HINDERING HEALTH EQUITY: OPPRESSION AND WHITENESS PERVADE TRAUMA, SUBSTANCE USE, AND THERAPY

By

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ABSTRACT

Co-occurring posttraumatic stress disorder and substance use disorder (PTSD/SUD) is a serious public health issue affecting millions. Compared to White people, people of color endure more chronic and severe cases of PTSD/SUD due to their heightened exposure to common risk factors (i.e., interpersonal violence) and to unique risk factors (i.e., racial discrimination) associated with the disorder. Despite this, they are significantly and systematically underrepresented in PTSD/SUD clinical research. There is also a lack of research on culturally tailored treatments for people of color and on addressing their unique issues. Consequently, current treatments may not meet their needs, which may explain their high treatment dissatisfaction and dropout rates. This qualitative study sought to address this gap by determining whether and how race and gender matters are relevant to PTSD/SUD and how clinics and clinicians' handling of these matters impact people of color's therapeutic experience. We found that oppression significantly contributes to PTSD/SUD incidence, exposure to discrimination exacerbates PTSD/SUD symptoms, and people of color wanted to address these issues in therapy. We also found that people of color seldom noted visible representation of staff of color in clinics and encountered discrimination from clinic staff. This made them feel unwelcome in clinics. Further, when people of color attempted to address matters of oppression and discrimination in therapy, clinicians invalidated their experiences or were underprepared to address them. This ruptured the client-therapist therapeutic alliance and made people of color either seek a new therapist or terminate treatment altogether. Our findings demonstrate the necessity of fostering a health equity focus in PTSD/SUD research so clinics and clinicians can address matters of oppression and discrimination appropriately.

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Introduction

It is a peculiar sensation, this double-consciousness, this sense of always looking at one's self through the eyes of others, of measuring one's soul by the tape of a world that looks on in amused contempt and pity. One ever feels [their] two-ness.

W.E .B. Dubois (1911, 1997, pg. 38)

Although the exact prevalence estimates are unknown, some researchers postulate that Indigenous, Black, and Latine[1] people have similar, if not higher, rates of co-occurring posttraumatic stress disorder (PTSD) and substance use disorder (SUD) as White[2] people (Blanco et al., 2013; Emerson et al., 2017; Reid & Buchanan, 2024b). Researchers have also found that compared to White people, racially oppressed groups are exposed to higher rates of risk factors for this disorder, including adverse childhood experiences, interpersonal violence, and poverty (Kessler et al., 2014; Roberts et al., 2011). Further, they are exposed to unique risk factors associated with co-occurring PTSD and SUD (herein PTSD/SUD), including racial discrimination and historical trauma (Alegría et al., 2013; Bird et al., 2021; Gone et al., 2019; Hall-Clark et al., 2016). Lastly, scholars have found that oppressed groups[3] face a disproportionate negative burden of PTSD/SUD compared to White people, including a more severe and chronic course of symptoms, multimorbid physical conditions, homelessness, and early mortality (Blanco et al., 2013; McGuire & Miranda, 2008; Simpson et al., 2019).

Despite these findings, racially oppressed groups are significantly and systematically under-included in PTSD/SUD clinical studies, and researchers rarely construct and test culturally

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[1] The Spanish language traditionally assigns gender to nouns. My use of "Latine" is an attempt to adopt the use of a gender-neutral term within the grammatical structure of the Spanish language.

[2] We have intentionally used lower case when referring to the construct "whiteness," which is not a race but a phenomena linked to but not solely predicated on race. In contrast, we use upper case describing a racial/ethnic group (e.g., "White" "Black").

[3] When using the term "oppressed groups," I am primarily referencing men and women of color. Indeed, statements and conclusions may be applicable to other traditionally marginalized groups (e.g., LGBTQ+). Yet, little PTSD/SUD research to date focuses on these groups; therefore, the scholarship organized into my introduction section is focused on people of color.

appropriate interventions and have not developed and tested treatments for these groups' unique risk factors (Reid & Buchanan, 2024a, 2024b). Rather, White people comprise nearly 60% of those studied in PTSD/SUD research despite potentially only comprising 40% of diagnostic cases, and researchers mostly study the traumas that are primarily experienced by White men (e.g., combat trauma; Simpson et al., 2019; Table 1). This may explain why people of color are more likely to terminate treatment early and suffer from PTSD/SUD longer than White people (Lester et al., 2010).

Given the significant lack of research attention to oppressed groups' PTSD/SUD, this qualitative study established the importance of and need for racial/gender-appropriate treatment. The research questions for this study were: a) how are matters of race and gender relevant to PTSD/SUD; b) how does the clinic and clinician's handling of race and gender concerns impact the therapeutic experience of oppressed groups? This study's purpose was to highlight the importance of ensuring PTSD/SUD research and clinical treatment is relevant to oppressed groups' needs. I used semi-structured qualitative interviews to answer this study's questions and interviewed twenty-three people across four states. Finally, feminist standpoint theory framed this study. This framework asserts that oppressed groups experience different and unique life circumstances that are often ignored in knowledge production and that if scholarship is to apply to them, it must be framed by and for them. Michigan State University's Institutional Review Board approved this study (IRB00009375; Appendix C).

Theoretical Framework: Feminist Standpoint Epistemology

Feminist standpoint epistemology (also known as standpoint theory) emerged from various fields as a critique of White men's dominance over science and how they shaped science in ways that prioritize their interests and neglect the needs of other groups, particularly those oppressed by race and gender (Collins, 1986; Harding, 1991; Hooks, 1989; Intemann, 2010; Toole, 2021). Standpoint theory has several fundamental propositions (Harding, 1991; Intemann, 2010): a) the situated knowledge thesis- people's experiences and access to knowledge depend on their positioning on a social gradient and that White men's situatedness dominates knowledge production; b) the thesis of epistemic advantage- oppressed groups have experiences and access to knowledge based on those experiences that are peripheralized in science; and c) the need for generating knowledge from oppressed people's lives to enhance the objectivity and applicability of science to all groups. I discuss each below.

Situated Knowledge Thesis

All Knowledge Production is Socially Situated

Structural oppression (e.g., racism and sexism) stratifies different groups into different social positions (e.g., White people are dominantly situated, and people of color are subordinately situated; Hartsock, 1983; Delgado, 2023). Stratification influences people's living conditions, experiences, constraints, and opportunities (Harding, 1992, 2004). Consequently, different groups have different and sometimes unique life experiences. For example, a society structured by patriarchy stratifies women into a subordinate position to men (Hunnicutt, 2009; Krahé, 2018). Patriarchal stratification increases women's risk of gender-based violence (Homan, 2019) because patriarchy facilitates male power and privilege over women and a permissive social attitude toward violence against women (Krahé, 2018; Mesok, 2016). To illustrate, a study of victimization rates of women in 16 countries showed that the more patriarchal a country's systems were, the higher women's victimization rates were (Archer, 2006). Women's subordinate situatedness means they must navigate unique threats that men do not.

