THE RELATIONSHIP BETWEEN SOCIOECONOMIC STATUS AND THE LEVEL OF ANXIETY

FINAL DEGREE PROJECT

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2. ABBREVIATIONS

PFC: prefrontal cortex

SES: socio-economic status

GAD: generalized anxiety disorder

CAP: primary health care center

HPA axis: Hypothalamic-pituitary-adrenal axis

CEIC: Comitè d'Ètica i Investigació Clínica

3. ABSTRACT

Background: Anxiety is a mental health condition that is really common between general population and it has a huge impact on people's daily life. It develops as a result of cognitive mechanisms generated as an answer to a chronic stress state that is considered a threat by the person's brain. Nowadays, in Spain, we live in a neoliberal society where there is huge social inequality present in every field of our day-to-day life, being the 4th country with a higher rate of social imbalances of Europe.

It is known that inequality creates an unsafe and insecure environment as well as stress in that most affected population, making them more prone to developing a mental health condition.

To analyse and evaluate this social and economic context impact on anxiety prevalence, we will be comparing those values and anxiety levels between people with a low socio-economic status and those with a higher one.

People whose socio-economic status is low are widely and more exposed to those stressors that inequality generates than people of a higher social class. Taking in consideration all these reasons, our hypothesis will state that people with a low SES suffer from considerably higher levels of anxiety than people with a high SES.

Objective: To determine the relationship between socio-economic status level and anxiety prevalence in general population in Girona and Salt.

Study design: Cross-sectional descriptive study conducted between January and December 2021 in Girona, Spain.

Participants: The study population will be conformed of all the population between 18 and 60 years old who attend to the targeted CAP during the year of study

Key words: anxiety, neoliberalism, capitalism, SES

4. THEORETICAL FRAMEWORK

The term anxiety refers to multiple mental and physical phenomena that include a state of concern for an unwanted future event or fear of a real situation.

Chronic anxiety is the most prevalent mental health disorder in Spain (14% of the population[1,2]) according to the *Enquesta nacional de salud* (ENSE) conducted in Spain in 2017[3]. It also ranks 6th years lived with a disability[4]. In order to understand this high prevalence and the high impact it has on the population, it is necessary to make a global and in-depth analysis of what anxiety is, how it occurs, and what causes it.

The neurobiological mechanism of anxiety is very similar to that generated by fear. An emotional response is generated with the goal of mobilizing resources to survive in the face of a danger that threatens our integrity. Like any other emotion, it contains a conscious and an unconscious component that can be understood by knowing the neuroanatomical circuit of fear: the brain anatomical structures involved in this circuit are the amygdala, the insular cortex, and the ventromedial and dorsal prefrontal cortex.

The circuit begins in the amygdala when it receives, through the senses, an alarming stimulus. The first thing the amygdala does is to activate the physical actions necessary to give an adaptive response to the perceived danger (commonly called 3 F: fight, flight, or freeze) mediated by the activation of the HPA axis. These actions involve a number of unconscious changes: musculoskeletal, postural, accelerating pulse and breathing, sweating, contraction of the stomach and intestinal muscles, and secretion of stress hormones such as cortisol.

Following this autonomic activation, another slower pathway initiates that connects the amygdala with the insular cortex. Here, the emotions that are expressed through physical manifestations are transformed into conscious knowledge allowing their identification. In addition, the amygdala is also connected to the prefrontal cortex, which regulates emotions and the way we express them, the conscious aspects of emotions, and their influence on cognition[5].

When a person is in an anxious state, they have a difficulty or even inability to discriminate the importance or danger of stimuli from one another. Consequently, many more stimuli trigger this circuit, whether or not they are really dangerous[6].

It has been observed in neuroimaging studies that the activity of the prefrontal cortex is decreased in the population exposed to chronic stress. Since the PFC has an inhibitory function on the amygdala (and therefore of the fear circuit), the population exposed to chronic stress has amygdala hyperactivation[7,8]. This can translate into a lower deterrence of stimulus relevance and a hyper response to neutral or slightly harmful stimuli.

Clinical manifestations and mechanisms of anxiety disorders

At the clinical level, the physical and cognitive manifestations of a person with high levels of anxiety are those listed in Table 1 according to the psychiatry manual[9]

Psychological symptoms	**Somatic symptoms**
Nervousness	Asthenia
Persistent and excessive worry about the future	Palpitations, tachycardia, dyspnoea chest pain
Fear and feeling of threat	Sweat, mouth dryness, constipation, diarrhoea
Loss of self confidence	Instability, dizziness, nausea, vomits
Persistent state of hyper-awareness	Headache, diffuse pain
Progressive social withdrawal	Paraesthesia, tremors, dysthymia
Irritability, moody	Hypertension, hypotension, polyuria
insomnia	Anorexia, bulimia
Uncontrollable crying	Muscle hypertonia, sexual dysfunction

Table 1: Main psychic and somatic symptoms of primary anxiety

Anxiety, like any human behaviour**,** is the product of a continuous interaction between the individual and all the environments stimuli in which they live at any given time (e.g., geographical, socioeconomic, ethnic, etc.)[10].

Familial aggregation of anxiety is known to be substantial. Research focused on the familial transmission of anxiety disorders usually follows two main approaches: family

studies and twin studies aimed at identifying shared and nonshared environmental contributions to the disease.

Twin studies demonstrated that genetic contribution is moderate ranging from 30 to 40% (including all entities within the spectrum of anxiety disorders)[11].

The remaining percentage of variability can be attributed to environmental factors[16], which I will refer to later.

The genetic contribution is even lower in specific studies with twins with GAD (15-20%)[7].

Moreover, the genome as well as the epigenome cannot be viewed as static entities, they continue to be environmentally responsive throughout the life course. According to Evan Charney *life experiences can permanently "reprogram" the epigenome and gene transcription with life-long behavioural consequence*s[10].

Although it is a field of research where much remains to be explored, causality has been found between the environment in which an individual develops and the epigenetic modifications related to the anxiety it expresses[12–14].

Explained in words of Evan Charney in his work *Genetics and the Life Course* "life experiences can permanently "reprogram" the epigenome and gene transcription with life-long behavioural consequences. At the same time, the epigenome as well as the genome continue to be environmentally responsive throughout the life course"[15]

Life experiences have a very high impact on the individual especially during the first years of life, due to the great neuroplasticity characteristic of early development.

It is highly demonstrated that both the experience of traumatic events (grief, parental psychopathologies, abuse and neglect among others) and the presence of emotional problems (higher in children with low socioeconomic status or SES)[17] during childhood are a very strong risk factor for developing psychiatric pathologies (including anxiety disorders)[11,18,19].

These traumas can cause epigenetic modifications that increase the risk of developing anxiety disorders[20].

Life experiences are built up from each individual interaction with the people and stimuli surrounding them. Some of these stimuli may become stressors. In this work, I will focus

on this type of stimuli, the stressors, to which the vast majority of the population is exposed throughout their lives and which generate a state of chronic stress.
Chronic stress is a major trigger for high levels of anxiety or anxiety disorders. As I will further expose, it does not affect everyone equally. It is more harmful in vulnerable populations. Prevalence of anxiety increases considerably in this population compared to others with less exposure to chronic stress and with greater resources to manage it.
Throughout this theoretical framework, I will discuss some of the factors that make a population vulnerable.

Chronic stress is a negative reaction in an individual which occurs from the inappropriate relationship between the overwhelming demands they receive and the little coping resources they own to manage them for a very long period of time.
If this unbalanced relationship in favour of demands persists over time, a series of adaptive cognitive mechanisms are developed with the goal of optimizing individual resources and avoiding or repairing as much damage as possible. These psychological mechanisms consist of:

- A selective attention bias by which priority is given to information that is most likely to be serious or harmful.
- A memory bias by which memories of situations of danger or risk are enhanced.
- An interpretive bias by which ambiguous stimuli are more easily interpreted as dangerous than as neutral, creating a state of hypervigilance.

These mechanisms generate a perfect substrate for the development of an anxious state, where there is an indefinite prolongation of thoughts of concern without the explicit need for an identifiable threat or stressor[21].

As mentioned earlier, the two most important elements of the pathophysiology of anxiety are stressors and coping resources.
Stressors can be classified into two main groups: physical and psychological. Within the physical ones, we find the physical activity, extreme external environmental conditions and pathophysiological factors (like diseases). Within the psychological stressors, we identify intellectual tasks, the threat to self-esteem, and interpersonal threats.

Psychological stressors are the most potentially harmful to mental health. In particular, those that threaten self-esteem and interpersonal relationships[21] are the ones that have the greatest impact. Studies have shown that these stressors can increase levels of cortisol up to 3 times more than other stressors[22] *(cortisol is the main hormone that is released in prolonged stress states and is used to quantitatively analyse the levels of stress that a given situation generates in a person*).

Stressors can also be classified according to their cognitive appraisal into:

- Damage assessment (when this is already established and the resources are intended to reduce, compensate, mitigate the consequences of the damage).
- Assessment of challenge (where a possibility to make a profit is foreseen).
- Threat assessment (in which the mobilization of resources is intended to prevent or avoid damage that may occur).

