Psychological Trauma: Theory, Research, Practice, and Policy

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"Being Who I Am Means Everything Bad Can Happen": Chronic Structural Stressors in Trauma Focused Therapy Sessions With Marginalized Adolescents

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Objective: Exposure to chronic structural stressors (e.g., poverty, community violence, and discrimination) exacerbates posttraumatic stress disorder (PTSD) symptoms and reduces how adolescents benefit from trauma-focused interventions. However, current evidence-based PTSD interventions seldom include concrete guidance regarding how to target chronic structural stressors in care. ***Method:*** This study utilized qualitative thematic analysis of audio-recorded PTSD therapy sessions with 13 racially diverse, low socioeconomic status adolescents to elucidate (a) how often adolescents disclose chronic structural stressors in therapy, (b) the types of chronic structure stressors that are disclosed, and (c) the context in which chronic structural stressors are disclosed and the content of these disclosures. ***Results:*** 77% of adolescents disclosed at least one chronic structural stressor and that the presence of stressors exacerbated psychological distress, reduced treatment engagement, and decreased perceptions of intervention effectiveness. ***Conclusions:*** Our findings suggest that there is a missed opportunity to improve the effectiveness of treatment for PTSD by incorporating intervention elements that directly target structural stressors.

Clinical Impact Statement
We hypothesize that if interventions for PTSD included clear evidence-based suggestions for targeting chronic structural stressors within therapy, treatment engagement and response among marginalized groups would significantly improve. In the interim, we recommend that individual clinicians take time to assess and address the range of chronic structural stressors that their clients are facing in service of improving their treatment outcomes. Our results highlight the profound impact of structural inequality on diverse adolescents' mental health. Therefore, clinicians are also advised to participate in public health and policy interventions aimed at decreasing structural inequality on the city, county, state, and national levels.

Keywords: structural inequality, adolescents, brief intervention, diversity, treatment

Supplemental materials: https://doi.org/10.1037/tra0001755.supp

In the United States, over half of all children and adolescents will experience at least one traumatic event by the time they turn 18 (Finkelhor et al., 2005; McLaughlin et al., 2013). Marginalized youths (in terms of racial/ethnic identity, sexual orientation, socioeconomic status, nativity status, and/or gender identity) are particularly likely to experience traumatic events (Bridges et al., 2010; Goldberg & Meyer, 2013; Maguire-Jack et al., 2020; Mustanski et al., 2016; A. L. Roberts et al., 2011, 2012). A portion of these youths will go on to develop posttraumatic stress disorder (PTSD), a potentially debilitating disorder characterized by profound stress and anxiety stemming from a traumatic incident. Fortunately, there are several evidence-based interventions (EBIs) that efficaciously treat PTSD among youth, including trauma-focused cognitive behavioral therapy and cognitive behavioral intervention for trauma in schools (Gutermann et al., 2017). Although the specific components of these EBIs vary, the central treatment philosophy is to help youth learn that the traumatic events have passed, that they are now safe, and to equip the youth with skills to adequately cope with reminders of the event.

However, marginalized youths are less likely to engage in and benefit from EBIs for PTSD despite being at disproportionate risk of trauma exposure (Bridges et al., 2010; Choi et al., 2018; Goldberg & Meyer, 2013; Interian et al., 2013; Kataoka et al., 2002;

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Maguire-Jack et al., 2020; Mustanski et al., 2016; A. L. Roberts et al., 2011, 2012). A hypothesized reason for the disparity in EBI engagement and effectiveness is that marginalized identity renders adolescents more likely to experience chronic structural stressors or persistent stressors related to their environmental circumstances (e.g., poverty, community violence, and discrimination) that further exacerbate psychological problems and are not adequately targeted in EBIs (Vines et al., 2017; Williams et al., 2019). Regarding PTSD, the presence of chronic structural stressors is associated with greater symptom severity and chronicity among marginalized groups, even when receiving evidence-based psychological treatment (McClendon et al., 2021; Mekawi et al., 2021; Sibrava et al., 2019).

