared to 'Europeans', as previously documented (López & Katz, 2001). However, rather than a *potential obstacle* to an individual focus of therapy, as portrayed in previous research (Interian & Diaz-Martinez, 2006), they seemed to be a reason to attend the group (i.e., to share the information with relatives or friends).

Further values alluded to included some of those repeatedly described as 'distinctive of Latinos' in anthropology, clinical and organisational psychology research (e.g., respect, personalism, familism, attitude to authority).The importance of feeling *respected* by the therapist was highlighted by some participants, illustrating the findings of previous research (Noble & LaCasa, 1991). However, when enacted by them, this value was also construed as 'excessive deference to authority', in line with previous research (Organista & Muñoz, 1996). The role of religious beliefs and practices as a source of solace, more reliable and culturally acceptable than mainstream mental health services concurs with previous evidence (Lujan & Campbel, 2006). Interestingly, most critical comments about some of these 'Latino values' (e.g., lack of assertiveness and resourcefulness and a call to take control over one's situation) were made by two participants who, prior to migrating to the UK, had spent a considerable number of years in another European country (i.e., Spain). This might have contributed to attuning themselves with Western values and adopt a more critical perspective on their cultural background.

Some participants deemed seeking help due to psychological difficulties 'not a priority', in keeping with their description of 'mental health' among Latinos as a 'taboo'. These findings do not fit with previous research (Peluso & Blay, 2004) which claims that no significant differences in perceptions of mental illness between Latinos and other developed countries exist. However, other studies show the relatively low uptake of mental health services, especially among immigrant Latinos (Vega *et al.*, 1999), and the stigmatising nature of mental illness especially within families has been confirmed (Shattell *et al.*, 2008). These

are aspects likely to point towards the existence of differences in perception of mental illness. Indeed, Rojano (2001) describes Latinos as people who are not keen to seek help from a psychiatrist. In this study, participants mentioned the word 'psychiatrist' as a means to convey a higher severity of difficulties warranting intensive support. However, Rojano states that the stigma attached to psychiatric treatment is not observed in relation to talking therapies.

Alternative support needed

Further improvements suggested for the intervention seemed in line with community-based approaches (Burton, Kagan & Duckett), making emphasis on integrating the members in the community and, in turn, integrating this into the bigger picture of the British societal landscape. Participants advocated for support with the difficulties Latinos tend to experience as a result of migration, e.g., migratory grief (Achotegui, 2008). Furthermore, they called for empowering the community to 'solve their own problems' and be more integrated in society, which resonates with research in the US looking at ways of promoting Latino mental health at mesocommunity and macrosocietal levels. Organista (2006) suggests that advocacy work with Latinos leading to increasing their political participation can help clinicians empathise with the social context underlying their psychological struggle and avoid attributing such problems to the individual. The importance of fostering empowerment when working with deprived Latinos is also stressed by other authors (e.g., La Roche, 2002).

Participants, however, stressed the importance of having a leading figure to undertake these changes. They agreed to entrust this leading role to a *professional*, who was placed as a *link* across organisations. Whilst this seems to clash with the empowering approach promoted by Community Psychology, where leadership remains within the community (Duffy & Wong, 2003, p. 13), it may indicate an incipient interest to push forward changes by people who feel too disempowered to undertake them by themselves.

The adoption of a community approach suits the social characteristics of Latinos. It would also allow for increasing people's awareness of history and socio-political factors underlying distress. Alternatively, providing decontextualised and apolitical psychotherapy may lead some low-income Latinos to assume that they are the sole cause of their distress (Comas-Díaz, 2006).

18.3. Convergence of quantitative and qualitative analyses

The aim of a triangulation design is the convergence of the information gathered by different methods in order to answer the research question(s) (Creswell & Plano Clark, 2007). This study, however, draws somewhat discrepant results. The quantitative analysis shows trends towards a reduction in participants' distress, as shown by the outcome measures which, not reaching conventional levels of significance, cannot be interpreted as evidence of a definite positive effect but as evidence of its limited effect on the distress experienced by the participants. However, this trend towards improvement which is not apparent in the absence of intervention (waitlist phase). Conversely, the participants' account, qualitatively analysed, seems overly positive in comparison (i.e. participants deemed the intervention helpful as a means of learning about the concept of anxiety and ways to manage excessive levels of anxiety and worry). The study by Aguilera et al. (2010) also described an improvement in outcome measures following the intervention, which were more modest than participants' verbal accounts. However, different outcome measures were used.

These results can be interpreted by prioritising one element over the other. Namely:

1. Primacy could be given to the participants' qualitative accounts and conclude that the intervention is effective, although this is not borne by the quantitative element of this study, as it does not reach conventional levels of significance. This failure to obtain actual significant differences between waitlist and intervention phases could be due, firstly, to its small sample size (i.e., 8 participants). Secondly, and in line with previous research on therapeutic effectiveness the adoption of an arbitrary level of significance (e.g., 95 per cent) could be critiqued as not reflecting clinically significant change (Sterne & Davey-Smith, 2001). Thirdly, the floor effect generated by some participants' low pre-intervention scores might have also prevented obtaining a more meaningful difference. Finally, the outcome measures, due to their specific focus on symptoms, may not have taken account of other possible outcomes of the intervention (e.g., normalisation of experience, sense of empowerment due to learning new ways of managing anxiety).

2. Alternatively, doubt could be cast on the qualitative analysis due to different factors. Methodologically, the bias generated by the researcher's double role, which may have prompted an overly positive account on the experience of attending and outcome of the intervention (this is explained more in detail as a limitation on pg. 85). Further reasons may underlie an unduly positive account, such as fear that the service be withdrawn due to negative feedback, leaving the community without suitable support. This could also be accentuated by features stereotypically characteristic of this cultural group such as their emphasis on *simpatía* (kindness) (Organista & Muñoz, 1996) and high deference to power (Hofstede, 2001), which may have contributed to minimising criticism of the intervention. An attitude of 'reverence' of scientific knowledge could also counter any negative comments. Finally, an attempt to be accepted (in order to fit in), common among marginalised minorities (Berry, 2001), could also be in place.

The discrepancy between the results of both parts of this study points at the need for further research on a field characterised by the lack of evidence base.

19. Limitations of the current study

A number of limitations in the scope and design of this study may have affected the validity and generalisability of the outcomes summarised above. These are:

19.1. Scope of the study

The title of the present work raises two controversial points. Namely:

19.1.1. Overgeneralisation
As mentioned above, conceiving the 'Latino culture' as a homogeneous set of values, characteristics and stereotypes, fails to acknowledge the significant variation existing among a large population on a range of aspects. Therefore, we should avoid falling into the *myth of sameness* (Wilson, Phillip, Kohn & Currey-El, 1995) or erroneous belief that participants' processes or dynamics are the same within a cultural group. Values should be regarded just as cultural norms, which people may abide by to a greater or lesser extent; awareness of these can help understand potential outcomes (Organista, 2006), without making *universalist* assumptions. This study, therefore, was carried out as a first step towards gathering a more culture-specific evidence-base, due to the lack of research

focused on this collective in the UK. Whilst participants talked about similarities among them, stark differences in their opinions on the 'Latino community' were also expressed (such as closeness to their relatives, religiosity, etc.), which should not be ignored when developing interventions.

19.1.2. Can we actually talk about 'effective' as different from 'meaningful'?

This thesis sets out to ascertain whether the intervention delivered is *effective* in quantitative terms (i.e., leads to symptomatic improvement, as measured by standardised self-report measures) and *meaningful* (i.e., is accepted as an explanation of their experience of distress which fits with their worldview). But the actual independence of both qualities should be discussed. In other words, do we need to understand how something works for it to be useful (i.e., relieve our distress)?

Distinguishing between both terms is a challenging task. From a pragmatic position, it could be stated that understanding the inner workings of a technique or procedure is not necessary for it to work effectively. However, it seems that meaning is a *sine qua non* for effectiveness in that for someone to experience something (e.g. a technique) as effective, they have to entertain, even remotely, some form of understanding or hope that it will work, for which this needs to fit with their worldview.

19.2. Intervention

19.2.1. Sample/Recruitment

Sample size. The complexity of the project and restricted time and resources limited the number of people recruited. Despite efforts to avoid an excessive dropout, fewer participants than expected started the sessions. This, alongside a moderate dropout and failure to complete the measures, led to only eight people being included in the statistical analysis and deeming a six-week follow-up invalid. These low numbers limit the power and generalisability of the quantitative findings. Furthermore, low attendance at the focus groups (i.e., seven participants) may have led to unduly emphasising individual experiences and opinions about the intervention that could have been more balanced if more people had attended.

Recruitment of participants. The selection criteria included people who, whilst not currently troubled by anxiety, were interested in learning techniques to prevent possible future difficulties. The lack of marked 'anxious symptomatology' in some participants may have generated a *floor effect*. This may call for the use of alternative outcome measures (e.g., self-efficacy), which, rather than actual improvement in anxious presentation, measure the confidence the person has on managing potential difficulties with anxiety.

Demographic factors. Whilst participants differed on a number of characteristics (e.g., age, nationality, time living in the UK, circumstances leading to migration), its representativeness of the 'Latino culture' is questionable (unequal representation of country of origin, gender, age, etc.). Male representation was very limited and the age range was skewed towards the 35-65 range. The participants were first generation migrants who decided to take part in an intervention delivered in Spanish offered as a pilot study, which may have influenced their motivation and engagement.

19.2.2. Type of intervention facilitated

The group nature of the intervention limits the results of this study to group-based programmes. Therefore, the effectiveness of individually delivered LI CBT interventions cannot be ascertained from this study. The likely use of group interventions with non-English speaking people within the NHS, due to cost-effectiveness, was the reason for choosing this format in the current study.

19.3. Data collection

19.3.1. Attrition

Permission to contact participants discontinuing their attendance was not included in the ethics application and, thus, the approval granted. Therefore, attempts to contact the five participants who left the intervention (33 per cent) consisted of one text message inviting them to send their postal addresses so that a short questionnaire could be posted to them. Since no replies were received, valuable information as to the participants' reasons for dropping out could not be gathered, limiting these to what some of them had stated verbally (e.g., conflicting family or work commitments).

19.3.2. Self-report measures

To explore the effectiveness of the intervention, this work relied on the use of self-report measures. Further to the limitations specific to each scale, described in the *Method* chapter (*pg. 34*), the literature reports advantages and disadvantages in the use of self-report measures.

Among the advantages, self-report measures provide exclusive information unavailable through other means, by gathering information directly from the individual (Derogatis & Meliseratos, 1983). They are also quick and easy to administer and a useful way of eliciting large amounts of information, saving clinicians' time (Morland & Tan, 1998).

However, using self-report measures involves disadvantages, such as difficulty in accurately assessing many concepts. It is also assumed that individuals can and will report their symptoms accurately (Derogatis & Meliseratos, 1983), which, for several reasons, may not be the case (e.g., social desirability, treatment expectations, defence or coping mechanisms, Morland & Tan, 1998).

19.3.3. The author's double role.

Difficulties identifying a Spanish-speaking practitioner with experience in running LI CBT interventions or focus group interviews forced the author to take up both roles. Despite efforts to minimise the social desirability bias in participants' responses (e.g., by emphasising the importance of constructive criticism and actively prompting discussion of 'unhelpful' aspects of the programme), this may have influenced their evaluation of the intervention, generating overly positive feedback. It is possible that participants' emphasis on specific over generic or group factors may be a direct consequence of being interviewed by the person who delivered the intervention.

Conversely, the double role played by the researcher may have unwittingly increased the ecological validity of the evaluation, due to the similarities it has with routine practice in IAPT services, where therapists themselves review with their clients the work done and the changes achieved at the end of therapy.

20. Quality of the study and reflexivity

20.1. Evaluation of the quality of this study

Elliott et al. (1999) suggest criteria to evaluate qualitative methods in psychology research. An explanation follows as to how these criteria were applied during the completion of this work.

a. *Owning one's perspective.*

The author's epistemological position was clearly stated. Additionally, the *Reflexivity* section highlights the reciprocal effects of the author's characteristics on the analysis and outcome of this research as well as the effect of this work on the author as a researcher and clinician.

b. *Situating the sample.*

Demographic and clinical details were facilitated about the participants and about the recruitment process and the organisations approached for their identification. The analysis and discussion of data included the participants' cultural and sociopolitical background informing their comments on the intervention.

c. *Grounding in examples.*

A variety of extracts was included in the *results* section to illustrate the thematic structure suggested. Effort was made not to go beyond the data in this section, following Braun and Clarke (2006). The audit trail in *appendix 15* aims at ensuring the dependability of the analysis (Koch, 2006).

d. *Providing credibility checks.*

Two clinical psychologists (academic and field supervisors) were involved during the data collection and analysis process, adding to the author's observations. Additionally, the comparison of qualitative and quantitative data provides further credibility to these results, which are, lastly, confirmed by means of the reflective account included below (Koch, 2006).

e. *Coherence.*

Appendix 16 offers a visual representation of the thematic structure which aims to further clarify the verbal account in the *results* section.

f. *Accomplishing general vs. specific research tasks.*

This work attempted to be seminal research into a topic on which no previous research has been conducted in the UK. Therefore, setting the context for this research required summarising a vast amount of research conducted in the US as well as the living conditions of the target population in the UK. Additionally, explicit emphasis was made on those aspects of the study which may limit the extent to which results can be generalised (e.g., small number of participants, only generalisable to group interventions).

g. *Resonating with readers.*

Following some amendments suggested by the academic supervisor, two lay people and another clinical psychologist read the final report and judged it to be a comprehensive analysis of the phenomenon under study. This, according to Koch (2006), ensures the transferability of the findings.

20.2. Reflexivity

This research topic was the author's choice, drawing on the use of his mother tongue to reach people in the UK who struggle to access services due, partly, to not speaking fluent English. However, despite important cultural similarities (e.g., mother tongue), socio-political differences between him and the participants (e.g., lesser restrictions to live and work in the UK for European citizens) were prominent and openly referred to. This made the facilitator feel a *privileged migrant* and relatively alien to the hardship described by some participants. This is particularly illustrated by the stories of several people who, extremely keen to participate, never made it beyond registration, presumably due to their unstable circumstances.

As a doctoral thesis, analyses were made solely by the author (under supervision), which may have rendered the findings vulnerable to his subjective interpretation. Indeed, Braun and Clark (2006) state the active role of the researcher, rather than themes 'emerging' or waiting to be 'discovered'. Willig (2008) affirms that the researcher's subjectivity will inevitably influence the interpretation, in that the researcher's interests will foreground particular aspects of the analysis. The author's personal and professional background as a Spanish-speaking migrant in the UK, who has trained at an institution renowned for its critical stance to mainstream Psychology practice and its awareness of the

myriad of social and political aspects surrounding psychological distress may have inadvertently influenced the analysis.

There were similarities and differences between the author, a Spanish national, and the participants, of Latino origin. Whilst some were not overtly disclosed (e.g., marital status), others were more noticeable (e.g., age). Sharing language is one of the most relevant and apparent cultural similarities. Although accent, vocabulary and phraseology clearly distinguished the Castilian Spanish spoken by the facilitator from the Latino Spanish of the participants, this did not compromise communication. Also, whilst educational attainment varied among the participants, most of them experienced similar obstacles in finding employment (e.g. restrictions due to being overseas nationals, non-fluent English).

The processes taking place during both intervention and focus groups show a clear power differential. This is inherent to any intervention with a teaching element, where the professional imparting it is ascribed expert knowledge. However, this particular intervention could be understood within its broader historico-cultural context (i.e., current and past relationships between Spain and Latin American countries). The position of power occupied by the facilitator as a trainee psychologist reflected the reality of the participants' ancestors, subordinated to Spanish *conquistadores* (conquerors), who imposed their knowledge, customs and values from a position of military power. This power relationship was continually addressed with words such as *profesor* (teacher), despite the facilitator's repeatedly discouraging it. Whilst interaction among participants was continually encouraged, most exchanges took place between individual participants and the facilitator. These were mainly aimed at requesting 'an expert opinion' on the topic discussed. The age gap, with the facilitator being considerably younger than most participants (and therefore likely to have less life experience) did not seem to ameliorate this power differential.

To conclude, the current study has undoubtedly contributed to the author's professional development as a researcher and psychologist. It has increased his awareness about the service users' perceptions on the support received and the importance of adopting a multi-level approach (i.e., individual and community-based) particularly when working with a deprived and impoverished community.

Alongside the logistics of devising and managing a complex project within the time constraints, it has been an opportunity to work with a rather deprived population with whom the author felt considerable affinity. However, using Spanish as vehicular language for the clinical intervention and analysis of the data and, then, reporting the findings in English constituted a further challenge.

21. Clinical Implications

The findings of this pilot study have implications at different levels. Namely:

- At an *individual* level:
  - This study, whilst showing a trend towards an improvement in levels of distress, does not provide compelling evidence as to the effectiveness and meaning of group CBT-based LI interventions in anxiety.
  - However, interventions aimed at reducing distress should be offered to Latino migrants experiencing anxiety difficulties, as indicated by the interest shown by the people approached.
  - Group interventions maximise learning among participants, as sharing experiences helps them to normalise their distress. However, this may prove difficult for certain clients, who might benefit from more individualised support. Group interventions should strike a balance between information-giving and space for people to *tell their story* in terms of providing opportunities for *desahogo* (relief) and contribution to the group. Providing these interventions in the participants' mother-tongue, when possible (i.e., sufficient attendees), could prove cost-effective, maximising their engagement over groups offered in English or via interpreters.
  - Help to this collective should not be limited to an individual, symptom-based approach and further input at community level should also be provided.
- At a *Systemic/family* level:
  - Interventions with Latinos should capitalise on the importance they give to family relationships in order to promote psychological well-being. Offering therapeutic input to individuals might have an indirect impact on

their close circle of relationships due to their interest in sharing their knowledge.

- At a *Community* level:

  - Therapeutic support provided in Spanish facilitated by a native Spanish-speaker with a grasp of Latino culture should be made more accessible to this community, particularly to people whose English is not fluent.

  - Campaigns to increase awareness of mental health issues are needed in order to overcome the taboo nature of this topic described by participants and avoid it being an obstacle to accessing to services.

  - Alternative approaches, focused on community empowerment should be explored, as suggested by some participants. Latino/Spanish-speaking third sector organisations should lie at the heart of these initiatives due to their presence and knowledge of the Latino culture. This could also prove a means of preventing inadvertently engendering therapy dependence in some people.

  - Interventions offered to first generation Latino migrants should address issues related to their migrant status, as these affect a great proportion of this community. Thus, raising awareness of the risk of isolation, racism and discrimination, exploitation at work, among other sources of distress should be included together with more individual means of managing excessive levels of distress.

- At a *Sociopolitical* level:

  - Many of the difficulties described by the participants are intrinsic to the disempowerment their condition of migrancy involves and apply to other migrant ethnic minorities. Therefore, policies aimed at increasing their representation and integration in society and politics would contribute to the prevention or amelioration of undue distress.

  - Partnerships between statutory and voluntary sector organisations should be sought for different reasons (e.g., to provide cultural brokerage or enhance the access of Latinos to services provided).

An approach that can encompass the different aspects highlighted by the participants in this intervention is an intervention akin to Holland's (1988) model of social action. Such framework could address the needs of a largely deprived

91

and excluded collective by moving from the realms of individual therapy to progressive involvement in groups and then to collective social and political involvement (Burton, Boyle, Harris & Kagan, n.d.).

22. Recommendations for future research

Due to the limitations of the current study, further research is recommended:

- to validate these preliminary findings, this pilot study should be replicated with a larger sample which allows comparisons to be made using parametric statistics. A clear division of the roles of facilitator and evaluator of the intervention would add validity to participants' comments.

- To ensure the cost-effectiveness of this intervention, future studies should ensure follow-up measures within feasible periods of time.

- To focus on more homogenous client groups, following participants' suggestions (e.g., according to age, level of acculturation or experience of anxiety) to ascertain the effect of these variables and avoid undue over-generalisations (i.e., myth of sameness).

- To refine further the research focus on the active therapeutic components under research (e.g., group vs. individual interventions) would also enhance these results.

- Whilst Spanish people have been excluded from the current study on the basis of having a different political status in the UK (as European nationals), research should be conducted to ascertain the needs of this population, which has recently increased its rate of migration due to the current financial climate.

23. Summary

This pilot study indicates that a quasi-standardised LI CBT psychoeducation group intervention leads to a limited improvement in anxiety levels, although comparisons do not reach conventional levels of statistical significance. Despite these modest quantitative findings, participants gave an overall positive qualitative account of their experience, emphasising a number of elements of the intervention as important (e.g., coping techniques, understanding of anxiety, intervention in Spanish, normalisation of their experience).