Second, research shows the questions investigators ask, areas of investigation they pursue, and conclusions they draw can differ depending on their race and gender, meaning researcher situatedness informs research questions and answers (Collins, 1986; Hofstra et al., 2020). Indeed, this is not always the case, and one can conduct research from an alternative situatedness. Yet, the position we most likely start from reflects our situatedness (Sprague, 2016). Thus, the makeup of scientific knowledge reflects the situatedness of those conducting science (Zuberi & Bonilla-Silva, 2008), and most researchers are White men– the most privileged group in the U.S. (Docter-Loeb, 2023; Kena et al., 2016). White men dominate publications in top academic journals (Tanne, 2022). White men's research is more frequently cited than other groups (Kozlowski et al., 2022). White men are more likely to be included in research than others (Knepper & McLeod, 2018). Lastly, White men are more likely to hold positions as journal editors and reviewers (Buchanan et al., 2021). This issue applies to all science, including psychology (Roberts et al., 2020). This is problematic because White men's privileged situatedness (Hartsock, 2019; Wylie, 2012) dominates research, meaning the experiences of others are peripheralized in science (Collins, 2020).

The Thesis of Epistemic Advantage

This thesis argues that marginalized people can recognize issues of power and oppression more readily than those in privileged positions (Intemann, 2010). According to standpoint theorist Patricia Hill Collins, epistemic advantage stems from the "insider-outsider" positionality marginalized group members typically occupy (Collins, 1986). According to Collins, marginalized group members must understand and navigate the assumptions constituting the dominant group's worldviews, thereby learning to act as insiders. Simultaneously, they often have experiences that conflict with that of dominant groups, revealing the disjuncture between oppressed and privileged group experiences and reflecting their outsider positionality. This disjuncture produces an epistemic advantage for oppressed groups by highlighting instances where the dominant group's experiences and knowledge differ from those of oppressed groups. Therefore, the epistemic advantage of marginalized group members is identifying limitations or problems with the dominant groups' background assumptions and scientific norms.

The "God Trick"

The situatedness of knowledge production is seldom acknowledged in mainstream science (Sprague, 2016). Often, researchers understand science to be an enterprise of impartiality. In fact, some argue that centering oppressed groups' perspectives in science hampers objectivity by introducing values into a “value-free” enterprise (Landau, 2008). However, standpoint theorists argue that all science is value-oriented, and that recognizing values in knowledge production *strengthens* objectivity. According to standpoint theorist Donna Haraway, claims of impartiality in knowledge production are "god trick" claims– statements that only a god who could see everything from above could make (Haraway, 1988). Haraway asserts that researchers claiming impartiality obscure their subjectivity and its influence on their work. Moreover, claims of value-neutrality make a project *appear* less partial than projects that explicitly link values with knowledge production. Because value-neutral knowledge claims appear less partial, they are deemed more objective. Consequently, the knowledge produced from "impartial" projects and the situatedness informing them are centered and made authoritative.

This creates power differences across scientific domains that superordinate "impartial" knowledge and peripheralize explicit values-driven knowledge projects (Rolin, 2009).

Most standpoint projects focus on producing knowledge with and for marginalized groups and acknowledge the values woven into these projects (Harding, 1991). Consequently, standpoint projects are peripheralized (Pereira, 2017); therefore, knowledge for marginalized groups is obscured (Collins, 1990; Cowen, 2019). In contrast, because traditional research approaches are centered and build knowledge from/on privileged groups without acknowledging the values influencing these projects, the preponderance of centered and authoritative knowledge pertains to privileged people's situatedness (Fricker, 2007; Hartsock, 1983; Settles et al., 2021).

The consequence of this is that knowledge about and for marginalized groups is less readily available. This lack of availability creates a gap in our shared knowledge about marginalized groups and their experiences, strengths, and needs (Dotson, 2014). Additionally, this issue disadvantages researchers' abilities to make sense of marginalized people’s lives and/or assist them with their unique challenges (Fricker, 2007). For example, social science has little to say about how LGBTQ+ people navigate substance addiction recovery (Aromin, 2016). This lack of knowledge makes it difficult to determine how treatments affect LGTQ+ people and how clinicians can help them (Williams & Fish, 2020).

All knowledge is situated and shaped by social, cultural, and historical contexts. There is no such thing as a knowledge claim separated from one’s particular social location. Instead, all theories are value-laden, all methods are theory-laden, and all research results are methodology-laden (Longino, 2010; Longino, 1989). Therefore, all research efforts are values-driven (Longino, 1989; Sprague, 2016). Claims of value-neutrality hide this reality, obscure knowledge by and for those who are marginalized, and weaken the objectivity of science.

Strong Objectivity

Mainstream perspectives of objectivity associate it with value-neutrality (Harding, 1992). Standpoint theorists disagree. According to standpoint epistemology, objectivity exists on a continuum from "weaker" objectivity to "stronger" objectivity (Harding, 1992). A project has "stronger" objectivity when a researcher: a) explicitly acknowledges their positionality's influence on knowledge production; b) acknowledges their situatedness relevant to their interpretation of data (known as reflexivity); and c) works to incorporate knowledge for the oppressed into the mainstream (Harding, 1992; Intemann, 2010). Overall, a researcher's objectivity is strengthened or weakened depending on the degree to which each factor is present. Strong objectivity challenges traditional objectivity by acknowledging the relationship between positionality, reflexivity, and the inclusion/exclusion of certain groups in research. Critically examining these influences enables investigators to reveal their subjectivity and counteract power imbalances in knowledge production.

Starting Knowledge-Generation from the Lives of the Oppressed

Traditional research studies the oppressed as objects or subjects. Standpoint theorists argue that researchers must focus on building insights and theories directly from the lives of the oppressed to prioritize the knowledge and experiences of oppressed groups (Harding, 1991, 2006; Harding, 1986). Beginning research from oppressed people's lives means centering marginalized perspectives and experiences (Rolin, 2009). In practice, this approach involves actively seeking out and engaging with the stories and experiences of the oppressed– conducting interviews, using oral histories, or other methods that prioritize their perspectives. By doing so, standpoint epistemology aims to challenge and broaden traditional ways of knowing, generate more critical knowledge, and bring about social change.

Overall, standpoint epistemology emphasizes that all scientific knowledge is partial (Shulman, 1994). When the bulk of knowledge is produced from and supervised by one group, we can expect knowledge to reflect that group's partiality. Further, when that group is the dominantly situated one, "one can expect that… in systems of domination, the vision available to the rulers will be both partial and perverse" (Hartsock, 1983, pg. 285). Moreover, we can expect that knowledge for the oppressed remains absent or shrouded from the wellspring of scientific knowledge. Standpoint theory emphasizes the importance of centering the perspectives of the oppressed in research to challenge dominant knowledge systems and advance knowledge.

Brief Detail of PTSD/SUD and PTSD/SUD Health Disparities

Prevalence

Posttraumatic stress disorder (PTSD) is the most prevalent psychopathological result of exposure to a traumatic event. Traumatic events are experienced as distressing and overwhelming and surpass the individual's ability to cope or integrate the emotions involved with that experience (Shalev et al., 2017). Indeed, not all people who are exposed to a traumatic event will develop PTSD; however, those who do subsequently endure a combination of biological, psychological, and social sequelae of issues stemming from the traumatic event (Shalev et al., 2017). Substance use disorder (SUD) is another common chronic and debilitating disorder and is the third leading cause of death in the U.S. (National Institute on Alcohol Abuse and Alcoholism [NIAAA], 2020). SUD contributes to a range of difficulties, including neurological changes eviscerating a person’s ability to control or abstain from using a substance, loss of friends and family, homelessness, and multimorbid physical and psychological disorders (Grant et al., 2015).

