17 Culturally Responsive Assessment and Treatment of Generalized Anxiety Disorder

Jessica R. Graham-LoPresti, Tahirah Abdullah, and Amber Calloway

Generalized Anxiety Disorder

Similar to other anxiety disorders, generalized anxiety disorder (GAD) is characterized by features of excessive fear and related behavioral disturbances. Specifically, GAD is characterized by a pattern of excessive worry that is pervasive and spans a wide range of events and activities (DSM 5, American Psychiatric Association, 2013). For example, adults with GAD may worry about financial matters, the quality of ongoing relationships, world affairs, their health and the health of loved ones, and everyday activities (e.g., job responsibilities, being punctual, completion of household chores). Individuals with GAD worry more days than not for at least 6 months and find it difficult to control the worry (DSM 5, American Psychiatric Association, 2013). This worry is accompanied by poor concentration, irritability, sleep disturbance, and physical symptoms, including muscle tension, restlessness, or feeling keyed up or on edge.

Worry, along with these accompanying symptoms, cause clinically significant distress or impairment across areas of psychosocial functioning. For example, generalized anxiety disorder is associated with occupational impairment, including higher rates of unemployment, more days of missed work, and more frequent occurrence of inability to perform usual role functioning activities (Henning, Turk, Mennin, & Fresco, 2007; Wittchen, 2002; Wittchen, Zhao, Kessler, & Eaton, 1994). GAD accounts for 110 million disability days per annum in the US population (Kessler et al., 2005; Merikangas et al., 2007). Thirty-seven percent of participants with GAD in the Epidemiological Catchment Area Study were receiving some type of public assistance with only about half of the total sample employed full time (Massion, Warshaw, & Keller, 1993). Individuals with GAD also show functional impairment in personal domains. Nearly one-third of those with GAD (28%) report severe disability within their romantic relationships (Henning et al., 2007). Specifically, GAD is associated with elevated rates of marital distress, divorce, and separation (Leon, Portera, & Weissman, 1995; Wittchen et al., 1994). GAD has also been linked to physical health prob-

J. R. Graham-LoPresti (✉)
Department of Psychology, Suffolk University, Boston, MA, USA
e-mail: JLoPresti@suffolk.edu

T. Abdullah
Department of Psychology, Suffolk University, Boston, MA, USA

University of Massachusetts Boston, Boston, MA, USA

A. Calloway
The Penn Collaborative for CBT and Implementation Science, Suffolk University, Boston, MA, USA

Philadelphia VA Medical Center, Philadelphia, PA, USA

L. T. Benuto et al. (eds.), *Handbook of Cultural Factors in Behavioral Health*,
https://doi.org/10.1007/978-3-030-32229-8_17

lems, including coronary morbidity (Martens et al., 2010) and cardiovascular mortality (Denollet et al., 2009; Phillips et al., 2009). In fact, GAD is among the most prevalent mental health conditions seen in primary care (Lieb, Becker, & Altamura, 2005) and specialty clinics (Fogarty, Sharma, Chetty, & Culpepper, 2008; Ormel et al., 1994; Schonfeld et al., 1997). GAD alone is significantly related to greater disability than other anxiety disorders, pure alcohol and drug use disorders, nicotine dependence, and personality disorders even after controlling for sociodemographics and any comorbid disorders (Grant et al., 2005). Comorbidity increases the impairment and severity of GAD (Judd et al., 1998; Stein, 2001; Wittchen, 2002; Wittchen et al., 1994).

Generalized anxiety disorder is the most common of the anxiety disorders with an approximate 2.9% 12-month prevalence and 9% lifetime prevalence in the general population in the USA. There has been increasing examination into rates of GAD within marginalized populations such as racial/ethnic and sexual minorities as well as immigrant populations. Overall, racial and ethnic minority groups tend to meet criteria for lifetime GAD at a lower rate as compared to White Americans (Budhwani, Hearld, & Chavez-Yenter, 2015; Soto, Dawson-Andoh, & BeLue, 2011). In a study evaluating prevalence rates of anxiety disorders across ethnic groups in the USA, it was found that White Americans consistently endorsed symptoms of GAD (8.6%) more frequently than African Americans (4.9%), Hispanic Americans (5.8%), and Asian Americans (2.4%; Asnaani, Richey, Dimaite, Hinton, & Hofmann, 2010). Asian Americans consistently endorsed symptoms of a range of anxiety disorders less frequently than other ethnic groups. A similar pattern in the prevalence of GAD across ethnic groups has been observed in other large-scale epidemiological datasets (Grant et al., 2005, 2006). This pattern has been observed in older adults as well (Woodward et al., 2012). However, it has been suggested that these differences could reflect cross-cultural measurement biases related to the diagnostic instrument rather than true differences in rates of GAD (Parkerson et al., 2015). DSM 5 recommends that mental health providers take "cultural contextual factors into account" when making a diagnosis of any anxiety disorder.

Prevalence of GAD has also been shown to vary by immigration status. Generally, those who have immigrated tend to be at less risk of any anxiety disorder compared to their American-born counterparts (Alegría et al., 2007; Breslau, Borges, Hagar, Tancredi, & Gilman, 2009; Breslau & Chang, 2006; Takeuchi et al., 2007). For GAD, ethnic minorities born outside the USA exhibit lower lifetime prevalence rates as compared to their American-born counterparts (Budhwani et al., 2015).

While ethnic minorities and immigrant populations are less likely to meet criteria for GAD, individuals in the LGBTQ population are more likely to meet criteria than heterosexual and cisgender men and women (Cochran, Sullivan, & Mays, 2003). Transgender women have the highest prevalence of severe to extremely severe generalized anxiety symptoms followed by bisexual women, followed by lesbians. Transgender men exhibit the highest degree of anxiety followed by gay men and bisexual men (Smalley, Warren, & Barefoot, 2016). Additionally, higher odds of any lifetime anxiety disorder are more pronounced among sexual minority men than among sexual minority women (Bostwick, Boyd, Hughes, & McCabe, 2010). It has been suggested that the mental health disparities experienced by gender or sexual minority populations are related to greater exposure to gender/sexual orientation-related experiences of rejection, discrimination, harassment, and victimization (e.g., Bockting et al., 2013; Effrig & Bieschke, 2011; Grant et al., 2006; Nuttbrock et al., 2013; Woodford, Kulick, Sinco, & Hong, 2014).