A number of possible reasons for these outcomes are considered (i.e., from anthropological to more socio-political). Positive feedback may reflect participants' genuinely satisfactory experience. However, it could also be due to a desirability bias. Additionally, it could reflect participants' apprehension at critiquing an intervention which does not entirely meet their needs, in the context of a myriad of entrenched socio-political factors underlying their daily struggle. An underlying fear of a decision not to implement an intervention being piloted following overly critical feedback may have led participants to downplay its negative aspects.

Whilst acknowledging its limitations, participants recognised the place of LI CBT interventions as an approach to individual distress. However, aware of the difficulties generated by their socio-political situation, they suggested a more preventative approach suited to their needs (e.g., migratory grief) and more community-based support, aimed at empowering themselves as a community. It is, therefore, suggested that a combination of both approaches should be offered to this community. Further research is, however, required to optimise the effect of such interventions, aimed at the minimisation of individual distress and empowerment of a deprived community.

BIBLIOGRAPHY

Achotegui, J. (2008). Migración y crisis: el síndrome del emigrante con estrés crónico y múltiple (Síndrome de Ulises) [Migration and crisis: migrant's chronic and multiple stress syndrome (Ullyses' Syndrome]. *Avances en Salud Mental Relacional , 7* (1) no pp.

Aguilera, A., Garza, M., & Muñoz, R. (2010). Group Cognitive-Behavioral Therapy for Depression in Spanish: Culture-sensitive Manualised Treatment in Practice. *Journal of Clinical Psychology , 66* (8), 857--867.

Alvidrez, J. (1999). Ethnic variations in mental health attitudes and service use among low-income African American, Latina and European American young women. *Community Mental Health Journal , 35* (6), 515-530.

American Psychiatric Association (APA). (2000). *Diagnostic and statistical manual of mental disorders (4th ed., text rev.).* Washington, DC: Author.

American Psychological Association. (2006). *APA presidential task force on evidence based practice.* Washington, DC: Author.

Applewhite, S. (1995). Curanderismo: demystifying the health beliefs and practices of elderly mexican americans. *Health and Social Work , 20* (4), 247-53.

Ardila-Espinel, N. (1982). Criterios y valores de la cultura anglo-saxo-americana y de la cultura latina: sus implicaciones para la psicología transcultural. [Criteria and values of the anglo-saxo-american and Latino cultures: implications for transcultural psychology] *Revista Latinoamericana de Psicología , 14* (1), 63-79.

BACP (British Association for Counselling and Psychotherapy). (2010). *British Association for Counselling and Psychotherapy*. Accessed on 12/4/2012, from Introduction to IAPT: http://www.bacp.co.uk/iapt/

Badat, O. (2010). Ethnic minorities and mental health services: developing a more sustainable approach. *The British Journal of Psychiatry , 196*, pp. 265.

Banister, P., Burman, E., Parker, I., Taylor, M., & Tindall, C. (1994). *Qualitative methods in psychology: A research guide.* Buckingham: Open University Press.

Barkham, M., Gilbert, N., Connell, J., Marshall, C., & Twigg, E. (2005). Suitability and utility of the CORE-OM and CORE-A for assessing severity of presenting problems

in psychological therapy services based in primary and secondary care settings. *The British Journal of Psychiatry , 186*, 239-246.

Bennett-Levy, J., Richards, D., & Farrand, P. (2010). Low Intensity CBT interventions: a revolution in mental health care. In D. R. James Bennett-Levy, *Oxford Guide to Low Intensity CBT Interventions* (pp. 3-18). Oxford: Oxford University Press.

Bermúdez-Torres, A. (2003). *Navigation Guide to Refugee Populations: Colombians.* London: Information Centre about Asylum and Refugees in the UK.

Bernal, G. (01 de 05 de 2009). *Cultural adaptation of psychotherapy.* Accessed on 20/11/ 2011, from Melissa Institute: www.melissainstitute.org/documents/CAEthnoCultural.ppt

Berry, J. (2001). A psychology of immigration. *Journal of Social Issues , 57* (3), 615-631.

Bhaskar, R. (1989). *Reclaiming Reality: A Critical Introduction to Contemporary Philosophy.* London: Verso.

Bhugra, D. (2004). Migration, distress and cultural identity. *British Medical Bulletin , 69* (1), 129-141.

Bhugra, D., & Becker, M. (2005). Migration, cultural bereavement and cultural identity. *World Psychiatry , 4* (1), 18–24.

Bhugra, D., Wojcik, W., & Gupta, S. (2011). Cultural bereavement, culture shock and culture conflict: adjustments and reactions. In D. Bhugra, & S. Gupta, *Migration and mental health* (pp. 139-148). Cambridge: Cambridge University Press.

Bhui, K., Warfa, N., Edonya, P., McKenzie, K., & Bhugra, D. (2007). *Cultural competence in mental health care: a review of model evaluations.* Accessed on 18/11/2011, from PubMed Central: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1800843/

Bieling, P., McCabe, R., & Anthony, M. (2006). *Cognitive-Behavioral Therapy in Groups.* New York: Guilford.

Bloch, S., & Reibstein, J. (1980). Perceptions by patients and therapists of therapeutic factors in group psychotherapy. *The British Journal of Psychiatry , 137*, 274-278.

Bloch, S., Reibstein, J., Crouch, E., Holroyd, P., & Themen, J. (1979). A Method for the Study of Therapeutic Factors in Group Psychotherapy. *British Journal of Psychiatry , 134*, 257-263.

Block, D. (2008). The Increasing Presence of Spanish-Speaking Latinos in London: An Emergent Community? *Journal of Language, Identity and Education , 7*, 5–21.

Botella, L. (2006). Routine evaluation in a psychotherapy service: The use of CORE System data. *European Journal of Psychotherapy & Counselling , 8* (2), 235-241.

Bower, P., Richards, D., & Lovell, K. (2001). The clinical and cost-effectiveness of self-help treatments for anxiety and depressive disorders in primary care: a systematic review. *British Journal of General Practice , 51*, 838-845.

Boyle, M. (2007). The problem with diagnosis. *The Psychologist , 20* (5), 290-292.

Braun, V., & Clarke, V. (2006). Using Thematic Analysis in Psychology. *Qualitative Research in Psychology , 3*, 77-101.

Burton, M., Boyle, S., Harris, C., & Kagan, C. (n.d.). *Community Psychology in Britain*. Retrieved July 13, 2012, from Community Psychology UK: http://www.compsy.org.uk/Community_Psychology_in_Britain_History_version%202 _MB,CK.pdf

Burton, M., Kagan, C., & Duckett, P. (n.d.). *Making the psychological political - challenges for community psychology.* Accessed on 30/4/ 2012, from Community Psychology UK: http://www.compsy.org.uk/Making%20the%20psychological%20political.pdf

Carlisle, F. (2006). Marginalisation and ideas of community among Latin American migrants to the UK. *Gender & Development , 14* (2), 235-245.

Carter, M., Mitchell, F., & Sbrocco, T. (2012). Treating ethnic minority adults with anxiety disorders: current status and future recommendations . *Journal of Anxiety Disorders , 26*, 488–501.

Clark, D., Layard, R., Smithies, R., Richards, D., Suckling, R., & Wright, B. (2009). Improving access to psychological therapy: Initial evaluation of two UK demonstration sites. *Behaviour Research and Therapy , 47* (11), 910-920.

Clarke, I. (2008). The case for CBT. In R. R. House, & D. Loewenthal, *Against and for CBT. Towards a constructive dialogue?* Ross-on-Wye: PCCS.

Comas-Díaz, L. (2006). Latino healing: the integration of ethnic psychology into psychotherapy. *Psychotherapy: Theory, Research, Practice, Training , 43* (4), 436-453.

CORE IMS. (2010). *CORE System User Manual.* Accessed on 5/4/ 2012, from www.coreims.co.uk

Corrigan, P. (2007). How clinical diagnosis might exacerbate the stigma of mental illness. *Social Work , 52* (1), 31-39.

Creswell, J., & Plano Clark, V. (2007). *Designing and conducting mixed methods research.* Thousand Oaks, CA: Sage.

Cuijpers, P., & Schuurmans, J. (2007). Self-help Interventions for Anxiety Disorders: an Overview. *Current Psychiatry Reports , 9*, 284–290.

Department of Health (DoH). (04/2008). *Improving Access to Psychological Therapies (IAPT) Commissioning Toolkit.* Accessed on 07/11/2011, from http://www.dhcarenetworks.org.uk/_library/IAPT_commissioning_toolkit.pdf

Department of Health (DoH) (2009). *Black and Minority Ethnic (BME). Positive practice guide.* Accessed on12/11/2011, from http://iapt.nmhdu.org.uk/silo/files/black-and-minority-ethnic-bme-positive-practice-guide.pdf

Derogatis, L., & Melisaratos, N. (1983). The Brief Symptom Inventory: an introductory report. *Psychological Medicine , 13* (3), 595-605.

Diez-Quevedo, C., Rangil, T., Sánchez-Planell, L., Kroenke, K., & Spitzer, R. (2001). Validation and Utility of the Patient Health Questionnaire in Diagnosing Mental Disorders in 1003 General Hospital Spanish Inpatients. *Psychosomatic Medicine , 63* (4), 679-686.

Dowrick, C., Dunn, G., Ayuso Mateos, J., Dalgard, O., Page, H., Lehtinen, V., et al. (2000). Problem solving treatment and group psychoeducation for depression: multicentre randomised controlled trial. *British Medical Journal , 321*, 1-6.

Duffy, K., & Wong, F. (2003). *Community Psychology* (3rd ed.). Boston, MA: Pearson Education.

Dugas, M., & Robichaud, M. (2007). *Cognitive-Behavioral Treatment for Generalized Anxiety Disorder.* New York: Routledge.

Escobar, J. (1995). Transcultural aspects of dissociative and somatoform disorders. *Psychiatric Clinics of North America , 18* (3), 555-569.

Evans, C., Connell, J., Barkham, M., Margison, F., Mcgrath, G., Mellor-Clark, J., et al. (2002). Towards a standardised brief outcome measure: psychometric properties and utility of the CORE—OM. *The British Journal of Psychiatry , 180*, 51-60.

Evans, R., Mellor-Clark, J., Barkham, M., & Mothersole, G. (2006). Developing the resources and management support for routine evaluation in counselling and psychological therapy service provision: Reflections on a decade of CORE development. *European Journal of Psychotherapy & Counselling , 8*, 141-161.

Fernando, S. (2010a). *Mental Health, Race and Culture.* New York: Palgrave MacMillan.

Fernando, S. (2010b). Multicultural counselling. *Openmind , 161*, 25.

Field, A. (2005). *Discovering statistics using SPSS* (2nd ed.). London: Sage Publications.

Foreign and Commonwealth Office (FCO). (2007). *Latin America to 2020: A UK Public Strategy Paper.* Accessed on 26/11/2010, from Foreign and Commonwealth Office: http://www.fco.gov.uk/Files/kfile/Latin%20America%20Booklet%20final.pdf

García-Campayo, J., Zamorano, E., Ruiz, M. P., Pérez-Páramo, M., López-Gómez, V., Freire, O. et al. (2010). Cultural adaptation into Spanish of the generalized anxiety disorder-7 (GAD-7) scale as a screening tool. *Health and Quality of Life Outcomes , 8* (8), 1-11.

Gega, L., Kenwright, M., Mataix-Cols, D., Cameron, R., & Marks, I. (2005). Screening People With Anxiety/Depression for Suitability for Guided Self-help. *Cognitive Behaviour Therapy , 34* (1), 16–21.

Gilbert, P. (2009). Moving beyond Cognitive Behaviour Therapy. *The Psychologist , 22* (5), 400-403.

Gloria, A., Ruiz, E., & Castillo, E. (2004). Counselling and Psychotherapy with Latino and Latina clients. In T. Smith, *Practicing multiculturalism: affirming diversity in counseling and psychology* (pp. 167–189)*.* Boston: Pearson Education.

Grames, H. (2006). Depression, anxiety and ataque de nervios: the primary mental health care model in a Latino population. *Journal of Systemic Therapies , 25* (3), 58-72.

Greater London Authority (GLA). (2008). *DMAG Update: ONS Ethnic Groups Population Estimates. Mid-2006. GLA Demography Update 15-2008.* London: Author.

Griner, D., & Smith, T. (2006). Culturally adapted mental health intervention: A meta-analytic review. *Psychotherapy: Theory, Research, Practice, Training , 43* (4), 531-548.

Guarnaccia, P., & Martinez, I. (n.d.). "It's like going through an earthquake". Anthropological perspectives of depression from focus groups with latino immigrants. Paper presented at Mount Sinai Medical Center. New York.

Guba, E., & Lincoln, Y. (1988). Do inquiry paradigms imply inquiry methodologies? In D. Fetterman, *Qualitative approaches to evaluation in education: the silent scientific revolution.* London: Praeger.

Hagan, T., & Smail, D. (1997). Power-mapping - I. Background and basic methodology. *Journal of Community and Applied Social Psychology , 7*, 257-267.

Hardy, G., Cahill, J., & Barkham, M. (2009). Active ingredients of the therapeutic relationship that promote client change. A research perspective. In P. Gilbert, & R. Leahey, *The therapeutic relationship in the Cognitive Behavioral psychotherapies* (pp. 24-42). Hove: Routledge.

Harper, D. (2012). Choosing a qualitative research method. In D. Harper, & A. Thompson, *Qualitative research methods in mental health and psychotherapy. A guide for students and practitioners.* Chichester: John Willey.

Haste, P. (31 May 2007). *Colombia's magical realism.* Accessed on 23rd April 2012, from Dissident Voice: http://dissidentvoice.org/2007/05/colombia%E2%80%99s-magical-realism/

Hays, P. (2009). Integrating Evidence-Based Practice, Cognitive-Behaviour Therapy and Multicultural Therapy: then steps for culturally competent practice. *Professional Psychology, Research and Practice , 40* (4), 354-360.

Hays, P. (1995). Multicultural applications of cognitive-behavior therapy. *Professional Psychology: Research and Practice , 26* (3), 309-315.

Hemmings, A. (2008). A response to the chapters in Against and For CBT. In R. House, & D. Loewenthal, *Against and For CBT* (pp. 42-51). Ross-on-Wye: PCCS.

Hofstede, G. (2001). *Culture's consequences: comparing values, behaviours, institutions and organisations across nations. 2nd ed.* Thousand Oaks, CA: Sage.

Holland, S. (1988). Defining and experimenting with prevention. In S. Ramon & M. Giannichedda (Eds.), *Psychiatry in Transition: the British and Italian experiences.* London: Pluto.

 Houghton, S., & Saxon, D. (2007). An evaluation of large group CBT psycho-education for anxiety disorders delivered in routine practice. *Patient Education and Counseling , 68*, 107–110.

Huang, F., Chung, H., Kroenke, K., Delucchi, K., & Spitzer, R. (2006). Using the Patient Health Questionnaire-9 to Measure Depression among Racially and Ethnically Diverse Primary Care Patients. *Journal of General Internal Medicine , 21*, 547–552.

Hwang, W., Myers, H., Abe-Kim, J., & Ting, J. (2008). A conceptual paradigm for understanding culture's impact on mental health: The cultural influences on mental health (CIMH) model. *Clinical Psychology Review , 28*, 211–227.

Interian, A., & Díaz-Martínez, A. (2007). Considerations for Culturally Competent Cognitive Behavioral Therapy for Depression with Hispanic Patients. *Cognitive and Behavioral Practice , 14*, 84-97.

Interian, A., Allen, L., Gara, M., & Escobar, J. (2008). A Pilot Study of Culturally Adapted Cognitive Behavior Therapy for Hispanics with Major Depression. *Cognitive and Behavioral Practice , 15* (1), 67-75.

Joffe, H. (2012). Thematic analysis. In D. Harper and A. R. Thompson, *Qualitative research methods in mental health and psychotherapy. A guide for students and practitioners* (pp. 209-224). Chichester: John Willey.

Kaye, J. (2008). Thinking thoughtfully about Cognitive Behaviour Therapy. In R. House, & D. Loewenthal, *Against and For CBT* (págs. 169-178). Ross-on-Wye: PCCS.

Kennerley, H. (1997). *Overcoming anxiety.* London: Robinson Publishing.

Khan, N., Bower, P., & Rogers, A. (2007). Guided self-help in primary care mental health: Meta-synthesis of qualitative studies of patient experience. *The British Journal of Psychiatry, 191*, 206-211.

Koch, T. (2006). Establishing rigour in qualitative research: the decision trail. *Journal of Advanced Nursing , 53* (1), 91-100.

Kroenke, K., Spitzer, R., & Williams, J. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine , 16* (9), 606-613.

Krueger, R. (1999). The structure of common mental disorders. *Archives of General Psychiatry , 56*, 921-926.

Krueger, R., & Casey, M. (2009). *Focus groups : a practical guide for applied research* (4th ed.). London: SAGE.

La Roche, M. C., & Christopher, M. S. (2009). Changing paradigms from empirically supported treatment to evidence-based practice: A cultural perspective. *Professional Psychology: Research and Practice , 40* (4), págs. 396-402.

La Roche, M. (2002). Psychotherapeutic considerations in treating Latinos. *Harvard Review of Psychiatry , 10*, 115-122.

Lambert, M., & Barley, D. (2001). Research Summary on the therapeutic relationship and psychotherapy outcome. *Psychotherapy , 38* (4), 357-361.

Lawson, R., & Guite, H. (2005). Psychological therapies for common mental illness: how effective and equitable is provision? *Primary Care Mental Health , 3*, 5-12.

Layard, R. C. (2006). *The depression report: a new deal for depression and anxiety disorders.* London: The Centre for Economic Performance's Mental Health Policy Group, London School of Economics.

Lin, T-Y.L., Tardiff, K., Donetz, G., & Goresky, W. (1978). Ethnicity and patterns of help-seeking. *Culture, Medicine and Psychiatry , 2* (1), 3-13.

Linneker, B., & McIllwaine, C. (2011). *Estimating the Latin American population of London from official data sources.* London: Queen Mary's University of London.

López, A., & Katz, I. (2001). An introduction to Latinos in the United States. In A. López, & E. Carrillo, *The latino psychiatric patient* (pp. 3-18). Washington, DC: American Psychiatric Publishing, Inc.

López, S., & Guarnaccia, P. (2000). Cultural Psychopathology: Uncovering the Social World of Mental Illness. *Annual Review of Psychology , 51*, 571–598.

Löwe, B. D. (2008). Validation and standardization of the generalized anxiety disorder screener (GAD-7) in the general population. *Medical Care , 46* (3), 266-274.

Löwe, B., Spitzer, R., Williams, J., Mussell, M., Schellberg, D., & Kroenke, K. (2008b). Depression, anxiety and somatization in primary care: syndrome overlap and functional impairment. *30* (3), 191-199.

Lujan, J., & Campbel, H. (2006). The role of religion on the health practices of Mexican Americans. *Journal of Religion and Health , 45* (2), 183-195.

Macdonald, W., Mead, N., Bower, P., Richards, R., & Lovell, K. (2007). A qualitative study of patients' perceptions of a 'minimal' psychological therapy. *International Journal of Social Psychiatry, 53* (1), 23–35.

Marín, G., Sabogal, F., VanOss Marín, B., Otero-Sabogal, F., & Pérez-Stable, E. (1987). Development of a short acculturation scale for Hispanics. *Hispanic Journal of Behavioral Sciences, 9*, 183-205.

Marsella, A., & Yamada, A. (2007). Culture and Psychopatology. Foundations, Issues and Directions. In S. Kitayama, & D. Cohen, *Handbook of Cultural Psychology* (pp. 797-818)*.* New York: Guilford Press.

Martínez-Pincay, I., & Guarnaccia, P. (2007). "It's Like Going through an Earthquake": Anthropological Perspectives on Depression among Latino Immigrants. *Journal of Immigrant Minority Health , 9*, 17–28.

Marzillier, J., & Hall, J. (2009). The challenge of the Layard's initiative. *The Psychologist , 22* (5), pp. 395-399.

McEvoy, P., & Richards, D. (2003). Critical realism: a way forward for evaluation research in nursing? *Journal of Advanced Nursing , 43* (4), 411–420.

McIlwaine, C. (2007). *Living in Latin London: How Latin American Migrants Survive in the City*. Accessed on 26/11/2010, from Institute for the Study of the Americas: http://americas.sas.ac.uk/newsletter/docs/LivingInLatinLondon.pdf

McIlwaine, C., Cock, J. C., & Linneker, B. (2011). *No Longer Invisible: the Latin American community in London.* London: Queen Mary's University.

McManus, F., Shafran, R., & Cooper, Z. (2010). What does a 'transdiagnostic approach' have to offer the treatment of anxiety disorders? *British Journal of Clinical Psychology , 49* (4), 491-505.

Mead, N., McDonald, W., Bower, P., Lovell, K., Richards, D., Roberts, C., et al. (2005). The clinical effectiveness of guided self-help versus waiting-list control in the management of anxiety and depression: a randomized controlled trial. *Psychological Medicine , 35*, 1633-1643.

