PILOT STUDY ON THE CLINICAL USEFULNESS AND ACCEPTABILITY OF THE UNIFIED PROTOCOL FOR THE TRANSDIAGNOSTIC TREATMENT OF EMOTIONAL DISORDERS IN ONLINE AND GROUP FORMAT IN ARGENTINA

ESTUDIO PILOTO SOBRE LA UTILIDAD CLÍNICA Y ACEPTABILIDAD DEL PROTOCOLO UNIFICADO PARA EL TRATAMIENTO TRANSDIAGNÓSTICO DE TRASTORNOS EMOCIONALES EN FORMATO ONLINE Y GRUPAL EN ARGENTINA

MILAGROS CELLERI[1], CAMILA FLORENCIA CREMADES[1], RODRIGO LAUTARO ROJAS[1], CRISTIAN JAVIER GARAY[1] Y JORGE OSMA[1,2]

Cómo referenciar este artículo/How to reference this article:

Celleri, M., Cremades, C. F., Rojas, R. L., Garay, C. J., & Osma, J. (2022). Pilot Study on the Clinical Usefulness and Acceptability of the Unified Protocol for the Transdiagnostic Treatment of Emotional Disorders in Online and Group format in Argentina [Estudio piloto sobre la utilidad clínica y aceptabilidad del Protocolo Unificado para el tratamiento transdiagnóstico de trastornos emocionales en formato online y grupal en Argentina]. *Acción Psicológica, 19*(2), 63–80. https://doi.org/10.5944/ap.19.2.37004

Abstract

The aim of the present study was to provide evidence on the preliminary clinical usefulness and treatment satisfaction with the Unified Protocol (UP) designed by Barlow et al. (2011), applied in group and online format in adults with emotional disorders in Argentina. To this end, a non-controlled study was conducted with pre- and post-treatment measurements. The group included seven partici-

Correspondence address [Dirección para correspondencia]: Milagros Celleri, Universidad de Buenos Aires, Argentina.
Email: mcelleri@psi.uba.ar

ORCID: Milagros Celleri (https://orcid.org/0000-0002-0102-339X), Camila Florencia Cremades (https://orcid.org/0000-0002-1051-6073), Rodrigo Lautaro Rojas (https://orcid.org/0002-7153-5155), Cristian Javier Garay (https://orcid.org/0000-0003-4082-8876) y Jorge Osma (https://orcid.org/0000-0002-7293-318X).

[1] University of Buenos Aires, Argentina.
[2] Universidad de Cádiz, España.

Acknowledgments: To the University of Buenos Aires for its support to clinical research and particularly to the Faculty of Psychology, headquarters of the research project in which this study is framed. To all study participants, who voluntarily participated in our investigation, for their warmth and commitment

Recibido: 20 de julio de 2022.
Aceptado: 26 de octubre de 2022.

pants with symptoms belonging to the anxiety-depression spectrum. The intervention consisted of 11 weekly 90-minute synchronic meetings held on an online platform. The results showed a significant reduction in participants' levels of depression, hopelessness, emotional regulation difficulties, and negative affect, as well as a significant increase in their quality of life. In turn, large effect sizes were found for depression, anxiety, hopelessness, emotional regulation difficulties, and negative affect. The preliminary findings in this study are promising as regards the UP's clinical usefulness and utilization acceptability in online group format for Argentina's population.

Keywords: Unified Protocol; Group Intervention; Online Intervention; Emotional Disorders; Argentina.

Resumen

El objetivo del presente estudio fue aportar evidencia sobre la utilidad clínica preliminar y la satisfacción con el tratamiento del Protocolo Unificado (PU) de Barlow et al. (2011), aplicado en formato grupal y online en adultos con trastornos emocionales en Argentina. Para tal fin se realizó un estudio no controlado con medidas pre y post-tratamiento. El grupo estuvo formado por siete participantes con sintomatología del espectro ansioso-depresiva. La intervención consistió en 11 sesiones semanales sincrónicos de 90 minutos realizados en una plataforma virtual. Los resultados mostraron una reducción significativa en los niveles de depresión, desesperanza, dificultades en la regulación emocional y afecto negativo, y un aumento significativo en la calidad de vida. A su vez, se observaron tamaños del efecto grandes para depresión, ansiedad, desesperanza, dificultades en la regulación emocional y afecto negativo. Los resultados preliminares del presente estudio sobre la utilidad clínica y aceptabilidad del uso del PU en formato grupal y online en población argentina son prometedores

Keywords: Protocolo Unificado; Intervención grupal; Intervención online; Trastornos emocionales; Argentina.

Introduction

Anxiety and depression have become the most prevailing disorders in the world's population (World Health Organization [WHO], 2017). In Argentina, a recent study revealed an 8.7% prevalence of major depression disorders and a 16.4% prevalence of anxiety disorders, with the latter holding the greatest life prevalence (Stagnaro et al., 2019). For both disorder groups, the National Institute for Health, and Care Excellence (NICE) guidelines have established cognitive behavioral therapy (CBT) as a primary treatment (NICE, 2013).