An additional challenge may be that the ongoing unpredictability of chronic structural stressors is incompatible with the focus of PTSD interventions. As stated above, a key goal in clinical interventions for PTSD is to increase the adolescent's sense of safety and control over their environment, given that traumatic events are largely unexpected and beyond the youth's control. Similarly, the chronic structural stressors that marginalized youths face are also unexpected and beyond their control, likely diminishing youth's sense of safety and perhaps limiting opportunities for posttraumatic growth. Chronic stressors, often referred to as "daily stressors," significantly influence PTSD symptom severity above and beyond the influence of trauma exposure (K. E. Miller & Rasmussen, 2010). It is hypothesized that the presence of chronic structural stressors leaves marginalized individuals with fewer available resources to cope with the consequences of trauma exposure and maintains the heightened reactivity of the stress response system, therefore diminishing intervention effectiveness (Ayazi et al., 2012; H. N. Miller et al., 2021; K. E. Miller & Rasmussen, 2010; Mock & Arai, 2011; Sibrava et al., 2019).

Despite evidence that suggests that chronic structural stressors play a significant role in PTSD etiology and recovery, attention to such stressors in EBIs following trauma exposure is limited, and scholarship regarding the presence of these stressors in therapy sessions is scant (Bryant-Davis, 2019; Carlson et al., 2018; Gómez et al., 2021; Livingston et al., 2020; Sibrava et al., 2019). The lack of direct attention to structural stressors in trauma-focused EBIs in favor of targeting individual-level behaviors is hypothesized to make EBIs less acceptable to marginalized populations and, therefore, may be a driver of lower treatment engagement and effect sizes (Carlson et al., 2018; Dixon et al., 2016; Maercker & Hecker, 2016).

Researchers have called for making existing trauma-focused EBIs more responsive to chronic structural stressors in service of improving disparities in treatment response and engagement among marginalized groups (McClendon et al., 2021; Mekawi et al., 2021). We posit that one reason why clinical scientists have yet to identify an appropriate solution for attending to chronic structural stressors within psychological interventions is that, while there is evidence that such stressors impact the efficaciousness of psychological interventions broadly, the actual frequency of the disclosure of such stressors as well as their content and context within individual client therapy sessions are unknown.

The purpose of the study was to use qualitative analysis of audio-recorded therapy sessions to investigate how diverse, low-income adolescents talk about chronic structural stressors during short-term trauma-focused therapy sessions. Specifically, this study aims to elucidate how often participants disclose chronic structural stressors in therapy, the types of chronic structure stressors that are disclosed, as well as the context in which chronic structural stressors are disclosed, and the content of these disclosures. This study is novel in that it allows for the unique opportunity to examine the natural emergence of chronic structural stressors within a treatment that, although delivered to a diverse group of minority-status clients, did not explicitly focus on identity, culture, or associated structural stressors. Results from the study may highlight strategies for considering chronic structural stressors in therapy in service of improving EBIs for marginalized youth with trauma exposure.

Method

Participants and Design

Participants were recruited as part of a pragmatic feasibility trial of the Primary Care Intervention for PTSD (PCIP): a novel, short-term treatment for adolescent PTSD to be delivered in primary care with existing clinic staff (Ng et al., 2023; Srivastava et al., 2021). The PCIP is delivered in three therapy sessions and targets several mechanisms to reduce PTSD symptoms, including psychoeducation, breathing retraining, and coping skills (Srivastava et al., 2021). The intervention was delivered in Boston Medical Center (BMC), a large safety net hospital that primarily serves minority-status individuals, with 72% of clients insured by publicly funded insurance, such as Medicaid (Ng et al., 2023; Srivastava et al., 2021).

Participants were clients within the Adolescent Medicine multidisciplinary clinic at BMC and were referred to the study by clinic staff. Participants were eligible for the study if they experienced clinically significant PTSD symptoms or had a PTSD diagnosis. Study staff contacted eligible participants to obtain informed consent if they were over 18 and parents of eligible participants if they were under 18. Participants were then recruited to the study and completed pre- and post-treatment quantitative and qualitative assessments to assess symptom change and the acceptability of the intervention. The therapists were three clinical social workers employed in the Department of Pediatrics at BMC. The therapists self-identified as White/European American women and held master's degrees in social work. The therapists were trained to deliver the PCIP through two half-day trainings delivered by the developer of the intervention (L.C.N.). Further information regarding the details of the study design can be found in Ng et al. (2023).