Mezzich, J., Kirmayer, L., Kleinman, A., Fabrega, H., Parron, D., Good, B., et al. (1999). The place of culture in DSM-IV. *The Journal of Nervous and Mental Disorders , 187* (8), 457-464.

Middleton, H. (2007). Critical Psychiatry. *Mental Health Review Journal , 12* (2), 40-43.

Milton, J. (2008). Psychoanalysis and Cognitive Behaviour Therapy: rival paradigms or common ground? In R. House, & D. D. Loewenthal, *Against and for CBT. Towards a constructive dialogue?* (101-117)*.* Ross-on-Wye: PCCS.

Miranda, J., Azocar, F., Organista, K., Dwyer, E., & Areane, P. (2003). Treatment of depression among impoverished primary care patients from ethnic minority groups. *Psychiatric Services , 54* (2), 219-225.

Miranda, J., Bernal, G., Lau, A., Kohn, L., Hwang, W., & Lafromboise, T. (2005). State of the science on psychosocial interventions for ethnic minorities. *Annual Review of Clinical Psychology , 1*, 113-142.

Moloney, P., & Kelly, P. (2008). Beck never lived in Birmingham. Why Cognitive Behaviour Therapy may be a less helpful treatment for psycholocial distress than is often supposed. In R. House, & D. Loewenthal, *Against and For CBT: Towards a constructive dialogue* (pp. 278-288). Ross-on-Wye: PCCS.

Morales, E., & Norcross, J. (2010). Evidence-based practices with ethnic minorities: strange bedfellows no more. *Journal of Clinical Psychology , 66* (8), 821-829.

Mundry, R., & Fischer, J. (1998). Use of statistical programs for nonparametric tests of small Samples often leads to incorrect p values: examples from animal behaviour . *Animal Behaviour , 56*, 256–259.

Naeem, F., Ayub, M., Gobbi, M., & Kingdon, D. (2009). Development of Southampton Adaptation Framework for CBT (SAF-CBT) : a framework for adaptation of CBT in non-western culture. *Journal of Pakistan Psychiatric Society , 6* (2), 79-84.

Narayanan, A., & Watts, D. (1996). *Exact Methods in the NPAR1WAY Procedure.* Accessed on 16th March 2012, from UCLA Academic Technology Services: http://www.ats.ucla.edu/stat/sas/library/exact.pdf

National Institute for Health and Clinical Excellence (NICE). (2004). *Anxiety: management of anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care.* London: Author.

National Institute for Health and Clinical Excellence (NICE). (2005). *Guidelines for the treatment of obsessive compulsive disorder (OCD) and body dysmorphic disorder (BDD) (CG31).* London: Author.

National Institute for Health and Clinical Excellence (NICE). (2009). *Depression: the treatment and management of depression in adults (update).* London: Author.

National Institute for Health and Clinical Excellence (NICE). (2011). Guidelines for the treatment and management of post-traumatic stress disorder (PTSD) (CG26). London: Author.

Nel, P. (2009). Improving access to psychological therapies: It's the end of the world as we know it (and I feel fine). *Clinical Psychology Forum* (194), pp. 7-11.

Noble, J., & LaCasa, J. (1991). *The Hispanic way: Aspects of behavior, attitudes and customs of the Spanish-speaking world.* Chicago, Ill.: Passport Books.

Nesdale, D., & Mak, A. (2000). Immigrant acculturation attitudes and host country identification. *Journal of Community & Applied Social Psychology , 10*, (6), 483–495

Northumberland Tyne & Wear Mental Health Foundation Trust (n.d.). *Northumberland, Tyne & Wear Mental Health Foundation Trust - Leaflet*

search/request. Accessed on 4th April 2011, from

http://www.ntw.nhs.uk/pic/leaflet.php#

Norton, P. (2008). An open trial of a transdiagnostic cognitive-behavioral group therapy for anxiety disorder. *Behavior Therapy , 39* (3), 242-250.

Oei, T., & Shuttlewood, G. (1997). Comparison of specific and nonspecific factors in a group cognitive therapy for depression. *Journal of Behavioral Therapy and Experimental Psychiatry, 28* (3), 221-230.

Organista, K. (2006). Cognitive-behavioral therapy with Latinos and Latinas. In P. Hays, & G. Iwamasa, *Culturally responsive cognitive-behavioral therapy: Assessment, practice, and supervision* (pp. 73-96). Washington, DC: American Psychological Association.

Organista, K., & Muñoz, R. (1996). Cognitive Behavioral Therapy with Latinos. *Cognitive and Behavioral Practice , 3*, 255-270.

Padesky, C., & Mooney, K. (1990). Presenting the Cognitive Model to Clients. *International Cognitive Therapy Newsletter , 6*, pp. 13-14.

Peluso, E., & Blay, S. (2004). Community perception of mental disorders: a systematic review of Latin American and Caribbean studies. *Social Psychiatry and Psychiatric Epidemiology , 39*, 955–961.

Phinney, J., Horenczyk, G., Liebkind, K., & Vedder, P. (2001). Ethnic identity, immigration and well-being: an international perspective. *Journal of Social Issues , 57* (3), 493-510.

Pilgrim, D. (2000). Psychiatric diagnosis: more questions than answers. *The Psychologist , 13* (6), 302-305.

Pilgrim, D. (2008). Reading "Happiness": CBT and the Layard hypothesis . In R. House, & D. Loewenthal, *Against and For CBT* (pp. 256-268). Ross-on-Wye: PCCS.

Pilgrim, D., & Bentall, R. (1999). The medicalization of misery: A critical realist analysis of the concept of depression. *Journal of Mental Health , 8* (3), 261-274.

Rabiee, F. (2004). Focus-group interview and data analysis. *Proceedings of the Nutrition Society , 63*, 655–660.

Rathod, S., & Kingdon, D. (2009). Cognitive Behaviour Therapy across cultures. *Psychiatry , 8* (9), 370-371.

Revollo, H., Qureshi, A., Collazos, F., Valero, S., & Casas, M. (2011). Acculturative stress as a risk factor of depression and anxiety in the Latino immigrant population. *International Review of Psychiatry , 23* (1), 84-92.

Richards, D., & Suckling, R. (2008). Improving access to psychological therapy: The Doncaster demonstration site organisational model. *Clinical Psychology Forum , 181*, 9-16.

Richards, D., & Whyte, M. (2008). *Reach Out. National Programme Educator Materials to Support the Delivery of Training for Practitioners Delivering Low Intensity Interventions.* York: Rethink-University of York.

Rojano, R. (2001). Colombians. In A. López, & E. Carrillo, *The Latino Psychiatric Patient* (pp. 57-74). Washington, DC: American Psychiatric Publishing, Inc.

Roselló, J., & Bernal, G. (1999). The efficacy of cognitive-behavioral and interpersonal treatment for depression in Puerto Rican adolescents. *Journal of Consulting and Clinical Psychology , 67*, 734-745.

Ruiz, M., Zamorano, E., García-Campayo, J., Pardo, A., Freire, O., & Rejas, J. (2011). Validity of the GAD-7 scale as an outcome measure of disability in patients with generalized anxiety disorders in primary care. *Journal of Affective Disorders, 128* (3), 277-286.

Shattell, M., Hamilton, D., Starr, S., Jenkins, C., & Hinderliter, N. (2008). Mental health service needs of a Latino population: A community-based participatory research project. *Issues in Mental Health Nursing, 29* (4), 351-370.

Siegel, S., & Castellan, N. (1988). *Nonparametric Statistics for the Behavioral Sciences.* New York: McGraw-Hill.

Söchting, I., Wilson, C., & De Gagné, T. (2010). Cognitive Behavioural Group Therapy (CBGT): capitalising on efficiency and humanity. In D. R. Bennett-Levy, *Oxford Guide to Low Intensity CBT Interventions* (pp. 323-329). Oxford: Oxford University Press.

Spitzer, R., Kroenke, K., & Williams, J. (1999). Validation and Utility of a Self report Version of PRIME-MD. The PHQ Primary Care Study. *Journal of the American Medical Association, 282* (18), 1737-1744.

Spitzer, R., Kroenke, K., Williams, J., & Löwe, B. (2006). A Brief Measure for Assessing Generalized Anxiety Disorder: The GAD-7 . *Archives of Internal Medicine, 166*, 1092-1097.

Sterne, J., & Davey-Smith, G. (2001). Sifting the evidence-what's wrong with significance tests? *British Medical Journal , 322* (7280), pp. 226-231.

Sue, S. (2001). In defense of cultural competency in psychotherapy and treatment. *American Psychologist , 42*, 37-45.

Sue, S., & Zane, N. (2009). The Role of Culture and Cultural Techniques in Psychotherapy: a Critique and Reformulation. *Asian American Journal of Psychology, S* (1), pp. 3-14.

Swartz, L., & Rohleder, P. (2008). Cultural Psychology. In C. Willig, & W. Stainton-Rogers, *The SAGE handbook of Qualitative Research in Psychology* (pp. 541-553). London: SAGE.

Temple, B., Edwards, R., & Alexander, C. (2006). Grasping at Context: Cross Language Qualitative Research as Secondary Qualitative Data Analysis [46 paragraphs]. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research*, *7*(4), Art. 10, http://nbn-resolving.de/urn:nbn:de:0114-fqs0604107.

Thomas, P., Bracken, P., & Yasmeen, S. (2007). Explanatory models for mental illness: limitations and dangers in a global context. *Perspective , 2* (3), 176-181.

Torres-Rivera, E. (2004). Psychoeducational and Counseling Groups with Latinos. In J. L. DeLucia-Waack, *Handbook of Group Counseling and Psychotherapy* (pp. 213-223). London: Sage Publications.

Turpin, G., Richards, D., Hope, R., & Duffy, R. (2008). Improving Access to Psychological Therapies: A national initiative to ensure the delivery of high quality evidence-based therapies. *Papeles del Psicólogo, 29* (3), 271-280.

UK Council for Psychotherapy (UKCP) (2011). *NICE under scrutiny.* London: Roehampton University.

UK Parliament (1998). *Data Protection Act.* Accessed on 21st November 2011, from Information Commissioner's Office website:

http://www.legislation.gov.uk/ukpga/1998/29/contents

Upshur, R., VanDenKerkhof, E., & Goel, V. (2001). Meaning and measurement: an inclusive model of evidence in health care. *Journal of Evaluation in Clinical Practice , 7* (2), 91–96.

Ussher, J. (2010). Are We Medicalizing Women's Misery? A Critical Review of Women's Higher Rates of Reported Depression. *Feminism & Psychology , 20* (1), 9–35.

Varela, R., & Hensley-Maloney, L. (2009). The influence of culture on anxiety in Latino youth: a review. *Clinical Child and Family Psychology Review , 12*, 217-233.

Waller, R., Trepka, C., Collerton, D., & Hawkins, J. (2010). Addressing spirituality in CBT . *The Cognitive Behaviour Therapist , 3*, 95-106.

Williams, C. (2003). *Overcoming Anxiety: A five areas approach.* London: Hodder Arnold.

Williams, R.T., Heinemann A.W., Bode R.K., Wilson C.S., Fann J.R. & Tate D.G. (2009). Improving measurement properties of the Patient Health Questionnaire-9 with rating scale analysis. *Rehabilitation Psychology , 54* (2), 198-203.

Willig, C. (2008). *Introducing qualitative research in psychology adventures in theory and method* (2 ed.). Maidenhead: McGraw-Hill Open University Press.

Wilson, J., Armoutliev, E., Yakunina, E., & Werth, J. (2009). Junior practicing psychologists' reflections on evidence-based practice in psychology. *Professional Psychology: Research and Practice , 40* (4), 403-409.

Wilson, M., Phillip, D., Kohn, L., & Curry-El, J. (1995). Cultural relativistic approach toward ethnic minorities in family therapy. In J. Aponte, R. Rivers, & J. Wohl, *Psychological interventions and cultural diversity* (pp. 92-108). Boston: Allyn & Bacon.

Wolf, Z. (2003). Exploring the Audit Trail for Qualitative Investigations. *Nurse Educator , 4*, 175-178.

Wulsin, L., Somoza, E., & Heck, J. (2002). The feasibility of using the Spanish PHQ-9 to screen for depression in primary care in Honduras. *Primary Care Companion Journal of Clinical Psychiatry* , *4* (5) , 191-195.

Yalom, I. (1995). *The Theory and practice of of group psychotherapy (4th ed.).* New York: Basic Books.

Yardley, L., & Bishop, F. (2008). Mixing qualitative and quantitative methods: a pragmatic approach. In C. Willig, & W. Stainton-Rogers, *The SAGE handbook of qualitative research in psychology* (pp. 352-369). London: SAGE.

Zacharias, S. (2006). Mexican Curanderismo as Ethnopsychotherapy: A qualitative study on treatment practices, effectiveness, and mechanisms of change. *International Journal of Disability, Development and Education , 53* (4), 381–400.

APPENDIX

Appendix 1. Stepped-care model of delivery (Richards & Whyte, 2008)

Staff	Disorder	Intervention
Step 3: High-intensity	Depression – mild, moderate and severe	CBT, IPT, behavioural activation[3]
	Depression – mild to moderate	Counselling, couples
	Panic disorder	CBT
	GAD	CBT
	Social phobia	CBT
	PTSD	CBT and EMDR
	Obsessive compulsive disorder (OCD)	CBT
Step 2: Low-intensity service	Depression – mild to moderate	cCBT, guided self-help, behavioural activation, exercise
	Panic disorder – mild to moderate	cCBT, guided self-help, pure self-help[2]
	GAD – mild to moderate	cCBT, guided self-help, pure self-help,[2] psychoeducational
	PTSD	n/a
	Social phobia	n/a
	OCD – mild to moderate	Guided self-help
Step 1: Primary care/IAPT service	Recognition of problem	Assessment/watchful waiting

Appendix 2. Programme outline

Session 1 – **Introduction to workshop & generic psychoeducation re. anx & worry**

Outcome measures

- Introductions.
- Discuss objectives, expectations and procedures of the workshop.
- Overview of the course (format, expectations, between-session tasks).
- Questions and Answers
  - about the workshop,
  - about the difficulties filling out questionnaires
- Group discussion about the concept of anxiety and excessive worry and how these manifest themselves in the participants' lives.
- Defining related constructs (stress, depression).
- Overview of main anxiety disorders
- Psychoeducation on anxiety/worry
  - Anxiety (elements, fight/flight-freeze response, triggers, coping strategies, management).
  - Positive and negative aspects of anxiety.
  - Worry (concept, pros/cons, themes)
- CBT and anxiety. CBT conceptualisation of anxiety
- Homework : complete anxiety monitoring sheet
- Session review and 'Most Important Event' question.

Session 2 – **CBT model of anxiety & physiological arousal reduction techniques**

Outcome measures

- Review previous session + homework
- CBT model (hot cross bun) (review)
- CBT model of anxiety (longitudinal and transversal explanation)
- Pair exercise: discussing a personal incident of anxiety and identify the different elements of the experience following the CBT model
- Linking different aspects of the experience to different coping strategies (e.g. relaxation, problem solving, thought challenging)
- Physiological arousal reduction techniques – relaxation (rationale)
  - Relaxation techniques people use (group discussion)
  - Progressive muscle relaxation exercise + feedback
  - Imagery relaxation exercise + feedback

(Give out relaxation CD)

- Homework: practise relaxation techniques x3 during the week.
- Session review and MIE question.

Session 3 – **Graded exposure/behavioural activation & sleep management**

Outcome measures

- Review last session + homework
- Rationale for graded exposure (role of avoidance in anxiety maintenance)
  - Features of effective exposure: repeated, graded, prolonged and without distraction).
- Construct graded hierarchy
- Agree work schedule (plan)
- Sleep problems related to stress/anxiety
  - Sleep hygiene
  - Sleep restriction programme
- Questions and answers
- **Further support – linking with other local agencies** (a list of local services, both statutory and 3rd sector will be provided and reviewed with the participants for them to consider further support)
- Session review and MIE question.

Session 4 – **Worry management & cognitive techniques**

Outcome measures

- Review last session + homework
- Cognitive biases – challenging your unhelpful thoughts
- Problem-solving techniques
- Other useful techniques
  - The worry sieve
  - Boxing your worries
- Questions and answers
- Session review and MIE question.
- Discuss focus group and hand out outline for discussion

Appendix 3. Programme sessions (handouts) –spanish-

15/07/2012
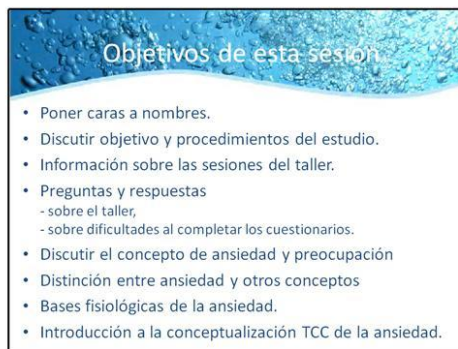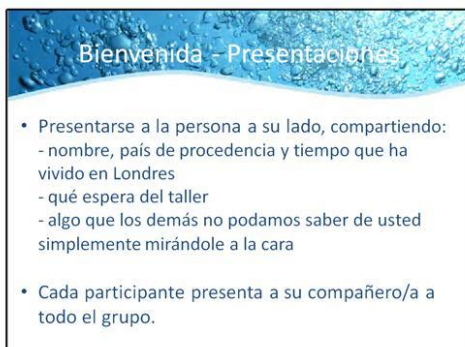
UEL University of East London　IRMO　LAWRs　mrc

Manejo de la Ansiedad y Preocupación Excesiva

IRMO
Verano 2011

Proyecto de investigación doctoral "Efectividad y Sentido de la Terapia Cognitivo Conductual de Baja Intensidad para Inmigrantes Latinoamericanos Residentes en Londres"

Primera sesión
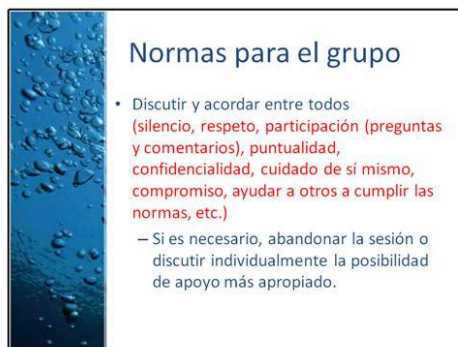
Objetivos de esta sesión

- Poner caras a nombres.
- Discutir objetivo y procedimientos del estudio.
- Información sobre las sesiones del taller.
- Preguntas y respuestas
  - sobre el taller,
  - sobre dificultades al completar los cuestionarios.
- Discutir el concepto de ansiedad y preocupación
- Distinción entre ansiedad y otros conceptos
- Bases fisiológicas de la ansiedad.
- Introducción a la conceptualización TCC de la ansiedad.

Bienvenida - Presentaciones

- Presentarse a la persona a su lado, compartiendo:
  - nombre, país de procedencia y tiempo que ha vivido en Londres
  - qué espera del taller
  - algo que los demás no podamos saber de usted simplemente mirándole a la cara

- Cada participante presenta a su compañero/a a todo el grupo.

Normas para el grupo

- Discutir y acordar entre todos (silencio, respeto, participación (preguntas y comentarios), puntualidad, confidencialidad, cuidado de sí mismo, compromiso, ayudar a otros a cumplir las normas, etc.)
  - Si es necesario, abandonar la sesión o discutir individualmente la posibilidad de apoyo más apropiado.

Estructura del curso

- **1ª sesión (Sábado 9 Julio / Lunes 4 Julio):**
  Introducción - Conceptos
  - introducción del taller y presentaciones,
  - normas de grupo,
  - discusión de conceptos 'ansiedad' y 'preocupación'
  - modelo TCC.
- **2ª sesión (Sábado 16 Julio / Lunes 11 Julio):**
  Técnicas de disminución de la activación fisiológica
  - introducción a la Terapia Cognitivo Conductual (TCC/CBT)
  - ansiedad y preocupación desde una perspectiva TCC
  - Relajación (muscular progresiva y por imaginación)

Estructura del curso (2)

3ª sesión (Sábado 23 Julio / Lunes 18 Julio):
Exposición gradual/Activación conductual y manejo del sueño
- Introducción a la *exposición gradual*
- Introducción a la *activación conductual*
- Técnicas para el manejo del insomnio debido a la ansiedad
- Servicios comunitarios

4ª sesión (Sábado 30 Julio / Lunes 25 Julio):
Manejo de la preocupación y técnicas cognitivas
- Sesgos cognitivos – retar tus pensamientos inútiles
- Técnicas para la resolución de problemas
- Otras técnicas útiles
- Discutir grupo de diálogo y entregar hoja para la discusión

1

113

15/07/2012

Estructura del curso (3)

- Última sesión - Grupo de discusión (Sábado 6 Agosto / Lunes 1 Agosto)
  - Discusión sobre la experiencia de participar en el grupo.
  - La conversación versará sobre el modelo TCC, sus aspectos útiles y aquellos más difíciles de aplicar o no tan útiles. Se discutirán posibles formas de mejorar la intervención, haciéndola más relevante para Latinoamericanos.