These disorders are two of the most common mental health disorders in the U.S. (Back & Jones, 2018) and despite several diagnostic criteria changes for each over the last several decades, they continue to be highly prevalent and co-occurring, meaning someone with one disorder is at great risk of experiencing the other (Smith & Cottler, 2018). In the U.S., those with PTSD (9% of the population) are 1.5 times more likely to meet SUD criteria, and 58% of people with PTSD have a co-occurring SUD (Goldstein et al., 2016; Simpson et al., 2019). Those with an SUD diagnosis (7.7%) have 1.3 higher odds of having PTSD than those without (Grant et al., 2015). In total, a national epidemiological survey estimates that over six million US adults experience PTSD/SUD (Simpson et al., 2019). Those with PTSD/SUD have worse health outcomes than those with only PTSD or SUD, including greater social and psychiatric impairment, higher rates of suicidal ideation and suicide attempts, homelessness, incarceration, and a higher magnitude of disabling comorbid physical and psychological disorders contributing to early mortality (Simpson et al., 2019).

Researchers have recently found that the prevalence of PTSD/SUD differs across racial/ethnic groups, but study results vary, and there is scant literature on the topic. Some studies estimate that Indigenous and Black people have the highest prevalence rates of PTSD/SUD, and White and Latine people have similar rates to one another (Blanco et al., 2013), whereas others report that prevalence is highest among White people (Breslau et al., 2003). Not only are there limited studies with conflicting evidence, but most studies using national data either do not report prevalence by race/ethnicity or group all people of color into a category called "racial minority" and compare their prevalence to White people (e.g., Simpson et al., 2019). Moreover, no studies report prevalence by race *and* gender. Consequently, it is difficult to estimate the prevalence of PTSD/SUD by race x gender groups (such as Black men or Asian women).

Despite these limitations, one can hypothesize that Indigenous, Black, and Latine people have PTSD/SUD rates equal to or higher than those of White people by drawing from PTSD and SUD prevalence data and a recognition of the comorbid nature of these disorders. Black, Latine, and Indigenous men and women have higher rates of PTSD than White men and women (Goldstein et al., 2016). Indigenous men and women have the highest rates of SUD (Center for Behavioral Health Statistics Quality [SAMHSA], 2021), and the prevalence of SUD across Black, Latine, and White men and women differs depending on the substance but is roughly equivalent to White men and women's prevalence rates (SAMHSA, 2021). Given these data, it is probable that people of color and White people have at least similar PTSD/SUD prevalence rates.

Risk Factors and Treatment Disparities

The U.S. is an inegalitarian nation-state structured by white supremacy, and this trenchant ideology has constructed racial stratification and inequality throughout the U.S., causing people of color to experience an onslaught of harm (Beliso-De Jesús & Pierre, 2020; Haeny et al., 2021). White supremacy has been indelibly linked to the trauma and addiction challenges people of color face by exposing them to higher rates of poverty and neighborhood disorder and the attendant issues of these challenges (e.g., violent victimization). Additionally, it has been linked to people of color's exposure to forms of discrimination that White people seldom experience and a lack of access to beneficial social resources that could address these challenges (Farahmand et al., 2020; Williams et al., 2023). For instance, because of the impoverishment and neighborhood disorder levied onto Indigenous, Black, and Latine people and the stressors accompanying these issues, they are more likely than White people to be exposed to interpersonal violence like child abuse and physical assault (Roberts et al., 2011), and PTSD is linked with these traumas more than any other (Kessler et al., 2014; Yehuda, 2002). Therefore, it is no surprise that Indigenous, Black, and Latine people have higher rates of PTSD and that this PTSD is most often due to interpersonal violence (Roberts et al., 2011; Goldstein et al., 2016).

People of color also face *unique* PTSD and SUD risk factors (Farahmand et al., 2020; Williams et al., 2023). To illustrate, Black people's chronic exposure to racial discrimination via overt acts of racism and/or microaggressions produces symptoms sufficient to meet the criteria for PTSD and enhances their risk for, and chronicity of, SUD (Bird et al., 2021; Blume et al., 2012; Desalu et al., 2019). Further, results from a longitudinal study of Black and Latine people showed that exposure to racial discrimination explains a significant amount of the variance contributing to one's diagnostic status for PTSD (Sibrava et al., 2019). This study also found that those experiencing racial discrimination have lower levels of symptom relief and more chronic PTSD *despite* receiving treatment. Additionally, research shows that historical, intergenerational trauma has elevated oppressed groups' genetic and social risks for the incidence and chronicity of PTSD and SUD (Gone et al., 2019; Skewes & Blume, 2019).

In sum, in comparison to White people, racially oppressed groups may have a higher or similar prevalence of PTSD/SUD. Moreover, they face a disproportionate negative burden of PTSD/SUD (Blanco et al., 2013). Therefore, using standpoint epistemology and drawing from an umbrella review (a review of research findings from systematic reviews and meta-analyses) of 74 PTSD/SUD studies (Reid & Buchanan, 2024), I will demonstrate that PTSD/SUD research is structured by whiteness, and clinical guidance for treating marginalized groups is exceedingly limited, placing marginalized groups at risk for experiencing discrimination in treatment.

Standpoint Critique of PTSD/SUD Research

Who is included in PTSD/SUD Studies

In our review of 74 studies across eight systematic and meta-analytic reviews of PTSD/SUD, the published clinical research to date included 52 randomized controlled trials, eight pilot studies, eight published protocol and feasibility studies, seven quasi-experimental studies, and one chart review (see Appendix A for our umbrella review methods, Reid & Buchanan, 2024). The racial composition of the 74 studies included ~56% White people, ~25% Black, ~9% Latine, 4% multiracial/other, ~2% American Indian/Alaska Native, and ~1% Asian participants (Figure 1, Table 1). None of the studies reported demographics by race *and* gender. These results reveal that most research findings about the clinical effectiveness of PTSD/SUD treatments are built from the experiences and inclusion of White people. Drawing from standpoint theory, because most research is built from White people, the majority of PTSD/SUD knowledge is likely applicable to White people's situatedness. Therefore, PTSD/SUD research is structured by whiteness (a state of normalized White racial domination; Lund, 2022; Mura, 2022) and can be rendered visible by the extent to which White people and their experiences are emphasized over people of color (Mura, 2022; Sue & Spanierman, 2020). To estimate this, one must explore the PTSD/SUD issues investigated by research and identify the extent to scholars make efforts to generate knowledge that is applicable to oppressed groups needs.

What Do PTSD/SUD Studies Examine

Combat Trauma

Although military sexual trauma is far more common and more likely among women (Lofgreen et al., 2017), most of the research that identifies a qualifying trauma focuses on military combat trauma. White men constitute the majority demographic in the military (Amaral et al., 2018) and are the majority of people engaged in military combat (Patten & Parker, 2011) . Thus, most PTSD/SUD research studies a trauma that White men most often experience (Roberts et al., 2011). It is problematic that PTSD/SUD research almost exclusively focuses on trauma experienced by White men. Doing so centers clinical knowledge on White men and peripheralizes knowledge by and for others.