Cultural Responsiveness and Competency

Cultural competency and responsiveness are a benchmark for ethical and effective clinical practice which means that the implementation of these practices throughout the different stages of the assessment, diagnosis, and treatment of GAD

in traditionally underserved and marginalized populations is crucial. It is important to consider the research highlighting significantly higher rates of mental health treatment dropout and lack of access to quality, culturally competent care for racial and ethnic minorities (Jackson et al., 2007; Lester, Artz, Resick, & Young-Xu, 2010; Roberts, Gilman, Breslau, Breslau, & Koenen, 2011) as well as gender and sexual minorities (Parameshwaran, Cockbain, Hillyard, & Price, 2017) as compared to the general population. Much of the literature surrounding barriers to access to quality mental health care point to the lack of cultural responsiveness of mental health-care systems and providers (Freimuth et al., 2001; Snowden, 2001), for example, the history of misdiagnosis for clients of color, the experience of racial macro- and microaggressions in the context of mental health treatment, lack of familiarity of clinicians with common medical conditions associated with racial or ethnic group membership, and lack of access to evidence-based practices or resources. Cultural competence and responsiveness is described as a clinician's commitment to gaining awareness, knowledge, and skills that can promote optimal functioning in clients presenting with varied clinical presentations as well as various intersecting identities, with an understanding of the impact of societal and institutional systems (Sue & Sue, 2004). In addition, a focus of culturally responsive assessment and treatments is the ability to understand clients' cultural norms and values while also attending to clients' unique experience within any identity category or cultural group. Theorists have described two different approaches to prevention, assessment, and intervention processes, the etic and emic approaches, with the latter being a culturally responsive approach (Sue & Sue, 2004). The *etic* approach is the manner in which therapy has been traditionally practiced. This approach is housed within the theory of cultural universality and assumes that approaches to therapeutic interventions are universal in nature. Specifically, the *etic* approach maintains that psychological disorders, like GAD, develop and express similarly across cultures and prevention, assessment, diagnostic, and intervention approaches for GAD should be uniformly applied across identities. Although this approach is widely used, it may impose dominant group cultural biases upon clients from traditionally marginalized backgrounds (e.g., racial and ethnic minorities, sexual minorities, gender minorities). More specifically, applying the approach of cultural universality during the therapeutic process can lead clinicians to fail to address unique experiences (e.g., oppression, cultural and familial influences, identity-based trauma) that may contribute to the development, maintenance, and expression of mental health difficulties.

The *emic* approach to prevention, assessment, diagnosis, and treatment challenges the assumptions that mental health difficulties are of the same nature and development across cultures. This approach suggests that culture and life contexts significantly influence the manifestation, course, and expression of mental health difficulties and, in turn, should influence the therapy process. The *emic* approach to therapeutic processes is at the core of culturally responsive prevention, assessment, diagnosis, and treatment and leads to a multidimensional model of identity development that includes individual-, group-, and universal-level influences.

The first step in engaging in culturally responsive assessment of GAD is developing awareness of our own assumptions, values, attitudes, and biases based on our intersecting identities and the intersecting identities of our clients. Hays (2008) presents an acronym, the ADDRESSING framework that helps therapists attend to their own identities and the identities and lived experiences of clients. This framework focuses on nine cultural factors that therapists should attend to in the context of the assessment, diagnosis, and treatment of GAD: **A**ge and generational influences, **D**evelopment disabilities, acquired **D**isabilities, **R**eligion and spiritual orientation, **E**thnicity and race, **S**ocioeconomic status, **S**exual orientation, **I**ndigenous heritage, **N**ational origin (citizenship and immigrant status), and **G**ender. See Fig. 17.1.

In addition, D'Andrea and Daniels (2001) present the RESPECTFUL model of interviewing. This model presents ten dimensions of identity including **R**eligion/spirituality, **E**conomic/social class background, **S**exual identity, **P**ersonal

ADDRESSING Definitions	Client Information	Therapist Information
Age and generational influences		
Disability Status (Developmental and Acquired)		
Religion and Spiritual Orientation		
Ethnicity (and Race)		
Socioeconomic Status		
Sexual Orientation		
Indigenous Heritage		
National Origin and Generational Status		
Gender		

Fig. 17.1 Addressing Framework (Hays, 2008)

style and education, **E**thic/racial identity, **C**hronic/lifespan status and challenges, **T**rauma/crisis, **F**amily background and history, **U**nique physical characteristics, and **L**ocation of residence/language differences. See Fig. 17.2.

These models present a framework for therapists to engage in culturally responsive assessment and treatment of GAD with diverse clients. An example of culturally responsive assessment of GAD can be seen in the case of Anita, a 25-year-old Mexican woman seeking therapy to discuss her mounting worry which is making it difficult for her to leave her home. She reports having difficulty falling asleep due to her worry which leads to 4 h of sleep per night and feelings of "exhaustion." Anita reports worrying about her safety, ability to effectively do her job as a store manager because of struggles with concentration, the health and well-being of her children and husband, as well as financial stability. An initial assessment of Anita's symptoms might find that she meets DSM 5 diagnostic criteria for GAD in that she is reporting significant worry about a number of aspects of her life more days than not, for 6 months, and experiences fatigue, difficulty concentrating, and sleep disturbance. However, an initial assessment of symptoms and diagnosis of GAD for Anita would be missing a significant aspect of her anxiety. It is important for therapists to inquire about the connection between this young woman's worry and her various identities. First, her therapist should inquire about Anita's racial and ethnic identity and explore the ways in which aspects of her identity, discrimination, and/or oppression may be related to Anita's mounting worry. By opening the door for this conversation as the therapist, it signals to the client that it is important, and appropriate, for them to discuss issues related to marginalization or discrimination as a part of their therapy process. In Anita's case, her mounting worry is related to her fears of deportation. Specifically, she worries that if she leaves her home that she will come into contact with ICE (US Immigration and Customs Enforcement) and be detained and deported which would mean that she would be separated from her husband and three school-aged children indefinitely. This separation would also mean that her family would not have financial stability and most likely end up homeless. It is difficult to develop an effective case conceptualization for the treatment of diverse clients experiencing GAD without the full context of their worry. Assessing for the intersection of mental health and identity contexts is of crucial importance as it relates to therapy engagement and retention for clients from traditionally marginalized backgrounds as well as effective development of case conceptualization and treatment plans.

Intervention

There are numerous models that explain the nature and the potential cause of GAD. For example, cognitive avoidance theory posits that worry serves an avoidant function to diminish the nega-

10 Dimensions	*Identify yourself as a multicultural being.*	*What personal and group strengths can you develop for each multicultural dimension?*	*How effective will you be with individuals who differ from you?*
Religion/Spirituality			
Economic/social class			
Sexual identity			
Personal Style and Education			
Ethnic/Racial Identity			
Chronical/Lifespan status and challenges			
Trauma/Crisis			
Family Background and History			
Unique Physical Characteristics			
Location of Residence, Language Differences			

Fig. 17.2 Respectful Model (D'Andrea & Daniels, 2001)

tive emotional reactivity to perceived internal and external threats (Borkovec, Alcaine, & Behar, 2004). An acceptance-based model of GAD builds on the cognitive avoidance theory and conceptualizes anxiety as stemming from a maladaptive relationship with internal states, experiential avoidance, and behavioral constraint (Roemer & Orsillo, 2002). The intolerance of uncertainty model proposes that individuals with GAD find uncertain or ambiguous situations to be "stressful and upsetting" (Dugas & Koerner, 2005, p. 62) and experience chronic worry in response to such situations. These individuals believe that worry will help them to either prevent these feared events or cope with them if they occur.