Estructura del curso (4)

- Presentación de material.
- Ejercicios y discusión en grupo.
- Tareas para casa (trabajo entre sesiones).
- Breve conversación sobre lo más importante ocurrido al finalizar la sesión.
- Importancia de
  - completar los cuestionarios cada sesión.
  - asistir a <u>todas</u> las sesiones y al grupo de discusión.
  - grabar las sesiones a fin de evaluar su efectividad.

¿Qué es la ansiedad?

Discusión en parejas y puesta en común

¿qué palabras asociamos a la de ansiedad?

¿cómo sabemos que estamos experimentando ansiedad?

¿y cómo sabemos si otros están experimentándola?

¿qué cosas/situaciones producen ansiedad?

¿es la ansiedad positiva o negativa?

Definición de ansiedad

Es una respuesta emocional o patrón de respuestas (triple sistema de respuestas) que engloba aspectos **cognitivos** displacenteros, de tensión y aprensión; aspectos **fisiológicos**, caracterizados por un alto grado de activación del sistema nervioso autónomo y aspectos **motores** que suelen implicar comportamientos poco ajustados y escasamente adaptativos. La respuesta de ansiedad puede ser **elicitada tanto por estímulos externos o situacionales como por estímulos internos al sujeto** (respuestas anticipatorias), tales como pensamientos, ideas, imágenes, etc, que son percibidos por el individuo como peligrosos o amenazantes.

Síntomas físicos de la ansiedad

La ansiedad a menudo se presenta acompañada de **síntomas físicos** tales como:

- Dolor abdominal (puede ser el único síntoma de ansiedad)
- Molestias de estómago, diarrea, náuseas o necesidad frecuente de orinar
- Resequedad en la boca o dificultad para masticar, cambio en el apetito
- Mareo y dolores de cabeza
- Tensión muscular (especialmente las manos y la mandíbula)
- Respiración rápida y sensación de ahogo
- Frecuencia cardíaca rápida o irregular
- Sudoración
- Hormigueo en las extremidades y temblores
- Insomnio (dificultad para conciliar el sueño o mantenerse dormido)
- Visión borrosa, visión de túnel
- Dificultad para mantenerse quieto

Síntomas cognitivos de la ansiedad

Síntomas cognitivos de la ansiedad incluyen:

- Dificultad de concentración
- Problemas para pensar de forma lógica
- Distractibilidad
- Fatiga mental
- Problemas de memoria
- Disminución de la capacidad de resolución de problemas
- Pensamiento negativo

2

15/07/2012

Síntomas conductuales de la ansiedad

Síntomas conductuales de la ansiedad pueden ser:

- Estado de alerta y de vigilancia muy alta (hipervigilancia)
- Bloqueos, torpeza o dificultad para actuar,
- Impulsividad,
- Inquietud motora, dificultad para estarse quieto y en reposo
- Cambios en la expresividad corporal,
- Cambios en la voz, expresión facial de asombro, duda o crispación, etc
- **Evitación**
  - posponer tareas importantes
  - aislarse de los demás
  - conductas de seguridad (en situaciones sociales): hablar en voz muy baja y rápido, permanecer callado, ensayar antes de hablar, rehuir contacto visual, ir al WC para escapar de otros, beber alcohol, etc.
  - dar excusas para evitar salir o hacer algo
  - evitar ir a lugares con mucha gente o donde uno se puede perder

Síntomas emocionales de la ansiedad

Hay otras **emociones** asociadas a la ansiedad. Éstas son:

- Irritabilidad
- Ira-enfado
- Miedo
  - Miedo a un ataque cardíaco
  - Miedo a morir
  - Miedo a algo horrible
- Sospecha
- Vergüenza/ridículo

La ansiedad: ¿buena o mala?

La ansiedad: ¿buena o mala?

La ansiedad es una respuesta adaptativa al medio (peligro-demandas). Nuestro cuerpo se prepara para afrontar un peligro.

La ansiedad en un grado óptimo nos ayuda a responder al medio. Si supera ese nivel, nuestro rendimiento empeora.

Igualmente, si estos altos niveles de ansiedad se mantienen en el tiempo, podemos desarrollar una variedad de problemas.

Positivo	Negativo
Mayor productividad	Menor productividad
Más motivación/energía	Problemas de salud (salud cardivascular)
Más creatividad	Cambios en carácter
Mejor rendimiento (académico/laboral)	Efectos en los demás

Espectro de la ansiedad

La ansiedad no es un concepto único.

Aunque es una respuesta del organismo a un peligro, varía en función de:

a. la intensidad de la respuesta

Ans. leve _____ Ataque de pánico

b. la duración de la respuesta

Ans. aguda_____ Ans. Crónica

a. la generalización de la respuesta

Fobia específica_____ Ans. generalizada

La ansiedad y otros conceptos

ANSIEDAD Y DEPRESIÓN

Ansiedad	Depresión
Sistema de alerta	Sist. conservación/regulación de energía
Eventos de daño o amenaza	Eventos de fallo, pérdida o degradación
Pensamientos de daño o amenaza	Pensamientos de fallo, pérdida o degradación
Aumento de la activación y conductas de ataque, lucha o huida	Dismin. de la actividad física y social (retraim. y enlentec. de los movimientos)
Aspectos específicos de los trastornos de ansiedad (rituales, flashbacks, miedo al miedo...)	Tristeza y dificultad para sentir placer-Pérdida del sentido de la existencia-Culpa inapropiada-Baja autoestima y sentimientos de inferioridad
Trmto: reducción de la activación y no relación entre situaciones y una amenaza real y altamente probable.	Trmto: aumento de la actividad y enseñar relación entre actuar y recibir recompensas

3

15/07/2012

La ansiedad y otros conceptos

ANSIEDAD Y DEPRESIÓN (2)

Un 70% de las personas con trastornos depresivos refieren ansiedad de diferentes grados y tipos. Un porcentaje todavía mayor de personas que sufren trastornos de ansiedad, terminan por presentar también sintomatología depresiva de diversa consideración.

La relación entre ansiedad y depresión no es fija ni inamovible. Al contrario, presenta oscilaciones a lo largo del tiempo.

Importancia de averiguar qué es primario y qué es secundario para poder decidir el tratamiento idóneo.

Pero, ¿no hablamos de un sólo problema?

FIGURE
ANXIETY AND DEPRESSION EXIST ON A CONTINUUM

Anxiety   Depression

La ansiedad y otros conceptos

ANSIEDAD Y MIEDO

a. Causa:
   - miedo: sentimiento producido por un **peligro presente e inminente**,
   - ansiedad: **anticipación** de un peligro, indefinible, e imprevisible, siendo la causa más vaga.

b. Proporcionalidad:
   - miedo: cuando la reacción es **proporcional al peligro** real u objetivo.
   - ansiedad: reacción **desproporcionadamente intensa.**

Muchos autores han equiparado miedo y ansiedad. Aunque existe la tendencia a diferenciarlos (el conductismo utiliza el miedo). Porque por ejemplo las fobias son trastornos de ansiedad.

La ansiedad y otros conceptos

ANSIEDAD Y ANGUSTIA

Angustia: predominan síntomas físicos, la reacción del organismo es paralización motora y sobrecogimiento, el grado de nitidez del fenómeno se encuentra atenuado.

Ansiedad: predominan síntomas psíquicos (peligro inminente), reacción de sobresalto, búsqueda de soluciones, más eficaz que la angustia, fenómeno más nítido.

Se utiliza un término u otro según desde que corrientes se hable. Desde la investigación científica se habla de ansiedad. Y la corriente humanista utiliza angustia.

La ansiedad y otros conceptos

ANSIEDAD Y ESTRÉS

Mientras que la ansiedad es una emoción, el estrés es un proceso adaptativo que genera emociones pero en sí mismo no es una emoción.

La ansiedad se desencadena ante situaciones muy específicas, mientras que el estrés se desencadena ante cualquier cambio que cambie las rutinas cotidianas.

La emoción posee unos efectos subjetivos o sentimientos específicos de la misma, mientras que el estrés no.

El estrés

El estrés ocurre cuando creemos que las demandas que experimentamos son mayores que nuestra capacidad para responder a ellas.

Situación

↓

Primer pensamiento: "¿Estoy en peligro?" DEMANDAS

↓

Segundo pensamiento: "¿Qué puedo hacer?" RECURSOS

↓

Estrés

El estrés

Demandas

1. Demandas de la vida diaria: emocionales, físicas, financieras, sociales.
2. Ajuste a nuevas situaciones: trabajo, desempleo, separación, enfermedad, relaciones, inmigración
3. Nuestras actitudes y expectativas sobre nosotros mismos y los otros

Recursos

1. Salud física
2. Abilidades y experiencia
3. Actitudes y creencias
4. Constitución emocional
5. Apoyo social
6. Capacidad para relajarse

4

15/07/2012

¿Qué es la preocupación?

Discusión en parejas y puesta en común

¿qué palabras se asocian a la preocupación?

¿es bueno o malo preocuparse?

¿qué cosas/situaciones nos preocupan?

¿existe la preocupación excesiva?

¿es fácil reconocerla en uno mismo/los demás?

¿cuál es la diferencia entre ansiedad y preocupación? ¿o estamos hablando de lo mismo?

La preocupación

Proceso cognitivo enfocado a determinar el **curso de acción más conveniente** para nosotros la resolución de problemas.
-**Planificación de respuestas al medio**, ponderando diferentes opciones y formas de atajar problemas y dificultades y las consecuencias de éstas.
-**Proceso normal y adaptativo**

- Basada en **creencias de que es positivo preocuparse**, puesto que colabora en la solución (ej. motivarse para hacer las cosas; definir como prevenir o evitar sucesos negativos; prepararse para lo peor; resolver problemas; reducir la probabilidad de sucesos negativos, que es una creencia supersticiosa).

-La preocupación patológica no reduce la probabilidad de resultados negativos ni aumenta la probabilidad de un afrontamiento exitoso ni es efectiva para resolver problemas concretos.
- **Pensamiento "mágico"**. Preocupación por sucesos con baja probabilidad – estos sucesos no ocurren – refuerzo de la preocupación y la creencia en su eficacia.

Preocupación (2)

Para los individuos que desarrollan un trastorno de ansiedad generalizada la amenaza mayor es la **incertidumbre**. El TAG se puede entender como una *alergia a la incertidumbre*.

Existen **detonantes** de la preocupación, que pueden ser **situaciones, estados de ánimo o sucesos de la vida** que generan amenazas, o pueden ser vistos como tales.

Aparecen en esas circunstancias **pensamientos de la forma "¿Y si...?"** que generan incertidumbre y para evitarla se pone en marcha la preocupación.

El proceso ocurre con mayor probabilidad cuando se tienen las **creencias de que la preocupación es buena** porque nos prepara para afrontar la amenaza, o que evita decepciones, o que nos ayuda a proteger a los que queremos.

¿Preocuparse de estar preocupado?

Tanto las creencias positivas como las negativas acerca de la preocupación pueden llevar a convertirla a ella misma en una amenaza.

Cuando se piensa de forma rígida que la preocupación es buena e imprescindible para resolver problemas, aparece la **preocupación de tipo 1**. La persona inicia el desarrollo de planes de acción hasta que encuentra uno que le satisface; pero estos criterios suelen ser arbitrarios o supersticiosos. La persistencia y repetición de este proceso es la causa de que se implante una preocupación patológica.

Finalmente se llega a activar las creencias negativas, como considerarla incontrolable o dañina para el cuerpo o la mente de las personas, con lo que se dispara la **preocupación tipo 2**. En este caso se establece la *metapreocupación*, ya que se llega a estar preocupado por el hecho de estar preocupado, se cree que la preocupación puede volver loco o llevar a hacer locuras, o a causar un estrés tan grande que produzca finalmente una enfermedad física.

Anatomía de la ansiedad

Amígdala → alarma general

Sist. adrenal → **adrenalina**

Cambios corporales:
- procesos fisiológicos no esenciales se interrumpen (p. ej. digestión),
- sangre se desvía a los músculos,
- ritmo respiratorio se acelera (= más O₂),
-ritmo cardíaco se acelera y la presión sanguínea incrementa (= la sangre circula más rápido)

Y esto... ¿para qué?

Lucha / huída o paralización

5

117

15/07/2012

Lucha / huída o paralización

El cuerpo vuelve a su estado normal

Evento externo percibido como amenazante para el individuo

Respuesta de lucha/huída activada

Niveles de adrenalina, noradrenalina y cortisol bajan

Incremento de tasa cardiaca
Incremento en la respiración
Grasas y glucosa segregadas para energía
El riego sanguíneo se desvía de órganos no esenciales a músculos y cerebro
Incremento de la sudoración
La actividad del sistema inmune se suprime

Se segregan adrenalina, noradrenalina y cortisol

Se segrega acetilcolina

La amenaza desaparece

El sistema nervioso central y la ansiedad

El sistema nervioso central controla la actividad de nuestros órganos corporales. Lo hace por medio de nervios que llevan y traen información entre el cerebro y distintas partes del cuerpo.

El sistema nervioso central está compuesto de **dos subsistemas**: el simpático y parasimpático.

El sistema **parasimpático es anabólico**: promueve efectos vegetativos asociados a la conservación y restauración energética (ej. promueve la digestión).
El sistema **simpático es catabólico**: prepara al organismo para la lucha o huida.

1. Durante un examen oral... estrés, nervios ("HUIDA") Estás en situación de alarma... predomina el simpático sobre el parasimpático: taquicardia, incremento de la secreción sudorípara, broncodilatación asociada al aumento de la ventilación pulmonar (en ese momento no tienes ni hambre ni ganas de ir al baño).
2. Tras comer te sientes somnoliento... predomina el parasimpático sobre el simpático (se promueve la digestión, estás relajado) Pero si te tiran la puerta abajo y te apuntan con un arma, adiós digestión... se activa el simpático, que entre otras cosas va a redistribuir el flujo sanguíneo hacia la musculatura esquelética (correr, huir).

Hiperventilación y ansiedad

El **desequilibrio entre CO$_2$ y O$_2$** resultante de hiperventilar es el **causante de la mayoría de las sensaciones fisiológicas** que notamos durante episodios de ansiedad aguda (palpitaciones, sudoración, hormigueo, calambres musculares, tirantez en el pecho, etc).

Por ello controlar la respiración es algo fundamental para evitar ataque

El curso normal de la ansiedad es...

ANSIEDAD

TIEMPO (20-60 MIN)

Aumento   Meseta   Disminución

Pero la evitación hace que sea así...

ANSIEDAD

EVITACIÓN

EXPOSICIÓN

TIEMPO
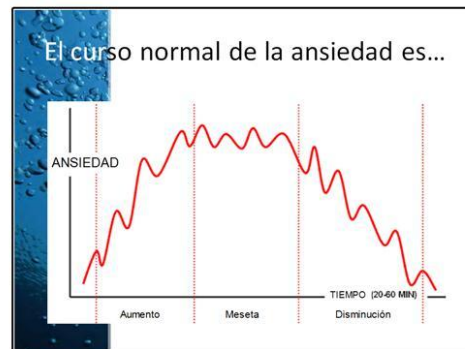
¿Qué nos provoca ansiedad?

- Presión para rendir al máximo en el trabajo, estudios y deporte
- preocupaciones económicas
- desempleo ... o trabajo insatisfactorio
- amenaza de violencia física
- riñas y peleas con otros
- conflictos familiares, violencia familiar
- divorcio
- enfermedad, duelo o pérdida de un familiar
- mudanza de casa
- uso de alcohol y drogas (?)
- A veces no hay una razón particular para sentir estrés/ansiedad, o aparece como consecuencia de pequeñas irritaciones.

6

118

15/07/2012

Trastornos de ansiedad

1. Trastorno de ansiedad generalizada

ansiedad y preocupación excesivas sobre actividades cotidianas la mayoría de los días durante un período de seis meses o más. La ansiedad es **difícil de controlar** y causa **complicaciones notables en situaciones de trabajo y sociales**. Los síntomas físicos del trastorno incluyen tensión nerviosa, fatiga, dificultad para concentrarse, irritabilidad, tensión muscular y problemas para dormir.

2. Trastorno de pánico con/sin agorafobia

ataques de pánico **recurrentes e inesperados** (episodios de miedo e incomodidad extrema) caracterizados por **síntomas físicos** como palpitaciones, sudor, temblores, falta de aire, sensación de ahogo, dolor de pecho, náusea, mareo, desorientación, miedo a perder el control o a morir, adormecimiento, escalofrío y sofocos. Los ataques de pánico normalmente vienen acompañados de una **sensación de peligro inminente y del fuerte deseo de escapar.**

Trastornos de ansiedad

3. Fobias

Miedo exagerado, involuntario e irracional a situaciones o cosas en particular. Se distinguen 3 tipos:
a. **Fobia específica (o simple)** provocada por un objeto o una situación específica
b. **Fobia social (trastorno de ansiedad social)**
Miedo extremo a encontrarse o conocer nuevas personas o de ser avergonzado, humillado o juzgado por los demás. Aparece por primera vez durante la adolescencia y a veces surge por antecedentes de timidez durante la niñez.
c. **Agorafobia** Miedo intenso de quedar atrapados en lugares y situaciones o de no poder encontrar ayuda si tienen un ataque de ansiedad. Los miedos de las personas que sufren este tipo de fobia frecuentemente se relacionan con estar solo en un lugar abierto o en medio de una multitud.

Trastornos de ansiedad

3. Trastorno obsesivo-compulsivo (TOC)
Pensamientos o imágenes persistentes, intrusivos e inadecuados (obsesiones) y comportamientos repetitivos que la persona siente que debe hacer (compulsiones). Las obsesiones comunes incluyen miedo a contaminarse, fijación en números que traen suerte o que alejan a la suerte, miedo de que la persona o los demás están en peligro, necesidad de mantener el orden y la exactitud y dudas excesivas. Las compulsiones más comunes que se realizan en respuesta ritualista a estas obsesiones incluye lavarse las manos, contar y acumular y arreglar cosas.

4. Trastorno de estrés postraumático (TEP)
Reexperimentar de forma recurrente eventos violentos o trágicos que causaron miedo, impotencia y horror intensos (pesadillas, alucinaciones o "flashbacks"); **evitación de todo lo que esté asociado con el evento, alto grado de excitación** durante más de un mes.

Ansiedad y medicación

Los ansiolíticos actúan deprimiendo la conducción nerviosa en las neuronas del sistema nervioso central, produciendo desde una leve sedación hasta hipnosis o coma en función de la dosis administrada.

El grupo de ansiolíticos de uso más común son las benzodiacepinas, de las cuales el diazepam ("Valium") es el más usado (40 mill. de cajetillas en España el año pasado).

¿Qué es la terapia cognitivo conductual?

La TCC se centra en la forma en que pensamos, sentimos (emocionalmente), las sensaciones físicas que tenemos y la forma en que nos comportamos (lo que hacemos). Pensamientos, sentimientos y conducta están unidos y se afectan unos a otros.

Figure: The "hot cross bun" model. (Adapted from Greenberger D, Padesky CA[?])

Ciclo de la ansiedad

7

15/07/2012

Ciclo de la ansiedad
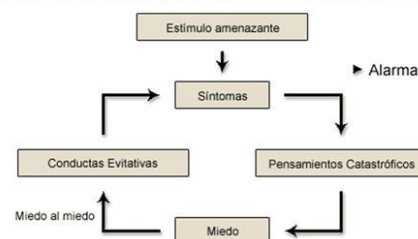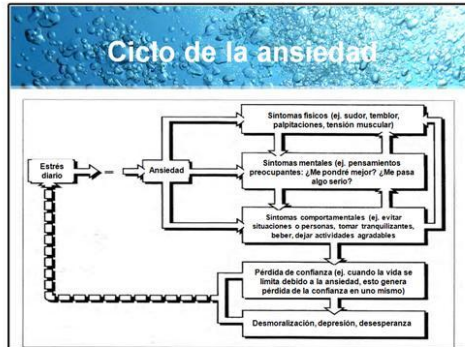
Tarea para casa

1. Para familiarizarse con el modelo cognitivo conductual, completen el registro de pensamientos-conductas-sentimientos durante esta semana.

2. Completar los cuestionarios (PHQ-9 y GAD-7) antes de llegar a la próxima sesión.

Fin de sesión

Antes de concluir…

Si tuvieran que nombrar **lo más importante que ha ocurrido en esta sesión**, una sola cosa que se llevan con ustedes hoy,

¿qué sería?

Fin de sesión

¡¡¡Gracias por venir y espero verles la semana próxima!!!

Próxima sesión…

Sesión 2.

