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Reactions to an Acceptance-Based Behavior Therapy for GAD: Giving Voice to the Experiences of Clients From Marginalized Backgrounds

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There is emerging evidence supporting the acceptability of mindfulness and acceptance-based therapies with individuals from marginalized backgrounds. The current phenomenological study aimed to understand the extent to which clients from marginalized backgrounds who had completed an acceptance-based behavioral therapy (ABBT) for GAD felt that their identities affected their experience of the treatment and the therapist. Purposeful sampling methods were used to identify seven clients from a larger RCT who identified with one or more marginalized identities. Nine themes related to the treatment components, treatment focus and/or delivery, and the therapist emerged. Themes reflected aspects of treatment that clients were satisfied with and areas where they experienced some discord with treatment. Clinical implications for working with marginalized individuals include the importance of inviting conversations about barriers to valued actions, balancing the need to maintain treatment fidelity with the need to be responsive to clients' concerns, the utility of assessing responses to mindfulness exercises as they are presented, and making client-centered adjustments to either the content or delivery of mindfulness practice to help make connections between exercises and clients' lives.

As the demographic composition of the United States shifts, rapid growth is predicted for groups that have traditionally been underserved with respect to mental health services. For example, it is projected that within 30 years, non-Hispanic, single race White individuals will become the minority in the U.S. (U.S. Census Bureau, 2008). While there has been a significant increase in attention to cultural competence in mental health treatment in response to the changing demographics, inequities in access to quality mental health services continue to exist (U.S. Department of Health and Human Services, 2010). Specifically, several studies have noted that racial and ethnic minorities consistently receive poorer quality mental health care and are less likely to receive mental health care compared to White Americans (Carpenter-Song et al., 2010; Harris, Edlund, & Larson, 2005; Hunter & Schmidt, 2010; Institute of Medicine, 2002).

Increasing access to efficacious mental health services is one step toward reducing mental health disparities. However, a careful look at Evidence Based Treatments (EBTs) is also needed (Bernal & Domenech Rodríguez, 2012; Gone, 2009), as treatment development and outcome studies of EBTs often do not include individuals from diverse and/or marginalized backgrounds (Bernal & Scharrón–del-Río, 2001; Miranda et al., 2005). Individuals from *marginalized* groups are those who have been excluded or separated from mainstream society, received unequal treatment and/or access to resources, and generally been devalued based on aspects of their identities (Sue, 2010). In the U.S., marginalized groups include racial and ethnic minorities, people from poor or working class backgrounds, LGBT individuals, people from immigrant communities, people who identify with non-Christian religions, older adults, and individuals with impairments in physical health functioning and disabilities. The social inequalities associated with marginalized identities have been linked to negative health outcomes (Carpiano, Link, & Phelan, 2008;

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Wilkinson, 2005). Perceived discrimination has been found to be positively associated with poor mental health outcomes in Black Americans (Pieterse et al., 2012), Asian Americans (Lee & Sue, 2011), and lesbian, gay, and bisexual adults (Bostwick et al., 2014), making efficacious treatment provision to individuals who experience marginalization particularly important.

There is growing evidence to suggest that EBTs, particularly CBT, with and without cultural adaptations, are efficacious in treating a range of disorders with individuals from marginalized groups, including racial and ethnic minority groups (Griner & Smith, 2006; Hinton et al., 2004; Huey & Polo, 2008; Kohn & Oden, 2002), LGBT individuals (Martell, Safren, & Prince, 2004), older adults (Hendriks et al., 2008; Laidlaw, et al., 2008), and individuals with intellectual disabilities (Lew, Matta, &Tripp-Tebo, 2006). While EBTs have shown efficacy with individuals from marginalized groups, research on treatment engagement and acceptability has been less promising. A recent meta-analysis of CBT for substance abuse revealed that studies with predominantly Black and Hispanic samples showed lower retention rates and treatment engagement than studies with predominantly White samples (Windsor, Jemal, & Alessi, 2015). Studies of EBTs for depression have found that racial minority members have higher attrition and lower rates of homework completion (Aguilera, Garza, & Munoz, 2010; Arnow et al., 2007) than White clients. Similarly, in a recent study of computer-assisted CBT for anxiety disorders among primary care patients, Latino patients reported lower understanding of CBT principles at each session and higher attrition rates than White patients in the study, despite no differences in treatment outcome (Chavira et al., 2014). The ways in which marginalization might affect treatment engagement and acceptability is not well understood. Therefore, an improved understanding of the experiences that clients from marginalized backgrounds have with EBTs and how those experiences affect treatment adherence, efficacy, and effectiveness is needed.

Treatments that emphasize the role of acceptance- and mindfulness-based principles, including Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999), Dialectical Behavior Therapy (DBT; Linehan, 1993), Mindfulness-Based Stress Reduction (MBSR; Kabat-Zinn, 1991), Mindfulness-Based Cognitive Therapy (MBCT; Segal et al., 2002), and integrations of these approaches (e.g., Roemer & Orsillo, 2009) aim to reduce reactivity to, and avoidance of, internal experiences (cognitions, emotions, physical sensations) and encourage openness and acceptance of these experiences, while encouraging engagement in valued actions (i.e., behaviors that are important to the individual) that may have previously been avoided. A recent meta-analysis that included 32 studies of mindfulness- and acceptance-based treatments with clients from a range of nondominant cultural and/or marginalized backgrounds suggested preliminary efficacy of these treatments (Fuchs, Lee, Roemer, & Orsillo, 2013). Mindfulness, defined as paying attention, on purpose, in a particular nonjudgmental way (Kabat-Zinn, 1994), is often used as a clinical strategy to encourage open-hearted, compassionate, and curious awareness (Kabat-Zinn, 2003). Clinical strategies like cognitive defusion (Hayes et al., 1999) or decentering (Segal, Williams, & Teasdale, 2013) are used to help individuals view their thoughts as transient, rather than indicators of truth. These strategies may help to reduce the intensity and duration of the distress caused by discrimination and marginalization. Further, clients are asked to engage in a process of values clarification in which they identify what is personally meaningful to them within several life domains, explore the extent to which their actions have been consistent with those values, and identify opportunities to mindfully engage in valued actions in the future. It has been suggested that values clarification can be particularly helpful in decreasing reactivity to the internal distress caused by externally stressful environments (Sobczak & West, 2013), such as those often encountered by individuals from marginalized groups. Preliminary research suggests that mindfulness and values clarification may buffer the negative effects of racist experiences (Graham, West, & Roemer, 2013; West, Graham, & Roemer, 2013). For individuals who feel that they lack control over their environment due to systemic oppression and discrimination, validating this reality while also helping these individuals identify the actions that are within their control and consistent with what matters most to them, may be particularly helpful. The exploration of client-specific values also allows for consideration of the role of cultural and familial expectations and the extent to which these expectations may or may not match the client's own values. The dialectic of validating and promoting change may also serve to minimize the power dynamic inherent in traditional psychotherapeutic communication and help encourage a collaborative alliance between the therapist and client.

The focus of the current study is on understanding how individuals from marginalized groups experience a mindfulness- and acceptance-based treatment. It is not the goal of the current study to explore whether mindfulness- and acceptance-based treatments are superior to other evidence-based treatments when used with individuals from marginalized backgrounds. Several authors have suggested that mindfulness- and acceptance-based behavioral therapies may serve as a good fit for diverse groups (e.g., Christopher, Woodrich, & Tiernan, 2014; La Roche & Lustig, 2013). Mindfulness- and acceptance-based treatments are highly contextualized treatments where the emphasis is on acknowledging and working with the natural distress that arises from the unique stressors each

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