Only One Culturally Adapted Study and Zero Race-Specific Studies

Finally, only one study tested a culturally adapted treatment for PTSD/SUD (Pearson et al., 2019), and none of the studies tested treatments specifically for the experiences and needs of racially oppressed groups (e.g., racial discrimination). Yet, it was common for researchers to tailor interventions to the needs of women and veterans, indicating an openness to tailoring interventions to special populations' needs. Further, and indicative of the white-situatedness of PTSD/SUD research, ~15% of studies with a racially diverse sample only reported demographics for White participants and did not report other races' demographic details. Two study's authors composed a footnote declaring that the remaining participants were "minorities" but did not state which people of color were represented. Authors of racially diverse studies always reported White demographics and never relegated White people to a footnote, illustrating the pervasive norm of whiteness in this research field.

Study Recruitment Primarily Occurs in Predominately White Locales

Over 80% of PTSD/SUD studies recruited participants from areas where White people are the majority demographic (Reid & Buchanan, 2024b). Additionally, researchers recruited participants from locations where White people predominately seek treatment, including recruiting from substance use clinics 42% of the time, even though racially oppressed groups are more likely to seek and receive PTSD/SUD services from hospitals or outpatient clinics (Simpson, 2020). Another 42% of studies recruited participants from veteran clinics, where White men are more likely to seek care from veteran clinics than other groups (National Library Of Medicine, 2020). By primarily recruiting participants in White locales, researchers are increasing the odds of situating whiteness in PTSD/SUD research. This indicates that the insights of PTSD/SUD research reflect the milieu of predominately White clinical settings.

Potential Consequences of a Minimal Focus on Oppressed Groups in PTSD/SUD Research

Microaggressions

When whiteness is the norm in settings, people of color may be at a higher risk of experiencing various forms of microaggressions (verbal or non-verbal exchanges in which a perpetrator unknowingly or knowingly causes harm to another by slighting them because of their race, gender, or some other marginalized identity feature; Sue & Spanierman, 2020). For instance, research has found that because clinicians are often inexperienced in working with and addressing matters of racial discrimination, they are often likely to commit a microinvalidation (interpersonal interactions that exclude, negate, or nullify oppressed groups' psychological thoughts, feelings, or experiential reality) against a person of color in clinical treatment (Lee et al., 2018; Sue et al., 2007). Further, research has found that clinicians are more likely to commit microinsults (enactments of verbal or nonverbal exchanges containing subtle stereotypes, rudeness, or insensitivity that demean a person’s identity) against oppressed groups when they lack diversity training (Sue & Spanierman, 2020). Because PTSD/SUD researchers have poorly included oppressed groups in their studies, it is plausible that clinicians who address PTSD/SUD are underprepared to interact with them and address their needs. Therefore, their lack of preparedness may increase the chances that they commit microaggressions during treatment.

Environmental Macroaggressions

Environmental macroaggressions refer to institutional practices communicating demeaning, threatening, or exclusionary social cues to oppressed groups (Sue & Spanierman, 2020). They are primarily visually perpetrated and affect marginalized groups’ sense of belongingness to an environment (Sue & Spanierman, 2020). Importantly, environmental macroaggressions differ from environmental microaggressions. To illustrate, if a therapist displayed a book in their office espousing racist beliefs, this constitutes an environmental microaggression because an individual’s biased worldview constructs the environment. In contrast, if a clinic primarily displays images of White people or mainly employs White staff, this reflects an environmental macroaggression because an institutionally biased worldview constructs the setting. When oppressed groups are significantly under-included in research, their interests are not likely to be considered (Collins, 1986; Roberts, 2020). Therefore, it is plausible that, because PTSD/SUD scholarship has so significantly under-included oppressed groups in knowledge production, they will not have visible representation and may feel outcasted.

Overall, Indigenous, Black, and Latine populations are disproportionately exposed to PTSD/SUD risk factors like childhood trauma, interpersonal violence, and poverty, and face unique challenges like racial discrimination and historical trauma. Moreover, oppressed groups face a more severe and enduring burden of PTSD/SUD. Yet, PTSD/SUD research has predominantly studied White people challenges, resulting in a dearth of culturally appropriate interventions and treatments addressing racially oppressed groups' needs. Consequently, when oppressed groups seek PTSD/SUD treatment, they may be at risk of enduring microaggressions, macroaggressions, or other forms of discrimination, which may explain why they have higher treatment dropout rates than White people. Given the significant lack of research into oppressed groups' experiences and treatment needs and the potential consequences of under-inclusion listed above, one must ask whether matters of race and gender are clinically meaningful in treatment and whether how matters of race and gender are handled in a clinical setting impacts one's pursuit and maintenance of clinical treatment. Doing so may indicate the importance of restructuring PTSD/SUD research to prioritize equity.

A Note on Qualitative Methods as This Study's Approach

Oppressed groups are systematically more likely to drop out of treatment (Green et al., 2020), terminate treatment early (Lester et al., 2010), and suffer from PTSD/SUD for longer durations (Sahker et al., 2020). Yet, the current, primarily quantitative approaches that PTSD/SUD scholars have taken have failed to illuminate and remediate these concerns. Thus, a qualitative approach to exploring and addressing PTSD/SUD health disparities is warranted.

Qualitative research is valuable for investigating underexplored and new phenomena because of its exploratory and inductive nature (Huberman, 2014). Qualitative methods are open-ended, allowing researchers to deeply explore of the experiences and perspectives of participants (Maxwell, 2012). Additionally, they are participant-centric, meaning they prioritize the perspectives and experiences of the people who are studied over the insights and hypotheses of the researcher (Maxwell, 2012). The richness of qualitative data, including narratives, quotes, and observations, provide a nuanced understanding of phenomena (Huberman, 2014).

Additionally, qualitative research is often the preferred method of feminist researchers for several reasons. First, feminists emphasize producing contextual knowledge from lived experiences, particularly from oppressed groups (Sprague, 2016). Second, feminists acknowledge the situatedness of knowledge, a practice that aligns with the principles of reflexivity in qualitative research (Lykes et al., 2018). Third, feminists use qualitative research to provide a platform for participants to share their experiences, challenging traditional power dynamics in research (Roberts, 2013). Finally, feminist research aims to challenge oppression and drawing on insight into individuals' experiences produces data to inform advocacy and policy change (Roberts, 2013). Therefore, my use of qualitative methods for this study reflects the goals of feminist research and is practically necessary to explore the issue at hand.

Current Study

Racially oppressed groups are under-included in PTSD/SUD research, and researchers have yet to investigate and address PTSD/SUD racial health disparities. Therefore, I conducted a qualitative study using semi-structured interviews with racially oppressed group members who have been diagnosed with PTSD/SUD and who have received therapy for PTSD, SUD, or PTSD/SUD in a clinical setting. This study aimed to establish the relative importance and need for culturally appropriate and race/gender-specific treatment, exploring: a) how are matters of race and gender relevant to PTSD/SUD; and b) how does the clinic and clinician's handling of race and gender matters impact the therapeutic experience of oppressed groups?

Method

Sample

I leveraged pre-existing relationships with community partners at a community mental health clinic in Michigan, a trauma treatment center in New Mexico, a hospital-affiliated outpatient behavioral health center in Georgia, and a community health clinic in California to recruit participants for this study. I picked these settings because they allowed for wide recruitment from different parts of the U.S. These clinics serve a broad number of people yearly, ranging from around 100 people at the trauma treatment center to several thousand clients seen at the remaining clinic locations. Each serves diverse populations, and the clinics in Georgia and New Mexico are in predominately Black and Latine areas, respectively. I created a recruitment flyer (Appendix D) for this project that my community partners hung it in their clinics. Participants sought to be included in this study by responding to the flyer.