The aforementioned disorders, along with the obsessive-compulsive disorder, the post-traumatic stress disorder, and the illness anxiety disorder (hypochondria), have been characterized as part of the emotional disorder group (ED; Bullis, et al., 2019), as they share a number of traits—both in terms of etiology and maintenance—including frequent and intense negative emotions (heightened neuroticism and low extraversion) (Barlow, 2000), negative and aversive reactions to these emotional experiences, and efforts to avoid or suppress them (Bullis, et al., 2019). In these disorders, the dysfunctional effects of emotional suppression significantly hinder people's ability to regulate their own emotions (Campbell-Sills et al., 2006).

The high comorbidity among these disorders in clinical practices—as well as how hard it is for therapists to train on multiple psychotherapeutic models and treatment protocols—has led to the recent development of transdiagnostic approaches (Harvey et al., 2004). These approaches focus on the traits shared by the disorders rather than on their differences, allowing for a more efficient treatment that also proves more cost-effective for therapists (Mansell et al., 2009). With the recent advancements in the fields of learning, neurosciences, and the study of emotions, three major therapeutic components have been identified for the transdiagnostic treatment of EDs: (a) cognitive reappraisal, (b) emotional avoidance prevention, and (c) modifying tendencies to act under emotional impulsivity (Barlow et al., 2016).

The Unified Protocol for transdiagnostic treatment of EDs (UP) is a transdiagnostic therapy based on working with emotional regulation processes published in 2011 by

David H. Barlow et al. (Barlow et al., 2011). It consists of eight treatment modules, with five of them being central (mindfulness, cognitive flexibility, countering emotional behaviors, tolerating physical sensations, and emotional exposure). This protocol has proven effective at treating EDs individually, with similar outcomes to those of specific protocols for each disorder (Barlow et al., 2017; Eustis et al., 2020).

In turn, group approaches in psychotherapy facilitate access to the treatments required (Garay et al., 2008). This is especially relevant in Argentina, where access to CBT tends to be difficult due to a lack of trained therapists (Korman et al., 2018). Additionally, group approaches allow for the normalization of the experiences shared by therapeutic group members (Whitfield, 2010). Moreover, several studies have demonstrated the effectiveness of CBT in group format (e.g., Burlingame et al., 2018; Davidson et al., 2019).

Indeed, the UP has proven to be a treatment that can be adapted to a group format, with promising results in several international studies (Bullis et al., 2015; Laposa et al., 2017; Osma et al., 2015; Osma et al., 2021a). In Argentina, there have been two UP group in-person applications thus far. One study was conducted in Mar del Plata, a city in Buenos Aires Province, with results that resembled those of the aforementioned international studies (Grill et al., 2017), and the other application is currently underway in Buenos Aires City, the nation's capital, with a population suffering from irritable bowel syndrome (Celleri et al., 2020).

As in other healthcare fields, the current COVID-19 pandemic has driven therapists to adapt face-to-face or in-person treatments to remote therapy (Garfan et al., 2021) in order to minimize infection risks and to abide by social distancing norms implemented in every country. Against the backdrop of the restrictions and social confinement (lockdown) imposed, the need for psychological treatments in Argentina during the pandemic (Etchevers, et al., 2021; Torrente et al., 2021) led to the primary use of synchronous teletherapy, a proven format to treat the aforementioned disorders (Osenbach et al., 2013; Rees & Maclaine, 2015; Varker et al., 2019). To date, we have only found a study that use online UP in a case of perinatal depression (Crespo-Delgado et al., 2020), a study that use online UP to prevent emotional symptoms or EDs in a group of women suffering from infertility (Martínez-Borba et al., 2022), and a study protocol that use online UP in a group of patients awaiting bariatric surgery (Quilez-Orden et al., 2020). All these studies have been or will be carried out in Spain; there are no studies with these characteristics in Argentina.

Given the world's current epidemiological situation and the in-facto adaptation of psychological treatments for synchronous teletherapy, this study intends to assess the clinical usefulness and acceptability level of the UP online group format in Argentina—specifically in the Greater Buenos Aires and Buenos Aires City areas—as well as participants' satisfaction with the treatment. Our hypothesis is that, given that the UP has proven effective for EDs treatment in in-person group format, it might also prove clinically useful in online group format. To this end, a pilot, open, non-controlled study was conducted with pre- and post-treatment measurements after an 11-week period using the UP in an online group format.

Methodology

A quasi-experimental study with pre- and post-treatment measurements and no control group (Ato et al., 2013) was carried out.

Participants

The participants in this study included seven individuals with an average age of 27.71 years (SD = 5.53). Six identified themselves as female (85.7 %) and one as male (14.3 %). One reported taking clonazepam as needed. None reported currently engaging in psychotherapy. Four participants had undergone psychotherapy over the past five years (between 2018 and 2020). None of the seven participants was being treated by a psychiatrist at the beginning of this treatment. Table 1 below summarizes the participants' social and demographic data, while Table 2 shows group members' diagnoses.