These conceptual models of GAD have borne different psychological interventions. Applied relaxation (AR; Öst, 1987) is based on the premise that anxiety involves the interaction of cognitive, physiological, affective, and behavioral responses. Because each response influences the intensity of the other, learning to reduce physiological activation should also reduce activation in the other systems and therefore reduce anxiety overall. The treatment involves recognizing the early signs of anxiety, learning and practicing relaxation skills, and applying relaxation at the first sign of anxiety. AR is one of the few empirically supported treatment for GAD (Chambless & Ollendick, 2001) and is consistently used as the gold standard against which newer treatments are compared. Cognitive behavioral therapy (CBT) for GAD, based on the cognitive avoidance model (Borkovec & Costello, 1993) has been shown to be superior to the alternative treatments (e.g., placebo, psychopharmacological, psychodynamic, supportive) or control in most cases (Borkovec & Ruscio, 2001). CBT based on the intolerance of uncer-

tainty model has also been shown to be efficacious (Dugas et al., 2010; Gosselin, Ladouceur, Morin, Dugas, & Baillargeon, 2006; Ladouceur et al., 2000). However, CBT has the lowest average effect size for GAD, when compared to effect sizes of CBT for other anxiety disorders (Brown, Barlow, & Liebowitz, 1994). An acceptance-based behavioral treatment was developed with an attempt to improve these outcomes. ABBT combines mindfulness- and acceptance-based strategies with behavioral approaches. It focuses on acceptance or allowing the presence of internal experiences while developing flexible behavioral repertoires that are consistent with the individual's values (Orsillo & Roemer, 2011). ABBT has been shown to be equally as effective as applied relaxation (Hayes-Skelton, Roemer, & Orsillo, 2013).

Cognitive Restructuring (CR)

Cognitive restructuring (CR) is a process employed in cognitive and cognitive behavioral therapy that involves identifying, evaluating, and modifying negative or limited thoughts (Wenzel, Dobson, & Hays, 2016). At the core of CR for GAD is the notion that one cause of the anxiety individuals with GAD experience is faulty, irrational, or distorted thinking and that learning to notice these thoughts, evaluate their accuracy and usefulness, and modify them will reduce anxiety symptoms. Prior to beginning cognitive restructuring with a client, therapists provide information about the process and provide a basis for using CR techniques. When introducing CR to clients, therapists take care to connect information about CR and the basis for using it to clients' experiences. Therapists encourage clients to "acknowledge all of the information that affects their life problems and to recognize that some of those pieces might not be as negative as they are concluding" (Wenzel et al., 2016, p. 91). For culturally responsive clinicians, part of this introduction to CR may involve contextualizing clients' anxiety and recognizing that some life problems related to marginalization and oppression are, in fact, as negative as the client is concluding. Acknowledging and validating as real the experiences of marginalization that the client has expressed experiencing strengthens the therapeutic relationship and may also improve therapy retention and outcomes.

CR requires clients to identify the automatic thoughts or images they have that are tied to their experience of anxiety. Therapists ask clients questions to elicit identification of automatic thoughts and images. Clients must first be able to identify the automatic thoughts and images in order to evaluate their accuracy and usefulness (Wenzel et al., 2016). Therapists work with clients to evaluate their automatic thoughts related to situations in which they experience anxiety through the use of strategic questions such as, "What evidence do you have for that?" "Might there be other explanations for the situation?" and "How likely is it that the worst case scenario would occur? How bad would the worst case scenario be?" However, for clients whose anxiety is tied to their experiences of oppression or discrimination as a person with marginalized identities, questioning whether there may be other explanations for oppressive or discriminatory encounters is invalidating, is marginalizing, can exacerbate symptoms, and could reduce clients' likelihood of returning to therapy. Instead of questioning the validity of these types of encounters, culturally responsive therapists can instead question the internalization of the oppression or discrimination experienced (Graham, Sorenson, & Hayes-Skelton, 2013).

For example, the fictional client Kayla is a 26-year-old Black woman diagnosed with GAD who worries about a number of things in her life. She works at a law firm where she is the only Black lawyer. She has encountered a combination of racism and sexism throughout her career and worries that she is perceived as less knowledgeable and less competent than her counterparts and will not be able to earn a promotion at her firm despite her hard work and success winning cases. These worries have made it difficult for Kayla to focus at work, and she often stays awake at night worrying about whether she will be able to have a successful career. Kayla tells her therapist that whenever she tries to share her concerns with colleagues, they are dismissive and tell her she has a lot to be grateful for so she should not complain.

Recently, a new lawyer at the firm assumed she was an administrative assistant and requested she copy some documents for him when she came to his office to give him the file for a case they would be working on together. Kayla stated that her automatic thoughts in this situation were, "Here's another co-worker who thinks I'm just the help because I'm a Black woman" and "People will give him credit, and not me, for winning the case." Asking Kayla, "what evidence do you have for that?" or "might there be other explanations for the situation?" would be incredibly invalidating.

Culturally responsive therapists "need to think deeply about the ways they are teaching clients to restructure their thoughts and the implications of these decisions" (Graham et al., 2013, p. 105). Primarily, it is important for therapists to recognize that clients with marginalized backgrounds may have experiences that have resulted in seemingly catastrophic, distorted thinking that actually is accurate and based in reality. In such cases, challenging that experience or thoughts about that experience could be detrimental to the therapeutic relationship, could worsen symptoms, and could reduce the possibility of therapeutic gains (Graham et al., 2013). Thus, instead of asking Kayla, "what evidence do you have for that?" or "might there be other explanations for the situation?" a more culturally responsive reply to her automatic thoughts would be, "your automatic thoughts seem to reflect your real experiences of racism. I think it is important to recognize that experience as real, and not 'all in your head.'…What automatic thoughts come up for you when you think, 'Here's another co-worker who thinks I'm just the help because I'm a Black woman' or 'People will give him credit, and not me, for winning the case?'" Here, the therapist would look for any signs that Kayla may think she is "less than" or unworthy of credit and normalize the experience of having those thoughts while using strategic questioning to evaluate them.

Applied Relaxation (AR)

Applied relaxation (AR) is an anxiety intervention aimed at working with clients to identify their early indicators of anxiety and develop skills to relax in the moments following those early indicators of anxiety (Hayes-Skelton et al., 2013; Öst, 1987). The basis of the theory underlying AR is that the physiological, cognitive, affective, and behavioral responses associated with GAD reinforce each other, resulting in increased intensity of symptoms. Reducing the intensity of any single manifestation of the anxiety response will, in turn, reduce the intensity of the other responses, so reducing the intensity of the physiological response will reduce the intensity of the cognitive, affective, and behavioral manifestations of GAD. Similarly, abating one aspect of the physiological response would abate other physiological responses. Intervening early in the anxiety cycle by using AR can prevent the anxiety response from intensifying and lead to a response pattern characterized by increased relaxation as opposed to intensified anxiety (Hayes-Skelton et al., 2013). AR consists of self-observation skills; relaxation skills including progressive relaxation, release-only relaxation, cue-controlled relaxation, differential relaxation, and rapid relaxation; and application training (Öst, 1987).