There are various thoughts on how many participants are needed for qualitative studies to generate transferable results. Scholars suggest sample size depends on the nature of the topic, the data quality, the type of interview conducted, and the study's goal (Huberman, 2014; Morse, 2000, 2015a). Additionally, it is determined by practical factors like funding and time limitations (Huberman, 2014). Generally, adequate sample sizes range from 15 to 60 people if a researcher explores new phenomena using semi-structured interviews to inform new investigation areas (Guest et al., 2006; Maxwell, 2012). This study explores new topics in PTSD/SUD and aims to inform future investigations to ensure this field promotes health equity. I use semi-structured interviews (described below) to chart this area of exploration. Finally, balancing limited funding and time restrictions due to community partners needing the results to inform their programming, I anticipated interviewing approximately 20 participants over three months. Participants were eligible to participate in the study if they met the following criteria:

1. They identify as a person of color.
2. They have been diagnosed with co-occurring PTSD and SUD by a clinician.
3. They have received clinical treatment for PTSD, SUD, or PTSD/SUD.
4. They speak English.
5. They were $\geq$ 18 years old.

Thirty-one people responded to the recruitment flyer requesting to participate in the study; however, eight were excluded because they did not have a PTSD/SUD diagnosis. The remaining 23 were diagnosed with PTSD/SUD by a clinician and had or were currently receiving therapy for PTSD, SUD, or PTSD/SUD. Eight received SUD treatment only, four received PTSD treatment only, and eleven received PTSD/SUD treatment. Participants were from Michigan (n = 4), Georgia (n = 7), New Mexico (n = 4), and California (n = 8). Sixteen participants were female, two of whom were transgender women. Ten were Latine, eight were Black, four were multiracial, and one was Asian. Seven were Latina, one of whom was a transgender woman. Four women were Black. Among multiracial participants, two expressed that they are racialized as Black, one as White, and one as Latina (see Table 2 for participant demographics).

Design

I conducted open-ended, semi-structured qualitative interviews. Conventional qualitative interview techniques emphasize interviewer control, a one-way flow between the interviewer and respondents, and detachment (Sprague, 2016). However, this study was framed by feminism, emphasizing a two-way relationship between a researcher and a participant (Reid et al., 2023; Sprague, 2016). To accommodate this feminist framing, I used a responsive, semi-structured interviewing model developed by Rubin & Rubin (2011). This model allows an interviewer to adapt questions in response to what participants share. These new questions are carried over into subsequent interviews, making the interview guide an iterative living document. However, the interview questions must still focus on the guiding research questions. According to Rubin & Rubin and others (Maxwell, 2012), this format allows for more conversational flow and capturing rich detail. Interview Guide One (see Appendix B) shows the interview questions.

Procedure

Twenty participants were interviewed over HIPAA-compliant video conferencing software (i.e., Zoom) and three were interviewed in person. A trained research assistant and I interviewed the participants. My research assistant (RA) is an undergraduate at Michigan State University, majoring in criminal justice and minoring in psychology. She is a Black woman who has demonstrated an interest and aptitude in working with people experiencing oppression. I spent three hours training her on the interview protocol and procedures. Additionally, I have spent the last year and a half supervising her in her work as a mentor and advocate for youth in the juvenile justice system. The RA interviewed two participants, and I interviewed the rest.

We began each interview with rapport building, privacy, and confidentiality and shared our positionality and how it related to this study's purpose. With permission, we recorded every interview. On average, the first round of interviews (*n* = 23) lasted approximately one hour, excluding a 10-minute break during each interview. The shortest interview took ~40 minutes, and the longest was around one hour and 30 minutes. Participants were paid $75 at the end of their interview. Every participant was asked if they would be willing to speak again to answer any questions that emerged after data analysis. They were informed they would be paid another $75 for their time. Five participants participated in a member-checking (second) interview, resulting in a total of 28 interviews. On average, member-checking interviews lasted 30 minutes. After the interview, each participant received their interview transcript and confirmed its accuracy. Additionally, all participants will receive a copy of the results of this study.

The RA helped with interview transcription, coding, and developing a codebook. She transcribed 10 interviews, reviewed approximately 50% of the transcriptions with me, and we spent three separate one-hour sessions coding together to design a codebook. Overall, she helped code half of the data. Sadly, in the middle of the research process, the RA endured a family tragedy and had to leave the study. I applied the codes to the remaining half of the data and iteratively designed new codes until I arrived at the final codebook.

Analysis

To analyze the data, I used strategies outlined by qualitative scholars Miles, Huberman, and Saldaña (Huberman, 2014). Their scholarship provides a comprehensive, systematic framework for analyzing qualitative data, which includes detailed strategies for coding, categorizing, theming, and interpreting data (Maxwell, 2012). The steps of analysis outlined below align with Miles, Huberman, and Saldaña's (2014) approach.

Transcription

Based on Huberman's (2014) recommendations, we carefully listened to the recorded interviews and transcribed them into Word as we listened. After the transcriptions were completed, we sent them to the participants for verification of accuracy. Initial insights about the data were recorded through notes and memos.

Coding Transcripts

The RA and I iteratively reviewed and coded transcriptions until we established a set of categories and codes that appeared to capture the data. We coded by highlighting phrase segments and full sentences and by summarizing the primary topic of a passage of qualitative data with a short phrase or a single word (i.e., descriptive coding; Saldaña, 2021). We finalized the codebook with 37 codes and 17 sub-codes. The RA coded approximately 50% of the data and I coded the remaining half. To ensure coding remained rigorous after the RA had to depart from the study and to finalize the coding structure, I submitted the transcripts to the qualitative analysis software program, *Dedoose*. I iteratively coded the transcripts and finalized a set of 32 codes with 15 sub-codes that could be divided into distinct categories.

Categorizing Codes

The categorizing process involves organizing codes into groups that capture the essence of the data (Huberman, 2014). This requires examining relationships between codes, identifying patterns in those relationships, and clustering similar or related codes together. This clustering results in a category. After generating categories, I iteratively refined and revised them to ensure they accurately reflect the data, maintaining a balance between the data's richness and the analysis's clarity (Huberman, 2014). When creating categories, I explicitly searched for relationships between PTSD/SUD clinical experiences and race and gender.

Theming Categories

Drawing from the categories in the data, I developed three themes (central, higher-order concepts) that informed this study's conclusions. These themes allowed me to connect the broader context of PTSD/SUD to my research questions. Table three illustrates the categories cohering my themes.

Saturation

Another central concept in qualitative research is saturation, which concerns the data's depth, richness, and comprehensiveness (Morse, 2000, 2015a). It ensures that the diversity and complexity of participants' experiences and perspectives have been adequately captured (Morse, 2015b). Saturation is typically determined iteratively and subjectively by the researcher through continuous data analysis (Guest et al., 2006). Researchers must look for redundancy in codes, categories, and themes as they review the data (Morse, 2015b). Whether a researcher has reached saturation is a judgment call of whether their data continually diverges throughout the interview, coding, categorizing, and theming processes or if codes, categories, and themes are converging (Morse, 2015a, 2015b). When concepts drawn from the data consistently converge, a researcher can say they have “reached saturation,” which signals that data collection can be concluded. My analytic findings consistently converged by the time the 23rd participant was interviewed, and convergence was strengthened throughout secondary interviews. Therefore, I concluded that my study was saturated from the 28 interviews I conducted with 23 participants.