Data Collection

Qualitative data came from audio-recorded individual therapy sessions. In total, there were 23 participants referred to participate in the feasibility trial. Of those participants, 20 consented to the trial, and 19 completed the preassessment. Of the 19, four participants no showed to the first session and were unable to be reached, and one participant canceled and declined to participate. Therefore, only 14 completed at least one therapy session. In total, seven (50%) participants completed all three therapy sessions, four (28.5%) participants completed two therapy sessions, and three participants completed just one therapy session (21.4%). Participants often missed scheduled therapy sessions, which then had to be rescheduled. The average number of missed sessions per participant was two. However, one participant did not have any therapy sessions recorded and is

therefore excluded from the present study. Participants completed 32 therapy sessions, of which 25 sessions were recorded and transcribed. Seven therapy tapes were missing from the data analysis because they were not recorded by the therapists conducting the therapy sessions. One recording of a therapy session was prematurely cut off, likely due to the recording device either being switched off or running out of battery power.

A demographic questionnaire was also created for the feasibility trial of the PCIP intervention and was utilized to obtain information on participants' self-reported race/ethnicity, age, gender, education, and prior utilization of mental health services to contextualize the qualitative data. Additional demographic information, when available, was obtained by reviewing participant's medical charts or from information disclosed during taped therapy sessions. There were 13 participants included in the sample, the majority of whom (92.31%) were racial or ethnic minority adolescents. Participants were between 14 and 22 years old. Two participants identified as transgender women, one identified as a transgender man, nine identified as cisgender women, and one identified as a cisgender man. Four participants disclosed lesbian, gay, bisexual, or queer sexual orientation during the therapy sessions.

Data Analysis

Taped therapy sessions were analyzed using a mixture of deductive and inductive thematic content analysis (Fereday & Muir-Cochrane, 2006; K. Roberts et al., 2019). To start, the first author (G.C.), who is a doctoral student in clinical psychology with training in trauma-focused psychological interventions and qualitative research methods, utilized deductive content analysis to develop a preliminary codebook. The preliminary codebook, including code labels, definitions, and descriptions, was based on a review of relevant literature and the research question. A team of four undergraduate research assistants was then trained on codebook application by the first author. As part of this process, the research aims, codes, and definitions were explained to the research assistants, who were then asked to apply the codebook to a sample transcript. The research team met to correct mistakes and answer questions. Then, the research team applied the preliminary codebook to five additional transcripts, such that each additional transcript was coded by the first author and two research assistants. Inductive content analysis was utilized at this stage in the coding process as the research team noted the emergence of new themes within the transcripts and possible changes to existing codes. The research team met weekly to review progress in coding and memos and to update the codebook based on new information gathered from the transcripts. Disagreements between coders were settled by consensus. After data saturation was reached and a finalized codebook was developed, the final codebook was applied to all of the transcripts utilizing Taguette, an open source qualitative coding software (See Supplemental Materials for final codebook; Rampin et al., 2019). The finalized codebook included code labels, definitions/descriptions, qualifications or exclusions, and examples.

The finalized codebook was applied to each transcript, including the transcripts utilized during training and development of the final codebook. Each transcript was coded by two research assistants. Research assistants were asked to write memos while coding regarding patterns in code applications they noticed that were relevant to the disclosure of chronic structural stressors. The first author reviewed each transcript and identified discrepancies in the application of codes by the research assistants. Discrepancies and patterns in memos were discussed and resolved by consensus within weekly coding team meetings. Cohen's Kappa was calculated on the preconsensus coded transcripts to determine intercoder reliability ($\kappa = .86$, across all codes).

Once data were coded, data analysis focused on determining how frequently chronic structural stressors emerged within therapy sessions by computing how many transcripts the "structural stressors" code was applied to. Qualitative thematic analysis was utilized to identify themes in the content and context of chronic structural stressors disclosure (Braun & Clarke, 2006).

Results

Aim 1: How Often Are Chronic Structural Stressors Disclosed Within Therapy Sessions?

The code "structural stressors" was applied to therapy transcripts in service of assessing how frequently participants spontaneously mentioned chronic stressors related to their environment or minority identity status. Chronic structural stressors mentioned by participants included lower socioeconomic status, discrimination, lack of community resources, tenuous living situations, family incarceration, unequal policing, and the presence of community violence. We included an additional code: "identity," to capture when participants explicitly mentioned a characteristic of their identity, including race/ethnicity, gender identity, or sexual minority status. The identity code was utilized to examine how often participants explicitly mentioned their identity status(s) and whether participants explicitly linked the presence of structural stressors to their identities.

The "structural stressors" code was applied at least once in at least one therapy session for ten out of thirteen participants, suggesting that chronic structural stressors do naturally emerge within therapy sessions with marginalized adolescents. Please see the Supplemental Materials for a table with example quotes from each transcript.