- Modelo TCC (repaso)
- Modelo TCC de ansiedad (versión longitudinal y transversal)
- Ejercicio en parejas
- Unir diferentes aspectos de la experiencia con diferentes estrategias de manejo de la ansiedad (p. ej. Relajación, solución de problemas, retar los pensamientos inútiles)
- Técnicas para la reducción de la activación fisiológica - relajación
- Técnicas de relajación que usa la gente (discusión en grupo)
- Ejercicio de relajación progresiva muscular + feedback
- Ejercicio de relajación imaginativa + feedback
- Repaso a la sesión y pregunta MIE.

8

15/07/2012

Manejo de la Ansiedad y Preocupación Excesiva

IRMO
Verano 2011

Proyecto de investigación doctoral "Efectividad y Sentido de la Terapia Cognitivo Conductual de Baja Intensidad para Inmigrantes Latinoamericanos Residentes en Londres"

Segunda sesión

Normas para el grupo (recordatorio)

• Discutir y acordar entre todos (silencio, respeto, participación (preguntas y comentarios), puntualidad, confidencialidad, cuidado de sí mismo, compromiso, ayudar a otros a cumplir las normas, etc.)
 – Si es necesario, abandonar la sesión o discutir individualmente la posibilidad de apoyo más apropiado.
• Escribir en una hoja flipchart y mantener visible a lo largo del curso.

Revisión de la última sesión

• **Introducción**
• Presentación del taller y contenido.
• Discutir el concepto de ansiedad y preocupación
• Distinción entre ansiedad y otros conceptos
• Bases fisiológicas de la ansiedad.
• Introducción a la conceptualización TCC de la ansiedad.

Objetivos de esta sesión

• Modelo TCC de la ansiedad
• Ejercicio en parejas
• Unir diferentes aspectos de la experiencia con diferentes estrategias de manejo de la ansiedad (p. ej. Relajación, solución de problemas, retar los pensamientos inútiles)
• Técnicas para la reducción de la activación fisiológica - relajación
– Técnicas de relajación que los participantes utilizan (discusión en grupo)
– Ejercicio de respiración diafragmática
– Ejercicio de relajación progresiva muscular
– Ejercicio de relajación imaginativa + feedback

¿Qué es la terapia cognitivo conductual?

La TCC se centra en la forma en que pensamos, sentimos (emocionalmente), las sensaciones físicas que tenemos y la forma en que nos comportamos (lo que hacemos). Pensamientos, sentimientos y conducta están unidos y se afectan unos a otros.

Figure: The "hot cross bun" model. (Adapted from Greenberger D, Padesky CA[2])

La ansiedad según la TCC

Estímulo amenazante → Síntomas ► Alarma

Conductas Evitativas ← → Pensamientos Catastróficos

Miedo al miedo → Miedo

1

15/07/2012

2

15/07/2012

3

15/07/2012

Respiración controlada: alternativas a la bolsa de papel

Enough with the panic attack! I want them back, please!

1·2 Breathe In

Tipos de respiración
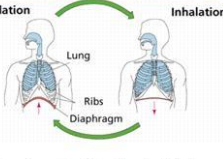
TIPOS DE RESPIRACIÓN

1. **Respiración clavicular.** Es muy superficial, incompleta y poco efectiva. Durante la inspiración los hombros y las clavículas se elevan mientras que el abdomen se contrae. Se realiza un gran esfuerzo para obtener una cantidad de aire muy reducida.

2. **Respiración torácica**. Se realiza por los músculos intercostales expandiendo el tórax, y, como la anterior, constituye un tipo de respiración incompleta y escasamente efectiva.

3. **Respiración diafragmática**. Cuando se realiza profundamente es la más aconsejable, ya que lleva aire a la parte más baja ya la vez más amplia de los pulmones. La respiración es lenta y profunda, con lo que se efectúa un adecuado uso del diafragma.

Respiración diafragmática: principios

Cuando nos encontramos nerviosos, tendemos a respirar con la parte superior de la caja torácica solamente. Cuando estamos relajados, usamos el diafragma, un músculo grande al fondo de la caja torácica que funciona como un pistón.

Exhalation — Inhalation
Lung
Ribs
Diaphragm

Al usar sólo una parte de nuestra capacidad pulmonar, hemos de respirar más rápido. Por otro lado, al no utilizar el diafragma, no estimulamos los nervios situados justo debajo de él, que contribuyen a la sensación de relajación

---

Respiración diafragmática: principios

RESPIRACIÓN COMPLETA

Para que la respiración sea completa debe combinar los tres tipos de respiración, llevando en primer lugar el aire a la zona del vientre, luego a la del estómago y finalmente al pecho. Todo lo anterior debe efectuarse en una misma inspiración. La espiración debe ser pausada y sin brusquedades. Es conveniente realizarla con los labios bastantes cerrados con el fin de que produzca un tenue sonido que nos informará *(feedback)* para poder regularla adecuadamente.

LA **RESPIRACIÓN DIAFRAGMÁTICA** NOS RELAJA AL ACTIVAR EL NERVIO VAGO, RESPONSABLE DE LA PUESTA EN MARCHA DEL S.N.A.P. (Sistema Nervioso Autónomo Parasimpático)

Respiración diafragmática: cómo hacerlo (1)

- Pon una mano en el pecho y otra sobre el estómago, para asegurarte de que llevas el aire a la parte de debajo de los pulmones, sin mover el pecho.

- Al tomar el aire, lentamente, lo llevas a la parte de abajo de tus pulmones, hinchando un poco estómago y barriga, sin mover el pecho.

1 · 2

Respiración diafragmática: cómo hacerlo (2)

- Retienes un momento el aire en esa posición

4

15/07/2012

Respiración diafragmática : cómo hacerlo (3)

- Sueltas el aire, lentamente, hundiendo un poco estómago y barriga: sin mover el pecho.

- Procura mantenerte relajado y relajarte un poco más al soltar el aire.

- Puedes utilizar un mantra que te ayude a relajarte más. Por ejemplo decir "relájate" o "relax" al soltar el aire.

Tras practicarlo lo suficiente, esta forma de respirar se hace automática, y la puedes utilizar en todo momento (de pie, cuando vas caminando, etc.).

Ejercicio para casa

Para automatizar esta (nueva) manera de respirar es importante practicarla a menudo al principio.

Así, se sugiere que los participantes intenten practicar este tipo de respiración al menos tres veces al día durante 1 o 2 minutos.

Una idea es activar la alarma de su teléfono móvil para que éste les recuerde que es momento de practicar.

Relajación progresiva muscular

Uno de los efectos de la ansiedad es la **tensión muscular**. Pero cuando ésta se mantiene durante un período **prolongado**, se generan **problemas secundarios**, como **dolor de cabeza** y un **agotamiento físico** que se añade a los efectos negativos de la ansiedad.

Por eso, la relajación progresiva muscular consiste en **tensar deliberadamente los músculos que se tensan en una situación de ansiedad o temor para posteriormente relajarlos conscientemente**.

Esta técnica nos posibilita relajarnos cuando queramos, incluso en situaciones que ahora consideremos imposibles o evitamos a toda costa.

Practicar este ejercicio dos veces al día o antes de enfrentarnos a una situación estresante nos ayudará a mantener un nivel bajo de ansiedad y a perder el miedo a ciertas situaciones.

Debido a la naturaleza de esta técnica, no se aconseja a personas que sufran dolor artrítico u otros problemas musculares.

Relajación muscular progresiva

La técnica consta de dos fases:
En la **primera fase** se aprende a discriminar cuando un músculo está tenso y cuando está relajado. Para ello, estando en una posición cómoda, tumbado o recostado, se va tensando cada músculo y después de mantenerlo tenso, se relaja centrándose en la sensación de relajación que se genera.

Los ejercicios siguen la secuencia siguiente:
1º tensar los músculos al máximo durante 3 o 4 segundos.
2º note la sensación de tensión.
3º relaje esos músculos.
4º sienta la agradable sensación que percibe al relajar esos músculos.
Por último, cuando tense una zona, debe mantener el resto del cuerpo relajado.

Relajación muscular progresiva

Los grupos musculares que suelen trabajarse son los siguientes:
- Manos, apretando los puños (primero una y después la otra).
- Antebrazos (primero uno y después el otro).
- Brazos, poniendo los brazos rectos (id).
- Hombros, levantándolos hacia arriba.
- Parte posterior del cuello, apretando la barbilla contra el pecho.
- Nuca, apretándola contra el sillón.
- Frente, alzando las cejas hacia arriba y arrugando la frente.
- Ojos, apretando los párpados.
- Boca, abriéndola lo más posible.
- Mandíbulas, tensándolas.
- Lengua y parte interna del cuello.
- Pecho
- Abdomen, empujando hacia fuera los músculos abdominales.
- Nalgas, tensándolas.
- Muslos, extendiendo las piernas.
- Pantorrillas, extendiendo las piernas hacia fuera.
- Pies, curvando los dedos hacia abajo y después hacia arriba.

Relajación muscular progresiva

5

15/07/2012

Relajación muscular progresiva

En una **segunda fase**, una vez hayas aprendido a discriminar fácilmente cualquier tensión muscular y a relajarla a voluntad, te centrarás solamente en prestar atención a tu cuerpo, e ir relajando cualquier tensión que detectes en él.

Para ello irás **revisando mentalmente** cada zona o grupo muscular y relajando cualquier tensión que detectes en ella, sin necesidad de tensarlas antes.

Con ese estos ejercicios aprenderás a relajarte fácilmente y a percibir cualquier señal de tensión corporal, a la que podrás aplicar automáticamente la relajación.

En esta fase conviene que practiques la relajación centrando tu atención en la respiración diafragmática lenta que llevas a cabo, y repitiéndote a ti mismo alguna palabra o frase tranquilizadora. Por ejemplo al soltar el aire puedes pensar "relájate".

Relajación muscular progresiva

Una vez consigas relajarte bien, en la posición de acostado o recostado, conviene que te acostumbres a relajarte, en posición de sentado, y después en diferentes lugares y situaciones.

En cuanto a los lugares y posiciones en que la practicas, conviene seguir estos pasos:

- En un lugar tranquilo y silencioso, cómodamente tumbado o recostado.

- Cuando la domines en la posición anterior, practicarla en diferentes posiciones (sentado, de pie) y en diferentes lugares.

- Después, mientras llevas a cabo otras actividades, empezando por las más fáciles (ej., mientras caminas estando sólo).

- Finalmente, has de conseguir aplicarla mientras llevas a cabo tus actividades cotidianas.

Ejercicio para casa

Escuchar el CD con el ejercicio de relajación.

Hacerlo al menos tres veces durante la semana, cuando encuentren un momento más tranquilo.

Monitorizar lo nervioso/incómodo que se encuentra al comienzo y al final del ejercicio.

Visualización

Consiste en visualizar en su mente (normalmente con los ojos cerrados) una escena relajante. Se ha de intentar usar los diferentes sentidos (olfato, gusto, tacto, vista, oído).

Cuando se practican ejercicios de relajación con visualización, las imágenes están controladas por uno mismo. Casi siempre utilizamos la imaginación de forma negativa, con la visualización cambiamos esta tendencia y enseñamos a nuestro cuerpo un nuevo tipo de experiencia posible a través de una imaginación auténtica ya que no se produce inconscientemente, es la forma legítima de imaginación que nos corresponde como seres humanos.

Visualización

Ejercicio para casa
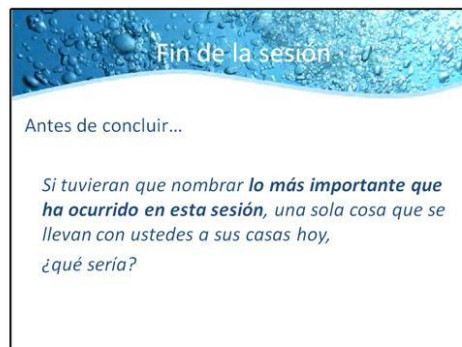
Practicar la relajación por visualización al menos dos veces durante la próxima semana (siguiendo las pautas en la hoja que se ha entregado).

6

15/07/2012

Próxima sesión...

- 3ª sesión (Sábado 15 Julio / Lunes 18 Julio):
- **Exposición gradual/Activación conductual y manejo del sueño**
- Repaso de la sesión previa
- Propósito de la *exposición gradual* (papel de la evitación en el mantenimiento de la ansiedad)
- Construir una jerarquía de exposición
- Técnicas para el manejo del insomnio debido a la ansiedad (higiene del sueño y programa de restricción del sueño)
- Apoyo en la comunidad – otros servicios locales (una lista de organizaciones y servicios se entregará a los participantes en caso de que necesiten más apoyo)
- Repaso de la sesión y pregunta MIE.

Fin de la sesión

Antes de concluir…

Si tuvieran que nombrar **lo más importante que ha ocurrido en esta sesión**, *una sola cosa que se llevan con ustedes a sus casas hoy,*

¿qué sería?

7

15/07/2012

1

15/07/2012

2

15/07/2012

...gradual... o no

...de duración suficiente...

... para que el nivel de ansiedad experimentado disminuya

...sin distracción ni conductas de seguridad

Los ejercicios de exposición han de hacerse con plena consciencia.

Se ha de prestar atención a lo que está pasando y cómo el cuerpo reacciona.

Distraerse y otras conductas de seguridad sólo sirven para reforzar la conclusión de que hubiera sido horrible si la persona se hubiera expuesto "de verdad".

Items de la jerarquía	Ansiedad anticipada	Ansiedad real
Apagar el computador sin volver a comprobar que está apagado		
Usar el secador de pelo y sólo comprobar una vez si está apagado		
Usar el secador de pelo y dejarlo sin comprobar si está apagado		
Dejar la casa y sólo comprobar que los aparatos eléctricos están apagados sólo una vez		
Dejar la casa y sólo comprobar que los aparatos eléctricos de la planta de arriba están apagados sólo una vez		
Dejar la casa sin comprobar que los aparatos eléctricos están apagados		

La escalera de la ansiedad

Most Feared

6. Say more and speak more slowly in a group

5. Mix with people other than close friends

4. Look at people when ain a group. Don't monitor own symptoms and thoughts

3. Stay with other people instead of keeping busy with jobs the whole time

2. Go to club on my own and meet friends inside

1. Meet friend and go into club

Least Feared

Haz una lista de actividades o situaciones que generan más o menos ansiedad. Calcula su valor de ansiedad (unidad subjetiva de ansiedad, USA) a cada una (de 0 a 100, siendo 0 la tranquilidad absoluta y 100 el peor grado de ansiedad que has experimentado).

Comienza a exponerte a estas situaciones. Hazlo hasta que notes una disminución del nivel de ansiedad.

Ejercicio: Mi jerarquía de exposición

En parejas con la persona a su lado o de forma individual, pensar brevemente en cómo sería su escalera de ansiedad.

Piensen en los diferentes escalones de los que constaría y cuántas unidades de ansiedad tendría cada uno de estos escalones.

3

15/07/2012

La Activación Conductual

Aumenta   Ansiedad   Disminuye   Ansiedad

DEPRESIÓN: Desesperanza, desánimo, pérdida de metas...

Aprehensión

Evidencia de que podemos sobrellevar las dificultades de la vida

Aprehensión

Disminuye la confianza en uno mismo

Evitación (de actividades placenteras, lúdicas, de gente)

Incrementa la Confianza en uno mismo

Perseverancia (actividades de la rutina diaria, placenteras, con otros, etc)

¿ Por qué la Activación Conductual?

Efectos de la actividad

1. Nos hace sentirnos <u>menos</u> cansados
2. Nos ayuda a distraernos
3. Mejora nuestra confianza en nuestras habilidades
4. Mejora nuestra capacidad para pensar/resolver problemas
5. Puede involucrar a otros, y ...
6. Nos ayuda a mantener el equilibrio entre lo positivo y lo negativo de la vida diaria

+   -

Activación Conductual: pasos

1. Monitorización de la actividad – registrar lo que haces en un diario (p.ej. durante una semana). Esto ayuda a tener una "línea de base" y comprobar la relación entre actividades, emoción, pensamientos, sentido de satisfacción con uno mismo.

2. Evaluación de metas y valores - pensar sobre lo que valoramos en la vida, en nosotros mismos y los demás, para identificar nuestros valores en diferentes áreas de nuestra vida. Nuestra actividad deberá ir encaminada hacia esos valores.

3. Programación de actividades - establecer varias actividades placenteras y/o necesarias que <u>te comprometes a realizar</u> (normalmente al día siguiente) <u>no importa cómo te sientas o cuánto te apetezca</u>. Piensa también cómo te puedes premiar por conseguir lo que te propones.

Activación Conductual: pasos
1. *Monitorización de la actividad*

	Lunes	Martes	Miércoles	Jueves	Viernes	Sábado	Domingo
Mañana							
Tarde/ noche							

Es importante registrar lo que haces, cómo crees que lo haces y cuánto lo disfrutas. Usa la escala que te doy a continuación.

0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5

D (dominio):   fatal   muy mal   mal   regular   bien   muy bien

P (placer):   una tortura   no estuvo tan mal   lo he disfrutado bastante   lo he disfrutado mucho

---

Activación Conductual: pasos
2. *Evaluación de metas y valores*

Valores: aquellas cualidades hacia las que aspiramos. Nunca llegamos a conseguirlas completamente (ej. ser un/una buen/a padre/ madre).

Metas: objetivos claros y concretos que nos establecemos. Podemos saber si/cuándo los hemos conseguido o no (ej. acompañar a mi hijo al fútbol).

Specific (Específico)
Measurable (Medible)
Achievable (Alcanzable)
Realistic (Realista)
Time-bound (En un tiempo concreto, p. ej. una semana)

Activación Conductual: pasos
3. *Programación de actividades*

Una vez que sabemos
a. lo que estamos haciendo (o no) y cómo influye en nuestro estado de ánimo, y
b. lo que nos gusta/queremos hacer…

¡HAY QUE PONERSE MANOS A LA OBRA!

To-Do list / NOTHING

Propónte qué vas a hacer al día siguiente, teniendo en cuenta tus valores y metas en la vida, tus aficiones y gustos y las cosas que necesitas hacer y, poco a poco, comienza a trabajar en ello.

Importante: ¡**Ponlo todo por escrito!** Es la mejor forma de revisar y comprobar si estás consiguiendo tus objetivos… y obsequiarte por ello… También puedes buscar testigos a los que rendir cuentas.

4

15/07/2012

Ansiedad y sueño

Información sobre el sueño

1. No existe un tiempo de sueño ideal. Varía de persona a persona y a lo largo de la vida

2. A medida que nos hacemos mayores, necesitamos menos sueño.

3. No hay peligro en perder unas noches de sueño. La gente asume que caerán enfermos o que su rendimiento se verá afectado

4. Nuestro cuerpo dormirá lo que tiene que dormir a menos que se lo impidamos.

5. Las personas que sufren de insomnio tienden a sobreestimar el tiempo que les lleva conciliar el sueño. Al día siguiente, se encuentran sobresensibilizadas a síntomas físicos, interpretando éstos como signos de cansancio.

Ansiedad y sueño (2)

Trucos para conciliar y mantener el sueño

1. **Prepárate antes de ir a la cama**
   a. haz ejercicio durante el día;
   b. evita la cafeína poco antes de ir a dormir;
   c. bebe leche antes de ir a la cama
   d. relájate, date un baño caliente o completa un ejercicio de relajación.
   e. asegúrate de que tu dormitorio es tranquilo y tu cama cómoda.

2. **Ve a la cama sólo cuando tengas sueño**; no intentes dormir más yéndote más temprano a la cama.

3. **Usa la cama sólo para dormir.** No leas o veas TV o comas a no ser que sepas por experiencia que esto te ayuda a dormir.

4. **En la cama no pienses en cosas preocupantes.** Si hay algo que te preocupa, anótalo en un papel para retomarlo al día siguiente.

Ansiedad y sueño (3)

Trucos para conciliar y mantener el sueño

5. Distráete con juegos mentales, como recordar los nombres de tus compañeros o contar hacia atrás de siete en siete.

6. Utiliza la relajación progresiva muscular

7. Si tras 15-20 minutos no te has dormido o no puedes volver a dormir tras despertarte temprano, sal de la cama y haz otra cosa hasta que te sientas cansado. Haz algo aburrido y vuelve a la cama cuando tengas sueño.

8. Pon la alarma todos los días a la misma hora, no importa cuánto hayas dormido.

9. Pon el reloj donde no lo veas para no preocuparte por la hora que es.

10. No te eches siestas durante el día.

Ejercicio físico y ansiedad

La actividad física es una buena forma de mantener la ansiedad y el estado de ánimo en general bajo control, ya que:

- es una forma de liberar tensión muscular y adrenalina acumulada.
- mantiene la circulación sanguínea, tensión y mejora el sist. inmune.
- mejora nuestro estado de ánimo, autoimagen, apariencia y control de peso.
- ayuda a limpiar pensamientos preocupantes y ansiedad.
- aporta estructura a nuestro día, cuando se realiza de forma regular
- estimula la liberación de endorfinas

Se recomienda **20-30 minutos de ejercicio a la semana, comenzando despacio e incrementando en intensidad.**

Ejercicio que combina flexibilidad, resistencia y fuerza es el ideal. **Nadar, ir en bicicleta y pasear (a ritmo ligero)** son ejemplos de este ejercicio.