Validity

Qualitative scholars argue that special attention must be given to validity in qualitative research manuscripts (Maxwell, 2012; Huberman, 2014). However, before I do so, I will briefly detail why I use the term validity over trustworthiness (another concept akin to validity). Trustworthiness is a qualitative research term coined by Yvonna Lincoln and Egon Guba in the 1980s and then elaborated on in the 1990s (Guba & Lincoln, 1994). Over time, the term has been critiqued for lack of clarity and precision. It has come to refer to various concepts, including credibility, transferability, dependability, and confirmability, and the lack of clarity around the concept makes it difficult to determine what a researcher means when they say their findings are trustworthy (Kirk & Miller, 1986; Maxwell, 2012; Silverman, 2013). Indeed, trustworthiness was meant to signal that qualitative research emanated from a different paradigm than quantitative research (i.e., constructionist vs post-positivist), and the use of the word over validity was intended to signal that scholars recognized this distinction (Guba & Lincoln, 1994). However, as qualitative research has become more popular in the social sciences, it has ceased to emanate only from a constructionist paradigm. Today, qualitative research can be post-positivist (Sprague, 2016), and quantitative research can be constructionist or even transformative (e.g., see work by del Rìo-Gonzàlez et al., 2021). Because mainstream scholars often critique feminist research as ambiguous or unclear (Harris, 2021), I parallel qualitative scholars who use validity because it has a well-established meaning regarding the accuracy of research findings.

In qualitative research, validity is the credibility or correctness of my descriptions, conclusions, and interpretations (Maxwell, 2012). Validity is a property of inferences; no method can completely assure validity (Maxwell, 2012). Therefore, I identify and address this study's primary validity threats. The first is the incongruence between my situatedness and some participants. I am a middle-class Chicano academic, and my situatedness involves opportunities and constraints that differ from the participants'. Thus, I cannot be sure that I will notice and interpret the experiences participants share perfectly. I share my interpretations and transcriptions with participants to address this validity threat (Maxwell, 2012).

Next, I addressed common threats to validity like thin description, lack of comparison, and a lack of numbers (Maxwell, 2012). To combat thin description (poorly detailed data), I conducted semi-structured, open-ended interviews with every participant. I reinterviewed several to get their perspectives on categories (Maxwell, 2012). Also, I constructed detailed transcriptions and memos and concluded by explicitly linking the raw data from these sources to my themes via a data display matrix (Maxwell, 2012). Finally, I used numbers to identify the "amount" of evidence in my data to support my conclusions. For example, I stated how many people shared a belief or experience (Maxwell, 2012).

Ethics and Safety

Study participants have experienced or are experiencing a significantly distressing disorder. Therefore, matters of ethics and safety are deeply relevant to my intake and interview processes. Ethical principles, such as respect for autonomy, beneficence, and justice, will guide my interactions with participants. My intake and interview will describe the purpose of the study and obtain informed consent. I ensured that participants knew the study's purpose before voluntarily engaging in the research process. I then shared with the participants that I prioritize confidentiality and anonymity to protect their identities and sensitive information. I requested consent to record and deleted recordings after transcribing them. I changed all participant names to pseudonyms during transcription. Then, I shared my transcriptions with participants to ensure my writing was accurate and acceptable. Every participant confirmed the transcript was accurate and acceptable.

Beyond ethical considerations, ensuring the safety and well-being of participants involves creating a supportive environment, particularly when exploring sensitive topics. I never asked participants to detail their traumatic experiences, and those who shared them did so of their own will. After each interview, I shared national behavioral health resources with every participant. No participant asked for additional resources. Although no participant expressed feelings of self or other harm or shared about child abuse/neglect, I had a protocol in place to call my supervisor and connect the participant with local resources should they do so. I also established clear communication channels with Michigan State and my supervisor for participants should they struggle with me or the research process. I told each participant that we would halt or modify the study if any adverse effects emerged on the participants.

Results

I identified three themes based on what participants shared about the relationship between race, gender, and PTSD/SUD. First, intersectional oppression contributes to PTSD/SUD incidence. Second, encounters with discrimination aggravate PTSD/SUD symptoms. Thus, matters of oppression are important issues that should be discussed in therapy. Third, whiteness structures clinics and clinician actions. Therefore, participants felt unwelcome in clinics, and their experiences with oppression were mishandled or poorly understood by clinicians. These themes are discussed below, and pseudonyms are used when naming participants.

Intersectional Oppression, Trauma and PTSD/SUD Incidence

Most participants (*n* = 21) voluntarily discussed the experiences that contributed to their PTSD/SUD diagnosis. Although most participants experienced multiple forms of trauma and the substances people used varied widely, almost all women (~85%) endured some form of sexual victimization, and most men (71%) endured some form of interpersonal and childhood violence. These experiences formed the foundation of participants' PTSD/SUD. After analysis, it became clear that intersectional oppression deeply influenced the nature and course of the trauma and substance use experiences participants reported.

For women, intersecting oppressions related to gender-based victimization played a major role in fostering their PTSD/SUD. To illustrate, Maritza shared, "I got raped when I was 16. I didn't start using drugs right away… but I didn't feel like I could talk about it to anyone… It's he said, she said kinda thing, and people *always* [emphasis original] blame the girl. I didn't want to go through that. I couldn't stop thinking about it or dreaming about it… One day, I got pain pills from a soccer injury… I took them and felt like [the trauma] didn't matter anymore… I felt better for the first time in a while." Maritza then stated, matter-of-factly, "It was taking pills or having my life under a microscope, so I took the pills." Her experience resembled other women's stories and demonstrated how sexism, which cultivates a permissive environment of violence against women, renders them vulnerable to sexual violence. Her story also illustrates that patriarchy intersects with our society's victim-blaming ethos to influence women to cope with sexual trauma with drugs rather than speak out about their victimization and risk blame.

In another example, Geena shared a harrowing experience that she is still enduring, "My parents freaked when I came out to them. They hated the idea that I'm trans. They hated *me* [emphasis original]… so I pretend I'm not trans to them. It's agonizing. Like I have weeds growing on my body that I can't pick and that my parents won't acknowledge…". Because of this, Geena shared, "…I started using drugs because it was the only thing that made me not notice that I hated my body… I couldn't always pay for the drugs, so sometimes I had to sleep with the guy I was getting them from. I didn't always want to sleep with him, but it was either that or feel suicidal…". The intersecting oppressions of anti-transgender ideology and sexism caused Geena to feel suicidal, to seek drugs from a classmate, and to use her body (not always consensually) to get drugs.

Next, elements of the criminalization of oppressed groups' experiences and the cultural stigma against men discussing mental health intersected to stoke PTSD/SUD among men. To illustrate, Martin shared, "I was younger when I saw my friend get shot. I was right there next to him. It still sticks to me… I couldn't tell anyone. I couldn't tell no damn therapist or school counselor or whatever because who are they gonna call [referencing the police]? I wasn't even poor growing up, but I still knew not to trust the cops… so I drank. I drank a lot. It helped me…". Then Martin discussed other barriers that sustained his anguish when he shared, "Men don't talk about their feelings. So, going to therapy was double not for me for a long time. I still haven't told my dad I'm in therapy because he'd be like, "Don't be weak, boy!" Martin's story was emblematic of many other men's stories. Many were exposed to some kind of interpersonal trauma, yet they were concerned about revealing their trauma because men of color are often criminalized when facing violence. Further, this issue was compounded by the cultural stigma around discussing mental health issues. These oppressive forces intersected and kept them suffering and using substances to numb their pain.