Only two out of 13 participants explicitly verbally linked the presence of structural stressors to their identity. When participants did link the presence of a structural stressor to their identity, it was often because the salience of a particular stressor was magnified due to one or more minorized identity statuses of the participant. For example, a participant mentioned her identity as a transgender woman to describe how her living in her current all-male foster care group home was especially stressful:

> It is a male group home. I am not a male. Yes. You heard that correctly. And I'm living there right now, and it is killing me'cause I want to smack them all 24/7.

However, the association between the presence of a chronic structural stressor and marginalized identity status was typically less explicit in exchanges between participants and therapists. For example, one participant described how his identity status as a gay man has limited his ability to seek social support from a straight male friend.

> Straight guys and gay guys have an interesting relationship, all of them. … My relationships with a lot of straight men, I tend to walk on eggshells around them cause like you don't want to do something to keep them out. You don't want to do something to push them away.

Aim 2: What is the Context During Which Chronic Structural Stressors Are Disclosed, and What is the Content of These Disclosures?

Thematic analysis revealed three patterns of when participants were most likely to disclose chronic structural stressors: when structural stressors (1) exacerbated psychological distress, (2) impacted treatment engagement, and (3) decreased intervention effectiveness.

Chronic Structural Stressors Exacerbating Psychological Distress

Participants described chronic structural stressors exacerbating their existing psychological distress. The stressors participants disclosed as exacerbating their distress were socioeconomic status, family incarceration, community violence, and their living situation. Notably, participants often described complex relationships between different kinds of structural stressors impacting their existing psychological symptoms. For example, a participant described the chronic structural stress of her socioeconomic status exacerbating the impact of family interactions leading to negative self-evaluations:

> And then like she's like mentally ill as well so. … She just lashes out. I don't really have a lot of money, but when she asks, I feel bad not giving it to her, so then I get angry at myself … all the grown-ups in my life, I've been taking care of them for years and they expect things of me. When am I going to be able to take care of myself?

Another participant described how the structural stress of the threat of community violence in her neighborhood has made her more fearful:

> When I go outside, especially like when I'm walking to the train, I feel like I have to be on the phone with somebody. Like, I can't just walk outside to the train cause I feel like something is gonna happen. There's like a lot of violence in [neighborhood], so I always feel the need. … I have to be on the phone.

The same participant went on to describe how unequal policing and a lack of adequate access to health care in her neighborhood has exacerbated feelings of anger following a traumatic event:

> I was also angry with what the police cause the-There's a police station right there. I don't understand why, there's like so much violence, and the ambulance they don't come on time. Every time they get transferred here, they don't make it.

Participants also reported that structural stressors have contributed to their sense of alienation from their community. For example, one participant described how the disparity between her socioeconomic status and that of her friend's has led to interpersonal problems and a lack of perceived understanding:

> I just feel like [my classmates] don't understand me. Yeah, like they just don't get it … my roommate, she is privileged, and, um, I'm just-I go to school, and I go to work. Like I'm really not … they don't understand. She's like, "Why do like working so much?"

Chronic Structural Stressors Impacting Treatment Engagement

Several participants stated that structural stressors, most often related to their socioeconomic status, impacted their ability to engage in the requirements of the PCIP. The individuals served at the hospital where the study took place are largely below the poverty line and, therefore, face a greater magnitude of uncertainty regarding their income and access to necessary resources. Uncertainty regarding work schedules was a particular barrier for participants scheduling therapy sessions in advance. An inconsistent schedule also impacted participants' ability to make a plan to ensure between-session homework completion, which was a specific treatment component of the intervention:

Therapist: *What is a time of day that you feel like you might be able to practice it and it's not a stressful time?*

Participant: *That's hard because. … I work all the time.*

Therapist: *How many times a week do you think you-is realistic for you to try to do it? And again, only for a few minutes each time. We're just trying to help build the habit.*

Participant: *… Maybe … depends. I mean, I work so many hours at work. … I don't know.*

Another participant reported that she had to work numerous hours each week to make ends meet, which resulted in overall exhaustion and limited time to complete therapy homework assignments:

> When I'm not working, I'm sleeping. … And when I'm not sleeping, I'm working. So, that thirty minutes a day or even twenty-five minutes a day can be very hard to find.