Buena alimentación

Una buena dieta ayuda a incrementar nuestro rendimiento, mejorar nuestro sistema inmune y nuestro manejo del estrés.

El comer debe ser placentero y relajante. Se debe comer sentado y disfrutar las comidas. Idealmente tres veces al día.

1. Come **más alimentos altos en fibra** (cereales, judías, verduras, fruta, pan integral y pasta), que reduce el colesterol en la sangre.

2. Come **menos grasa** . Grasas saturadas (carne, lácteos, pastelería) aumentan calorías, peso y niveles de colesterol. Grasas no saturadas (aceite vegetal y de pescado) son más sanas. Intenta cocer o asar a la parrilla más que freír.

3. **Recorta en "comida de estado de ánimo"** (sal, azúcar, alcohol y cafeína).

4. **No superes la cantidad máxima de alcohol** recomendada.

¡TODO EN MODERACIÓN!

Estrés y equilibrio en la vida

5

15/07/2012

Apoyo en la comunidad

Próxima sesión...

4ª sesión (Sábado 22 Julio / Lunes 25 Julio):
Manejo de la preocupación y técnicas cognitivas
- Repaso de la sesión anterior
- Sesgos cognitivos – retar tus pensamientos inútiles
- Técnicas para la resolución de problemas
- Otras técnicas útiles
- La criba de la preocupación
- La caja de la preocupación
- Repaso de la sesión y pregunta MIE
- Discutir grupo focal y entregar hoja para la discusión

Fin de la sesión

Antes de concluir...

Si tuvieran que nombrar **lo más importante que ha ocurrido en esta sesión**, una sola cosa que se llevan con ustedes a sus casas hoy,

¿qué sería?

6

15/07/2012

Manejo de la Ansiedad y
Preocupación Excesiva

IRMO
Verano 2011

Proyecto de investigación doctoral "EFECTIVIDAD Y
SENTIDO DE LA TERAPIA COGNITIVO CONDUCTUAL DE
BAJA INTENSIDAD PARA INMIGRANTES LATINOAMERICANOS
RESIDENTES EN LONDRES"

Cuarta sesión

Revisión de la última sesión

- 3ª sesión (Sábado 15 Julio / Lunes 18 Julio):

Exposición gradual/Activación conductual y manejo del sueño

- Repaso de la sesión previa
- Propósito de la *exposición gradual* (papel de la evitación en el mantenimiento de la ansiedad)
- Construir una jerarquía de exposición
- Técnicas para el manejo del insomnio debido a la ansiedad (higiene del sueño y programa de restricción del sueño)
- **Apoyo en la comunidad** – otros servicios locales (una lista de organizaciones y servicios se entregará a los participantes en caso de que necesiten más apoyo)

Objetivos de esta sesión

- 4ª sesión (Sábado 22 Julio / Lunes 25 Julio):

Manejo de la preocupación y técnicas cognitivas

- La criba de la preocupación
- El árbol de la preocupación
- La caja de la preocupación
- El papel de la distracción
- Sesgos cognitivos – modificar tus pensamientos inútiles
- Técnicas para la resolución de problemas
- Presentación de la sesión de coloquio

Objetivos de esta sesión

Figure: The "hot cross bun" model. (Adapted from
Greenberger D, Padesky CA[27])

Ejercicio en parejas

De forma individual o en parejas.

Piensen en un problema que les esté preocupando últimamente. Puede ser algo que le ronde por la cabeza pero que usted crea no tiene mucha importancia o algo más serio que usted no sabe cómo va a solucionar.

La preocupación es buena

Preocuparse puede ser útil

1. Si nos hace prestar atención

Preocuparnos por el tiempo no hace que deje de llover, pero estar atento nos ayuda a meter la ropa tendida si comienza a llover.

2. Si nos lleva a un plan de acción

Preocuparse por la electricidad nos ayuda a pagar la factura a tiempo. Tras pagarla, la preocupación debería desaparecer.

3. Si nos hace estar mejor preparados

La preocupación puede ayudarnos a pensar « qué podría hacer si... » o « qué pasaría si... ». Ej. pensar que te pueden robar te podría llevar a asegurar tu casa.

1

15/07/2012

La preocupación es buena

… siempre que lleve a la acción!

WHAT IF…?

¿Merece la pena preocuparse? La criba de la preocupación

4 cosas de las que no debemos preocuparnos:

1. **Lo que no es importante**

Tres modos de saber si algo es importante

a. La regla de los 5 años (o una semana o mes o año)

b. La vara de medir: en una escala de experiencias negativas, dónde queda aquello por lo que me preocupo?

c. La calculadora: ¿cuánto cuesta esta preocupación?

¿Merece la pena preocuparse? La criba de la preocupación (2)

2. Lo improbable

Todo tipo de cosas terribles podrían ocurrir cualquier día, pero casi todo es improbable. Si te dejas preocupar por lo improbable, tu preocupación no tendrá fin.

La preocupación como forma de evitar problemas es una FALACIA

YOU WORRY TOO MUCH… IT DOESN'T DO ANY GOOD…

IT DOES FOR ME… 75% OF THE THINGS I WORRY ABOUT NEVER HAPPEN!

¿Merece la pena preocuparse? La criba de la preocupación (3)

3. Lo incierto

No sabemos normalmente cómo las cosas van a terminar. Muchas cosas por las que nos preocupamos no han ocurrido y sólo podemos hacer algo cuando sabemos qué ha pasado (ej. estudiar tras suspender un examen).

4. Lo incontrolable

Hay muchas cosas sobre las que no tenemos control, p. ej. hacernos mayores. Hay muchas cosas que ocurrirán, nos preocupemos o no.

¿Qué hacer con la preocs. persistentes? El árbol de la preocupación

El árbol de la preocupación es una forma de representar los pasos que se deben dar para la resolución de problemas.

A continuación se explica en qué consiste cada uno de los pasos sugeridos.

THE WORRY TREE

¿Qué hacer con la preocs. persistentes? El árbol de la preocupación

Distinguir entre preocupaciones acerca de las que puedes hacer algo y aquellas por las que no puedes hacer nada.

1. Ten claro **cuál es la preocupación**:
   a. Pregúntate: ¿Sobre qué me estoy preocupando?
   b. Piensa sobre cada preocupación y escríbelas una a una.
   c. Anota las preocupaciones tan claro como puedas.
2. Decide **si puedes hacer algo** al respecto:
   a. Considera cada preocupación y pregúntate "¿puedo hacer algo acerca de esta preocupación?"
   b. Si la respuesta es no, preocuparte por ello no solucionará nada.
   c. Piénsalo y trata de explicarte que no tiene sentido preocuparse. Intenta distraerte.
   d. Si la respuesta es sí, entonces continúa al paso 3.

2

15/07/2012

¿Qué hacer con preocupaciones persistentes?

3. Escribe **una lista de lo que puedes hacer** para solucionar el problema. Haz una lluvia de ideas, no importa lo difícil o "tontas" que parezcan.

4. Cuando tengas una lista de las diferentes opciones de respuesta, somételas a tela de juicio, analizando **las ventajas e inconvenientes de cada una**.

5. **Escoge la opción más apropiada.**

   a. Mira la lista y pregúntate: "¿Hay algo que pueda

   b. Si hay algo que puedas hacer, entonces hazlo.

   c. Si no lo hay, entonces elabora un plan de acción incluyendo **cuándo, dónde y cómo** vas a solucionarlo.

   d. Cuando lo hayas hecho, convéncete que has hecho lo que tenías que hacer y continúa con tu tarea.

Formas de distraerte de preocupaciones inútiles

La distracción es útil para hacer frente a preocupaciones recurrentes por las que no podemos hacer nada.

Actividad física: Hacer ejercicio es una buena forma de detener la preocupación.

Juegos mentales: hacer pasatiempos (ej. crucigramas, sudoku), recitar un poema o una canción o contar hacia atrás de 7 en 7.

Céntrate en tus alrededores: concéntrate en detalles específicos del entorno. Por ejemplo, hacer palabras de las matrículas de coches, adivinar a qué se dedica la gente que ves por la calle.

Si la preocupación perdura, recuérdate a ti mismo que has hecho todo lo que podías y continúa con tu tarea.

¡No uses la distracción para evitar lidiar con la tarea!

La caja de la preocupación

Si estás agobiado con muchas preocupaciones distintas, trata de dedicar media hora cada día a preocuparte. Decide el lugar y el momento que será "el momento de la preocupación" y sé constante.

Si comienzas a preocuparte a otras horas, pospón la preocupación hasta que llegue el momento asignado (ej. en casa a las 7pm) y céntrate en lo que estés haciendo.

Durante tu "tiempo de preocupación" deja a tu mente preocuparse. Coje papel y bolígrafo y anota tus preocupaciones una a una. Guíate por los pasos anteriores. Algunas personas son incapaces de preocuparse cuando pueden y su "tiempo de preocupación" termina sin problemas.

Comparte tu preocupación

Las preocupaciones no sobreviven fácilmente fuera de nuestras cabezas. Hablar de tu preocupación te puede ayudar a **ver la situación desde otro ángulo**. Otras personas pueden ver tus problemas de forma más objetiva, ya que ellos no estarán tan comprometidos con las soluciones que tú has intentado. Quizás ellos pueden haber superado situaciones similares o conocen a otras personas que lo han hecho.

Intenta quedar con un/a amigo/a o familiar y decirle lo que te preocupa.

No dejes que tus preocupaciones te lleven a aislarte de los demás. Piensa que todos tenemos preocupaciones, a veces muy similares. Posiblemente comprartiendo las tuyas tú también puedes ayudar a otros a tu alrededor.

Ansiedad e incertidumbre

No saber qué pasará, cuál será el resultado de nuestros proyectos o cómo reaccionarán otras personas es incómodo.

Para algunas personas esta situación es algo insoportable. Estas personas tienen *intolerancia a la incertidumbre*. Al igual que una persona con alergia al polen reacciona de manera *exagerada* a una pequeña cantidad de polen, alguien con intolerancia a la incertidumbre reaccionará de forma negativa a una pequeña cantidad de incertidumbre.

Así reaccionarán **evitando o posponiendo** situaciones y actividades, **no comprometiéndose** con nada y pidiendo a los demás que les aseguren que todo va/irá bien a modo de disminuir la incertidumbre en todo lo que hacen.

Pero sabemos que **intentar aumentar la certeza disminuye la tolerancia a la incertidumbre. Por el contrario, incrementar la tolerancia a la incertidumbre ayuda a disminuir la preocupación.**

Ansiedad e incertidumbre (2)

La mejor manera de trabajar en este problema es **realizar actividades que te ayuden a incrementar tu tolerancia a la incertidumbre de forma gradual**. Esto se llama *exposición a la incertidumbre*.

Se comienza con actividades que no son difíciles de realizar. Al principio debes *actuar como sí* tuvieras tolerancia o como actuaría otra persona que es tolerante de la incertidumbre.

Este ejercicio te hará sentirte incómodo y te verás tentado a echar mano de tus estrategias normales. Ten en cuenta que es normal sentirse nervioso cuando se comienza una nueva conducta y que esta ansiedad desaparecerá gradualmente. Además la motivación sigue a la acción: cuanto más actúas, más motivado te sientes a continuar actuando de esa manera.

3

15/07/2012

Ejercicio

De vuelta al problema que les preocupa.

Intenten aplicar los principios que hemos presentado y comprobar cómo se ajustan a su problema en particular.

Si creen que es adecuado hacerlo en parejas, únanse a la persona a su lado e intenten "entrevistar" uno al otro sobre su problema en particular, considerando los pasos presentados.

Si prefieren trabajar individualmente, háganlo así.

Sesgos atencionales

La ansiedad es una respuesta de anticipación al peligro. De ahí que nuestra atención funcione de manera diferente cuando nos encontramos nerviosos.

*Nuestra atención se centra en aquello que nos preocupa, filtrando información irrelevante, de modo que **percibimos sólo aquello que estamos buscando***

Veamos un ejemplo:

http://www.youtube.com/watch?v=2pK0BQ9CUHk&feature=player_embedded

Sesgos del pensamiento

Primero tienes que saber reconocer qué es un **pensamiento inútil**. Después tienes que ser capaz de **retarlo**. Ser consciente de patrones normales de pensamientos inútiles te puede ayudar a reconocerlos cuando tú los tengas. Éstos son algunos de ellos:

- **Predecir el futuro:** *cuando nos sentimos nerviosos es fácil pensar en el futuro y predecir lo que podría salir mal. Normalmente la mayoría de lo que predecimos nunca ocurre y perdemos tiempo y energía preocupándonos y alterándonos por ello.*
- **Catastrofizar:** *exagerar un resultado negativo es común cuando nos encontramos angustiados.*
- **Frases "Debería":** *pensar cómo a uno le gustaría que fueran las cosas o cómo "deberían ser ellos" en lugar de aceptar las cosas como son. Este estilo de pensamiento crea una ansiedad excesiva.*
- **Sobregeneralizar:** *Asumir, basados en un episodio aislado, que todos los demás van a seguir un patrón similar. Dificultad en percibir un incidente negativo como un caso único, lo cual nos hace sentirnos desesperanzados.*

Sesgos del pensamiento (2)

- **Frases "¿Y si...?":** *Centrar el pensamiento en un resultado negativo. Estos pensamientos limitan nuestras actividades.*
- **Pensamiento en Blanco y Negro:** *cuando estamos angustiados, vemos las cosas "en blanco y negro" (no hay punto entre medias). Así vemos la ansiedad como una debilidad. Si hacemos algo y no es perfecto, es un desastre. Nos ponemos expectativas que nos echan atrás.*
- **Ignorar lo positivo:** *a veces ignoramos los aspectos positivos de la vida o la situación y nos centramos en lo negativo. Esto mantiene nuestros niveles de confianza bajo y tendemos a hacer menos cosas.*
- **Etiquetar(se):** *ponerse adjetivos a uno mismo que justifican determinadas acciones. Esto perpetúa una forma determinada de actuar, que no ayuda a superar las dificultades.*
- **Confundir alta y baja probabilidad de eventos negativos:** *pensar que cosas que nos preocupan son más frecuentes de lo que en realidad son.*

¿Cómo cambiar pensamientos inútiles?

Una vez que hemos reconocido un pensamiento inútil, el siguiente paso es retarlo, para sustituirlo por otro más preciso, basado en evidencia.

6 pasos para retar un pensamiento negativo

1. *¿Tienes evidencia que contradice este pensamiento?*
2. *¿Puedes identificar alguno de los patrones de pensamiento descritos antes?*
3. *¿Qué dirías a un amigo/a que pensara así en una situación similar?*
4. *¿Cuáles son los costes y beneficios de pensar de esta manera?*
5. *Hay alguna solución proactiva a este pensamiento negativo?*

Sesgos del pensamiento: ejercicio

En parejas, piensen en alguna ocasión en la que recuerden haber incurrido en alguno de los sesgos de pensamiento discutidos y que luego haya comprobado no eran la mejor manera de ver la situación.

La persona que "entrevista" debe pensar en una forma más útil de ver la situación.

4

15/07/2012

5

Appendix 4. Workshop promotion material

TALLER DE MANEJO DE LA ANSIEDAD - VERANO 2011

¿Tiene usted problemas de ANSIEDAD?

¿Encuentra difícil controlar su PREOCUPACIÓN EXCESIVA?

Estamos organizando un taller sobre técnicas para el manejo de la ansiedad durante los meses de <u>julio y agosto</u>. Las sesiones son <u>gratuitas</u> y se facilitarán <u>en español.</u> El programa está abierto a personas <u>de procedencia latinoamericana residentes en Londres</u>.

El taller consta de **1 sesión** de hasta 1 hora y media durante **5 semanas**. Se facilitarán **dos grupos de hasta diez personas** cada uno. En ellos usted podrá:

- discutir acerca de la ansiedad y cómo ésta le afecta a usted
- aprender cómo la ansiedad afecta a otras personas
- aprender y practicar diferentes técnicas para controlar la ansiedad y preocupación excesiva.

El taller tendrá lugar <u>en las oficinas de IRMO</u> en Brixton:

     UNIT 8 Warwick House, Overton Road, London SW9 7JP

(Otros lugares se considerarán p. ej. Casa Hispanoamericana, si esto es posible).

Un psicólogo en formación facilitará las sesiones. El taller forma **parte de un proyecto de investigación**, así que es importante que considere varios aspectos antes de decidir si quiere participar (ej. completar cuestionarios, disponibilidad, asistencia, etc.).

Al finalizar las sesiones, se le invitará a una última sesión junto con las personas que asistieron a su grupo para discutir su experiencia y opinión sobre el taller.

Si usted está interesado/a o tiene más preguntas, por favor **contacte conmigo en** jelopez80@hotmail.com **o deje su nombre a un miembro de la plantilla del servicio donde ha visto este cartel** y yo contactaré con usted dándole más detalles.

Gracias por su interés.

Manejo de la Ansiedad — jelopez80@hotmail.com (repetido)

Appendix 5. UEL Ethics approval

SCHOOL OF PSYCHOLOGY
Dean: Professor Mark N. O. Davies, PhD, CPsychol, CBiol.
uel.ac.uk/psychology

UEL
University of
East London

Doctoral Degree in Clinical Psychology
Direct Fax: 0208 223 4967

June 2011

Name of Student	Jose Lopez Martin-Vares
Title of Research Project	Effectiveness and Meaning of 'Low-intensity' Cognitive Behavioural Interventions for Latin American Immigrants in London.

To Whom It May Concern:

This is to confirm that the above named student is conducting research as part of the requirements for the Professional Doctorate in Clinical Psychology. The Ethics Committee of the School of Psychology, University of East London has approved their proposal and they are, therefore, covered by the University's indemnity insurance policy. . This policy should normally cover for any untoward event provided that the experimental programme has been approved by the Ethics Committee prior to its commencement. The University does not offer "no fault" cover, so in the event of untoward event leading to a claim against the institution, the claimant would be obliged to bring an action against the University and seek compensation through the courts.

As the above named is a student of UEL the University will act as the sponsor of their research. UEL will also fund expenses arising from the research, such as photocopying and postage.

Yours faithfully,

Kenneth Gannon PhD
Research Director

Dr Martyn Baker	020 8223 4411	M.C.Baker@uel.ac.uk	Dr Nimisha Patel	020 8223 4413	N.Patel@uel.ac.uk
Dr Maria Castro	020 8223 4422	M.Castro@uel.ac.uk	Prof Mark Rapley	020 8223 6392	m.rapley@uel.ac.uk
Dr Sarah Davidson	020 8223 4564	S.Davidson@uel.ac.uk	Dr Neil Rees	020 8223 4475	N.Rees@uel.ac.uk
Dr Kenneth Gannon	020 8223 4576	K.N.Gannon@uel.ac.uk	Dr Rachel Smith	020 8223 4423	r.a.smith@uel.ac.uk
Dr David Harper	020 8223 4021	D.Harper @uel.ac.uk	Dr Robyn Vesey	020 8223 4409	r.vesey@uel.ac.uk
Dr M Jones Chesters	020 8223 4603	m.h.jones-chesters@uel.ac.uk	Ruth Wacholder	020 8223 4408	r.wacholder@uel.ac.uk
Dr Paula Magee	020 8223 4414	p.l.magee@uel.ac.uk	Administrators 020 8223 4174/4567 c.wickham@uel.ac.uk/ j.chapman@uel.ac.uk		

Stratford Campus, Water Lane, Stratford, London E15 4LZ
Tel: +44 (0)20 8223 4966   Fax: +44 (0)20 8223 4937   MINICOM 020 8223 2853
Email: mno.davies@uel.ac.uk

Appendix 6a. Information sheet – Spanish version

HOJA DE INFORMACIÓN PARA PARTICIPANTES

TÍTULO DEL ESTUDIO: EFECTIVIDAD Y SENTIDO DE LAS "INTERVENCIONES COGNITIVO-CONDUCTUALES DE BAJA INTENSIDAD" CON LATINOAMERICANOS EN LONDRES.

Le invito a participar en una investigación. Antes de que usted decida si quiere tomar parte, es importante que usted entienda por qué estamos llevando a cabo y qué conlleva este estudio. Por favor, lea con detenimiento esta hoja y pregunte si hay algo que no esté claro.

¿Cuál es el propósito de este estudio?

Estoy llevando a cabo este estudio como parte de mi doctorado en psicología clínica en la university of east london.

Quiero comprobar si las terapias cognitivo conductuales de baja intensidad (un tipo de terapia ofrecida en el nhs) son efectivas y tienen sentido para personas de procedencia latinoamericana.

¿Tengo que participar?