Culturally Responsive AR

As is often the case with culturally responsive practice, culturally responsive AR aligns with "good AR," that is, general best practices for conducting an AR intervention. For example, developing a working conceptualization based on the client's presentation and the theoretical basis of AR and sharing that conceptualization with the client in a way that is validating and that the client understands are important parts of AR. A strong therapeutic alliance in which the client trusts the therapist is also crucial, particularly since the intervention requires buy-in from the client, who is required to practice AR outside of the session (Hayes-Skelton, Roemer, Orsillo, & Borkovec, 2013). For clients whose anxiety is connected to or exacerbated by their experiences of marginalization or discrimination, a suggestion that is interpreted as "just relax" would feel especially invalidating and off-putting. Thus, it is important to contextualize the recommendation of AR and emphasize that AR will not reduce the

frequency of discrimination or make the pain of such experiences go away, but it can help the client to deal with it more effectively.

For example, the fictional client Syed is a 40-year-old Pakistani American Muslim man diagnosed with GAD. He worries frequently, feels tense throughout most of the day, is irritable, has difficulty remaining focused, and regularly experiences headaches and stomachaches. Despite building up a modest amount of wealth and receiving several promotions at the job he has worked the past 15 years, Syed worries about financial matters and job security. Syed experiences racial profiling and targeting almost every time he goes to the airport, and travelling has become a hassle for him. He generally worries about his own safety and that of his family, and he worries that they will experience more difficulties because of the increasingly anti-Muslim and anti-immigrant climate. Syed has close friends who have been victimized by hate crimes due to being perceived as immigrants or as Muslim and others who felt they were denied jobs or housing for the same reasons. After hearing about Syed's symptoms and experiences, his therapist introduces AR saying, "I think learning how to relax could help with your anxiety. Research suggests that for most people, anxiety is like a feedback loop, with physiological responses leading to negative thoughts, which intensify the physiological response. One of the ways to break the cycle of anxiety is to intervene in the physiological response so that you learn not to react so strongly."

Although the therapist is not incorrect, and this explanation aligns with Öst's (1987) suggestion for discussing AR, a more culturally responsive way to introduce AR to Syed would begin with validation of his experiences of anti-Muslim and anti-immigrant discrimination. After validating Syed's experiences, a culturally responsive therapist might introduce AR by starting with an explanation that AR will not be able to get rid of the anti-Muslim, anti-immigrant climate, but it may be helpful in reducing the intensity of the understandable anxiety he experiences. Such an explanation appropriately contextualizes and situates the major issue outside of the client as opposed to internal to him.

Worry Exposure (WE)

Worry exposure (WE) is an intervention that requires clients to create and focus for 25 min on a vivid mental image of their most feared outcome or expectation from a situation they worry about. This exposure results in "habituation to the feared image and the accompanying arousal, and changing the meaning of the feared situation" (van der Heiden & ten Broeke, 2009; p. 388). Consideration of the potential unintended outcomes that could arise because of this habituation is important for culturally responsive WE. For example, becoming habituated to experiences of oppression may result in reduced anxiety, but it also may have the unintended consequence of reducing the emotions that push people to resist oppression. As part of the informed consent process, it is important for therapists to fully explain the intervention, particularly highlighting the likelihood of experiencing emotional discomfort and the possibility of unintended consequences like lessened drive for resistance. Culturally responsive therapists might consider how they could work with a client who values resistance to engage in it without being motivated by worry. Ideally, therapists also would take steps to reduce systemic inequities as part of their own work.

In WE, clients are first asked to engage in self-monitoring to determine the nature of their worrying, and they are taught to identify the worries that cannot be addressed by problem solving, which will be the targets for WE. With one of those worries in mind, the therapist helps the client to hone in on the worst possible outcome of the situation. Clients are then asked to picture the worst possible outcome in as much detail as possible, fully experiencing the uncomfortable emotions that accompany the imagined outcome. In selecting the worries and worst possible outcomes to focus on, culturally responsive therapists should attend to the credibility of the worry and the worst possible outcome, in the context of historical, social, and cultural factors. Following the 25-min exposure, cognitive restructuring is employed to

encourage the client to consider as many alternative outcomes as possible. Particularly in the case of a more credible worst possible outcome, culturally responsive therapists might focus the postexposure work on helping clients to realize the personal and social resources at their disposal should they encounter their most feared outcome. Finally, the therapist works with the client to determine how effective the exposure was at eliciting emotion, reducing the intensity of the emotion, and eliciting believable alternative outcomes (van der Heiden & ten Broeke, 2009).

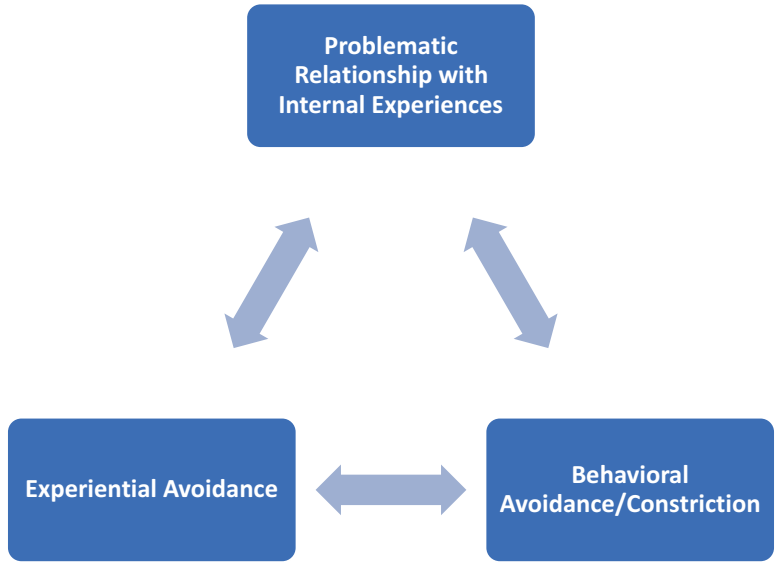
For example, the fictional client Rosa is an 18-year-old Guatemalan woman who came to the USA when she was 5 years old. She is a DACA recipient and has a mixed-status family. Rosa has been diagnosed with GAD. She frequently worries and feels anxious and apprehensive more often than not. Rosa worries about a number of situations including school, her family, making mistakes, and both the past and the future. In therapy, Rosa agrees to receive WE treatment for her GAD. When discussing the worries Rosa had written down, she and her therapist identify hypothetical worries, one of which is Rosa's worry that her mother, who is undocumented, will be deported. Rosa identifies her worst possible outcome as not being able to see her mother again. Her therapist has her focus the exposure on that outcome, and afterwards, the therapist asks Rosa to think about the possible alternative outcomes. Rosa becomes angry, stating that "this isn't just a thought exercise; this is my life!" A culturally responsive approach to WE would involve the therapist asking questions to better understand the circumstances surrounding Rosa's worry and her worst possible outcome. The therapist might still choose to use WE with this worry and outcome; however, after the exposure, instead of asking Rosa to think about alternative outcomes, the therapist might ask questions related to how Rosa might handle the real possibility of her mother's deportation and the real possibility of not being able to see her again.