Anxiety is the reaction that arises from a threat assessment to a stressor.

Vulnerability factors and resources in response to chronic stress

As I mentioned previously, stressors do not affect everyone equally. In addition to the genetic and epigenetic factors, an individual's exposure to stress and the response to it is conditioned by what we know today as social determinants of health (Figure 1). These result from the social and labour relationships within a given socioeconomical system. In particular, the conceptual framework depicted in *figure* 1 is based on the social determinants of health within the neoliberal socioeconomic system. to which I shall refer later.

The following aspects can be extracted from this conceptual framework:

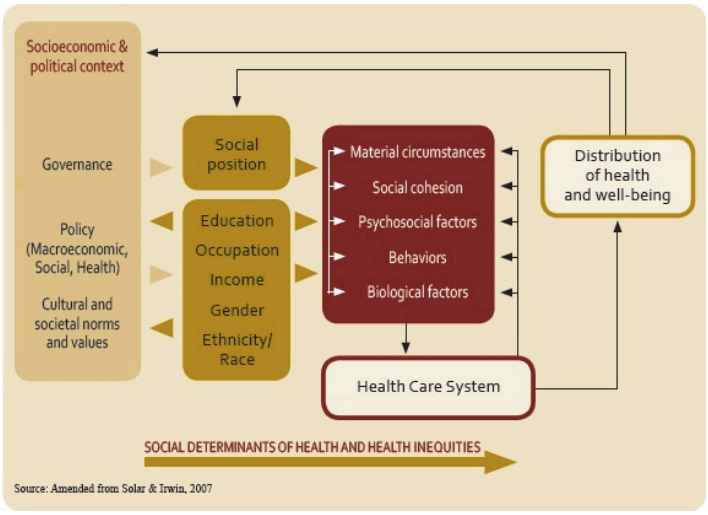

Figure 1: Conceptual framework of social determinants of health. Based on Solar e Irwin y Navarro

The socioeconomic and political context (left), generates mechanisms of power of some groups over the others through elements such as the policies generated by the government and the actions taken by social and economic actors, culture and values of society. These elements, called axes of inequality (central part of the image), manifest as privileged groups that exercises power, and oppressed group on which this power is operated. For example, capitalism divides productive activity into social classes where the upper classes have power over the lower classes.

Therefore, within neoliberal capitalism, political and socio-economic context as well as culture and values of society generate specific axes of inequality that cause and condition the determining intermediaries (right). We understand as determining intermediaries the conditions in which we live: these include various aspects of life such as economic resources (quality of work, schedules, income, and material resources to which we have access, among others) the quality of the environment where we live and the characteristics and access, we have to the health system of which we are users.

In short, stratification in social groups according to the axes of inequality (by gender, class, age, ethnicity, territory) directly affects the determinants in between and causes of unequal exposure to the factors that can lead to health or disease. All these processes, in turn, generate inequality in health and ultimately lead to some social groups having a higher prevalence of diseases than others[23].

Socio-economical context

The importance of analysing the socio-economical context relies on being able to understand how it affects the mental health in the population, and, consequently, how to revert it, both in the clinical practice and in public Health and prevention policies.
This perspective could be reflected in a quote from the German doctor and founder of social medicine Rudolf Virchow: "*Medicine is a social science, and politics is nothing else but medicine on a large scale*".

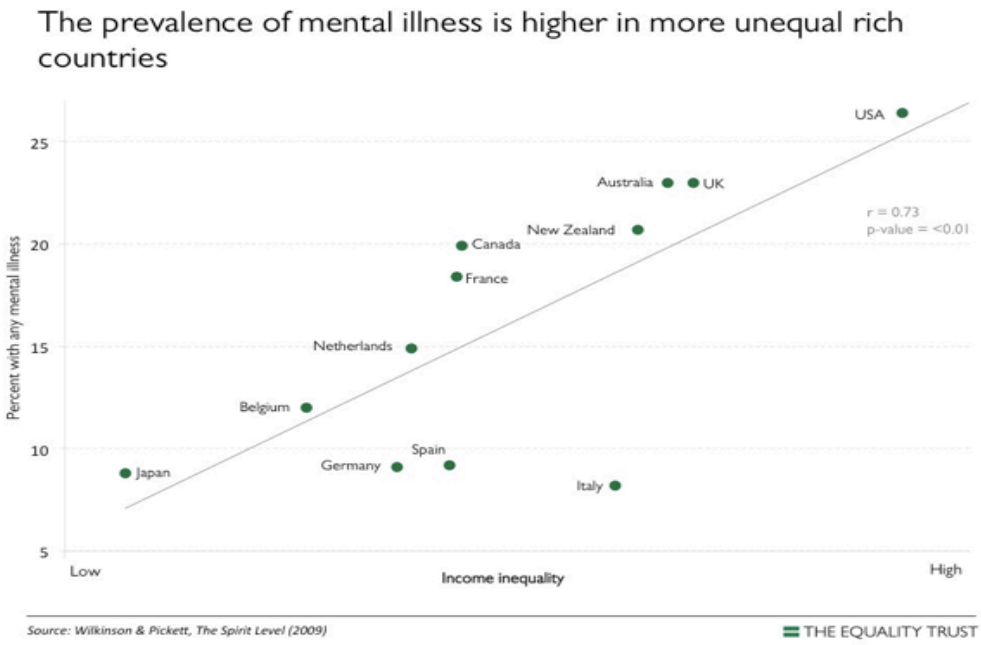

Figure 2: country unequality and mental health. Wilkinson, R.

Mental health problems and especially anxiety, along with other stress-related mental illnesses, increase substantially with socio-economic inequality[22] as shown by studies conducted in different countries according to the inequality indices (*Figure 2)*. This figure depicts the relationship between income inequalities and the percentage of the population diagnosed with any psychiatric disorder (including drug addictions).

Inequality in Spain, as in the vast majority of countries in the world, has been increasing exponentially since the 1970s, when the stage from capitalism to neoliberalism began to change[24]. This increase in inequality acquired a major indictment following the 2008 crisis. Fluctuations in inequality can be seen in the graph in *Figure 3* which shows the

evolution of inequality in five rich countries from 1900 to 2010 according to data from the World Wealth and Income Dataset. The graph shows how much inequality decreases from the New Deal (beginning of an interventionist policy initiated by FD Roosevelt in the United States to reduce the effects of the Great Depression following the 1929 crack) and how after the 70s it starts steeply increasing again. An important interpretation of this graph is that it shows that the distribution of wealth and, therefore, inequality are modifiable according to state policies.

Spain is the 4th country with major income inequalities according to 2017s Oxfam study[25]

Neoliberalism is the socio-economic system that prevails in the vast majority of Europe and the world. It is the phase of capitalism where the inequality between the different social strata has been most accentuated as can be seen in *Figure 3* and its ideological fundaments can be summarized on three main pillars:

1) Intervention of the state in social and economic activities is reduced and limited exclusively to protecting the right of private property
2) Labour and financial markets need to be deregulated in order to promote the competitivity of the market.
3) Trade and investment must be stimulated by removing borders and barriers to the full mobility of labour, capital, goods and services.

The pragmatic result of the measures carried out in accordance with the pillars described above are the following:

- An ever-increasing appropriation, by the groups concentrating the economic power, of the effective control of the state power, which is the only body with the possibility of protecting the basic rights to labour, health and housing of the population. In particular the dysregulation of the labour conditions leads to a reduction of the minimum wages, increasing socio-economic inequality.
- A relocation of the industry to (ex)colonized countries with a reduction in the price of raw materials and labour. This allows setting prizes at a lower value. And, in consequences the competitive market forces all companies, especially small

business, to lower prices in order to be able to stay in the market at the expense of the workers.

These structural changes end up leading to an accumulation of wealth in fewer and fewer hands due to the difficulty of maintaining a competitive product in the market (generation of monopolies) and a further increase in poverty (reduction of working conditions of workers to obtain a higher profit with a lower expense).

In other words, it ends up reaching an inequality greater than ever[26].

The social and economic inequalities that are generated in this system have a direct impact on people's health and many pathologies have an underlying root or social cause[27].

A clear example of this impact would be the studies conducted by the *Agència Catalana de la Salut* in Barcelona every 4 years about how bad mental health and chronic pathologies are distributed unequally in Barcelona. In these studies, a significantly unequal distribution of pathology can be seen according to the social class of the population. People with low SES have a significantly higher incidence of pathology than those with high SES[28].

Although the influence of the socio-economic context is very clear, most scientific studies of mental health prioritize research in the development of effective individual therapeutic strategies over a more preventive and collective approach that would require analysing the underlying causes of diseases to apply effective public health measures. These would probably have a much more positive impact on the general population in the long run, both in terms of quality of life and economic indicators (either because of the care burden they entail or because of the impact on lost working days).