Table 1

Sample Characteristics (N = 7)

	N	%
Place of residence		
Buenos Aires City	1	14.30
Southern suburbs	2	28.60
Western suburbs	3	42.90
Northern suburbs	1	14.30
Marital status		
Single	6	85.71
Married	1	14.29
Education		
High School diploma	4	57.10
Tertiary/university degree	3	42.90
Children		
0	6	85.71
1	1	14.29

Table 2

Participants' Diagnoses Depending on Interference with Daily Life (N = 7)

Participant	*Primary Diagnosis*	*Secondary Diagnoses*
ID 1	SAD	UAD
ID 2	PD	MDD, GAD
ID 3	SAD	MDD, GAD
ID 4	MDD	GAD
ID 5	GAD	PD
ID 6	SAD	MDD
ID 7	MDD	GAD, DYS, SAD

Note: Obtained from Mini-International Neuropsychiatric Interview (MINI; Ferrando et al., 2000); DYS = dysthymia; GAD = generalized anxiety disorder; UAD = unspecified anxiety disorder; SAD = social anxiety disorder; MDD = major depressive disorder; PD = panic disorder

Instruments

Ad-hoc socio-demographic questionnaire. An ad-hoc questionnaire has been administered to gather participants' social and demographic information. It included questions on age; self-perceived gender; place of residence; educational level; whether he/she has undergone or is undergoing psychotherapy, when and for how long; whether he/she takes psychopharmacological medication and, if so, which, whether he/she was formerly given a psychiatric diagnosis, and, if so, which one.

Ad-hoc acceptability, perceived satisfaction with the treatment, usefulness, and task adherence questionnaire. An ad-hoc questionnaire (Table 6) was designed with the aim of evaluating the experience with the treatment, the usefulness of skills learned and adherence with the practice of skills. For this purpose, nine items were constructed with a Likert-type response format from 1 to 10. The construction of the questions was based on the previous study by Osma et al. (2015).

Beck Depression Inventory II (BDI II; Beck et al., 2006; Argentine adaptation by Brenlla & Rodríguez, 2006). The BDI II is a questionnaire designed to gauge how severe people's depressive symptoms are. It includes 21 items that probe the typical symptoms of a depressive episode. Every item feature 4 options, ranging from 0 (not at all) to 3 (severe, nearly unbearable), on a Likert-type scale. It was validated and adapted to Argentina's population, with an adequate internal consistency and a Cronbach's alpha coefficient of .88. The cut point considered in this scale is 14.

Beck Anxiety Inventory (BAI; Beck et al., 1988; Argentine adaptation by Vizioli & Pagano, 2020). The BAI is an inventory designed to measure the severity of anxiety symptoms. It consists of 21 items, each addressing an anxiety symptom. Every item is rated on a Likert scale answer format that goes from 0 (not at all) to 4 (it upset me very much). This instrument was validated and adapted to Argentina's setting, with a Cronbach's alpha coefficient of .93. The cut point considered in this scale is 14.

Positive and Negative Affect Schedule (PANAS; Thompson, 2007; Argentine adaptation by Moriondo et al., 2012). The PANAS inventory has been designed to measure affect in a dimensional fashion (negative affect and positive affect). The short version designed by Thompson (2007) and adapted to Argentina by Moriondo et al. (2012) has been chosen. This version covers four dimensions: trait positive affect (five items), trait negative affect (five items), state positive affect (five items), and state negative affect (five items). Every item uses a Likert-type scale rating from 1 (slightly or not at all) through 5 (very much or totally). This instrument features a Cronbach's alpha coefficient of .73 (Cronbach's alpha co-

efficient of .84 for Negative Affect and .75 for Positive Affect).

Multicultural Quality of life Index (MQLI; Mezzich, et al., 2003; adapted to Argentina by Jatuff et al., 2015). This instrument was created to assess the quality of life in a brief, multicultural, and multidimensional fashion. In this self-administered 10-item instrument, each item addresses an area of functioning on a Likert-type scale ranging from 1 (bad) to 10 (excellent). All these items are added up to obtain a Global Quality of Life Index—the higher the score, the better the quality of life perceived. This instrument was validated and adapted to Argentina's context with a Cronbach's alpha coefficient of .85.

Difficulties in Emotion Regulation Scale (DERS; Gratz & Roemer, 2004; Argentine adaptation by Cremades et al., 2021). This scale measures the extent to which people use several Emotional Regulation strategies. The adapted scale includes 30 self-administered items with a Likert-type five-option scale that goes from 1 (hardly ever) to 5 (almost always) and a six-factor structure, including: (1) impulse control difficulties (six items); (2) limited access to emotional regulation strategies (six items); (3) lacking emotional acceptance (six items); (4) interference in goal-oriented behaviors (four items); (5) lacking emotional awareness (three items), and (6) lacking emotional clarity (six items). This scale features a sound Cronbach's alpha coefficient of .94, as do its sub-scales individually (Cronbach's alpha coefficient of .87 for Impulse Control Difficulties; Cronbach's alpha coefficient of .85 for Limited Access to Emotional Regulation Strategies; Cronbach's alpha coefficient of .91 for Lacking Emotional Acceptance; Cronbach's alpha coefficient of = .88 for Interference in Goal-Oriented Behaviors; Cronbach's alpha coefficient of .69 for Lacking Emotional Awareness, and Cronbach's alpha coefficient of .81 for Lacking Emotional Clarity).