Mindfulness and Acceptance-Based Approaches

An abundance of research supports mindfulness and acceptance-based approaches as efficacious and effective in the treatment of GAD (Chiesa & Serretti, 2011; Hofmann, Sawyer, Witt, & Oh, 2010; Piet & Hougaard, 2011; Roemer & Orsillo, 2002; Strauss, Cavanagh, Oliver, & Pettman, 2014). However, there is a dearth of literature exploring the integration of multicultural principles and mindfulness and acceptance-based treatments in the treatment of GAD. Fuchs et al. (2015) engaged in a phenomenological study exploring the extent to which clients from traditionally marginalized backgrounds felt that their identities affected their experience of an acceptance-based behavioral therapy for GAD. Several themes arose from these clients including the importance of inviting conversation about barriers to engaging in valued action, or the things that are most important to the client, balancing the need to maintain treatment fidelity and tailoring the treatment to the unique needs of clients, and overall making client-centered adjustments as the needs of the client shifts during therapy. The results of this study highlight the ways in which the needs of clients from traditionally marginalized backgrounds can vary and the flexibility of therapists when working with diverse clients from mindfulness and acceptance-based approaches is of crucial importance.

Integration of Multiculturalism and Mindfulness and Acceptance-Based Approaches

As stated above, there are several themes associated with the development and maintenance of GAD including intolerance of uncertainty, problematic relationships with internal physiological and emotional responses, and behavioral avoidance (Dugas & Koerner, 2005; Roemer & Orsillo, 2002). Specifically, from a mindfulness and acceptance-based framework, the development of GAD stems from the following model by Hays (2008):



First, this model suggests that the development and maintenance of GAD is characterized by clients' problematic relationship with their internal experiences. Specifically, individuals who are struggling with GAD, from this perspective, often have a restricted awareness or focus on future-oriented threat, which is a barrier to taking in other aspects of their environment, which may include positive stimuli or contexts as well as safe spaces. In addition, according to the model, individuals suffering from GAD tend to be fearful of their emotions and critically judgmental about the difficult physiological and emotional anxious responses that come up for them in the context of GAD. Given that internal experiences are viewed as dangerous or threatening, people struggling with GAD are often motivated to avoid these internal experiences. Many problematic behaviors can serve as experiential avoidance including alcohol use or overeating (Hays, 2008). In fact, worry can serve an experientially avoidant function. Specifically, the function of worry is often the avoidance of somatic symptoms as well as distraction from more emotional contexts or topics (Borkovec et al., 2004; Borkovec & Roemer, 1995).

Paradoxically, having a critical and judgmental approach to one's emotional experiences tends to exacerbate those emotions, akin to adding gasoline to a fire. Therapeutic goals, from this perspective, include using both formal and informal mindfulness practice to develop an expanded awareness towards our internal experiences (e.g., emotions, physiological responses). An additional focus includes using emotional regulation skills to be able to gain awareness of, label, and regulate our emotions.

From a multicultural perspective, several aspects of this model can be tailored to the unique experiences of individuals from traditionally marginalized backgrounds. First, the literature provides a significant amount of evidence that individuals from traditionally marginalized backgrounds experience discrimination based on these identities with frequency and across contexts (e.g., work, school, social environments) (Donovan, Galban, Grace, Bennett, & Felicie, 2012; Ming-Foynes, Shipherd, & Harrington, 2013; Pieterse, Todd, Neville, & Carter, 2012). In fact, the experience of discrimination and its effects connect directly to the psychological mechanisms (e.g., lack of perception of control, intolerance of uncertainty, behavioral avoidance/constriction) that contribute to the development and maintenance of mental health struggles, including GAD (Graham-LoPresti, Abdullah, Calloway, & West, 2017).

An individual's perception of control over life contexts, safety, and environment is directly linked to stress and anxiety (Dugas & Koerner, 2005). People from traditionally marginalized backgrounds are not responsible for the experiences of discrimination they endure and, in fact, have very little, if any, control over whether or not the events occur. In this context, discriminatory experiences can elicit an understandable perception of lack of control of one's environment (a key feature of GAD), therefore contributing to the development and maintenance of GAD. Specifically, people from traditionally marginalized backgrounds (e.g., immigrants, sexual minorities, people of color) work hard to provide for themselves and their families, live in accordance with their own values and societal expectations, and expect to receive equitable treatment, dignity, and respect in response to this hard work. Despite hard work, determination, and perseverance, the perception that one cannot control their own safety, livelihood, and environmental contexts is initiated and maintained by the frequency of discriminatory experiences. This type of uncertainty can be directly connected to stress and worry that underpin GAD. Therapists must develop an understanding of the ways in which frequent and pervasive experiences of discrimination can elicit significant worries about emotional and physical safety. Most importantly, therapists should express to clients who experience frequent discrimination that their worry is reasonable given their history and the history of the US context. In addition, clients from traditionally marginalized backgrounds might develop worry patterns as a potentially maladaptive coping mechanism for the uncertainty of discrimination. Therapists can assist clients in seeing the ways in which worry can be a barrier to the use of effective emotional coping strategies (e.g., emotion regulation, valued living, social support). Teaching clients flexible ways to cope with their emotional responses to discrimination can empower them with a sense of agency over their emotional safety and livelihood. In fact, this can be described to clients as an act of resistance against oppression.

Additionally, experiences of discrimination might contribute to GAD for people from marginalized backgrounds through avoidance of the things that are most meaningful in their lives. Wilson and Murrell (2004) describe the ways that both avoidance of our emotions and avoidance of meaningful contexts contribute to the maintenance of stress and anxiety. The things that matter to us, our values, become limited when the focus is solely on attempts to avoid distressing emotions, specifically worry in the context of GAD. Moreover, negative life events (e.g., discrimination) can create rigid and inflexible ways of responding to our anxiety that limit our ability to engage in the things that are meaningful to us. For instance, an individual who experiences worry about their safety and the safety of their loved ones based on experiences of discrimination may begin to avoid places where they fear experiencing discrimination. For instance, a transgender woman may begin to worry about her physical safety as she is inundated with news of violence against people who identify as transgender across the USA. This worry and fear might be a barrier to her engaging socially, attending her classes, and living up to her work obligations. However, her avoidance of places where they might experience discrimination is in direct contrast to their value of getting an education, developing a professional identity, and developing close interpersonal relationships. As another example, there has been a significant uptick in violence against people who identify as Muslim in the US context. Given this uptick in violence targeting Muslims, it might make sense to avoid certain places to maintain physical and emotional safety. Therapists working with diverse clients need to be aware of these experiences of oppression and avoid suggesting or pushing people from traditionally marginalized spaces to move towards behavioral engagement in a way that is physically or emotionally damaging. Instead, therapists might assist diverse clients in clarifying their values in different contexts (e.g., school, work, family, community) and help clients decide on behavioral engagement strategies that limit exposure to physically and emotionally damaging contexts and increase engagement in personally meaningful activities.