Impact of neoliberalism on anxiety

Stressors

The essential characteristics and mechanisms of this system lead to a very high level of demands and a very low capacity to cope with them. Which I will be detailing below.
The main feature that causes a stressor to generate an anxious response, as discussed at the beginning of the framework, is the fact that it is valued as a threat or uncertainty[21]. The unpredictability and uncontrollability of this threat mean that it is not possible to choose the coping strategy needed to mitigate the possible damage that can be caused.

In the neoliberal socio-economic system, freedom of the market is more protected than the basic vital needs of the population (such as food or housing). In Spain, this statement is reflected in the political decisions taken by the government since 1977, from the beginning of the transition to the present day. These decisions have been aimed at protecting and facilitating the increase in business profits at the expense of the well-being of their workers. Some of the most relevant policies carried out during this period have been the increase in labour flexibility, the facilitation of dismissals without compensation (with the so-called economic dismissals), the decrease in the amount of unfair dismissal (Real Decreto-ley 5/2002), the regularization and promotion of temporary contracts (ley 14/1994), the decrease of social benefits (Decreto-ley 1/1992 del 3 de Abril), the creation of the so-called "junk" contracts (internship contracts with very low salaries)[29], the cuts and the privatization of the management of public services such as health[30], education or social services.
All these political and economic measures taken during these times are causing great growth in job instability and social deprivation. With 9.7 million workers in situation of poverty[31], and a decrease of 133 euros per year in the average salary[32] at the same time that in recent years there has been a growth in the business profits of large monopolies of 60%[33].

The current functioning of the world of work exposes the active population to a set of stressors contextualized in two possible scenarios: the unemployment situation, which

is growing as a result of the policies described; or in the labour market and employed persons, intrinsically generated by labour and market conditions.

Unemployment in Spain has grown considerably since the crisis of 2008, reaching numbers of up to 26% of the population in 2012[34]. It has since declined in detriment of the precariousness of the job market, with no detrimental impact on the benefits of the ruling class. In addition, political elites and the media promote a discourse that seeks to justify policies of cuts and lack of social aid. The argument is that of encouraging the unemployed to seek work. However, this stigmatizes people in this situation, characterizing them as lazy or useless and charging on them the responsibility for the situation. This blame on the individual has a major impact on individual self-esteem, which will add to the increasing practical difficulties in obtaining the resources needed to sustain oneself. Likewise, in a system in which work is the backbone of life, unemployed people are deprived of the functions that this fulfils in terms of organization of time, generation of social relationships, space of socialization, being subjected to a feeling of uncontrollability, helplessness, loss of identity, social isolation and lack of sense of belonging[35]. These feelings promote a very high anxiety state in the unemployed population as a direct consequence of their employment situation.

It is this same discourse, which by creating a gap between unemployed and employed workers, generates a constant fear of being fired. The argument that the situation of the other sector (unemployed) of society it's worse, makes difficult for the workers, to fight against precariousness measures. Thus, high levels of unemployment have a detrimental effect not only over this particular population, but on the workers.

This active working population also have their specific stressors that I will develop below.

The world of work in this capitalist context is governed by economic growth and obtaining the maximum profit from companies.

As stated earlier, for this growth to be possible, there is an intrinsic need to create a very high level of precariousness and pressure on workers. This, as expected, has a direct impact on their mental health.

The specific ways in which working life and precariousness in this system becomes a risk factor (which are intrinsically more pronounced in the neoliberal capitalist system) for mental health can be summarized with the model proposed in *Figure 4* which is the result of a systematic meta-review of work-related risk factors for developing poor mental health:

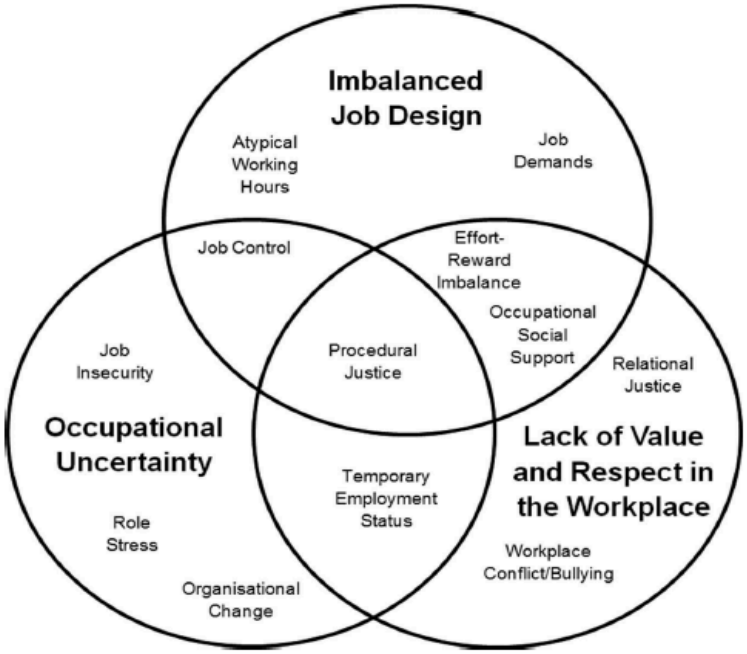

Figure 4 Unifying model of workplace risk factors

Highly demanding work, little control over the work itself, little social support in the workplace, a negative imbalance between the effort and the reward received, poor justice in the way decisions are distributed (procedural justice), a low level of respect and dignity received by senior officials (relational justice), organizational changes (such as workload, type, place where it is carried out, mergers, cuts), job insecurity, atypical schedules, working more than 40 hours per week, temporary jobs, bullying / moving work, lack of information on role responsibilities and objectives (role ambiguity) or opposing expectations about the role of the same worker (role conflict)[36].

Besides work stressors themselves, there is an extra burden: the constant threat of losing the job if one does not respond properly to work demands. This threat has several scenarios: On the one hand, to lose a job would result in not being able to acquire the basic subsistence minimums and, on the other hand, even when the risk of losing a job

is not present, there is the stress created by the (false) idea of social mobility. This idea advocates that everyone has the possibility of success and ascension in the social ladder. It is a chimera that contrasts with the stark reality that the greater the inequality is in a country, smaller the mobility of the population is (*Figure 4*).

In other words, both the fear of going down in the social ladder and the fear of not going up are very much present in the daily life of the population. These fears are widely reinforced by many channels such as the media, social networks, formal education, television references. These channels set the standards for wellbeing in the lifestyles of the elites, to which everyone should aspire. Not only that, but the message delivered establishes what the risks of falling into poverty are, and points to the individuals as ultimately responsible for this to happen.

The theoretical framework for this false premise of social mobility is meritocracy. This is an important concept for mental health since it provokes a sense of frustration for not achieving the social mobility goals.

Meritocracy is defined by Cambridge university as *"a social System, society or Organization in which people get success or power because of their abilities, not because of their Money or social position".*

This idea has easily become common sense because it holds within it some vivid elements of fairness. The idea of meritocracy states that everyone should have a chance to progress and develop themselves, and to work in fields they are capable of working in, regardless of their background. It also assumes that people should not be discriminated against. All these points, which are generally part of the package of meritocracy are irrefutable.

Another reason meritocracy has become common sense is that it has been used consistently in the service of a right-wing agenda in order to justify inequality. The idea has been promoted that social stratification is determined by the individual achievements of people and that it does not depend on the social position from which

each one comes since everyone has the same chances of reaching the social position that they really deserve[37].

This belief is in sharp contradiction with critical reality facts.

There is a great deal of evidence regarding the causal relationship between social class and the level of education, resources and skills that are acquired throughout development and which allow social ascension[22]. This proves that people who start from a disadvantaged starting point will have unequal opportunities to acquire the skills necessary to compete in the marketplace.

This explanation can also be supported by the ultra-low social mobility [24,25,38,39] present in the most unequal countries as shown in *Figure 5*.

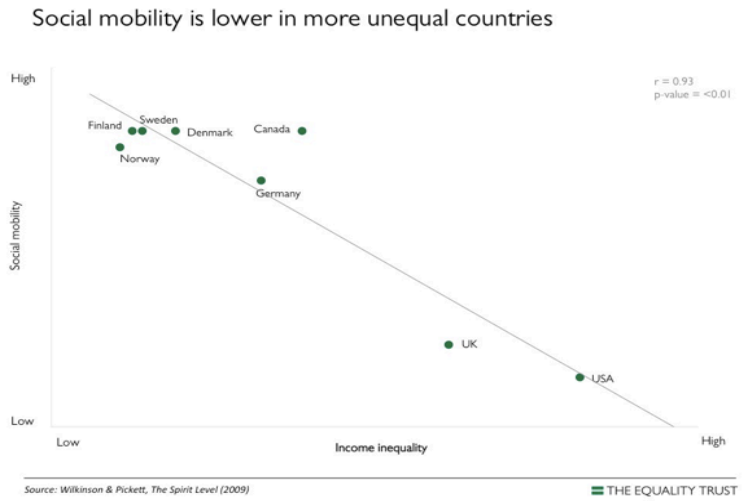

Figure 5: Social mobility

The false belief that we live in a meritocratic system entails that a hyper-individualized subject has been generated who is continuously judged for their performance and held responsible for their personal crises, their bad choices, their unemployment and their evictions instead of blaming the system[40].