Chronic Structural Stressors Impacting Perceived Intervention Effectiveness and Acceptability

Finally, one participant explicitly described how structural stressors impacted her perceptions of intervention effectiveness and, therefore, her willingness to remain engaged in therapy. The participant dropped out of the study after two therapy sessions. This participant was a transgender woman of color who was involved in the foster care system. She had undergone several traumatic events and faced chronic discrimination that rendered her more likely to become retraumatized. For example, despite being a transgender woman, the participant was placed in a foster group home for males. Analysis of this participant's therapy transcripts revealed explicit examples of intervention components being incompatible with the chronic structural stressors the participant faced, particularly considering continued discrimination and a lack of agency in ensuring her future safety. She explicitly described how the relaxation and psychoeducation skills introduced in the intervention were not suitable for targeting the distress associated with the traumatic events she has faced and continues to face due to her identity and associated structural stressors:

> I was forced to become an adult before I was ready. I had to take care of myself. I had to feed myself. I went to a place where I was different. I knew I was different, and when I came out as different, I was abandoned again. I lived on the streets. I am homeless … It's like, you know, there's like a whole bunch of things that I could have control over if I ha-if I have the ability, but I don't. … I have to look my trauma in the face every single day. The lack of control. The lack of power. And so, when

you have to look at your trauma every day, how do you cope with it? You can't.

The same participant went on to describe how messages she has received in treatment regarding feeling safe after trauma exposure are incompatible with the dangers she is exposed to, given her identity as a transgender woman of color:

Participant: *Participant: I'm scared of everything, and it's because I have to be because I don't have the luxury of nothing bad is gonna happen because being who I am means everything bad can happen. I could die leaving here. [laughs] … Those things sit with me, and although I don't think about them because that's way too depressing, I don't have the luxury to not think about them also.*

Therapist: *Mhm. I hear what you're saying. … The world's not a safe place for you. So, to say-to try to teach yourself or tell yourself that it is safe is potentially really dangerous.*

Discussion

There is growing empirical evidence to suggest that chronic structural stressors have a salient impact on the effectiveness of trauma-focused psychotherapy, particularly for marginalized populations. However, the nature of discussions on how structural stressors arise during therapy sessions is unknown. We used qualitative thematic analysis to examine how often and under what conditions chronic structural stressors emerge within therapy sessions with marginalized adolescents with trauma exposure. We found that a range of chronic structural stressors emerged in therapy sessions and that stressors often exerted mutual influence on one another. Additionally, chronic structural stressors were related to psychological distress, treatment engagement, and intervention effectiveness.

Structural stressors were mentioned in therapy sessions with 77% of study participants, suggesting that therapy clients with marginalized backgrounds are likely to mention chronic structural stressors, even when discussion of such stressors is not an explicit component of the intervention. The frequency at which participants explicitly disclosed stressors is consistent with research suggesting that marginalized individuals with trauma exposure are likely to experience frequent discrimination (Brooks Holliday et al., 2020; Sibrava et al., 2019) and expands on existing research by providing preliminary evidence that chronic structural stressors, such as experiences of discrimination, are likely to be explicitly mentioned by clients in therapy sessions. Although the sample size of the present study was small, the frequency at which participants disclosed chronic structural stressors within a brief three-session treatment suggests that similar disclosures are likely occurring within many therapy sessions with marginalized clients. This result is particularly striking given the overall lack of guidance in mainstream EBIs regarding how best to acknowledge structural stressors in treatment or address their impact on clients' symptomatology and treatment engagement.

Participants often described stressors that inherently exert a disproportionate impact upon marginalized individuals, such as community violence, financial stress, and discrimination. There were several instances when participants explicitly identified their minority status as contributing to the salience of structural stressors, but there were also many instances within therapy sessions wherein the connection between stressors and identity was simply implied. Therefore, the onus was often on the therapist to have knowledge regarding how systemic inequality disproportionately impacts marginalized participants and to make the connection between the stressors that participants described and overarching systems of oppression. For example, one participant reported significant alienation from friends in college due to differences in their socioeconomic statuses. The participant did not explicitly state that her interactions with her friends were influenced by classism, yet she reported that her higher-income friends had more privilege than her, which resulted in interpersonal conflict. In this exchange, the therapist had to recognize the connection between the described stressor and the systemic inequality the participant was exposed to in order to make sense of the salience of distress experienced by the participant.