Given that GAD is experienced by individuals from traditionally marginalized backgrounds and remains one of the most difficult anxiety disorders to effectively treat, we must think about innovative ways to intervene. Thinking deeply about the intersection of multicultural counseling principles and both traditional and mindfulness and acceptant-based cognitive behavioral interventions for GAD is at the forefront of this endeavor. Training therapists to integrate their knowledge of the underlying mechanisms of GAD and the unique experiences of people from traditionally marginalized spaces will undoubtedly provide access to effective and quality mental health treatment of GAD for diverse clients.

References

Alegria, M., Shrout, P. E., Woo, M., Guarnaccia, P., Sribney, W., Vila, D., … Canino, G. (2007). Understanding differences in past year psychiatric disorders for Latinos living in the US. *Social Science & Medicine, 65*(2), 214–230. https://doi.org/10.1016/j.socscimed.2007.03.026

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: Author.

Asnaani, A., Richey, J. A., Dimaite, R., Hinton, D. E., & Hofmann, S. G. (2010). A cross-ethnic comparison of lifetime prevalence rates of anxiety disorders. *Journal of Nervous and Mental Disease, 198*(8), 551–555. https://doi.org/10.1097/NMD.0b013e3181ea169f

Bockting, W., Miner, M., Romine, R., Hamilton, A., & Coleman, E. (2013). Stigma, mental health, and resilience, in an online sample of the US transgender population. *American Journal of Public Health, 103*, 943–951. https://doi.org/10.2105/AJPH.2013.301241

Borkovec, T., & Roemer, L. (1995). Perceived functions of worry among generalized anxiety disorder subject: Distraction from more emotionally distressing topics. *Behavior Therapy, 26*, 25–30. https://doi.org/10.1016/0005-7916(94)00064-s

Borkovec, T. D., Alcaine, O. M., & Behar, E. (2004). Avoidance theory of worry and generalized anxiety disorder. In R. Heimberg, C. Turk, & D. Mennin (Eds.), *Generalized anxiety disorder: Advances in research and practice* (pp. 77–108). New York, NY: Guilford Press.

Borkovec, T. D., & Costello, E. (1993). Efficacy of applied relaxation and cognitive-behavioral therapy in the treatment of generalized anxiety disorder. *Journal of Consulting and Clinical Psychology, 61*(4), 611–619. https://doi.org/10.1037/0022-006X.61.4.611

Borkovec, T. D., & Ruscio, A. M. (2001). Psychotherapy for generalized anxiety disorder. *The Journal of Clinical Psychiatry, 62*(Suppl 11), 37–42.

Bostwick, W. B., Boyd, C. J., Hughes, T. L., & McCabe, S. E. (2010). Dimensions of sexual orientation and the prevalence of mood and anxiety disorders in the United States. *American Journal of Public Health, 100*, 468–475. https://doi.org/10.2105/AJPH.2008.152942

Breslau, J., Borges, G., Hagar, Y., Tancredi, D., & Gilman, S. (2009). Immigration to the USA and risk for mood and anxiety disorders: Variation by origin and age at immigration. *Psychological Medicine, 39*(7), 1117–1127. https://doi.org/10.1017/S0033291708004698

Breslau, J., & Chang, D. F. (2006). Psychiatric disorders among foreign-born and US-born Asian-Americans in a US national survey. *Social Psychiatry and Psychiatric Epidemiology, 41*(12), 943–950. https://doi.org/10.1007/s00127-006-0119-2

Brown, T. A., Barlow, D. H., & Liebowitz, M. R. (1994). The empirical basis of generalized anxiety disorder. *The American Journal of Psychiatry, 151*(9), 1272–1280. https://doi.org/10.1176/ajp.151.9.1272

Budhwani, H., Hearld, K. R., & Chavez-Yenter, D. (2015). Generalized anxiety disorder in racial and ethnic minorities: A case of nativity and contextual factors. *Journal of Affective Disorders, 175*, 275–280. https://doi.org/10.1016/j.jad.2015.01.035

Chambless, D. L., & Ollendick, T. H. (2001). Empirically supported psychological interventions: Controversies and evidence. *Annual Review of Psychology, 52*, 685–716. https://doi.org/10.1146/annurev.psych.52.1.685

Chiesa, A., & Serretti, A. (2011). Mindfulness based cognitive therapy for psychiatric disorders: A systematic review and meta-analysis. *Psychiatry Research, 187*(3), 441–453.

Cochran, S. D., Sullivan, J. G., & Mays, V. M. (2003). Prevalence of mental disorders, psychological distress, and mental health services use among lesbian, gay, and bisexual adults in the United States. *Journal of Consulting and Clinical Psychology, 71*(1), 53–61. https://doi.org/10.1037/0022-006X.71.1.53

D'Andrea, M., & Daniels, J. (2001). Respectful counseling: An integrative multidimensional model for counselors. In D. Pope-Davis & H. Coleman (Eds.), *The intersection of race, class, and gender in multicultural counseling*. Sage. https://doi.org/10.4135/9781452231846.n17

Denollet, J., Maas, K., Knottnerus, A., Keyzer, J. J., & Pop, V. J. (2009). Anxiety predicted premature all-cause and cardiovascular death in a 10-year follow-up of middle-aged women. *Journal of Clinical Epidemiology, 62*(4), 452–456. https://doi.org/10.1016/j.jclinepi.2008.08.006

Donovan, R., Galban, D., Grace, R., Bennett, J., & Felicie, S. (2012). Impact of racial macro- and microaggressions in Black women's lives: A preliminary analysis. *Journal of Black Psychology, 39*, 186–196. https://doi.org/10.1177/0095798412443259

Dugas, M. J., Brillon, P., Savard, P., Turcotte, J., Gaudet, A., Ladouceur, R., … Gervais, N. J. (2010). A random-

ized clinical trial of cognitive-behavioral therapy and applied relaxation for adults with generalized anxiety disorder. *Behavior Therapy, 41*(1), 46–58. https://doi.org/10.1016/j.beth.2008.12.004

Dugas, M. J., & Koerner, N. (2005). Cognitive-behavioral treatment for generalized anxiety disorder: Current status and future directions. *Journal of Cognitive Psychotherapy, 19*(1), 61–81. https://doi.org/10.1891/jcop.19.1.61.66326

Effrig, J., & Bieschke, B. (2011). Examining victimization and psychological distress in transgender college students. *Journal of College Counseling, 14*, 143–157. https://doi.org/10.1002/j.2161-1882.2011.tb00269.x

Fogarty, C. T., Sharma, S., Chetty, V. K., & Culpepper, L. (2008). Mental health conditions are associated with increased health care utilization among urban family medicine patients. *Journal of American Board of Family Medicine, 21*, 398–407.