Beck Hopelessness Scale (BHS; Beck et al., 1974; Argentine adaptation by Mikulic et al., 2009). This inventory was created to measure pessimism and hopelessness, bearing in mind that these constructs serve as predictors of suicidal behavior. It contains 20 items with a true-or-false reply format, scoring from 0 to 20, with the highest scores pointing to the presence of strong hopelessness. This instrument was validated and adapted to Argentina, with a Cronbach's alpha coefficient of .78.

Mini-International Neuropsychiatric Interview (MINI; Sheehan et al., 1998; Spanish version by Ferrando et al., 2000). The MINI 5.0 is a short structured diagnostic interview designed to assess major psychiatric disorders according to the DSM-IV (APA, 1994) Axis I and the ICD-10. It includes 130 questions divided into 16 modules, with each one exploring the symptoms of a specific disorder. This instrument has acceptably high validity and reliability levels (Sheenan et al., 1998), and it can be administered in a much shorter period than other diagnostic interviews. Regarding interrater and retest reliability, the diagnostic dimensions obtained Cohen's Kappa values greater than .50, with the exception of drug dependence which obtained a Cohen's kappa of .43. Sensitivity was .70 or greater for all but three subscales (dysthymia with .67, OCD with .62 and drug dependance with .45). Specificity was greater than .85 for all subscales.

Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID II; First et al., 1994; Spanish version by Grilo, et al., 2003). This semi-structured diagnostic interview was designed to assess psychiatric disorders in the DSM-IV (APA, 1994) Axis II. It features 119 questions probing diagnostic criteria for all the personality disorders in DSM-IV (APA, 1994). The criteria must be present for at least two years and prove characteristic in individuals' adult life. Except for the sub-scale for the paranoid disorder, this interview shows acceptable levels of internal consistency (ranged .36 to .99; mean = .75; median = .81) as well as good psychometric properties (Grilo et al., 2003). The interrater reliability obtained a Cohen's Kappa value of .83.

The study has relied on DSM-IV evaluation interviews rather than their most recent counterparts (DSM-5; APA, 2013), as the latter are not currently available in Argentina.

Procedure

This study was approved by the responsible behaviors committee at Universidad de Buenos Aires' School of

Psychology. All participants were briefed on the research objectives and informed of the voluntary nature of their engagement, as well as of their ability to withdraw from the study at any time. The treatment was provided free of charge, as part of a research project conducted by Universidad de Buenos Aires' School of Psychology. All participants agreed to and signed the consent form with a digital signature via email, as per the principles stated in the Declaration of Helsinki and its amendments, as well as Argentina's Law Number 26,529 on Patients' Rights, Clinical Records, and Informed Consent.

The treatment was delivered by two professional psychologists with licenses for clinical practice in Argentina. One of them, the first author, a specialist in Clinical Psychology and CBT at Universidad de Buenos Aires, attended a UP workshop at the Boston University's Unified Protocol Institute delivered by Todd Farcchione. The other study coordinator, second author, is currently completing the requirements for Universidad de Buenos Aires' M.A. degree in Evaluation and Diagnostics. The sessions were recorded on video and overseen by a senior cognitive therapist certified by the Argentine Cognitive Therapy Association. Participants' assessment interviews were conducted by three already mentioned team psychologists and an additional team member—all trained in CBT at Universidad de Buenos Aires.

Study participants were recruited via flyers on social media (Facebook and Instagram) with a link to Google Forms and from references from colleagues (university faculty members, clinicians, and researchers). Candidates registered via a form on Google Forms, which participants filled out after accepting the informed consent by marking the corresponding box. The form gathered participants' socio-demographic information and administered the pre-treatment evaluation protocol. Figure 1 shows the study flow diagram.