Our results suggest that therapy clients are likely to mention chronic structural stressors in the context of such stressors exacerbating existing psychological distress. This finding is in line with existing research suggesting that higher exposure to chronic structural stressors may exacerbate psychological symptoms, even when individuals receive psychotherapy (Brooks Holliday et al., 2020; Price et al., 2021, 2022; Sibrava et al., 2019). Our results also highlight that individuals receiving therapy services seem to be explicitly aware of the impact that chronic structural stressors are having on their symptoms. Taken together, this result highlights the need for incorporating guidelines regarding the discussion and consideration of structural stressors within psychological interventions and how this content may maintain psychological distress.

Notably, many participants in the present research study reported satisfaction with the treatment and had positive treatment outcomes in terms of symptom reduction (Ng et al., 2023). However, there were several participants who explicitly reported that the presence of structural stressors impacted their ability or desire to engage in the intervention. This finding suggests that a one-size-fits-all solution to attending to structural stressors within therapy sessions may not be feasible.

Several participants described structural stressors as being a barrier to engagement in the intervention. Stressors related to participants' socioeconomic statuses made it particularly challenging for them to attend sessions and complete therapy homework assignments. This finding suggests that marginalized individuals likely face additional barriers to participation in EBIs, which may lead to lesser treatment engagement and perhaps a lower dose of the therapeutic intervention. Since financial stressors were a particular barrier to treatment completion, interventions aimed at increasing session attendance may be particularly helpful for retaining low-income, marginalized adolescents in care. Accessibility promotion interventions, or those aimed at making therapy services more convenient to access (e.g., offering free transportation to therapy sessions), may improve engagement for this group, given the challenges low-income marginalized adolescents face in attending weekly therapy sessions (Becker et al., 2018).

One participant identified structural stressors as negatively impacting her desire to engage in the intervention. She reported that the components of the intervention were incompatible with her symptom presentation and associated chronic structural stressors.

Notably, this participant's intersectional minority identity rendered her particularly likely to be exposed to multiple and interacting chronic structural stressors. For example, the participant reported that the treatment mechanisms included in the intervention were not useful in reducing PTSD symptoms amid the constant discrimination and threats of community violence she faced due to her transgender identity and racial minority status. These threats were further heightened for the participant due to her identity as a formerly homeless youth. This finding supports existing claims that the lack of attention to chronic structural stressors within EBIs for PTSD is related to the lower levels of treatment engagement and adherence observed among marginalized groups (Carlson et al., 2018; Dixon et al., 2016; Maercker & Hecker, 2016). It also suggests that adapting EBIs to directly address the influence of structural stressors within PTSD treatment may be necessary for individuals like this participant, particularly when considering the influence of discrimination and delivering care to adolescents with intersecting marginalized identities. This result is in line with scholarship recommending a data-driven approach to EBI adaptations (Lau, 2006). Taken together, these results could provide an explanation for the conflicting research evidence regarding whether cultural adaptations to evidence-based treatment are more efficacious than standard EBIs (Arundell et al., 2021; Castro et al., 2010; Escobar & Gorey, 2018; Healey et al., 2017). Perhaps the efficaciousness of culturally adapted interventions is moderated by the unique experiences (e.g., chronic discrimination) and associated treatment needs of the individual.

A final theme was that chronic structural stressors were often related to study participants lacking autonomy, control, and decision-making power. Notably, the participants in the study were adolescents, an age group that often does not have autonomy or control over their environment. Additionally, the marginalized status of the adolescents rendered them more likely to experience chronic structural stressors (e.g., their living situation, level of community violence, and shifting work schedules) that further exacerbated their lack of autonomy and control. We posit that the lack of autonomy, control, and decision-making power may be a primary mechanism through which chronic structural stressors decrease PTSD treatment effectiveness and acceptability for marginalized groups. The goal of PTSD treatment is to increase the client's sense of safety and control over their environment after experiencing a traumatic event wherein that client's sense of safety and control was taken away. However, the chronic stressors that marginalized adolescents face may drastically limit their ability to exert control over their environments in service of building a personal sense of safety and power. Existing PTSD EBIs do not provide clinical guidance regarding how to deal with this reality. Therefore, existing PTSD interventions may be less efficacious for marginalized youths because they do not account for the environmental constraints of chronic structural stressors.