Similarly, David shared, "My mom was illegal, and my dad abused us… he knew she couldn't get help because of her [legal] status… who could I tell because mom would get in trouble… I felt like I let her down because I couldn't stand up to him [the dad], and I couldn't get help either… no one in the family talked about it because we don't talk about those kinds of things [referencing cultural stigma around discussing behavioral health issues]." Although his mother's legal status was a unique issue, criminalization and stigma were laced into David's PTSD/SUD incidence. This data represents almost all participants' experiences. Intersecting oppression influenced the nature and course of participants' PTSD/SUD incidence. Although intersecting forces qualitatively differed by gender, it was clear that larger societal issues play a significant role in oppressed groups' PTSD/SUD incidence and must be seriously examined.

Discrimination and PTSD/SUD Symptom Aggravation

Nearly half of the participants (*n* = 10) noted that they often encounter discrimination because of their skin color, gender, or both and that these encounters aggravate their PTSD/SUD symptoms. For example, Wangari is an occupational therapist in an outpatient clinic. He asserted that White people seem scared of him because he is a "dark-skinned African-American." Throughout his career, white patients have avoided him in the clinic gym, and several have requested to work with a different therapist because they found him "angry" or "aggressive."

These accusations anger Wangari. With audible tension, he stated, "… I know it's because I'm African-American. They've never said that about anyone White… it makes me pissed. They don't know what I've been through." Over time, the recurrence of this issue caused Wangari to adopt a persona around his White patients, stating he must be "always smiling and easy-going… if I'm having a bad day or feeling quiet, I can't show that because someone might accuse me of being aggressive." The effects of discrimination are stressful for Wangari, prompt drug cravings, and cause him to go to a "dark place." He stated, "I'm exhausted because I'm either avoiding racism or I'm facing it. I get no rest. I woke up that morning telling myself today, "I'm not gonna smoke today" [referencing his struggle with substance misuse]. Then, halfway through the day [because of encounters with racism], I want to drink and smoke, and then I'm home doing it…". He further shared, "Sometimes someone says something racist, and it gets in my head. Then I'm thinking about that for a while, and then all of a sudden, I'm thinking back to the things that gave me PTSD. It's like I'm right back there." Discrimination caused Wangari to crave substances and re-activated a traumatic memory. Similarly, Audre shared, "…this guy wouldn't leave me alone. He kept saying… 'you're so exotic'… 'I've never been with a Black girl'… he had his hands all over me, and it was just so gross… I was so angry… I blacked out. I don't remember that night… I didn't even drink that night. I just think I dissociated because it was like before [referencing a sexual assault]." These examples are representative of participants' challenges with discrimination and how they aggravate PTSD/SUD symptoms.

Further, many of these participants shared that because they regularly endure discrimination, they hoped to address it in therapy. Nelson stated, "This [discrimination] is just as real as everything else. It affects me, and I need to be able to talk to a therapist about it… I need to learn how to not let it affect me." Similarly, Audre shared, "I deal with this stuff *all the* *time* [emphasis original]. I'm going to inevitably have to bring it up in therapy." Like the others, Wangari stated, "If I could talk to a therapist about this stuff, I don't think it'd have power over me." Because discrimination is pervasive and aggravates symptoms, participants were adamant that they must be able to discuss and address discrimination in therapy. Yet, few found therapy to be a safe space to address discrimination issues.

Overall, intersectional oppression and discrimination are deeply and significantly woven into participants' PTSD/SUD. Yet, despite this, and although participants want to address these issues in therapy, the findings below reveal that the experiences of oppressed groups are not considered in behavioral health. Consequently, they had few allies to discuss and address these issues in therapy. Instead, their stories reveal that behavioral health is structured by whiteness and boxes out anything that does not conform to whiteness.

Whiteness Structures the Behavioral Health Clinic

Participants described how clinics handled matters of race and gender, and the themes cohering their descriptions suggest that clinical settings are structured by whiteness. Most clinics were primarily composed of White staff, and images around the clinic (i.e., brochures, posters) seldom displayed people of color. The absence of people of color in the clinic setting constitutes an environmental macroaggression and reveals that the clinic was constructed without diversity in mind. Moreover, participants characterized their interactions with clinic staff as "insulting" and shared that they detected "subtle racism" when staff spoke with them. The insulting, subtle racism (i.e., microinsults) participants endured suggests that clinical institutions had not trained staff to identify and arrest racist implicit biases. Importantly, not all participants reported experiencing microinsults. Several participants shared that because they had light skin, staff seemed to assume they were White, which they attributed to the better treatment they received from staff (i.e., colorism). Overall, these factors combine to demonstrate that clinical settings are structured with White people's comfort in mind and not in ways that center or even accommodate the needs of people of color. These findings are discussed below.

Environmental Macroaggressions

Participants noted that clinic posters, pictures, brochures, and staff almost always prominently displayed White people, making them feel like Black and Brown bodies stuck out and were unwelcome. For instance, Angela mentioned, "I just walk in, and I notice... nobody looks like me… I don't know how people are gonna respond to me being there.". In another instance, Nelson shared, "… when it's just me looking like this [Black], I gotta be extra careful." Then, chuckling, he shared, "Even the pictures are lookin' at me asking what I'm doing here." Here, Nelson is derisively noting that all visible elements of the clinic are telling him that he is not welcome. Similarly, Isabel shared in an exasperated way, "I'm going to therapy because I feel alone… I get in there, and I don't see anyone looking like me or talking like me, which is weird because I live in Albuquerque. Everyone in the street looks like me. But then in here… nobody does... I thought I wasn't supposed to feel alone here." These environmental macroaggressions communicated that people of color were not thought of when the clinic was being structured and were, therefore, not welcome.

Importantly, some clinics displayed diversity, which was a welcome relief to participants. For example, DeRay shared that when he sought treatment in the clinic close to his home, many staff members, pictures, and art displayed racial diversity, making him feel more welcome in the clinic environment. Audre also noted that her clinic had racially diverse posters and brochures. She shared, "… when I saw that, I felt welcome [in the clinic]." However, visible diversity was rare; almost all participants felt that White images and staff were the most prominent features in the clinics where they were treated. Consequently, participants felt like outsiders in the clinic setting.

Microinsults

Participants (*n* = 13) shared that they often felt slighted when interacting with clinic staff and attributed that feeling to “subtle racism.” For instance, Leslie shared, “When I talk to them [staff], I always feel talked down to… I *know* [emphasis original] it’s because I’m Mexican.” Malcolm contextualized the experience further when sharing, “It’s not like they say anything rude to me. It’s the energy they use to talk to me. It’s condescending. I can’t describe it- you have to feel it.” He further characterized the experience by stating, “It’s this kind of subtle racism that you deal with every day. You can’t call people out for it because they can deny it. But [long, reflexive pause] you just know it's there.” Malcolm was clear that there was nothing overt about the interaction that could be easily called racism, yet the racism was palpable.