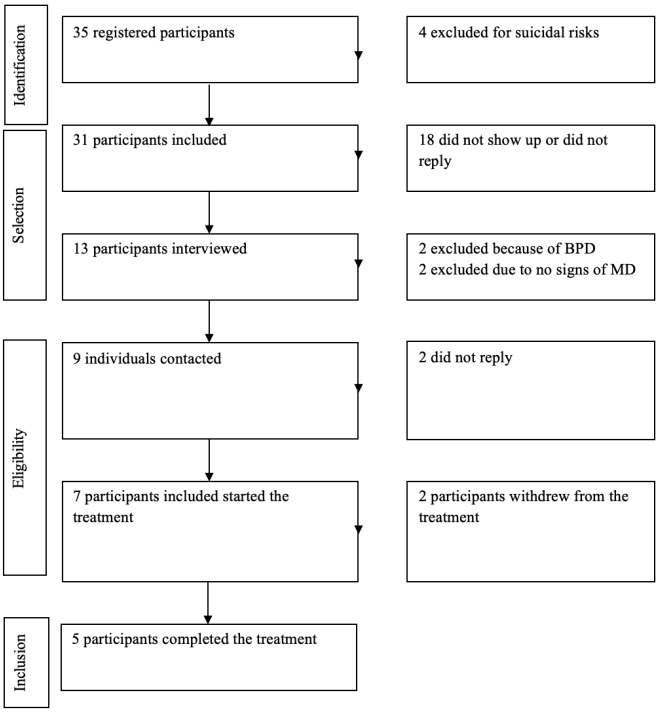
The group admission criteria were: (1) being 18 years old or older; (2) submitting the informed consent; (3) agreeing to participate in all the scheduled sessions; (4) agreeing to having the sessions recorded (both audio and video) for oversight purposes; (5) submitting a primary diagnosis of anxiety disorder (e.g., panic disorder; agoraphobia; social anxiety disorder; generalized anxiety disorder; unspecific anxiety disorder), unipolar depression (major depressive disorder; dysthymia), obsessive-compulsive disorder, or post-traumatic stress disorder, according to DSM criteria and disrupting individuals' daily life or causing significant discomfort.

The group exclusion criteria were: (1) comorbidity with psychotic disorders, bipolar disorder, eating disorders, borderline personality disorder, or active severe suicidal ideation, and (2) currently receiving pharmacological treatment. All candidates who were not included in the group were informed of this decision and received information on places to seek treatment within the public healthcare system in Buenos Aires Province and Buenos Aires City.

Evaluations were carried out via video calls on the Google Meet platform, using the MINI (Ferrando et al., 2000) and SCID-II (Grilo et al., 2003) diagnostic interviews.

Figure 1

Flow Chart



The first pre-treatment evaluation was conducted two weeks before the first session. The post-treatment evaluation was carried out during the last week of the treatment (week 11).

By session 6, one of the participants reported having made a private psychiatric consultation. In week 4, another participant left the group because he returned to in-person classes at the university. In week 6, a second participant left the group citing difficulties to organize herself and attend the sessions. A participant had to undergo nose surgery in week 8 and was unable to participate in the interoceptive exposure exercises or in following weeks, as she was in bed rest. She still attended the sessions until the end of the treatment. At the end of the treatment, participants received an ad-hoc form on Google Forms to establish their satisfaction with the treatment, and they also received all the assessment scales once again.

Treatment

Participants received online, synchronous group therapy based on the UP model for 11 subsequent weeks, with 90-minute meetings. After every session, they

Table 3

Session Description

Session	*Content*
1	Coordinators' and participants' introductions. Session framework. Introduction to the approach and EDs. Conceptualization of ED and participants' sharing. Assignment: reading chapter three from the patients' manual, continuing to identify their own intense emotions, aversive reactions, and avoidance efforts.
2	Reviewing participants' assignments. Describing issues, goals, and steps to accomplish them. Introduction to change motivation. Decision balance exercise. Assignment: reading chapter four from the patients' manual, completing their goals and decision balance form (Module 1).
3	Reviewing participants' assignments. Introduction to the topic of this session (psychoeducation of emotions). Presentation of the three-component model, as well as the antecedents and consequences of emotional experiences. This exercise was shared in the session. Assignment: reading chapters five and six from the patients' manual, self-monitoring emotions during the week (Module 2).
4	Reviewing participants' assignments. Introduction to mindfulness. The non-judgment emotional awareness exercise was carried out in the session, and participants later received by email the taped audio so that they could do it during the week. Assignment: reading chapter seven, mindfulness practice, and self-monitoring emotions (Module 3).
5	Reviewing participants' assignments. Emotional awareness exercise during the session. Introduction to emotional induction and practicing mindfulness when facing stimuli brought about by emotions (videos/audios). Introduction to anchoring in the present. Assignment: practicing mindfulness/emotional induction and self-monitoring emotions (Module 3).
6	Reviewing participants' assignments. Introduction to cognitive flexibility. Ambiguous image exercise. Introduction to mind traps and cognitive re-evaluation exercise during the session. Assignment: reading chapter eight, self-monitoring emotions, and practicing cognitive re-evaluation (Module 4).
7	Reviewing participants' assignments. Introduction to emotional behaviors. Introduction to CIEs and avoidance types. Cognitive suppression exercise during the session. Working with alternative actions. Assignment: reading chapter nine, self-monitoring emotions, identifying one's own emotional behaviors (Module 5).
8	Reviewing participants' assignments. Introduction to interoceptive exposure. Interoceptive exposure exercise during the session: hyperventilating, running on the spot, jumping, breathing through a straw, and twirling. Assignment: reading chapter ten, self-monitoring and practicing exposure to physical sensations on a daily basis (Module 6).
9 and 10	Reviewing participants' assignments. Introduction to the exposure to intense emotions. Building the exposure hierarchy. Introduction to the emotional exposure form. Weekly assignment: reading chapter eleven, practicing emotional exposure (Module 7).
11	Reviewing participants' assignments. Introduction to relapse prevention and plans for future practice. Closing and group farewell among therapists and participants (Module 8).

received the chapter with the notions addressed in the session from the UP's patient manual (Barlow et al., 2011) and the scales to work with during the week. Table 3 below describes the contents of every session.