Freimuth, V., Quinn, S., Thomas, S., Cole, G., Zook, E., & Duncan, T. (2001). African American's views on research and the Tuskegee syphilis study. *Social Science and Medicine, 52*, 797–808. https://doi.org/10.1016/S0277-9536(00)00178-7

Fuchs, C., Lee, J., Roemer, L., & Orsillo, S. (2015). Using mindfulness and acceptance-based treatments with clients from nondominant cultural and/or marginalized background: Clinical considerations, meta-analysis findings, and introduction to the special series. *Cognitive Behavioral Practice, 20*, 1–12. https://doi.org/10.1016/j.cbpra.2011.12.004

Gosselin, P., Ladouceur, R., Morin, C. M., Dugas, M. J., & Baillargeon, L. (2006). Benzodiazepine discontinuation among adults with GAD: A randomized trial of cognitive-behavioral therapy. *Journal of Consulting and Clinical Psychology, 74*(5), 908–919. https://doi.org/10.1037/0022-006X.74.5.908

Graham, J. R., Sorenson, S., & Hayes-Skelton, S. A. (2013). Enhancing the cultural sensitivity of cognitive behavioral interventions for anxiety in diverse populations. *Behavior Therapy, 36*(5), 101–108.

Graham-LoPresti, J., Abdullah, T., Calloway, A., & West, L. (2017). *The link between experiences of racism and stress and anxiety for Black Americans: A mindfulness and acceptance-based coping approach*. Silver Spring, MD: ADAA.

Grant, B. F., Hasin, D. S., Stinson, F. S., Dawson, D. A., Ruan, W. J., Goldstein, R. B., … Huang, B. (2005). Prevalence, correlates, co-morbidity, and comparative disability of DSM-IV generalized anxiety disorder in the USA: Results from the National Epidemiologic Survey on alcohol and related conditions. *Psychological Medicine, 35*(12), 1747–1759.

Grant, B. F., Hasin, D. S., Stinson, F. S., Dawson, D. A., Goldstein, R. B., Smith, S., … Saha, T. D. (2006). The epidemiology of DSM-IV Panic Disorder and Agoraphobia in the United States: Results from the National Epidemiologic Survey on alcohol and related conditions. *The Journal of Clinical Psychiatry, 67*(3), 363–374. https://doi.org/10.4088/JCP.v67n0305

Hays, P. A. (2008). *Addressing cultural complexities in practice: Assessment, diagnosis, and therapy* (2nd ed.). Washington, DC: American Psychological Association.

Hayes-Skelton, S. A., Roemer, L., & Orsillo, S. M. (2013). A randomized clinical trial comparing an acceptance-based behavior therapy to applied relaxation for generalized anxiety disorder. *Journal of Consulting and Clinical Psychology, 81*(5), 761–773. https://doi.org/10.1037/a0032871

Hayes-Skelton, S. A., Roemer, L., Orsillo, S. M., & Borkovec, T. D. (2013). A contemporary view of applied relaxation for generalized anxiety disorder. *Cognitive Behaviour Therapy, 42*(4), 292–302. https://doi.org/10.1080/16506073.2013.777106

Henning, E. R., Turk, C. L., Mennin, D. S., & Fresco, D. M. (2007). Impairment and quality of life individuals with generalized anxiety disorder. *Depression and Anxiety, 24*(5), 342–349.

Hofmann, S. G., Sawyer, A. T., Witt, A. A., & Oh, D. (2010). The effect of mindfulness-based therapy on anxiety and depression: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 78*(2), 169–183.

Jackson, J. S., Neighbors, H. W., Torres, M., Martin, L. A., Williams, D. R., & Baser, R. (2007). Use of mental health services and subjective satisfaction with treatment among Black Caribbean immigrants: Results from the National Survey of American Life. *American Journal of Public Health, 97*(1), 60–67.

Judd, L., Akiskal, H., Maser, J., Zeller, P., Endicott, J., Coryell, W., … Keller, M. (1998). Major depressive disorder: A prospective study of residual subthreshold depressive symptoms as a predictor of rapid relapse. *Journal of Affective Disorders, 50*, 97–108. https://doi.org/10.1016/s0165-0327(98)00138-4

Kessler, R., Chiu, W., Demler, O., Merikangas, K., & Walters, E. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*, 617–627. https://doi.org/10.1001/archpsyc.62.6.617

Ladouceur, R., Dugas, M. J., Freeston, M. H., Léger, E., Gagnon, F., & Thibodeau, N. (2000). Efficacy of a cognitive–behavioral treatment for generalized anxiety disorder: Evaluation in a controlled clinical trial. *Journal of Consulting and Clinical Psychology, 68*(6), 957–964. https://doi.org/10.1037/0022-006X.68.6.957

Leon, A. C., Portera, L., & Weissman, M. M. (1995). The social costs of anxiety disorders. *The British Journal of Psychiatry, 166*(Suppl 27), 19–22.

Lester, K., Artz, C., Resick, P., & Young-Xu, Y. (2010). Impact of race on early treatment termination and outcomes in posttraumatic stress disorder treatment. *Journal of Consulting and Clinical Psychology, 78*, 480–489. https://doi.org/10.1037/a0019551

Lieb, R., Becker, E., & Altamura, C. (2005). The epidemiology of generalized anxiety disorder in Europe. *European Neuropsychopharmacology,*

15(4), 445–452. https://doi.org/10.1016/j.euroneuro.2005.04.010

Martens, E. J., de Jonge, P., Na, B., Cohen, B. E., Lett, H., & Whooley, M. A. (2010). Scared to death? Generalized anxiety disorder and cardiovascular events in patients with stable coronary heart disease: The Heart and Soul Study. *Archives of General Psychiatry, 67*(7), 750–758. https://doi.org/10.1001/archgenpsychiatry.2010.74

Massion, A. O., Warshaw, M. G., & Keller, M. B. (1993). Quality of life and psychiatric morbidity in panic disorder and generalized anxiety disorder. *The American Journal of Psychiatry, 150*(4), 600–607. https://doi.org/10.1176/ajp.150.4.600

Merikangas, K. R., Ames, M., Cui, L., Stang, P. E., Ustun, T. B., Von Korff, M., & Kessler, R. C. (2007). The impact of comorbidity of mental and physical conditions on role disability in the US adult household population. *Archives of General Psychiatry, 64*(10), 1180–1188. https://doi.org/10.1001/archpsyc.64.10.1180

Ming-Foynes, M., Shipherd, J., & Harrington, E. (2013). Race and gender discrimination. *Cultural Diversity and Ethnic Minority Psychology, 19*, 111–119. https://doi.org/10.1037/a0030567

Nuttbrock, L., Bockting, W., Rosenblum, A., Hwahng, S., Mason, M., Macri, M., & Becker, J. (2013). Gender abuse, depressive symptoms, and HIV and other sexually transmitted infections among male-to-female transgender persons: A three year prospective study. *American Journal of Public Health, 103*, 300–307. https://doi.org/10.2105/AJPH.2011.300568

Ormel, J., VonKorff, M., Ustun, T. B., Pini, S., Korten, A., & Oldehinkel, T. (1994). Common mental disorders and disability across cultures: Results from the WHO Collaborative Study on Psychological Problems in General Health Care. *Journal of the American Medical Association, 272*(22), 1741–1748. https://doi.org/10.1001/jama.272.22.1741

Orsillo, S. M., & Roemer, L. (2011). *The mindful way through anxiety: Break free from chronic worry and reclaim your life*. New York, NY: Guilford Press.