This means that it exposes the vast majority of the population to a permanent risk of failure[41,42] and blame. Both because of the fear of losing their job and falling in the social stratum and because of the pressure to reach higher positions with greater prestige and greater economic reward that means an ascent to the social ladder[43].

On a practical level, these feelings translate into a deficit/inability to cope with difficulties collectively, as blame and failure translate into embarrassment for not being able to meet demands or expectations. This embarrassment makes it very difficult to ask for help, and finally, the most common form of coping is the individual.

Resources

As for the individual's ability to cope with stressors, it cannot be approached from an exclusively individual isolated perspective, since the presence or absence of certain coping, or the fact that certain resources are available are not a responsibility that falls or affects each person in isolation as an individual but to an entire society or a significant thickness of it.

One of the most fundamental strategies for coping as we have already mentioned, is social support[3,43,8,9], which is one of the primary factors that neoliberalism has damaged. Neoliberalism has generated a social atomization[45] which has especially affected the popular classes. This has made it difficult to weave networks of solidarity to avoid the constant and progressive violation of rights for the benefit of the economic elites.

The social support (people that someone can count on if they are in need of help) of people has been declining in recent decades and this is clearly lower as inequality increases[22]. In other words, the greater the compliance with the neoliberal System is.
A study by the University of Oxford finds that, as expected, European countries with greater inequalities have a population with a lower willingness to help their neighbours, the elderly, migrants, the sick or the disabled[46]. Another study conducted in 24 European countries shows that civic participation (membership in groups, clubs or organizations whether political, of leisure, charitable, religious or professional) is significantly lower in countries with greater inequality[47].

This decrease in social cohesion (and therefore social support) can be explained mainly by two factors.

- The social evaluative threat is greater as the social distance between people increases. In other words, the steeper is the slope of the social pyramid the smaller the space for two people to reside stably at the same level and, therefore, the greater the competitiveness between them and the greater the individuality that derives from them[48]. As a consequence, there is an increase of the importance of devoting more energy to appearances than to quality relationships. This can be seen very clearly with the upsurge in the use and importance that social media has acquired in people's lives.
- The decrease in leisure time due to the high need to invest many hours in the world of work to obtain a living wage or to maintain socio-economic status. Closely associated with this fact is the need to invest this little time in leisure that offers escape and dissociation from the overwhelming reality that is being lived. The most frequently used routes are the consumption of toxics and the consumption of social networks, internet and audio-visual resources, among others. In both cases there is a passive consumption that fulfils a dissociative function which does not allow to connect with the experiences that are being lived and to generate useful coping strategies.

Another very important protective factor is self-esteem and self-efficacy[49]. This is severely jeopardized by a neoliberal ideology. Insofar this ideology promotes entrepreneurship and meritocracy it imposes the need of being productive and competitive to better serve the market needs. This poses a threat to self-esteem by placing responsibility for economic failures on oneself. This generates a constant process of self-evaluation, with a heavy pressure to reinvent oneself and to take risks[40].
This vital instability and pressure clashes directly with the reality of the very low possibility of social mobility as well as the punishment/guilt that entails not reaching it. Therefore, it creates a perception of incapacity and worthlessness with a devastating effect on the self-esteem.

Finally, other strategies that can increase the ability to cope with situations of chronic stress or anxiety would be various forms of external help such as meditation[50],

mindfullness[51], therapy or sport[52] among others which are options that can be very effective but only available to people with more financial resources.
At the same time, no matter how hard low SES people work to improve the perception or experience of reality, their material deficiencies will not be resolved

SES as a proxy variable

Inequality, as we have been analysing throughout the theoretical framework, plays a very important role in the mental health of the population. The SES is a good way to study it, knowing in advance that we are in a country with a highly marked social inequalities and understanding the causes of this inequality.

The SES can be defined as the representation of the relationship / position that an individual has within the socio-economic and cultural hierarchy which is closely linked to power, prestige and control of resources[53]
The entire population is exposed to both risk factors and the absence of protectors, but the level of this exposure varies according to the SES.
As has been stated throughout the framework, the population with low SES is more exposed to work stressors (i.e: flexibility, precariousness, temporal contracts[4])
Due to the high inequality, they are also exposed to a greater distance between their social and labour situation and the ideal to meet capitalist consumer demands.
These greater stressors are associated with greater uncontrollability of their lives due to less control over material resources in order to modify their environment[53] as previously explained.
At the same time people with low SES have limited access to learn coping mechanisms during their development[54–56]. Because of that, they may end up with a diminished capacity of the prefrontal cortex for emotional regulation and cognitive assessment of stressful situations[53].
Referring to the external coping strategies, as stated before, people with lower SES are deprived of access to them and have no capacity to resolve their material deficiencies.
For all these reasons it is pertinent to use SES to measure how the socioeconomical system affects to the incidence of anxiety.

5. JUSTIFICATION

The aim of this project is to establish a theoretical and scientific framework focused on the unsustainable effects of the neoliberal system on mental health.

Mental health diseases are the primary cause of work leaves in most western countries[36,57]. Among these problems, the most common are depression, anxiety, and other stress-related disorders.
Chronic anxiety is the most common mental health issue among the Spanish population (14% of the population[1,2]) according to the national health survey (ENSE) made in 2017[3]. It is also the sixth cause of years lived with disability[4].

Besides the high prevalence and social load, it is also necessary to remark the low effectiveness of the therapeutical solutions (mostly pharmacological) offered for the cure or control of anxiety. This fact makes more evident the need to use a different health strategy to lessen this illness.

There is very little evidence on the aetiology of anxiety, and what is available is very confusing. Many studies use anxiety as an independent variable when diagnosing a pathology or the result of an intervention. Nevertheless, there are very few studies that focus on its aetiology, and even fewer that focus on the working adult population.
The most frequent approach when studying anxiety focuses on the individual events experienced by a single person and their effect on augmenting the risk of developing a disorder. This individualistic approach limits the possibility of creating a public health prevention strategy that manages to decrease the incidence of anxiety.

When a clinical entity has such a widespread prevalence among the population, it is necessary to look for environmental or social factors that affect a part or the whole of the population and might justify such prevalence.
In order to do so, it is necessary to have a deep knowledge of the context of the population that is being studied.

The socioeconomical organization in Spain is neoliberal with very high demands and very little resources for a large proportion of its population. Thus, the Spanish population is exposed to high levels of stress as it has been exposed in the theoretical frame. In consequence, a large proportion of the Spanish population is exposed to much chronic stress.

Over the last few years, several studies analysing the relationship between SES and mental health have been carried out[28].

In this project we use the SES parameter as a proxy indicator of the socioeconomic system, so that it becomes easier to build a comparison between SES in different countries with different economic systems, which otherwise would be pretty complicated. Therefore, we will focus on analysing the difference in exposure of the population to these systems.

I have decided to use SES as a variable and divided the population in three groups: low, medium and high SES in order to assess the level of anxiety in each group.

However, using this Proxy variable has some potential risk: the widespread and simplistic interpretation of positive results, in which the conclusion is that the problem is to be poor.

On one side, one must understand that inequity is inherent to the system (labour, distribution, housing policies, among others) and that it is impossible to alter these conditions without altering the system in itself; and on the other, health professionals must have all the possible etiologic knowledge of anxiety to treat patients individually and make them understand their situation.

Understanding that a patient's mental health depends heavily on structural factors allows them to stop blaming themselves and empowers them in a way that can have very positive clinical consequences.

With this project, I intend to bring up the importance of going further with the study and consideration of the social aspects of diseases, so that they are taken more into account both in clinical praxis and the planning of public health programs.

6. HYPOTHESIS AND OBJECTIVES

Hypothesis

People with low socio-economic status (SES) has higher anxiety prevalence than people with high SES

Main objective

To determine the relationship between socio-economic status level and anxiety prevalence in general population in Girona and Salt.

Secondary objective

Difference of SES between people with high anxiety diagnosed and not diagnosed

7. METHODOLOGY

STUDY DESIGN

Cross-sectional descriptive study conducted between January and December 2021 in Girona, Spain. Data will be collected from 602 patients who had assist to Primary health care.

All the patients who have between 18 and 65 years old will be delivered one general form and four questionnaires. The questionnaires will be

- Spanish National Classification of Occupations (2011)[58] to determine the SES (independent variable)
- STAI to determine the level of anxiety (dependent variable)
- CTQ-SF to determine the childhood trauma

STUDY POPULATION

The study population will be conformed of all the population between 18 and 60 years old who attend to the targeted CAPs during the year of study

INCLUSION AND EXCLUSION CRITERIA

- Inclusion:
  - population who attend to the targeted CAP during the year of study
  - Individual and legal tutors who agree to participate in the study by understanding and signing the informed consent (**Annex 1**)
- Exclusion
  - Population younger than 18 years old and older than 60 years old
  - Population with psychiatric diagnoses stablished by CIE-10 other than general anxiety disorder (GAD) or panic disorder (PD)

SAMPLE SELECTION

Patients will be selected when checked by administration table of the CAP. The selection will be done following a consecutive no probabilistic model

People who meet the inclusion/exclusion requirements will be informed of the aim of the study through the full *d'informació al pacient (Annex 2)* Those who accept to participate in the study will be given the informed consent.