Statistical Analyses

All statistical analyses were carried out with the IBM SPSS (Version 22.0) predictive analysis software. Descriptive statistics were calculated for socio-demographic data. For pre- and post-treatment comparisons, the Wilcoxon Test was used, due to the small size of the sample and the non-compliance with normality assumptions in the Kolmogorov-Smirnov test and homoscedasticity for the Levene test. In turn, the Cliff's delta is reported as effect size measure. Also, the Reliable Change Index (Jacobson & Truax,1992) has been calculated for all major clinical variables (anxiety and depression).

Results

Clinical Indicators

In general terms, all the participants in this study were found to evolve favorably as compared to their state before completing this intervention.

To assess the evolution of clinical measures, pre- and post-treatment scores on the anxiety, depression, hopelessness, emotional regulation difficulties, positive affect, and negative affect scales were compared. In turn, the scores on a quality-of-life scale were compared to provide an overall measure of individual patients' state. Table 4 below shows pre- and post-treatment means, as well as standard deviations.

After conducting Wilcoxon's signed rank tests (see Table 4), a statistically significant decrease was found in depression ($z = -2.02$; $p < .05$), hopelessness ($z = -2.04$; $p < .05$), emotional regulation difficulties ($z = -2.02$; $p < .05$), and state negative affect ($z = -2.03$; $p < .05$). In

Table 4

Means, Standard Deviations, Wilcoxon Test, and Effect Size

Variable	*Pre (n=5)*	*Post (n=5)*	*Pre -Post*	
	M (SD)	*M (SD)*	*Z*	*Cliff's delta*
Depression (BDI-II)	28.2 (10.71)	12.8 (7.56)	*-2.023**	*0.84*
Anxiety (BAI)	21.8 (18.19)	8.0 (7.65)	-1.625	*0.52*
Hopelessness (BHS)	9.2 (2.59)	5.8 (3.56)	*-2.041**	*0.64*
Emotion Dysregulation (DERS)	84.8 (25.37)	57.8(10.28)	*-2.023**	*0.76*
Quality of life (MQLI) [a]	62.6 (15.87)	69.6 (15.4)	*-2.032**	*-0.28*
Positive/Negative Affect (PANAS)				
PANAS-R-AN	16.4 (0.89)	13 (4.85)	*-1.355*	0.56
PANAS-R-AP [a]	14.4 (3.21)	13.2 (4.15)	*-.184*	*0.16*
PANAS-E-AN	16.6 (1.82)	10 (4.36)	*-2.032**	*0.92*
PANAS-E-AP [a]	13.6 (3.51)	12.4 (3.65)	*-.677*	*0.16*

Note: **BAI** = Beck Anxiety Inventory; **BDI** = Beck Depression Inventory; **BHS** = Beck Hopelessness Scale; **DERS** = Difficulties in Emotion Regulation Scale; **MQLI** = Quality of life index; **PANAS** = Positive and Negative Affect Schedule; **PANAS-R-AN** = Positive and Negative Affect Schedule-Trait-Negative Affect; **PANAS-R-AP** = Positive and Negative Affect Schedule-Trait-Positive Affect; **PANAS-E-AN**= Positive and Negative Affect Schedule-State-Negative Affect; **PANAS-E-AP** = Positive and Negative Affect Schedule-State-Positive Affect.

[a] In these scales, the higher scores show lesser difficulty, while negative effect sizes show greater improvement.

*$p < .05$; **$p < .01$; ***$p < .001$

turn, a significant increase in quality of life was found ($z = -2.03$; $p < .05$).

At the same time, effect sizes were analyzed with Cliff's delta (see Table 4). The following amounts were considered as estimates for effect magnitude: up to 0.15, small; from 0.33 upwards, moderate; from 0.47 upwards, large (Macbeth et al., 2011). Large-size effects were found for depression (Cliff's delta = .84), anxiety (Cliff's delta = .52), hopelessness (Cliff's delta = .64), emotional regulation difficulties (Cliff's delta = .76), trait negative affect (Cliff's delta = .56), and state negative affect (Cliff's delta = .92). For quality of life (Cliff's delta = -.28), state positive affect (Cliff's delta = .16), and trait positive affect (Cliff's delta = .16), small-size effects were found.

Reliable Change Index

The Reliable Change Index has been calculated for all major clinical variables (Jacobson & Truax, 1992). Regarding the depression variable, two patients have shown a reliable improvement, with their scores even indicating recovery, while two other participants have shown no changes as compared to their prior functionality. The remaining participant has shown a reliable improvement that, failing to reach non-clinical levels, prevents the consideration of this patient as recovered. Concerning the anxiety variable, two participants have shown a reliable improvement, returning to non-clinical scores, while two other participants have shown no changes in functionality, and the remaining patient has shown a reliable improvement as compared to prior scores but still fails to reach a non-clinical score. These findings are presented on Table 5 below.