Clinical Implications

Our findings have several clinical implications. Overall findings from the present study suggest a need for provider training regarding the influence of chronic structural stressors on psychological functioning, with a particular focus on how systemic inequality may impact symptom severity and presentation. It is recommended that clinicians seek out training in this domain and that graduate programs include this information in their standard coursework. In the present study, participants were likely to experience a range of chronic structural stressors that influenced the severity of their psychological distress. The treatment within the present study relied on participants spontaneously disclosing such stressors, and there was significant diversity regarding how structural stressors contributed to experiences of distress. It is recommended that future clinicians take time to assess the range of structural stressors that their clients are facing in service of increasing shared understanding within the therapeutic relationship. Clinicians are advised to respond to disclosures of chronic structural stressors with empathy and validation. We also recommend that, to the extent possible, clinicians engage in case management activities to mitigate the impact of chronic structural stressors on the lives of their clients. Ultimately, these strategies may increase therapeutic alliance and assist the clinician in forming a strong case conceptualization.

Our findings revealed that structural stressors related to socioeconomic status stood out as a salient barrier to intervention engagement. Therefore, clinicians may benefit from utilizing established interventions to improve engagement, such as accessibility promotion or problem-solving, to facilitate continued participation in treatment despite said stressors. For example, clinicians may utilize a more flexible scheduling policy for clients with variable work schedules or may adapt therapy homework assignments to be completed more flexibly.

Chronic structural stressors directly influence the severity of psychological distress, treatment engagement, and the acceptability of psychological interventions. However, it is more than likely that structural stressors impact clients' mental health in a myriad of ways not captured within the therapy room. Improving psychological interventions to address chronic structural stressors is one potential avenue to reduce mental health disparities among marginalized groups, but clinicians must go beyond the therapy room to truly contribute to impactful change. Clinicians should strive to get involved in public health and policy interventions aimed at decreasing structural inequality on the city, county, state, and national levels. For example, clinicians may become involved in efforts to reverse laws maintaining discriminatory practices. Another avenue for intervention may be for clinicians to leverage their expertise on the mental health implications of structural inequality to lobby for a more equitable division of resources within their communities (e.g., advocating for affordable housing). If clinicians shift their focus from the care of a single client to the care of the community, the impact on the lives of marginalized individuals is likely to be more pronounced.

Limitations

There were several limitations to the present study. First, the sample size in the study was small, and each participant received a maximum of only three therapy sessions. The sample had limited variability in gender identity, particularly in that there was only one cisgender male in the study. The therapists in the study were also homogeneous, as they were all White/European American cisgender women. It is possible that the identity status of the therapists impacted participants' willingness to disclose structural stressors. Therefore, the generalizability of these results is unclear. Future research studies may examine when and how structural stressors emerge within therapy sessions across different treatment modalities and lengths, as well as in therapy sessions delivered by a diverse

range of providers. Researchers should also examine structural stressors in therapy sessions with larger and more diverse samples of adolescents, with a particular focus on adolescents with intersecting marginalized identities. Additionally, although the present study provided preliminary results regarding how the disclosure of structural stressors in therapy sessions may be associated with treatment engagement and acceptability, the mechanisms driving these relationships remain unclear. Future studies should focus on examining the relationship between clients' experiences of chronic structural stressors and treatment effectiveness and engagement, with a particular emphasis on malleable mechanisms connecting stressors to outcomes. A final limitation was that study participants were not directly asked about how chronic structural stressors impact their experience of trauma-focused therapy. Instead, we relied on the naturalistic emergence of relevant themes within therapy sessions. Therefore, the relevance of chronic structural stressors within therapy sessions may be greater than what has been reported in this article.

However, the naturalistic emergence of themes within this research study is also a significant strength of the study. Although the participants were never explicitly asked about the influence of chronic structural stressors on their symptoms and experiences in treatment, participants often brought up these themes within their therapy sessions. To our knowledge, this was the first study to examine how structural stressors naturally emerge within therapy sessions, and our findings suggest that these stressors are an important factor to consider when delivering care to marginalized groups exposed to trauma. Simultaneously, current high-quality, evidence-based PTSD interventions seldom include concrete guidance regarding how to target structural stressors in care. Therefore, there is a missed opportunity to improve the effectiveness of interventions for PTSD by incorporating intervention elements that directly target structural stressors. We hypothesize that if interventions for PTSD included clear evidence-based suggestions for targeting chronic structural stressors within therapy, treatment engagement and response among marginalized groups would significantly improve. Therefore, future research studies should continue to investigate chronic structural stressors within therapy sessions, with a particular focus on appropriate means of therapeutic response when such stressors emerge.

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