SAMPLE SIZE

Accepting an alpha risk of 0.05 and a beta risk of 0.2 in a two-sided test, 86 subjects are necessary in the low socio-economic status group (group 1) and 516 in the high SES group (group 2) find as statistically significant a proportion between the High SES group (0,15) ant the low SES group (0,283) expected to be of 0.283 in group 1 and 0.15 in group 2. It has been anticipated a drop-out rate of 0% due to the cross-sectional nature of the study

The data used for this estimation comes from an article cited in the bibliography[59] and represented in the *Figure 5*

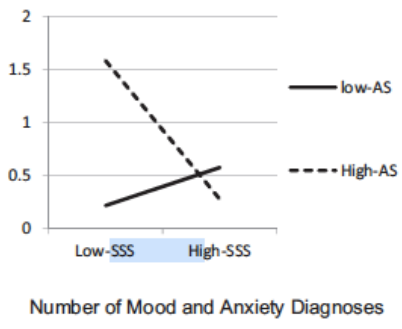

Figure 5: Number of mood and anxiety disorders depending on SES

STUDY VARIABLES

Dependent variable: Anxiety level measured with the **STAI scale** (Annex 6). A widely used anxiety risk cut number is 40[60]

Independent variable**:** SES will be approximated by the occupation and educational level of each person, following the work of Domingo et al. (1989, 1995, 2010)[61].

Covariables: (*Annex 3*)

- **Age**: Quantitative continuous variable and will be stratified by every 10 years
- **Gender**: Categorical nominal variable (1) Woman (2) Man (3) Non-binary
- **Nationality**: Categorical and nominal qualitative variable. Countries will be stratified into 3 groups (1) high (2) medium (3) low income depending on the country gross domestic product (GDP). The data will be acquired from the world bank web[1,62]
- **Psychiatric diagnosis of anxiety:** diagnosed by CIE-10 criteria Categorical nominal variable (0) No (1) Yes
- **Psychiatric diagnoses other than GAD and PD**[57] diagnosed by CIE-10 criteria, Categorical nominal variable (0) No (1) Yes
- **Psychiatric family history**: Categorical nominal variable (0) No (1) Yes
- **Drug use**: Categorical nominal variable (0) No (1) Yes
- **Childhood trauma**→ Childhood trauma questionnaire short form CTQSF[63] (*Annex 4*). Categorical nominal variable (0) Non-maltreated (1) Maltreated low to moderate (2) maltreated moderate to severe (3) Maltreated severe to extreme
- **Stressful life events**→ Holmes-Rahe Social readjustment rating Scale (*Annex 5*). Categorical nominal variable (0) Low (1) High
- **Chronic diseases**→ Categorical nominal variable (0) No (1) Yes
- **Employment situation**→ Categorical nominal variable (1) Unemployment (2) Stable job (3) Temporary job (4) Incapacitation (5) Student (6) homemaker

[1] the use of nationality as a variable aims to control the institutional and social racism that a person experience

- **Cohabitation**: Categorical nominal variable (1) Alone (2) Family (3)Partner (4) Friends (5) Homeless (6) Unknown people (room renting)

MEASURING INSTRUMENTS

STAI

STAI Scale was created in order to measures two types of anxiety: State anxiety, or anxiety about an event and Trait anxiety or anxiety level as a personal characteristic.
First version of STAI questionnaire was developed by Spielberger, Gorshuch y Lushene between the 1964 and 1970 years. The STAI version used in this project is validated in 2013 which is the latest validated in Spanish
Anxiety level is measured with STAI scale. These scales consist of 40 self-reported questions that measures each item on 4-point likert scale. It is needed to add up the score of each item to get a final score. There is not a stablished cut-off (it is often used as a gradual variable) but the number 40 is commonly used to determine a high level of anxiety

SES: National Classification of Occupations with neo-Marxist approach

The neo-Marxist classification is derived from variables related to capital and organizational and skill assets This classification consists of 12 categories in which home owners are divided into three categories based on capital goods and employed persons are grouped into nine categories composed of organizational and skill assets. These proposals are complemented by a proposed classification of educational level that integrates the various curricula in Spain and provides correspondences with the International Standard Classification of Education[58,64].
The categories considered are the following

1. Capitalist
2. Small entrepreneurs
3. Petty bourgeois
4. Expert manager
5. Semi-expert manager

6. Non-expert manager
7. Expert supervisor
8. Semi-expert supervisor
9. Non-expert supervisor
10. Expert worker
11. Semi-expert worker
12. Non-expert worker

Preguntas y algoritmos para la categorización de la clase social según Wright

		Propiedad		Autoridad			Cualificación	
		Autoempleado/a [a]	N° trabajadore/as[b]	Decisiones[c]	Supervisa[d]	Dirección[e]	Estudios[f]	Ocupación[g]
Categoría	*Propiedad*							
A	Capitalistas	Sí	≥ 10					
B	Pequeños/as empleadores/as	Sí	2-9					
C	Pequeña burguesía	Sí	0-1					
	Autoridad							
D	Directivo/a	No		Decide	Supervisa	Directivo/a		
		No		Decide	No supervisa	Directivo/a		
E	Supervisor/a	No		No decide	Supervisa	Directivo/a		
		No		Decide	Supervisa	Supervisor/a		
		No		No decide	Supervisa	Supervisor/a		
		No		Decide	No supervisa	Supervisor/a		
		No		Decide	Supervisa	No directivo/a		
F	Trabajador/a	No		No decide	No supervisa	Directivo/a		
		No		No decide	No supervisa	Supervisor/a		
		No		Decide	No supervisa	No directivo/a		
		No		No decide	Supervisa	No directivo/a		
		No		No decide	No supervisa	No directivo/a		
	Cualificación							
G	Experto/a	No					Universitario/a o no	I-II
		No					Universitario/a	III, IV
H	Semiexperto/a	No					Universitario/a	V, VI, VII
		No					No universitario/a	III, IV
I	No experto/a	No					No universitario/a	V, VI, VII

[a] ¿Está usted autoempleado/a o trabaja por cuenta propia?
[b] ¿Cuántas personas empleadas tiene?
[c] ¿Participa usted en las decisiones de su lugar de trabajo, tales como los bienes o servicios producidos, el número total de personas empleadas, el presupuesto, etc.?
[d] Como parte de su empleo principal, ¿supervisa usted el trabajo de otras personas empleadas o les dice a otros/as qué trabajo tienen que hacer?
[e] ¿Cómo se describe mejor la posición que usted ocupa dentro de su negocio u organización: directiva, de supervisión o no directiva?
[f] ¿Cuál es su máximo nivel de estudios?
[g] ¿Cuál es su ocupación actual? (siguiendo categorías de la CSO-SEE12).

The questions and algorithms needed for this categorization are the follow ones (*Figure 6*)

For the analysis of the results of this work I will classify the 12 categories in 3 groups. High class (1-4), middle class (5-8) and low class (9-12)

CHILDHOOD TRAUMA → CTQSF

Childhood trauma will be measured by the *Childhood Trauma Questionnaire–Short Form (CTQ-SF)* scale. (Annex 4). The CTQ-SF is a 28-item self-report instrument for adults and adolescents that assesses retrospective child abuse and neglect. The CTQ-SF assesses the following five types of maltreatment: emotional abuse, physical abuse, sexual abuse, emotional neglect, and physical neglect.

Each scale is represented with five items that are scored on a 5-point Likert-type scale ranging from 1 (never true) to 5 (very often true). Three additional items compose the minimization scale for detecting socially desirable responses or false-negative trauma reports.

Therefore, each clinical subscale score ranges from 5 (no history of abuse or neglect) to 25 (very extreme history of abuse and neglect). The final scores are classified according to manual's cut-off scores for the severity of abuse and neglect: ''none to minimal,'' ''low to moderate,'' ''moderate to severe,'' and ''severe to extreme''. The CTQ-SF has been translated into Spanish by bilingual Spanish and English native speakers. A group of psychologists and psychiatrists checked the translation and referred no major discrepancies and agreed on the final Spanish version. Based on this questionnaire, the participants will be classified in

- Maltreated: Experiences of abuse and/or neglect prior to age 10-12, with corresponding scores of ≥8 for physical abuse, ≥9 for emotional abuse, ≥6 for sexual abuse, ≥10 for emotional neglect and ≥8 for physical neglect. Nevertheless, more specific categories will be detailed according to the levels of severity of maltreatment.
    - Low to moderate: 8-9 for physical abuse, 9-12 for emotional abuse, 6-7 for sexual abuse, 10-14 for emotional neglect and 8-9 for physical neglect.
    - Moderate to severe: 10-12 for physical abuse, 13-15 for emotional abuse, 8-12 for sexual abuse, 15-17 for emotional neglect and 10-12 for physical neglect.
    - Severe to extreme: ≥13 for physical abuse, ≥16 for emotional abuse, ≥13 for sexual abuse, ≥18 for emotional neglect and ≥13 for physical neglect.
- Non-maltreated: No experiences of abuse and/or neglect prior to age 10-12, with corresponding scores of ≤7 for physical abuse, ≤8 for emotional abuse, ≤5 for sexual abuse, ≤9 for emotional neglect and ≤7 for physical neglect

HOLMES-RAHE SOCIAL READJUSTMENT RATING SCALE

This scale identifies major stressful life events. It consists of 43 events associated with different degrees of disruption and stress in the life of a normal person.