Assessing UP's Acceptability through Perceived Satisfaction with the Treatment, Usefulness, and Task Adherence

Overall, the treatment was well received by all group members, including the participants who did not complete all eleven sessions. All participants have stated that they would choose a group treatment if they needed assistance in the future. Table 6 below shows participants' answers.

Table 5

Reliable Change Index

					BDI						*BAI*	
ID	*Pre*	*Post*	*State*	*Rank*	*RCI*	*Interpretation*	*Pre*	*Post*	*State*	*Rank*	*RCI*	*Interpretation*
1	16	14	Improved	Clinical	0.37 (No change)	No functionality changes	8	3	Improved	Non-clinical	1.30 (No change)	No functionality changes
2	44	5	Improved	Non-clinical	7.32	Reliable improvement –Recovered	28	5	Improved	Non-clinical	5.99	Reliable improvement –Recovered
3	23	5	Improved	Non-clinical	3.38	Reliable improvement –Recovered	13	0	Improved	Non-clinical	3.38	Reliable improvement –Recovered
4	25	21	Improved	Clinical	0.75 (No change)	No functionality changes	51	18	Improved	Clinical	8.59	Reliable improvement –Not recovered
5	33	19	Improved	Clinical	2.62	Reliable improvement –Not recovered	9	14	No improvement	Clinical	1.30 (No change)	No functionality changes

Discussion

The results of this study are consistent with our predictions about the satisfaction and clinical usefulness of UP interventions delivered in online group format. Moreover, they are in line with studies using the UP treatment in group and onsite format conducted in Argentina in patients with depression, negative affect, and emotion regulation (Grill et al., 2017), as well as with international studies (Bullis et al., 2015; Osma et al, 2021) and their online interventions (Martinez-Borba et al., 2022).

Regarding the acceptability (satisfaction and adherence to the treatment) of the intervention applied in

Table 6

UP's Acceptability, Treatment Satisfaction, and Task Adherence

Statement	*Option Chosen*	*N*	*%*
Treatment experience—from 1 (bad) to 10 (good).			
	10	4	80
	8	1	20
From 1 (not at all) to 10 (a lot), how much do you think this treatment has helped you regulate your emotions?			
	9	3	60
	10	1	20
	7	1	20
Usefulness of skills learned—from 1 (useless) to 10 (very useful).			
	10	3	60
	9	1	20
	8	1	20
Usefulness of mindfulness—from 1 to 10.			
	8	3	60
	9	1	20
	5	1	20
Usefulness of cognitive flexibility—from 1 to 10.			
	10	3	60
	9	1	20
	6	1	20
Usefulness of opposing emotional behaviors—from 1 to 10			
	10	4	80
	7	1	20
Usefulness of interoceptive exposure—from 1 to 10.			
	10	3	60
	7	1	20
	1	1	20
Usefulness of live exposure—from 1 to 10.			
	10	2	40
	9	2	40
	5	1	20
Practicing skills and completing assignments.			
	Every week.	2	40
	Between 10 and 8 weeks.	2	40
	Between 2 and 4 weeks.	1	20

online group format, all participants in the study reported high satisfaction levels concerning both the treatment and the skills trained through the UP, and most of them reported using these skills almost every week. This is consistent with a recently published pilot study to evaluate UP intervention in online group format (Martínez-Borba et al., 2022), which yielded high levels of satisfaction and adherence to the treatment by pilot users. A main limitation of such study was participants' high educational level, to which adherence to the online format may be ascribed. In this study, however, most participants had received Argentina's basic, compulsory education (requiring completion of secondary school), thus providing evidence of acceptability in the general population.

Evidence of the acceptability and clinical usefulness of the UP delivered in group format is relevant to facilitate access to psychological intervention to populations experiencing EDs. This becomes particularly relevant in a context with very few professionals trained in evidence-based psychological treatments (Klinar et al., 2019). On the other hand, evidence of the acceptability and clinical usefulness of online UP application is critical to its implementation in pandemic settings. This remote therapy or teletherapy format reduces the likelihood of contagion of an infectious-contagious disease such as SARS-CoV-2. In addition, teletherapy eliminates travel expenses for patients, thus reducing costs. Both factors contribute to increasing patient access to psychological intervention. Since Argentina is a country that integrates the list of low- and middle-income countries, to increase the access to psychological treatments is a very important issue for public polices. In Argentina, the offer of evidence-based treatments in public health is scarce. This means that few people can access evidence-based treatments. Studying the efficacy of transdiagnostic treatments focused on the most prevalent disorders and offered in group format in the public sphere, helps more people to access evidence-based treatments in a country where psychologists with CBT training are scarce.