No. No hay ninguna obligación por su parte. Si usted decide participar en este estudio, deberá firmar una hoja de consentimiento informado. Aun así, si después de firmar, usted cambia de opinión, puede abandonar el programa en cualquier momento sin dar ninguna razón. Su decisión de retirarse o no participar no afectará el servicio que usted recibe de las organizaciones participantes.

¿Quién organiza este estudio?

Este estudio ha sido diseñado para satisfacer los requisitos académicos del programa de doctorado. Está dirigido por Jose López, estudiante de este programa. Jose cuenta con la supervisión de la Dra. María Castro y Dra. Melinda Rees, Psicólogas Clínicas. Este estudio no cuenta con financiación externa.

¿Qué me pasará si participo?

Si decide participar en el estudio, tras dejar su número de contacto en las listas que se facilitarán en las organizaciones colaboradoras, contactaré con usted. En esa primera conversación (por teléfono o en persona), discutiremos los detalles del estudio-intervención y le pediré que complete unos cuestionarios.

Usted será invitado/a a participar en una intervención de grupo de seis semanas centrado en el "manejo de la ansiedad". En este grupo, de hasta ocho participantes, usted podrá aprender y practicar una variedad de técnicas para el manejo de la ansiedad y preocupación excesiva (p. ej. relajación, exposición gradual, solución de problemas, etc.). Las sesiones tendrán lugar de forma semanal con una duración de hasta 1 hora y media. El grupo tendrá lugar durante los meses de verano de 2011 en las oficinas de la organización de ayuda a latinoamericanos IRMO, en Brixton, al sur de Londres.

Antes de que el grupo comience, posiblemente se le pida que complete los mismos cuestionarios que completó durante nuestra primera conversación tres veces durante un

141

periodo de seis semanas a fin de comprobar si la intervención es más efectiva que no hacer nada.

Usted deberá completar dos breves cuestionarios cada sesión a fin de saber cómo se siente usted, además de un cuestionario más extenso al comienzo y final del programa.

Al finalizar las 5 semanas de intervención, se le invitará a participar en una sesión más en la que usted podrá dar su opinión sobre el grupo: qué aprendió, si fue útil, qué encontró difícil de aplicar o menos útil, cambios que usted haría, etc.

¿Hay alguna desventaja o riesgo en participar en este estudio?
No se anticipa ningún riesgo en la participación en el grupo de ansiedad o el posterior grupo de discusión.

Aunque improbable, si al participar en el grupo, usted se sintiera angustiado o disgustado debido a la naturaleza de la discusión, usted puede dejar el grupo en cualquier momento. En tal caso, yo discutiré con usted formas de apoyo individual (p.ej. servicios de salud u otros).

¿Cuáles son los beneficios de su participación?
Espero que usted encuentre útil la intervención en grupo para aprender técnicas para el manejo de su ansiedad/preocupación. Su opinión acerca del grupo (completando cuestionarios y participando en el grupo de discusión al finalizar el programa) es esencial a fin de juzgar si estas terapias son beneficiosas o no y qué tipo de adaptación se requiere para su mejora.

Confidencialidad – ¿quién sabrá que usted participa en este estudio?

Si usted decide participar en este estudio, se le harán preguntas sobre usted mismo/a. Cualquier información personal que usted dé se tratará de forma confidencial. Se le asignará un código numérico al comienzo de su participación que usted utilizará para identificarse (y su nombre no aparecerá en ningún documento que usted complete); en todos los cuestionarios que usted rellene se usará este código.

¿Quién ha revisado este estudio?

Este estudio ha sido revisado por el Comité de Ética de Investigación de la University of East London.

¿Qué pasa con los resultados del estudio?

Los resultados del estudio se incluirán en una tesis presentada en la University of East London. También es posible que se dé un breve resumen de la investigación a las organizaciones que colaboran con el proyecto o que los resultados se publiquen en revistas científicas o conferencias. Toda la información que posibilite la identificación de los participantes se eliminará de informes y publicaciones. Todos los cuestionarios y transcripciones de entrevistas se destruirán tras la presentación de la tesis. Si usted quisiera obtener un resumen de los resultados, se le podrá enviar una copia.

Contacto para más información

Si usted necesita más información sobre este estudio, por favor llámeme (nombre del autor) por teléfono al **079…**   dejando un mensaje con su número de contacto y yo contactaré con usted. También puede contactar conmigo por e-mail en **…@hotmail.com**.
Gracias por considerar su participación en este estudio.

Appendix 6b. Information sheet – English version

Information sheet for participants

Title of research study: Effectiveness and meaning of 'low intensity Cognitive Behavioural interventions' for Latin Americans in London.

I am inviting you to take part in a research study. Before you decide whether to participate, it is important for you to understand why the research is being done and what it will involve. Please, take time to read the following information carefully and ask if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

I am conducting this study as part of a Doctoral Degree in Clinical Psychology at the University of East London.

I am looking at how helpful and meaningful Low Intensity Cognitive Behavioural Therapies (a type of therapy offered across the NHS) are for people from a South American background.

Do I have to take part?

No. There is no obligation on your part to participate in the study. If you do decide to take part you will be asked to sign a consent form. You may change your mind at any time and without giving any reason. A decision to withdraw at any time, or not to take part at all, will not affect the standard of service that you receive from the organisations collaborating with our project.

Who is organising the study?

This study has been conceived partly to meet the academic requirements of a Doctoral degree. It is being conducted by Jose Lopez, a student of this programme. He is supervised by Dr. Maria Castro and Dr. Melinda Rees, Clinical Psychologists. The study does not count on external funding.

What will happen to me if I take part?

If you decide to take part, after leaving your contact details on the lists available from the collaborating organisations, I will contact you. During our first conversation (either on the phone or face-to-face), we will discuss the details of the study and I will ask you to complete some brief questionnaires.

You will be invited to attend a 6-week group focused on anxiety management. In this group, of a maximum of 8 participants, you will be able to learn and practise a number of techniques CBT to manage excessive worry and anxiety (e.g. relaxation, graded exposure, problem solving techniques, etc.). The sessions will take place once a week for up to 1.5 hours. The group will take place during July-August 2011

in the premises of IRMO, an organisation catering for the needs of the Latin American population in Brixton, South London.

Prior to the start of the group, you may be requested to complete the same questionnaires that you filled out during our first conversation up to three times during a 6-week period. This is aimed at finding out whether the intervention is more effective than no intervention at all. Once the group starts, you will be asked to complete those 2 brief questionnaires every session you participate, to measure your progression in mood.

At the end of the 6-week group, you will be invited to one last session, where you could give your opinion about the group intervention: what you learnt, how helpful it was, what you found difficult or not helpful, what changes you would make, etc.

Are there any disadvantages or risks in taking part in this study?
We do not anticipate any disadvantages due to participating in the intervention group or the focus group.

Although unlikely, if during your participation, you became distressed by the nature of the topic discussed, you would be allowed to withdraw. I will discuss with you afterwards ways of helping you if necessary (i.e. contact with health services or other organisation).

What are the possible benefits of taking part?
I hope that you will find the group helpful to learn techniques to manage your anxiety/worry. Your feedback (completing questionnaires and participating in the focus group) will be helpful to find out whether these therapies are beneficial or need adapting.

Confidentiality – who will know I am taking part in the study?

If you consent to taking part in this research, you will be asked some questions about yourself. Any information which is collected about you will be kept strictly confidential. You will be assigned a numerical code from the very start of your participation, which will prevent your identification (your name will not appear in any document you complete). All the questionnaires that you fill will be marked with your allocated numerical code.

Who has reviewed the study?

This study has been reviewed by the University of East London Research Ethics Committee.

What will happen to the results of the study?

The results of the study will be submitted in an academic thesis to the University of East London. It is also possible that a feedback report is given to the collaborating organisations or that results are published in scientific journals and/or conferences. Any information that could be used to identify you will be removed. All the questionnaires filled and transcriptions of interviews will be kept locked in a safe place till the successful completion of the thesis. If you wish in due course to obtain a summary of the results, I will be happy to send them to you.

Contact for further information

If you would like more information about the study please call me (author's name) on **079...** leaving a message with your contact details and I will return your call. You can also contact me via email on **...@hotmail.com**.

Thank you for reading this information sheet and considering participating in this study.

Appendix 7a. Consent Form – Spanish version

HOJA DE CONSENTIMIENTO

Número de versión: 1 Fecha: 10/01/2011	

Número de versión: 1   Fecha: 10/01/2011

Título del proyecto: Cultura y modelos de salud mental. Efectividad y sentido de las "intervenciones cognitivo-conductuales de baja intensidad" para latinoamericanos en el Reino Unido.

Name of the researcher: **...**

Por favor, responda **SÍ** o **NO**

¿Ha leído la hoja de información para el participante?   *SI   NO*

¿Ha tenido la oportunidad de hacer preguntas y discutir el estudio?   *SI   NO*

¿Ha recibido respuestas satisfactorias a sus preguntas?   *SI   NO*

¿Con quién ha hablado?

¿Entiende que su participación es voluntaria y que usted se puede retirar del estudio en cualquier momento sin dar razones para ello sin que esto afecte su atención médica o derechos legales?   *SI   NO*

¿Le han dicho que la información personal que usted aporte se mantendrá confidencial?
                                                                         SI   NO

¿Acepta participar en este estudio?   *SI   NO*

Nombre del participante   Fecha   Firma

Nombre de la persona que toma consentimiento Fecha   Firma
(cuando ésta sea diferente del investigador)

Nombre del investigador   Fecha   Firma

Appendix 7b. Consent Form – English version

RESEARCH CONSENT FORM

Version number: 1 Date: 01/12/2010	
Title of the project:	CULTURE AND MODELS OF MENTAL HEALTH. EFFECTIVENESS AND MEANING OF 'LOW INTENSITY' COGNITIVE BEHAVIOURAL INTERVENTIONS FOR LATIN AMERICAN IMMIGRANTS IN THE UK.
Name of the researcher: ...	

Please, circle **YES** or **NO**

Have you read the participant information sheet?   *YES*   *NO*

Have you had the opportunity to ask questions and discuss the study?   *YES*   *NO*

Have you received satisfactory answers to all your questions?   *YES*   *NO*

Who have you spoken to?

Do you understand that your participation is voluntary and you are free to withdraw from the study at any time without having to give a reason, without affecting your future medical care or legal rights?   *YES*   *NO*

Are you willing to allow access to your medical notes?   *YES*   *NO*

Have you been told that strict confidentiality will be maintained?   *YES*   *NO*

Do you agree to take part in this study?   *YES*   *NO*

Name of participant	Date	Signature

Name of the person taking consent (if different from the researcher)	Date	Signature

Name of the researcher	Date	Signature

Appendix 8a. PHQ-9 (Spanish version)

Código de participante: _____   Fecha/Date: _____

Sesión nº   1   2   3   4   5   6   7   8

CUESTIONARIO DE LA SALUD DEL PACIENTE (PHQ-9)

NOMBRE: _____   FECHA: _____

Durante las *últimas dos semanas,* ¿con qué frecuencia se ha visto afectado por los siguientes problemas? (marque su respuesta con "✓")	Nunca	Varios días	Más de la mitad	Casi todos los días
1. Tiene poco interés o encuentra poco placer en hacer las cosas.	0	1	2	3
2. Se siente desanimado, deprimido o sin esperanzas.	0	1	2	3
3. Tiene problemas para dormir o mantenerse dormido o duerme demasiado.	0	1	2	3
4. Se siente cansado o tiene poca energía.	0	1	2	3
5. Tiene poco apetito o come en exceso.	0	1	2	3
6. Siente falta de amor propio o que es un fracaso o que se ha decepcionado a sí mismo o a su familia.	0	1	2	3
7. Encuentra dificultad en concentrarse, por ejemplo, al leer el periódico o ver televisión.	0	1	2	3
8. Se mueve o habla tan lentamente que la gente lo puede haber notado o de lo contrario, está tan agitado o inquieto que se mueve mucho más de lo acostumbrado.	0	1	2	3
9. Tiene pensamientos de que sería mejor estar muerto o de que quiere hacerse algún daño.	0	1	2	3

suma de las columnas: _____ + _____ + _____

TOTAL: _____

10. Si usted se identificó con cualquiera de estos problemas, ¿qué dificultad le han ocasionado estos problemas al hacer su trabajo, ocuparse de la casa o llevarse bien con los demás?	Ninguna dificultad _____ Algo de dificultad _____ Mucha dificultad _____ Extrema dificultad _____

Appendix 8b. PHQ-9 (English version)

<u>Patient Health Questionnaire-9</u>

Patient Name _____   **Date** _____

1. **Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully, and circle your response.**

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
a. Little interest or pleasure in doing things				
b. Feeling down, depressed, or hopeless				
c. Trouble falling asleep, staying asleep, or sleeping too much				
d. Feeling tired or having little energy				
e. Poor appetite or overeating				
f. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down				
g. Trouble concentrating on things such as reading the newspaper or watching television				
h. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual				
i. Thinking that you would be better off dead or that you want to hurt yourself in some way				
Totals				

2. **If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?**

Not Difficult At All	Somewhat Difficult	Very Difficult	Extremely Difficult
0	1	2	3

Appendix 9a. GAD-7 (Spanish version)

Escala GAD - 7

(Versión española de la escala Generalized Anxiety Disorder- 7)

Señale con qué frecuencia ha sufrido los siguientes problemas en los últimos 15 días:

	Nunca	**Menos de la mitad de los días**	**Más de la mitad de los días**	**Casi todos los días**
Se ha sentido nervioso, ansioso o muy alterado	0	1	2	3
No ha podido dejar de preocuparse	0	1	2	3
Se ha preocupado excesivamente por diferentes cosas	0	1	2	3
Ha tenido dificultad para relajarse	0	1	2	3
Se ha sentido tan intranquilo que no podía estarse quieto	0	1	2	3
Se ha irritado o enfadado con facilidad	0	1	2	3
Ha sentido miedo, como si fuera a suceder algo terrible	0	1	2	3

suma de las columnas:		+		+	
TOTAL:					

Appendix 9b. GAD-7 (English version)

GAD-7

Over the <u>last 2 weeks</u>, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer"*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Column totals: ___ **+** ___ **+** ___ **+** ___
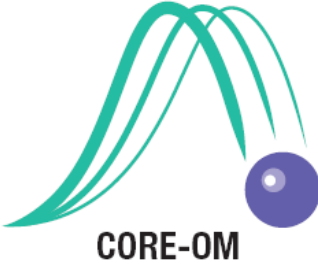
= *Total Score* _____

If you checked off <u>any</u> problems, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Appendix 10a. CORE-OM (Spanish version)

Gydymo įstaiga:
CODIGO CLIENTE

Psicoterapeuta

Fecha

A   A   A   A   M   M   D   D

Edad

Hombre

Mujer

Fase actual
S (screening)
R Derivado
A Asesoramiento
F Primera sesión terapéutica
P Pre-terapia
D Durante terapia
L Última sesión terapéutica
X Seguimiento 1
Y Seguimiento 2

Fase

Historial
psicológico

IMPORTANTE. POR FAVOR LEA ESTO ANTES DE EMPEZAR EL TEST.
A continuaciones encontrara 34 frases. Lea cada frase y piense con qué frecuencia
usted se ha sentido así **durante los últimos siete días**. Después, marque la casilla más
cercana a la respuesta que quiere dar.

Durante los siete últimos días…

		Nunca	Muy poco	Algunas veces	Frecuentemente	Siempre	USO PROFESIONAL
1	Me he sentido completamente solo y aislado.	0	1	2	3	4	F
2	Me he sentido tenso, ansioso o nervioso.	0	1	2	3	4	P
3	He sentido que he tenido a alguien en quien apoyarme cuando lo he necesitado.	4	3	2	1	0	F
4	Me he sentido bien conmigo mismo.	4	3	2	1	0	W
5	Me he sentido completamente sin energía y entusiasmo.	0	1	2	3	4	P
6	Me he sentido psicológicamente violento hacia los demás.	0	1	2	3	4	R
7	Me he sentido capaz de afrontar las cosas cuando han ido mal.	4	3	2	1	0	F
8	He tenido molestias, dolores y otros problemas físicos.	0	1	2	3	4	P
9	He pensado en hacerme daño a mi mismo.	0	1	2	3	4	R
10	Me ha costado hablar con la gente.	0	1	2	3	4	F
11	La tensión y la ansiedad me han impedido hacer cosas importantes.	0	1	2	3	4	P
12	Me he sentido satisfecho con las cosas que he hecho.	4	3	2	1	0	F
13	Me he sentido mal con pensamientos y sentimientos involuntarios.	0	1	2	3	4	P
14	He tenido ganas de llorar.	0	1	2	3	4	W

Por favor continúe en la página siguiente

Durante los siete últimos días…

	Nunca	Muy poco	Algunas veces	Frecuentemente	Siempre	USO PROFESIONAL
15 He sentido pánico o terror.	0	1	2	3	4	P
16 He pensado en suicidarme.	0	1	2	3	4	R
17 Me he sentido agobiado por mis problemas.	0	1	2	3	4	W
18 He tenido dificultad para conciliar el sueño o permanecer dormido.	0	1	2	3	4	P
19 He sentido afecto o cariño por alguien.	4	3	2	1	0	F
20 Me ha sido imposible dejar a un lado mis problemas.	0	1	2	3	4	P
21 He sido capaz de hacer la mayoría de las cosas que tenía que hacer.	4	3	2	1	0	F
22 He amenazado o intimidado a otra persona.	0	1	2	3	4	R
23 Me he sentido desesperado o sin esperanza.	0	1	2	3	4	P
24 He pensado que sería mejor estar muerto.	0	1	2	3	4	R
25 Me he sentido criticado por los demás.	0	1	2	3	4	F
26 He pensado que no tengo amigos.	0	1	2	3	4	F
27 Me he sentido infeliz.	0	1	2	3	4	P
28 Me han angustiado imágenes o recuerdos no deseados.	0	1	2	3	4	P
29 Me he sentido irritable con otras personas.	0	1	2	3	4	F
30 He pensado que yo tengo la culpa de mis problemas y dificultades.	0	1	2	3	4	P
31 Me he sentido optimista con mi futuro.	4	3	2	1	0	W
32 He conseguido las cosas que quería.	4	3	2	1	0	F
33 Me he sentido humillado o avergonzado por otras personas.	0	1	2	3	4	F
34 Me he hecho daño físico o he puesto en peligro mi salud.	0	1	2	3	4	R

GRACIAS POR COMPLETAR ESTE CUESTIONARIO.

Puntuación total

Puntuaciones significativas
(Puntuación total en cada apartado dividida entre el número de respuestas completadas en ese apartado)

(W)   (P)   (F)   (R)   Visi   Visi minus R

Appendix 10b. CORE-OM (English version)

CLINICAL
OUTCOMES in
ROUTINE
EVALUATION

OUTCOME MEASURE

Site ID — letters only / numbers only

Client ID

Therapist ID   numbers only (1)   numbers only (2)

Sub codes

D D / M M / Y Y Y Y
Date form given

Male ☐   Female ☐

Age

Stage Completed
S   Screening
R   Referral
A   Assessment
F   First Therapy Session
P   Pre-therapy (unspecified)
D   During Therapy
L   Last therapy session
X   Follow up 1
Y   Follow up 2

Stage

Episode

IMPORTANT - PLEASE READ THIS FIRST

This form has 34 statements about how you have been OVER THE LAST WEEK.
Please read each statement and think how often you felt that way last week.
Then tick the box which is closest to this.
Please use a dark pen (not pencil) and tick clearly within the boxes.