The unit of score is called the "vital change unit" (VCU) and each even has a different punctuation. Depending of the punctuation a different level of risk is stablished.

- Score of 300+: At risk of illness.
- Score of 150-299: Risk of illness is moderate (reduced by 30% from the above risk).
- Score <150: Only have a slight risk of illness.

8. WORK PLAN AND CHRONOGRAM

WORK PLAN

The study will be carried out from September 2020 to June 2022. Three coordination meetings will be programmed during, in order to transfer the data obtained from the research team to the main researchers.

Main researchers' team will be composed by Mariona Isbert Prades and Domènec Serrano Sarbosa.

Research team will be designated by the main researchers in order to have one reference physician from each centre that make up the study.

The centres will be all the CAPs from Girona and Salt: *CAP Santa clara, CAP Can Gibert del Pla, CAP Montilivi, CAP Vilarroja, CAP Dr Joan Vilaplana, CAP Jordi Nadal i Fàbrega* and *CAP Alfons Moré i Paretas*

TASK 1: preparation and coordination phase

- Bibliographic research and protocol elaboration. It is carried out through the approach of a study and the identification of the appropriate study variables to answer the hypothesis that has been formulated. Therefore, an extensive literature research is carried out. Then, the study methodology is established

- Ethical evaluation: We will submit our protocol to the Clinical Research Ethical Committee (CEIC, "Comitè Ètic d'Investigació Clínica") at Hospital Universitari Doctor Josep Trueta de Girona for its approval.
- Coordination of the research team: the principal investigators will coordinate with the clinical researchers to explain the operation of the entire study

TASK 2: field work and data collection

The sample will be distributed among the 7 clinical researchers and, therefore, each one will have to recruit 86 patients during 10 months with a margin of 2 months to get the necessary participants in case it has not been previously achieved

Each researcher will recruit two patients per week who meet the criteria for inclusion/exclusion.

The date and time of the patient's request to participate in the study will be randomised. If the patient does not meet the criteria or refuses to participate, the next available patient will be requested

The patient will be assigned a participant code. The operation of the study will be explained to the patient by means of a patient information sheet and the procedure for filling in the different self-questionnaires will be shown.

The patient will be informed that once all the questionnaires have been completed, they will have to be handed in on the administration board of the CAP where they were visited.

Each clinical researcher will be responsible for saving the documents to be submitted at the end of the data collection

TASK 3

- A qualified statistician will process the data collected performing a descriptive analysis, bivariate and multivariate analysis.
- The analyses and interpretation of the results will be carried mainly by the main researcher with the approbation of the clinical researchers
- Final report elaboration will be done by the main researchers

TASK 4:

Finally, the results will be summarized in format of scientific papers and will be sent to medical journals for their publication. Also, will be disseminated in conference presentations like the National Congress of Psychiatry.

TASKS	2020				2021												2022						PERSONAL RESPONSIBLE
	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	
TASK 1: PREPARATION AND COORDINATION PHASE																							
- Bibliographic research and protocol elaboration																							**Main researchers**
- Ethical evaluation																							**CEIC**[2]
- Coordination of the research team																							**All the research team**
TASK 2: FIELD WORK AND DATA COLLECTION																							
- Patients recruitment																							**Clinical researchers**
- Data collection																							
TASK 3: DATA ANALYSIS AND FINAL EVALUATION																							
- Statistical analysis																							**Statistician**
- Analysis and interpretation of results																							**Main researchers** **Clinical researchers**
- Final report elaboration																							
TASK 4: PUBLICATION AND DISSEMINATION																							
- Scientific publications and results divulgation																							**Main researchers**

[2] CEIC: Comitè d'ètica d'investigació clínica

9. STATISTICS

Statistical analysis will be performed using SPSS 25.0 for Windows. We will consider a p value below 0.05 to be statistically significant.

Descriptive analysis

First of all, we will summarize all the variables. Dependent, independent and covariables

In the context of our project, we cannot technically define our variables as independent and dependent due to the study is a descriptive cross-sectional study. However, for the analysis we will consider level of anxiety as the dependent variable and SES as the independent one.

For qualitative or categorical variables, results will be expressed as percentages. For quantitative variables (age), we will use mean, standard deviation, median and interquartile range.

Second, I will build a cross-table in which I will stratify the dependent variable based on the SES categories

Finally, I will stratify the cross-table by the categories of the covariates. I will categorize age into quartiles

Statistical inference

I will test the null hypothesis of no association between the dependent variable and the independent variable by means of the chi square test (χ^2). When the expected number in each cell is less than 5, I will use the exact F's test of Fisher.

This test will be stratified by the categories of the covariates. Again, I will categorize age into quartiles.

Multivariate analysis

The association between the dependent and the independent variable, controlling for the covariates, will be assessed by means of a logistic regression.

10. STUDY LIMITATIONS

By analysing the present study, some limitations that interfere in the investigation have been detected and considered. As it is an observational cross-sectional study the main potential limitations will be:

- Selection bias because it will only include patients who go to the CAP and it does not serve the highest strata of society (which most often attend private centres) or people without papers (which represent the level lower impoverishment
- Information bias for self-administered questionnaires. It could only be solved by accessing the bank details and it is not possible. We also find another information bias when using SES education and employment approximations because people do not declare the actual income level. Despite the latter being the most correlated with social inequalities in health[17]
- Confusion bias will be taken into consideration in the present study. Given that the study is cross-sectional, no causality can be inferred and confusion factors must be taken into account. In order to minimize this bias a lot of controlled covariables have been taken into account. Even though possibility of confusion will still be present because we cannot assure to have taken into account all the possible confusion factors.
- External validity: although the sample is taken in a population (Girona and Salt) with very different socio-economic levels due to its territorial limitation, its applicability to other territories may be affected. It will also be more extrapolable to populations with a similar national public health system and welfare state than to those that are more different.
- The scale used to assess the SES does not have an established consensus cut-off point and, therefore, this may be difficult at the time of interpretation.
- It is a preliminary study which means a lower possibility of making a comparison with other studies

11. FEASABILITY

This study will be carried out using 7 primary care centres in Girona and Salt. All of these centres are public, which will facilitate their collaboration and administrative coordination. Due to the high prevalence of anxiety, the doctors in charge of obtaining data will have a great deal of experience in treating the general population and the general population with anxiety.

The size of the sample, despite being high enough, will be distributed among the 7 professionals, which will place a much-reduced workload and compatible with their care tasks.

As for the Budget, we can add that it has been adjusted as much as possible considering that it is a cross-sectional study and its purpose will be to generate a hypothesis and future studies must be done to ensure the knowledge which we want to achieve.

For all this, we consider that this study us feasible on the availability of the sample, the professionals involved and the estimated budget.

12. ETHICAL AND LEGAL CONSIDERATIONS

This study will be conducted according to the ethical principles established by World Medical Association in the Declaration of Helsinki of Ethical Principles for Medical Research Involving Human Subjects.

Non-maleficence principle is respected here because any invasive procedure is done and all the data will be protected with a confidentiality agreement. The principle of beneficence is respected because this research project aims to have a positive impact on the mental health of the population. The principle of justice is also respected. On the one hand, because there is no discrimination in the selection criteria and on the other because the benefits arising from this project will be passed on equally to the whole population.

The last principle, autonomy, could be the most problematic because personal data of the people participating in the study are being used. This conflict is resolved by correctly informing the participants with the information sheet and signing the informed consent where it is explained that these data will be used only for information purposes.

The research protocol must be presented and submitted for consideration, guidance and approval by the Clinical Research Ethical Committee (CEIC) at Hospital Universitari Doctor Josep Trueta before the study begins, and at the end of the study, the final report must also be submitted to the CEIC. According to “Ley Orgánica 15/1999 de Protección de Datos de Carácter Personal”, personal and clinical information of participants will be confidential and only used for the purpose of the research.

Moreover, all data will be analysed anonymously.

All participants will be personally informed by researchers and an information document about the study will be given to them (Annex 2). Participants will have to sign voluntarily the informed consent (Annex 1) before being included in the study after receiving the appropriate information about procedures, according to “Ley 41/2002 Básica reguladora de la autonomía del paciente y de derechos y obligaciones en materia de información y documentación clínica” in order to eliminate the autonomy ethical conflict.