Öst, L. (1987). Applied relaxation: Description of a coping technique and review of controlled studies. *Behaviour Research and Therapy, 25*(5), 397–409. https://doi.org/10.1016/0005-7967(87)90017-9

Parameshwaran, V., Cockbain, B. C., Hillyard, M., & Price, J. R. (2017). Is the lack of specific lesbian, gay, bisexual, transgender and queer/questioning (LGBTQ) health care education in medical school a cause for concern? Evidence from a survey of knowledge and practice among UK medical students. *Journal of Homosexuality, 64*(3), 367–381. https://doi.org/10.1080/00918369.2016.1190218

Parkerson, H. A., Thibodeau, M. A., Brandt, C. P., Zvolensky, M. J., & Asmundson, G. J. G. (2015). Cultural-based biases of the GAD-7. *Journal of Anxiety Disorders, 31*, 38–42. https://doi.org/10.1016/j.janxdis.2015.01.005

Phillips, A. C., Batty, G. D., Gale, C. R., Deary, I. J., Osborn, D., MacIntyre, K., & Carroll, D. (2009). Generalized anxiety disorder, major depressive disorder, and their comorbidity as predictors of all-cause and cardiovascular mortality: The Vietnam Experience Study. *Psychosomatic Medicine, 71*(4), 395–403. https://doi.org/10.1097/PSY.0b013e31819e6706

Piet, J., & Hougaard, E. (2011). The effect of mindfulness-based cognitive therapy for prevention of relapse in recurrent major depressive disorder: A systematic review and meta-analysis. *Clinical Psychology Review, 31*(6), 1032–1040.

Pieterse, A., Todd, N., Neville, H., & Carter, R. (2012). Perceived racism and mental health among Black American adults: A meta-analytic review. *Journal of Counseling Psychology, 59*, 1–9. https://doi.org/10.1037/a0026208

Roberts, A., Gilman, S., Breslau, J., Breslau, N., & Koenen, K. (2011). Race/ethnic differences in exposure to traumatic events, development of posttraumatic stress disorder, and treatment-seeking for posttraumatic stress disorder in the United States. *Psychological Medicine, 41*, 71–83. https://doi.org/10.1017/S0033291710000401

Roemer, L., & Orsillo, S. M. (2002). Expanding our conceptualization of and treatment for generalized anxiety disorder: Integrating mindfulness/acceptance-based approaches with existing cognitive-behavioral models. *Clinical Psychology: Science and Practice, 9*, 54–68. https://doi.org/10.1093/clipsy.9.1.54

Schonfeld, W. H., Verboncoeur, C. J., Fifer, S. K., Lipschutz, R. C., Lubeck, D. P., & Buesching, D. P. (1997). The functioning and well-being of patients with unrecognized anxiety disorders and major depressive disorder. *Journal of Affective Disorders, 43*(2), 105–119. https://doi.org/10.1016/S0165-0327(96)01416-4

Smalley, K. B., Warren, J. C., & Barefoot, K. N. (2016). Variations in psychological distress between gender and sexual minority groups. *Journal of Gay & Lesbian Mental Health, 20*(2), 99–115. https://doi.org/10.1080/19359705.2015.1135843

Snowden, L. R. (2001). Barriers to effective mental health services for African Americans. *Mental Health Services Research, 3*(4), 181–187.

Soto, J. A., Dawson-Andoh, N. A., & BeLue, R. (2011). The relationship between perceived discrimination and generalized anxiety disorder among African Americans, Afro Caribbeans, and non-Hispanic Whites. *Journal of Anxiety Disorders, 25*(2), 258–265. https://doi.org/10.1016/j.janxdis.2010.09.011

Stein, D. J. (2001). Comorbidity in generalized anxiety disorder: Impact and implications. *The Journal of Clinical Psychiatry, 62*, 29–34.

Strauss, C., Cavanagh, K., Oliver, A., & Pettman, D. (2014). Mindfulness-based interventions for people diagnosed with a current episode of an anxiety or depressive disorder: A meta-analysis of randomised controlled trials. *PLoS One, 9*(4), E96110.

Sue, D. W., & Sue, D. (2004). *Counseling the culturally diverse: Theory and practice* (4th ed.). Hoboken, NJ: John Wiley and Sons.

Takeuchi, D. T., Zane, N., Hong, S., Chae, D. H., Gong, F., Gee, G. C., … Alegría, M. (2007). Immigration-related factors and mental disorders among Asian Americans. *American Journal of Public Health, 97*(1), 84–90. https://doi.org/10.2105/AJPH.2006.088401

van der Heiden, C., & ten Broeke, E. (2009). The when, why, and how of worry exposure. *Cognitive and Behavioral Practice, 16*, 386–393. https://doi.org/10.1016/j.cbpra.2008.11.003

Wenzel, A., Dobson, K. S., & Hays, P. A. (2016). *Cognitive behavioral therapy techniques and strategies*. Washington, DC: American Psychological Association. https://doi.org/10.1037/14936-000

Wilson, K. G., & Murrell, A. R. (2004). Values work in acceptance and commitment therapy: Setting a course for behavioral treatment. In S. C. Hayes, V. M. Follette, & M. Linehan (Eds.), *Mindfulness and acceptance: Expanding the cognitive-behavioral tradition* (pp. 120–151). New York: Guilford Press.

Wittchen, H. U. (2002). Generalized anxiety disorder: Prevalence, burden and cost to society. *Depression and Anxiety, 16*, 162–171.

Wittchen, H.-U., Zhao, S., Kessler, R. C., & Eaton, W. W. (1994). DSM-III-R generalized anxiety disorder in the National Comorbidity Survey. *Archives of General Psychiatry, 51*, 355–364.

Woodford, M. R., Kulick, A., Sinco, B. R., & Hong, J. S. (2014). Contemporary heterosexism on campus and psychological distress among LGBQ students: The mediating role of self-acceptance. *American Journal of Orthopsychiatry, 84*(5), 519–529. https://doi.org/10.1037/ort0000015

Woodward, A. T., Taylor, R. J., Bullard, K. M., Aranda, M. P., Lincoln, K. D., & Chatters, L. M. (2012). Prevalence of lifetime DSM-IV affective disorders among older African Americans, Black Caribbeans, Latinos, Asians and non-Hispanic white people. *International Journal of Geriatric Psychiatry, 27*(8), 816–827. https://doi.org/10.1002/gps.2790