Over the last week

Columns: Not at all | Only Occasionally | Sometimes | Often | Most or all the time | OFFICE USE ONLY

#	Statement	Not at all	Only Occasionally	Sometimes	Often	Most or all the time	Office
1	I have felt terribly alone and isolated	0	1	2	3	4	F
2	I have felt tense, anxious or nervous	0	1	2	3	4	P
3	I have felt I have someone to turn to for support when needed	4	3	2	1	0	F
4	I have felt O.K. about myself	4	3	2	1	0	W
5	I have felt totally lacking in energy and enthusiasm	0	1	2	3	4	P
6	I have been physically violent to others	0	1	2	3	4	R
7	I have felt able to cope when things go wrong	4	3	2	1	0	F
8	I have been troubled by aches, pains or other physical problems	0	1	2	3	4	P
9	I have thought of hurting myself	0	1	2	3	4	R
10	Talking to people has felt too much for me	0	1	2	3	4	F
11	Tension and anxiety have prevented me doing important things	0	1	2	3	4	P
12	I have been happy with the things I have done.	4	3	2	1	0	F
13	I have been disturbed by unwanted thoughts and feelings	0	1	2	3	4	P
14	I have felt like crying	0	1	2	3	4	W

Please turn over

Over the last week

		Not at all	Only Occasionally	Sometimes	Often	Most or all the time	OFFICE USE ONLY
15	I have felt panic or terror	0	1	2	3	4	P
16	I made plans to end my life	0	1	2	3	4	R
17	I have felt overwhelmed by my problems	0	1	2	3	4	W
18	I have had difficulty getting to sleep or staying asleep	0	1	2	3	4	P
19	I have felt warmth or affection for someone	4	3	2	1	0	F
20	My problems have been impossible to put to one side	0	1	2	3	4	P
21	I have been able to do most things I needed to	4	3	2	1	0	F
22	I have threatened or intimidated another person	0	1	2	3	4	R
23	I have felt despairing or hopeless	0	1	2	3	4	P
24	I have thought it would be better if I were dead	0	1	2	3	4	R
25	I have felt criticised by other people	0	1	2	3	4	F
26	I have thought I have no friends	0	1	2	3	4	F
27	I have felt unhappy	0	1	2	3	4	P
28	Unwanted images or memories have been distressing me	0	1	2	3	4	P
29	I have been irritable when with other people	0	1	2	3	4	F
30	I have thought I am to blame for my problems and difficulties	0	1	2	3	4	P
31	I have felt optimistic about my future	4	3	2	1	0	W
32	I have achieved the things I wanted to	4	3	2	1	0	F
33	I have felt humiliated or shamed by other people	0	1	2	3	4	F
34	I have hurt myself physically or taken dangerous risks with my health	0	1	2	3	4	R

THANK YOU FOR YOUR TIME IN COMPLETING THIS QUESTIONNAIRE

Total Scores

Mean Scores
(Total score for each dimension divided by number of items completed in that dimension)

(W)   (P)   (F)   (R)   All items   All minus R

154

Appendix 11a. SASH (Spanish version)

THE SHORT ACCULTURATION SCALE FOR HISPANICS (SASH)

Jeffrey A. Miller, Ph.D. - 1997

1. ¿En qué idioma(s) lee y escribe?

Sólo en Español	Más en Español que en Inglés	Ambos igual	Más en Inglés que en Español	Sólo en Inglés
A	**B**	**C**	**D**	**E**

2. ¿Qué idioma(s) habla usted normalmente en casa?

Sólo en Español	Más en Español que en Inglés	Ambos igual	Más en Inglés que en Español	Sólo en Inglés
A	**B**	**C**	**D**	**E**

3. ¿En qué idioma(s) piensa usted normalmente?

Sólo en Español	Más en Español que en Inglés	Ambos igual	Más en Inglés que en Español	Sólo en Inglés
A	**B**	**C**	**D**	**E**

4. ¿Qué idioma habla usted normalmente con sus amigos?

Sólo en Español	Más en Español que en Inglés	Ambos igual	Más en Inglés que en Español	Sólo en Inglés
A	**B**	**C**	**D**	**E**

Appendix 11b. SASH (English version)

THE SHORT ACCULTURATION SCALE FOR HISPANICS (SASH)

Jeffrey A. Miller, Ph.D. - 1997

1. In what language do you read and write?

Only in Spanish	More in Spanish than English	Both equally	More in English than Spanish	Only in English
A	**B**	**C**	**D**	**E**

2. What language do you normally use at home?

Only Spanish	More Spanish than English	Both equally	More English than Spanish	Only English
A	**B**	**C**	**D**	**E**

3. In what language do you think normally?

Only in Spanish	More in Spanish than English	Both equally	More in English than Spanish	Only in English
A	**B**	**C**	**D**	**E**

4. What language do you normally use with your friends?

Only Spanish	More Spanish than English	Both equally	More English than Spanish	Only English
A	**B**	**C**	**D**	**E**

Appendix 12. Demographic questionnaire (registration)

- DATOS DEL PARTICIPANTE – PARTICIPANT DETAILS -

Nombre / name:

Edad / Age:

Código / Code: _____
Asignada a grupo
Allocated to group   1

2

Educación / Education:

Edad a la que dejó educación a tiempo completo:

Age at which he/she left full-time education

Profesión-Trabajo / Profession-Occupation:

Años en el Reino Unido / Years in the UK:

País de origen / Country of procedence:

Puntuación en GAD-7 / GAD-7 score:

Puntuación en PHQ-9 / PHQ-9 score:

Puntuación en CORE-OM / CORE-OM score:

Previa experiencia de terapia psicológica / Previous therapy details:

Medicación psicotrópica / Psychotropic medication:

Presente/Current:

Pasado / Past:

Preferencia día de grupo:

Teléfono de contacto / Phone contact:

Mejor hora para llamar / Best time to contact:

Appendix 13a. Focus group handout (Spanish Version)

Estimado participante,

Me gustaría agradecerle el compromiso que usted ha mostrado por esta intervención y espero que le haya sido útil.

Como ya comentamos, durante la próxima sesión me gustaría que discutiéramos **su opinión como participante acerca del taller al que ha asistido**. Esta discusión será analizada posteriormente y se utilizará para evaluar la utilidad de este tipo de intervención para la población latinoamericana residente en Londres. Esperamos que esto nos ayude a hacer que los servicios públicos estén más adaptados a las necesidades de esta población y así sean más efectivos.

De este modo, quiero que en esta sesión **todos los participantes se sientan cómodos/as discutiendo lo que han encontrado útil y menos útil, lo que han echado en falta y lo que piensan que ha sido irrelevante para su situación personal**. Se aceptan **sugerencias sobre cómo mejorar** la intervención.

Sería ideal que **todos asistan a la sesión habiendo pensado sobre la experiencia de participar en el taller**. **Pueden traer notas con ustedes** si eso les ayuda a recordar los puntos que quieren resaltar. Algunos aspectos en los que usted quizás quiera reflexionar son:
1. Proceso de registro en el taller
2. Apoyo a la asistencia a las sesiones (mediante sms)
3. Uso de cuestionarios
4. Experiencia de estar en grupo (permanencia/movilidad de participantes)
5. Contenido de las sesiones
    - Conceptualización cognitivo-conductual de la ansiedad
    - Material/ideas más y menos útiles
    - Otros aspectos que se deberían incluir
    - Duración del taller
6. Aspectos/ideas que no coinciden o están en conflicto con valores/formas de ver la vida que usted tiene o que son comunes entre latinoamericanos.

Si usted tiene algo que decir que no está cubierto aquí y cree que es importante, por favor, no deje de compartirlo.

Muchas gracias con antelación por su dedicación, tiempo y pensamiento crítico.

Jose López.

Appendix 13b. Focus group preparation handout (English version)

Dear participant,

I would like to thank you for the commitment you have shown to this intervention and hope it has been useful to you.

As we discussed, during the last session, I would like us to discuss your opinion about the workshop you have attended. As you will remember, this discussion will be transcribed and analysed. It will be then used to evaluate the usefulness of this type of intervention for the Latin American community in London. It is hoped that this will help us shape the support that the LA community in London receive from public services.

Therefore, I would like that all attendees at this session feel comfortable and free to discuss what they have found most and least useful, what they have felt was missing and what felt irrelevant, what should have been devoted more or less time, etc.

It would be ideal that everyone comes to this last session having given some thought to the experience of participating in the workshop. Some aspects you may want to consider are:

1. Registration process
2. Support to attend sessions (text reminder of next session)
3. Filling up questionnaires
4. Experience of being part of a group (permanence/mobility of participants)
5. Session content
    - CBT conceptualisation of anxiety
    - More and less useful material/ideas
    - Other aspects that should be included
    - Length of intervention
6. Aspects/ideas which do not fit with values/ways of seeing life that you have or that are common among Latin American people.

If there is something else that you would like to share, please feel free to do so.

Thank you in advance for your time and thoughts.

Jose López

Appendix 14. Focus group agenda (English version)

Aspects to include in the discussion:

- Process of registration (individual interview,time,face-to-face/phone conversation, etc).
- Group composition / moving to/from groups.
    - Number of participants
- Questionnaire completion (pre- and during intervention).
- Length and Content of the sessions
    - Balance session tasks/discussion, sharing of personal experience and 'teaching'   component.
        - Material/techniques/ideas presented
        - Pace of explanation/discussion
- Understanding of CBT conceptualisation of anxiety/emotional distress
- Homework tasks
- Material given

- Most/least helpful ideas/techniques presented.

- Most difficult concept, techniques/principles participants struggled to make sense of.

- Aspects they did not agree with on the basis of previous experience/knowledge.

- If this group was to be rolled out across the NHS, what changes do you think should be made so it is more helpful? Consider:

-

- Number of attendees	• Duration of intervention
• Facilities/avenue/room	• Content
• Material (handouts)	• Language/terms
• Activities (during session)	• Homework
• Length of sessions	• Outcome measures

Anything that did not fit in with values/ways of thinking you had prior to coming to the group?

- Anything that should be adapted specifically for people from a South American background in the UK?

- Any other thoughts that have not been covered and participants think important to add.

- Thanking participants for attending.

- Giving questionnaires (and self-addressed envelopes) to be completed within 4 weeks.

- End of session

Appendix 15. Audit trail

A transcript excerpt (Focus group B lines 1120-1208) is offered below as an illustration of the process of analysing the text in order to identify the themes and subthemes presented above.

Notes	Text	Codes
	But, of course. This very change of environment makes people adopt certain ways... And no matter how united the family comes, you start to open and... everyone goes different ways. But it's here where it happens, not there.	1.Environmental reasons for change
	But we are talking about what could be here, not there...	
Latinos as different	Anyway... They don't see anything that can be 'rescued', but I do. I think that we, already knowing the topic, with the theory and practice, can be good tools for relatives and friends. And we are more communicative and try to exteriorise our things, we seek people of our own community to be able to communicate because we know that Europeans will not understand us in the true context. I am talking about the NHS professionals. I think both parts need to change. Of course, we adopt some things, certain European particularities but professionals also should accept that Latino mentality, no matter how much they want to change it, it won't be changed because it's already formed.	2.Differences among partics. 3.Sharing knowl with others. 4.Latino characteristics 5.Need for mutual change 6.Diff. changing one's culture
	It doesn't change. It has to be accepted.	
Why help based on British models?	Then, both parts must change.	7.Need for mutual change
	Well, what I was thinking is that [...] this guidance should be based on the British system, on how British psychologists solve these problems, and maybe a personal guide. Because maybe I'm close to my family. But the situation is that if I have a friend but can act as a sister, or I see her as a sister, that would be the Latino help. But I think that in this case, it should be addressed to the Latino community, to their common problems. For example, the migratory grief, things that are happening at a specific moment: a new migration wave... things like that. I don't know, maybe I'm going off-pist. These are things that bring about	6.Help to LA based on UK's knowledge 8.Latino characteristics 9.Specific help suitable for Lats.

	anxiety. [...] So, I would like some kind of help for Latinos to know how to overcome these things, due to English language, due to... Because having an interpreter or someone in each NHS [service] with all the stuff that is going on at the moment, is something that won't happen easily. So, I think that suggesting ideas as to how we, as a community, can solve our own problems, help each other...	10. Realism re. feasible support 11.Solution: empowering the community
	I suggest sharing our phone numbers and contact details. Because we need people like the ones here today: people who are up to listen, to talk, to understand, to learn...	12.Keep contact among attendees
	That's right. Very important. There is now a connection between these people and that's something difficult to get.	
Emphasis on comm. empow. But acknoled- ging need for prof'nal?	You could do it even bigger, connecting us here with those outside... maybe among friends, we tell them about it and maybe in the future the becomes a connection point for the community with the professional, who, it would be great, it they spoke Spanish. Knowing that we have a professional at the front but a community that seeks help. And not only seeking connection among the Spanish-speaking community, but also English-speaking people, as this is a community that is increasing in size, with new ideas, good ideas [...] Not only to sort out problems among us as a group, but also identifying problems coming from the community...	13.Need to enlarge group. 14. Prominence of the 'professional' 15.Need to integrate Lat. community with others 16.Comm. as problem-solver

Codes generated from this extract

1. Environmental reasons for change.
2. Differences among participants.
3. Sharing knowl with others.
4. Latino characteristics.
5. Need for mutual change.
6. Diff. changing one's culture.
7. Help to LA based on UK's knowledge.
8. Specific help suitable for Lats.
9. Realism re. feasible support.
10. Possible sol.: empowering the community.
11. Keep contact among attendees.
12. Need to enlarge group.
13. Need to integrate Lat. community with others.
14. Prominence of the professional.
15. Comm. as problem-solver.

'Empowering the community as a solution' (code #10) seemed a code which comprised several others in this excerpt. Therefore, it became a subtheme within the theme "Latino community needs", which subsumed other codes appearing in this excerpt.

Codes, themes and reviewing

Following the same process illustrated above, a sizeable list of initial codes (below) was subsequently r and codes were 'condensed' into a list of 50 approximately. Some codes were omitted from the overall thematic map because the did not seem to fit with the entire data set. They were either only said by one person or did not seem relevant to the themes or overall research questions.

Time constraints

Dual reason for attendance

Need to look for help by oneself

Interest in participating in further workshops

Facilitator as role model

'Cognitive restructuring' among participants

Relaxation as useful aspect

Worry work as useful aspect

Concept of anxiety as useful aspect

Anxiety crises as a result of lack of information

Importance of 'scientific, professional' knowledge

Self-disclosure as formulation following CBT principles

Preventative/ameliorating effect of anxiety awareness

Timeliness/degree of distress amenable to interv.

Combination theory/practice as useful aspect

Language barrier among Latinos

Need to use Spanish to speak about complex topics

Limitations when working through interpreters

Need for homogeneity re. experience of anxiety

Need 1st person experience

No need for homogeneity re. experience of anxiety

Group as source of relief/Importance of sharing experiences

Group as opportunity for exposure

Group as opportunity to make contacts/meet like-minded and supportive people

Group as source of advice

Need for people ready to listen

Psychologists/MH profs as people who help others to get relief

Apprehension to disclose difficulties to professionals/group

No expectation of self-disclosure

Mutual benefit (listener/listened to) /

homeostasis / normalisation

Need for individual support

Invitation to participate

Relevance of topics

Expectation of further input

Accesible material

Small print in handouts - difficult to read outside of group

Engagement/interest (transmitted by facilitator)

Constructive approach – emphasis on tools/strategies as helpful

Empowerment/space to discuss

'Patient/sick' identity

Importance that facilitator shares 'culture' with participants

Facilitator's characteristics enhancing outcome

Facilitator's need to be harsher with people

Need to be caring – comparison with teacher

Participants' expectations of therapy (= counselling)

Importance of being 'human' to be good therapist

Normalisation – 'all on the same boat'

Latino Familism vs. British Individualism

Familism not exclusive of Latinos / Some Latinos very detached

Adaptation of Latinos when abroad

Struggle in foreign country shared with others

Intervention beneficial for everyone

Need to spread the word 'mouth to mouth'

Drawing on spirituality/religion – more reliable than mainstream MH services?

Respect/formalism (as expectation)

Respect (as enacted)

Completeness of material

Questionnaire completion as useful aspect

'Personalised' material (really?)

Realism – problems don't get sorted overnight

More appropriate local

Gratefulness for the opportunity of attending the group

No appreciation/no priority

Young people do not appreciate it

Need to select participants according to age

Age expectations

Break halfway though sessions

Importance of laughter

More time allotted for group

More emphasis on practice than theory (experiential examples?)

Importance of veracity of case examples

Importance of mutual support outside the group

One-to-one space for people unwilling to share experience

Follow-up of group

Engagement - Warm-up exercise/task

Importance of personal work to practise what has been learnt

Need for more promotion of the group – assured 'success'

Ways of improving attendance (fine for non-attendance)

Importance of endings

Audiovisual

Alternative ideas for group: activities/material/settings

Latinos and suffering

Necessary help: specific needs of LA community

Feeling calmer

Sleep improvement

More enthusiasm

No importance of well-being for Latinos

Ideas for projects/involvement of young Latinos

Specific needs of Latino migrants – printed material

Tabu nature of mental health among Latinos

Importance of "conscientizacion"

Need for Mutual adaptation (migrant/host community)

Understanding of CBT

Expectation of need to talk/participate

Shame that others have dropped out

Shame that others have dropped out

Need for tools to find out who we really are

Need to adapt oneself to Host culture / 'step-down position'

Need for strength/wise up

Lack of realism in migrants

Distance from family as important factor in generating distress

Harsh reality of migration

Challenge to 'sick' identity

Importance of language in identity formation / pathological terminology

Need for follow-up / review session

Parent-child reassurance seeking

'Homework' tasks

Homework tasks –commitment

Importance of keeping in contact

Widening the group

Need for social action - Community Psychology

Prominence of facilitator

Importance of link person

Community + professional – Need for professional support

Latin community 'lagging behind'

Privilege of info in Spanish

Appendix 16. Diagrammatic representation of the themes

When is it a problem? –
Questionnaires

Positive aspects of anxiety

Questionnaires as
good/meaningful way of
measuring distress

Knowing what to do –
Techniques

Relaxation

Worry Management

Exposure principles/techniques

SPECIFIC CBT LOW

INTENSITY ELEMENTS

SEEN AS USEFUL

Need to practise –
Intersession tasks

Realism – need for regular
practice of tools learnt

Meaning of 'homework
tasks'

Knowing what it is –
Conceptualisation

Relevance of the concept:
Anxiety crises due to lack of
information

Importance of scientific/
professional knowledge

Accessible material

Provides language to express
distress

Separation in thoughts/behavs/
feelings meaningful

GENERIC ELEMENTS FOUND USEFUL

Group factors

Group as positive:

Source of relief/sharing experiences - Normalisation

Opportunity for exposure

Opportunity to meet supportive others

Cognitive Restructuring from peers

Empowerment

Group as 'not ideal':

Perceived need of self-disclosure

Apprehension due to fears re. confidentiality

Need for individual support

Facilitator's role

Importance of sharing culture

Characteristics enhancing clients' engagement

Intervention delivered in Spanish

Language barrier among Latinos

Need to use Spanish to talk about distress

Limitations when working through interpreters

NHS limited provision of interpreting services

Need for material in Spanish

INTERVENTION AS LIMITED/SCOPE FOR IMPROVEMENT

Intervention as starting point

Expectation of further input

Recovery as a pathway

Vague description of further input

Practical changes

Length of intervention

More emphasis on practice

Follow-up sessions/review of material covered in previous sessions

Break half-way through sessions

Warm-up exercises/games

Celebration of endings

Individual support to some to facilitate engagement with the group

Punishing non-attendance

Recruitment

All can benefit from intervention

Mutual learning

Timeliness/degree of distress amenable to intervention

Need for homogeneity
- re. age of participants
      young people don't appreciate

- re. experience/goals
      need for first person's

LATINO COMMUNITY NEEDS

Migratory grief

Adaptation to new country

Awareness-raising

Community involvement

Latino cultural values

Formalism

Respect

Familism vs. individualism

Help-seeking behaviour

Spirituality

MH as taboo/no priority

Expectations of help

Dual reason for attendance

Experience of migration

Harsh reality

Lack of realism

Disempowerment

Respect/lack of assertiveness

Paralelism migration/therapy:

Needy/self-pity

Need to adapt to circumstances

Relationship to facilitator

Need to adapt to help received

Community difficulties and needs

LA community 'lagging behind' others

Need for 'social action'

Bringing further issues within the community

Importance of keeping in contact

Widening the group – integration with non-Spanish Speakers

Prominence of facilitator

```
┌─────────────────────┐
│  Knowing what to    │
│  do – Techniques    │
└─────────────────────┘

╭─────────────────────╮     ┌─────────────────────┐
│   SPECIFIC CBT LI   │     │ Knowing what it is – │
│  ELEMENTS FOUND     │     │  Conceptualisation   │
│     USEFUL          │     └─────────────────────┘
╰─────────────────────╯
                           ┌─────────────────────┐
                           │ When is it a problem? – │
                           │    Questionnaires    │
                           └─────────────────────┘

┌─────────────────────┐
│  Need to practise – │
│  Intersession tasks │
└─────────────────────┘
```

```
┌─────────────┐     ╭─────────────────────╮
│  Practical  │     │   INTERVENTION AS   │
│  changes    │     │  LIMITED / SCOPE    │
└─────────────┘     │  FOR IMPROVEMENT    │
                    ╰─────────────────────╯
┌─────────────┐
│  For whom?  │
└─────────────┘

        ┌─────────────────────────────┐
        │ Intervention as starting point │
        └─────────────────────────────┘
```

```
┌─────────────────────────────┐
│ Intervention delivered in Spanish │
└─────────────────────────────┘

╭─────────────────────╮     ┌─────────────────────┐
│  GENERIC ELEMENTS   │     │  Facilitator's role │
│   FOUND USEFUL      │     └─────────────────────┘
╰─────────────────────╯
                           ┌─────────────────────┐
                           │    Group factors    │
                           └─────────────────────┘
```

```
                    ┌─────────────────────────────┐
                    │ Community difficulties and needs │
                    └─────────────────────────────┘

┌─────────────┐     ╭─────────────────────╮
│ Experience of │   │  LATINO COMMUNITY   │
│  migration    │   │      NEEDS          │
└─────────────┘     ╰─────────────────────╯

┌─────────────────────┐
│ Latino cultural values │
└─────────────────────┘
```