No conflicts of interests are declared by the investigators in charge of this study.

13. BUDGET

EXPENSES	COSTS (€)
Staff	
Statisticians (80h x 35€/h)	2.800€
Scales copyright	
STAI	0€
National Classification of Occupations	0€
CTQ-SF	0€
Holmes-Rahe	0€
Material	
Printing of documents	300€
Publication and dissemination	
Publication in open access journal	2.550€
English revision	300€
TOTAL	**5650€**

Employment or leadership: None declared.

Honorarium: None declared.

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15. ANNEXES

ANNEX 1: INFORMED CONSENT

CONSENTIMENT INFORMAT

Jo, _____

Declaro que:

- He llegit la fulla informativa sobre l'estudi que se m'ha entregat.
- He pogut fer totes les preguntes necessàries respecte l'estudi.
- He rebut suficient informació sobre l'estudi.
- He estat informat per l'investigador……..de les implicacions i finalitats de l'estudi.
- Entenc que la meva participació és voluntària.
- Entenc que puc revocar el meu consentiment de participació a l'estudi, sense haver de donar justificacions i sense afectar la meva assistència sanitària.

- Accepto que els investigadors principals del projecte puguin contactar amb vostè si en un futur es considera oportú? SI ☐ NO ☐
- Accepto rebre els resultats de l'estudi un cop aquest hagi finalitzat? SI ☐ NO ☐

Amb tot això present, ACCEPTO voluntàriament participar en l'estudi

Firma del participant **Firma de l'investigador**

Data: __/__/__ Data: __/__/__

ANNEX 2: INFORMATION DOCUMENT FOR THE STUDY

FULL D'INFORMACIÓ AL PARTICIPANT

1) **INVESTIGADORES PRINCIPALS**: Mariona Isbert, Domènec Serrano Sarbosa, Fabiana Scornik i Guillermo Pérez?

2) **TÍTOL DE L'ESTUDI**: The relationship between socioeconomic status and the level of anxiety

3) **GENERALITATS DEL PROJECTE**: El present estudi es durà a terme per l'equip investigador amb la col·laboració de 7 metges generalistes investigadors referents de cada CAP de Girona i Salt durant un període aproximat de 1 any. El projecte de recerca ha estat valorat i aprovat pel Comitè d'Ètica d'Investigació Clínica de l'IdibGi*?

4) **OBJECTIUS I FINALITATS DE L'ESTUDI**: L'estudi tindrà com a objectiu principal determinar la correlació entre nivell socioeconòmic i prevalença d'alts nivells e ansietat en la població general

5) **PARTICIPACIÓ**: La participació en l'estudi és totalment voluntària. El participant és lliure d'abandonar l'estudi si així ho desitja en qualsevol moment sense necessitat de justificacions sense que aquesta ecisió afecti a la seva assistència sanitària. La participació a aquesta investigació és totalment gratuïta i no s'obtindrà cap compensació econòmica en relació a la participació

6) **CONFIDENCIALITAT I PROTECCIÓ DE DADES**: S'adoptaran les mesures per garantir la confidencialitat de les seves dades en compliment de la Llei Orgànica 15/1999 i les dades recollides seran gestionades de forma anònima i només utilitzades amb fins d'investigació. També es garantiran els principis establerts per la Llei d'Investigació Biomèdica 14/2007.

7) **TASCA DEL PARTICIPANT EN LA RECOLLIDA DE MOSTRES**: La persona participant haurà de omplir els qüestionaris administrats per la professional investigadora i retornar-lo amb totes les dades sol·licitades al personal administratiu del CAP on ha sigut atesa

8) **RESULTATS I BENEFICIS DE LA INVESTIGACIÓ:** La participant està en el seu dret de ser informada dels resultats obtinguts de l'investigació, així com es respectarà la seva voluntat de no ser informat en cas que així ho desitgi. Els resultats de la investigació poden beneficiar a tota la població a través del plantejament de noves polítiques de salut pública per a disminuir la incidència de ansietat a l'estat espanyol.

Contacte de les investigadores en cas que es produeixi qualsevol imprevist: 622091211

ANNEX 3: MEDICAL INFORMATION SHEET

FULL D'INFORMACIÓ MÈDICA

DADES IDENTIFICACIÓ

CODI PARTICIPANT: __ __ __ __ CAP:_____ DATA: __/__/____ TELÈFON CONTACTE:_____

DADES PERSONALS

Data de naixement (DD/MM/AAAA): __/__/____

Gènere: Dona ☐ Home ☐ No binari ☐

Nacionalitat: _____

ANTECEDENTS FAMILIARS

El seu pare, mare o germà/na están diagnosticats d'algun transtorn psiquiàtric?

Pare SI ☐ NO ☐

Mare SI ☐ NO ☐

Germà/na SI ☐ NO ☐

ANTECEDENTS PERSONALS PATOLÒGICS

Estàs diagnosticada d'alguna transtorn psiquiàtric?

SI ☐ NO ☐

En cas d'haver respost SI, quin? _____

Estàs diagnosticada d'alguna malaltia crònica?

SI ☐ NO ☐

En cas d'haver respost **SI**, quina? _____

ANTECEDENTS TÒXICS

De la droga que apareix a continuació, quines ha consumit durant el darrer any?

Alcohol: SI ☐ NO ☐

Cànnabis: SI ☐ NO ☐

Opiacis: SI ☐ NO ☐

Cocaïna: SI ☐ NO ☐

Amfetamines: SI ☐ NO ☐

Cafeïna SI ☐ NO ☐

Altres: _____

En cas de resposta afirmativa en la pregunta anterior quin ha estat el seu consum?

Alcohol:	☐ Un cop/dia	☐ Un cop/setmana	☐ Un cop/mes	☐ Un cop/any
Cànnabis:	☐ Un cop/dia	☐ Un cop/setmana	☐ Un cop/mes	☐ Un cop/any
Opiacis	☐ Un cop/dia	☐ Un cop/setmana	☐ Un cop/mes	☐ Un cop/any
Cocaïna	☐ Un cop/dia	☐ Un cop/setmana	☐ Un cop/mes	☐ Un cop/any
Amfetamines	☐ Un cop/dia	☐ Un cop/setmana	☐ Un cop/mes	☐ Un cop/any
Cafeïna	☐ Un cop/dia	☐ Un cop/setmana	☐ Un cop/mes	☐ Un cop/any
Altres	☐ Un cop/dia	☐ Un cop/setmana	☐ Un cop/mes	☐ Un cop/any

DADES SOCIODEMOGRÀFIQUES

Quina és la seva situació laboral actual?

Atur ☐ Treball estable ☐ Treball temporal ☐ Incapacitació ☐ Estudiant ☐

Feines de la llar ☐

Classificació segons l'escala de nivell socioeconòmic

_____

Convivència:

Sola ☐ Família ☐ Parella ☐ Amistats ☐ Sensellar ☐

Amb persones desconegudes/sense vincle (lloguer d'habitació) ☐

Resultats de les escales

STAI: High ☐ Low ☐

Esdeveniments vitals (Holmes and Rahe): _____

Traumes infantil (CTQ-SF.): _____

ANNEX 4: CTQ-SF FORM

Directions: These questions ask about some of your experiences growing up as a child and a teenager. For each question, circle the number that best describes how you feel. Although some of these questions are of a personal nature, please try to answer as honestly as you can. Your answers will be kept confidential.

When I was growing up, . . .		Never true	Rarely true	Some times true	Often true	Very Often true
1.	I didn't have enough to eat.	1	2	3	4	5
2.	I knew that there was someone to take care of me and protect me.	1	2	3	4	5
3.	People in my family called me things like "stupid", "lazy", or "ugly".	1	2	3	4	5
4.	My parents were too drunk or high to take care of the family.	1	2	3	4	5
5.	There was someone in my family who helped me feel important or special.	1	2	3	4	5
When I was growing up, . . .						
6.	I had to wear dirty clothes.	1	2	3	4	5
7.	I felt loved.	1	2	3	4	5
8.	I thought that my parents wished I had never been born.	1	2	3	4	5
9.	I got hit so hard by someone in my family that I had to see a doctor or go to the hospital.	1	2	3	4	5
10.	There was nothing I wanted to change about my family.	1	2	3	4	5
When I was growing up, . . .						
11.	People in my family hit me so hard that it left me with bruises or marks.	1	2	3	4	5
12.	I was punished with a belt, a board, a cord (or some other hard object).	1	2	3	4	5
13.	People in my family looked out for each other.	1	2	3	4	5
14.	People in my family said hurtful or insulting things to me.	1	2	3	4	5
15.	I believe that I was physically abused.	1	2	3	4	5