All participants in this study have shown improvements in their initial symptomatology, although not all scores obtained reached statistical significance. Besides drop-out percentages in our study were consistent with previous studies (20 % to 37 %) (Osma et al., 2015; Osma et al., 2021). Major differences in depressive symptoms were observed at the end of the treatment (Cliff's Delta = .84). These results differ slightly from those reported by other studies that applied UP in group format, where UP intervention showed a greater impact on anxiety symptoms (Bullis, et al., 2015; Osma et al., 2015). While most patients in our study reported reduced anxiety symptomatology (Cliff's Delta = .52), one participant (diagnosed with panic disorder) displayed higher levels of anxiety during the last weeks of the treatment as compared to pre-intervention levels. This could be attributed to the participant's failing to practice the exercises in the interoceptive exposure module due to nasal surgery, which is consistent with data suggesting that interoceptive exposure is the central component of panic disorder (Boettcher & Barlow, 2019), and may explain the greater treatment effect on depressive symptoms found in our study.

More specifically, on an individual basis, anxiety and depressive symptoms remitted in two of five patients, who were consequently regarded to be in remission of their diagnosed disorders, in line with the assumption developed in UP's theoretical foundation, whereby transdiagnostic mechanisms are maintenance factors for EDs (Barlow et al., 2019). Likewise, most remaining participants showed improvement as compared to their previous anxiety and depression scores, although not all of them reached scores in non-clinical ranges, as previously reported (Osma et al., 2015).

With regard to negative and positive affect variables, the state negative affect showed a statistically significant improvement and the largest effect size (Cliff's Delta = .92). However, this was not the case of the state positive affect. These findings partly support other studies of negative affectivity and UP, whereby a relevant improvement in the neuroticism (or negative affect) dimension was established (Gallagher, et al., 2014; Osma et al., 2021b; Sauer-Zavala et al., 2020; Zemestani et al., 2021). Still, such studies have also showed an improvement in extraversion and positive affectivity. Although the most recent version of the UP (Barlow et al., 2019) placed greater emphasis on the importance of cultivating positive emotions, the version of UP used in

this study has focused on emotion regulation of anxiety and depressive symptoms, which could account for such difference. In turn, those studies showed that temperament changes became more stable and significant over time, yielding better results at six-month follow-ups (Osma et al., 2021b). The stability-of-temperament traits may presumably explain the small decline in negative affect and the increase in positive affect in the trait dimension. It would be interesting to assess the evolution of these variables in the following months in order to draw further conclusions. In turn, Barlow et al. (2019) suggest a greater number of treatment sessions is necessary to produce stable changes in temperament variables.

At the end of the treatment, we found a significant decrease in emotion regulation difficulties with a large size effect (Cliff's Delta = .76). This was to be expected given that emotion regulation is a key transdiagnostic variable in UP treatment, and its goal is to help patients learn adaptive emotion regulation strategies to achieve greater emotional acceptance. Furthermore, this proves consistent with studies reporting a strong correlation between negative affect and emotion dysregulation (Campbell-Sills et al., 2006).

Changes in scores on the quality-of-life scale proved statistically significant, albeit with a small effect size (Cliff's Delta = -.28). This is consistent with other UP studies which have reported efficacy both in reducing psychological symptoms and improving quality of life for people with emotional disorders (de Ornelas Maia et al., 2017; Gallagher et al., 2013). Indeed, it is important to bear in mind that quality of life is a complex construct that includes several dimensions and that changes in certain dimensions, such as economic or social status, require more time than the duration of these brief interventions. This could account for the small effect size in comparison with the other variables reported in this study, as noted in other studies that have shown an increased improvement in quality of life as of the six-month follow-up (Osma et al., 2015).

As for hopelessness, this study has identified a statistically significant decrease in this variable with a large effect size (Cliff's Delta = .64). Such data are consistent with another study where UP was used and adapted for the treatment of suicidal ideation (Bentley et al., 2017), and it proves particularly relevant considering the strong association between hopelessness and suicidal behavior (Beck et al., 1975).

This study shows several limitations. Given the small sample size, the study design prevents generalizing results, as well as the use of ad-hoc questionnaires may affect the reliability of the results. Moreover, the fact that participants were recruited via social media can be considered a bias. Having a sample of subjects who interact with our social networks or know someone who does also decreases the generalisability of the results. As pilot study, its value refers to the first step in order to build a strong study in the context of a Research Project. In terms of the analysis of fidelity, acceptability and preliminary effects of the intervention, this pilot study allows to take grounded decisions in further and more complex studies, (i.e. randomized controlled trials; Fernández-Sánchez et al., 2021). It would prove useful for future studies to replicate the protocol using a larger sample and longitudinal models in order to examine the UP's effect, controlled by group variance. Drawing the sample from social media implies that participants have access to the Internet and are familiar with its use, which may constitute a bias, thus excluding people in need of the intervention. Another limitation of the study is gender-related, as only one out of the five patients in the group is a male participant. However, this limitation should be considered within the higher prevalence of EDs in females (Stagnaro et al., 2019). Future studies are contemplating more robust research designs in order to provide more evidence, such as randomized clinical trials.

This is the first Argentine study to assess the implementation of a transdiagnostic cognitive-behavioral intervention delivered in online group format, providing preliminary data about the multicultural nature of the UP and its possible adaptation to different cultural settings. All things considered, preliminary findings in this study prove promising and add to reported results on the clinical usefulness and acdceptability of the UP applied in online group format.

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