When I was growing up, . . .		Never true	Rarely true	Some times true	Often true	Very Often true
16.	I had the perfect childhood.	1	2	3	4	5
17.	I got hit or beaten so badly that it was noticed by someone like a teacher, neighbor, or doctor.	1	2	3	4	5
18.	Someone in my family hated me.	1	2	3	4	5
19.	People in my family felt close to each other.	1	2	3	4	5
20.	Someone tried to touch me in a sexual way or tried to make me touch them.	1	2	3	4	5
When I was growing up, . . .						
21.	Someone threatened to hurt me or tell lies about me unless I did something sexual with them.	1	2	3	4	5
22.	I had the best family in the world.	1	2	3	4	5
23.	Someone tried to make me do sexual things or watch sexual things.	1	2	3	4	5
24.	Someone molested me (took advantage of me sexually).	1	2	3	4	5
25.	I believe that I was emotionally abused.	1	2	3	4	5
When I was growing up, . . .						
26.	There was someone to take me to the doctor if I needed it.	1	2	3	4	5
27.	I believe that I was sexually abused.	1	2	3	4	5
28.	My family was a source of strength and support.	1	2	3	4	5

ANNEX 5: HOLMES-RAHE SOCIAL READJUSTMENT RATING

ESCALA DE HOLMES Y RAHE SOBRE ESTRÉS PSICOSOCIAL

Muerte del cónyuge	100	Reajuste o conflictividad laboral en la empresa	38	Promoción en el trabajo	27
Separación o divorcio	70	Cambio en el tipo de actividad laboral	38	Peleas o desacuerdos con colegas o compañeros de trabajo	26
Proceso judicial o problemas legales que pueden acabar en cárcel	68	Hipoteca o préstamo de mas de seis mil euros	38	Reformas importantes en la casa	25
Muerte de un famliar cercano o de un amigo muy íntimo	65	Embarazo de la esposa	35	Deterioro notable de la vivienda o el vecindario	25
Enfermedad o accidente que obliga a guardar cama	55	Aumento radical en el número de disputas familiares	35	Cambio en las costumbres personales (salir, vestir...)	24
Contraer matrimonio	50	Enamorarse o iniciar una nueva amistad íntima y profunda	34	Cambio importante en el horario o condiciones de trabajo	23
Quedarse sin trabajo	47	Pérdida de empleo	33	Cambio en las opiniones religiosas	22
Retiro laboral	45	Mudanza	32	Cambio en las opiniones políticas	22
Reconciliación con el cónyuge	45	Cambio de lugar de trabajo	31	Modificaciones en la vida social	20
Enfermedad de un miembro de la familia	44	Accidente o situación de violencia física	30	Cambio en la manera o situación del sueño	18
Rotura de un noviazgo o relación	42	Un miemboro de la familia deja de vivir en la casa familiar	30	Cambio en la frecuencia de las reuniones familiares	17
Embarazo	40	La esposa deja de trabajar fuera de casa	29	Cambio en las costumbres alimenticias o apetito	16
Incoporación de un nuevo miembro a la familia	39	Conflictos con vecinos o familiares no rsidentes en la casa familiar	28	Vacaciones fuera de casa	15
Muerte de una amistad	38	Éxito personal de gran envergadura	28	Fiestas de navidad, Reyes o equivalente	13
Cambio brusco de las finanzas familiares (en más o en menos)	38	Exámenes	27	Problemas legales menores (como sanciones de tráfico)	11

ANNEX 6: STAI

ANSIEDAD-ESTADO

Instrucciones: A continuación encontrará unas frases que se utilizan corrientemente para describirse uno a sí mismo. Lea cada frase y señale la puntuación de 0 a 3 que indique mejor cómo se *siente usted ahora mismo*, en este momento. No hay respuestas buenas ni malas. No emplee demasiado tiempo en cada frase y conteste señalando la respuesta que mejor describa su situación presente.

1. Me siento calmado	0. Nada 2. Bastante	1. Algo 3. Mucho
2. Me siento seguro	0. Nada 2. Bastante	1. Algo 3. Mucho
3. Estoy tenso	0. Nada 2. Bastante	1. Algo 3. Mucho
4. Estoy contrariado	0. Nada 2. Bastante	1. Algo 3. Mucho
5. Me siento cómodo (estoy a gusto)	0. Nada 2. Bastante	1. Algo 3. Mucho
6. Me siento alterado	0. Nada 2. Bastante	1. Algo 3. Mucho
7. Estoy preocupado ahora por posibles desgracias futuras	0. Nada 2. Bastante	1. Algo 3. Mucho
8. Me siento descansado	0. Nada 2. Bastante	1. Algo 3. Mucho
9. Me siento angustiado	0. Nada 2. Bastante	1. Algo 3. Mucho
10. Me siento confortable	0. Nada 2. Bastante	1. Algo 3. Mucho
11. Tengo confianza en mí mismo	0. Nada 2. Bastante	1. Algo 3. Mucho
12. Me siento nervioso	0. Nada 2. Bastante	1. Algo 3. Mucho
13. Estoy desasosegado	0. Nada 2. Bastante	1. Algo 3. Mucho
14. Me siento muy «atado» (como oprimido)	0. Nada 2. Bastante	1. Algo 3. Mucho
15. Estoy relajado	0. Nada 2. Bastante	1. Algo 3. Mucho
16. Me siento satisfecho	0. Nada 2. Bastante	1. Algo 3. Mucho
17. Estoy preocupado	0. Nada 2. Bastante	1. Algo 3. Mucho
18. Me siento aturdido y sobreexcitado	0. Nada 2. Bastante	1. Algo 3. Mucho
19. Me siento alegre	0. Nada 2. Bastante	1. Algo 3. Mucho
20. En este momento me siento bien	0. Nada 2. Bastante	1. Algo 3. Mucho

ANSIEDAD-RASGO

Instrucciones: A continuación encontrará unas frases que se utilizan corrientemente para describirse uno a sí mismo. Lea cada frase y señale la puntuación de 0 a 3 que indique mejor cómo se *siente usted en general*, en la mayoría de las ocasiones. No hay respuestas buenas ni malas. No emplee demasiado tiempo en cada frase y conteste señalando la respuesta que mejor describa cómo se siente usted generalmente.

21. Me siento bien	0. Casi nunca 1. A veces 2. A menudo 3. Casi siempre
22. Me canso rápidamente	0. Casi nunca 1. A veces 2. A menudo 3. Casi siempre
23. Siento ganas de llorar	0. Casi nunca 1. A veces 2. A menudo 3. Casi siempre
24. Me gustaría ser tan feliz como otros	0. Casi nunca 1. A veces 2. A menudo 3. Casi siempre
25. Pierdo oportunidades por no decidirme pronto	0. Casi nunca 1. A veces 2. A menudo 3. Casi siempre
26. Me siento descansado	0. Casi nunca 1. A veces 2. A menudo 3. Casi siempre
27. Soy una persona tranquila, serena y sosegada	0. Casi nunca 1. A veces 2. A menudo 3. Casi siempre
28. Veo que las dificultades se amontonan y no puedo con ellas	0. Casi nunca 1. A veces 2. A menudo 3. Casi siempre
29. Me preocupo demasiado por cosas sin importancia	0. Casi nunca 1. A veces 2. A menudo 3. Casi siempre
30. Soy feliz	0. Casi nunca 1. A veces 2. A menudo 3. Casi siempre
31. Suelo tomar las cosas demasiado seriamente	0. Casi nunca 1. A veces 2. A menudo 3. Casi siempre
32. Me falta confianza en mí mismo	0. Casi nunca 1. A veces 2. A menudo 3. Casi siempre
33. Me siento seguro	0. Casi nunca 1. A veces 2. A menudo 3. Casi siempre
34. No suelo afrontar las crisis o dificultades	0. Casi nunca 1. A veces 2. A menudo 3. Casi siempre
35. Me siento triste (melancólico)	0. Casi nunca 1. A veces 2. A menudo 3. Casi siempre
36. Estoy satisfecho	0. Casi nunca 1. A veces 2. A menudo 3. Casi siempre
37. Me rondan y molestan pensamientos sin importancia	0. Casi nunca 1. A veces 2. A menudo 3. Casi siempre
38. Me afectan tanto los desengaños que no puedo olvidarlos	0. Casi nunca 1. A veces 2. A menudo 3. Casi siempre
39. Soy una persona estable	0. Casi nunca 1. A veces 2. A menudo 3. Casi siempre
40. Cuando pienso sobre asuntos y preocupaciones actuales me pongo tenso y agitado	0. Casi nunca 1. A veces 2. A menudo 3. Casi siempre

ANNEX 7: SES SCALE

Preguntes clase social neomarxista

1. Està vostè autocontractat o treballant per compte propia? **Si/No**
2. Quantes persones contractades?
3. Participa vostè en les decisions al seu lloc de treball, com serien els bens o serveis produits, el nombre de persones contractades, els pressuposts destinats a cada tasca? **Si/No**
4. Com a part del seu treball principal: supervise vostè el treball d'altres treblladores o els diu què han de fer? **Si/No**
5. Com es descriu millor la posición que vostè ocupa dins el seu negoci o organització?
    - Directiva
    - De supervisión
    - No directiva
6. Quin és el seu nivel màxim d'estudis?
7. Quina és la seva ocupació actual?