Other participants shared similar details, using words like “vibe,” “energy,” or “sense.” Alicia offered a succinct analogy to clarify her point: "It’s the vibe you get when they talk to you. It’s insulting. It’s like… when you’re in trouble with your mom in public, but she’s not saying anything she wouldn’t say in public. She’s talking to you, but you know you’re in trouble by how she’s talking to you. But nobody else can notice it because it’s the vibe only you guys understand. It’s like that. When they talk to you, you know something is underneath.” These microinsults made participants feel unwelcome in clinic settings. Importantly, participants were not subjected to microinsults at every appointment, but it occurred on multiple occasions. Microinsults and the lack of visible diversity in clinics show that clinic settings center whiteness by not being inclusive of or alert to racial dynamics. Consequently, many participants attempted to appease whiteness to reduce the likelihood of experiencing microinsults (described below).

Colorism

Colorism is the act of offering privilege to or committing discrimination against people according to the darkness of their skin (Burke & Embrich, 2008). It was a relevant factor associated with three participants' treatment in the clinic and demonstrates whiteness structuring the clinical setting. Caesar, Gloria, and David have light brown skin; each mentioned they "passed" for White. They attributed their light skin color to their limited experiences with microinsults. For instance, Gloria shared that her welcome in the clinic "depends on how I'm read… I look White to some people, so sometimes they treat me like I'm White… they don't talk to me like they talk to others [other people of color]. They always say ma'am and ask if they can get me something…". Colorism afforded these participants privilege, further illustrating that whiteness structures the clinic setting. Others had to seek the "privilege" of being treated with respect by altering their appearance or speech when interacting with staff.

Altering Ways of Being to Appeal to Whiteness

Black men and women avoided wearing hoodies, baggy clothes, hats, and sunglasses, sharing that wearing these clothing would put them at risk for discrimination. They also avoided using slang. Several Latine participants deemphasized their accents and did not roll their R's when speaking to staff because they believed doing so might cause staff to discriminate against them. Lastly, both Transgender women did their best to look and speak "as femininely as possible" because they did not want to be discriminated against, misgendered, or treated rudely. As Bamby stated, "It's just better if they don't know I'm trans," asserting that if staff knew she was transgender, she would be at risk for harm. Participants were mixed as to whether these efforts made a difference. Each Black male participant believed making these alterations reduced their chances of facing overt discrimination, like having the police called on them for “looking threatening.” Also, both transgender women were confident altering their appearance effectively reduced their chances of enduring discrimination. However, no other participants were confident that their strategic alterations made any difference. Indeed, though there are differences in the sources of oppression affecting Black men and transgender women of color, both groups endure high levels of violence and discrimination based on their physical appearance. This may explain why these groups believed their alterations were effective while others did not.

As has so far been detailed, matters of oppression are woven into PTSD/SUD, yet race and gender issues are neglected and mishandled at the clinic level. Further, as will be detailed below, therapists struggled to address matters of oppression. This indicated that, just as in the clinic, whiteness structured therapeutic engagements.

Whiteness Structures Therapeutic Engagements

Participants indicated that because of exposure to discrimination in society and prior experiences with discrimination in healthcare settings, they tested the waters with their therapists before discussing important racial issues. When they did, many participants reported that their therapists committed microinvalidations, which negatively impacted their therapy experiences. However, some participants shared that their therapists were receptive to discussing race matters, but they had to take significant time during the session to educate their therapists about race. This process was tiresome and frustrating for participants. Participants' reticence to discuss race matters and their therapists' inability or under-preparedness to address matters of race are illustrations of how therapy is structured by whiteness. These findings are detailed below.

Testing The Waters

> … My mom used to tell me when I was in front of White people things she didn't tell me when I was in front of others- like don't act up in front of these White people… you can act up anywhere else, but don't act up in front of them. Then, in the therapy world, I have to be on my best behavior with this therapist who's not a person of color, but if I'm gonna work on my issues, I need to be able to be open. But I don't even know if she [the therapist] understands all that.
>
> Malcolm

Malcolm's quote reveals that people of color are taught at a young age the importance of accommodating whiteness to prevent exposure to discrimination. Further, after referencing the recent spate of vigilante shootings of people of color by White people, "Karen" outbursts, and threats to involve police or immigration on people of color, Oscar stated, "making white people comfortable is [a matter of] survival." Several participants shared these sentiments, stating that they were concerned about opening up to a therapist because they, as stated by Fannie, “live in a White world.” They were concerned about bringing up matters of oppression as it pertained to their PTSD/SUD for fear that therapists would not understand or perpetuate harm. As stated succinctly by Malcolm, “I wonder if she’s gonna get where I’m coming from, or even gonna try to get me. And is she gonna say some out-of-pocket shit [i.e., is she going to say something racist]. It’s a lot on my mind when I get in there [in the therapy room].”

Some participants, like Dolores, had previously experienced racial discrimination in healthcare settings by doctors and clinicians, which negatively impacted her trust that her therapist would be receptive to discrimination issues. She said, “I’ve gone through this before [referencing discrimination]. Doctors have been racist to me, and so I know they don’t know any better. So I’m sitting there asking myself if this one [her therapist] is gonna do that, too.” As these quotes illustrate, when participants worked with a White therapist, various social and historical circumstances caused them to be concerned about whether their therapist would understand them or discriminate against them.

Because of this uncertainty, participants would “test the waters” to find an answer. Most participants made strategic observations and statements during this period to render insight. First, when participants met their therapist, they judged whether they were greeted with indifference or if the greeting was “humanizing.” Positively, participants reported that they were greeted kindly. Additionally, participants were aware of diversity signals in the therapists’ room. They shared that they would look for photos, insignia, flags, books, and even clothing or jewelry that indicated an awareness of diversity. The most consistent signs relevant to diversity were rainbow flags. Participants noted that rainbow flags were welcome and signaled to them that diversity might be welcomed and understood by their therapist. Interestingly, however, Audre, who is

Black and queer, stated that rainbow flags were insufficient signals. She noted that she saw a pride flag in her therapist's office as a sign that she could "discuss queer issues." Yet, she saw no racial solidarity insignia, which cause her to question whether she could "be black."

Some participants tested the waters in other ways. They would use slang, make statements about race, or share observations about racism with a therapist and judge the therapist's response. Some shared that their therapists' responses demonstrated that diversity matters were uncomfortable discussion topics. For example, Rosa shared she "used some slang… she [the therapist] just wasn't about that… she just had this nervous laugh and looked at the clock… It's funny now, but then I was like, oooooh [folding arms and legs to indicate feeling self-protective]." Most faced similar responses. Fannie stated, "She didn't really say anything to me. I could just see she got tight. Like clutching her chair. You could see she didn't know how to respond to me. I don't remember what I said… something like driving while Black or something stupid. Nuh uh [she clicked her tongue and wagged her finger] 'none of that here' [indicating what the therapist's physical response said to her]." Overall, many participants noted their therapist's verbal and physical responses to these comments indicated the therapist was uncomfortable. Therefore, they held off discussing them until it was necessary.

In contrast, some participants reported that their White therapist handled these moments well. Audre commented on the pride flag in her therapist's office, and she reported that her therapist said, "I can't remember exactly what she said, but something like 'it's important that you can talk to me about these things." However, Audre shared that it was more than just the words: "It was her body language. She was open and nodding her head. Her energy just said that she was telling the truth." The combination of words and how her therapist held space during the statement made Audre feel she had "space" to discuss these matters. Similarly, Leslie shared that her therapist asked her about her plans for the day during her intake. She shared that she was going to her niece's quinceañera. Leslie stated, "She asked me to tell her about it, that she didn't know [about it]… I was just like… ok, this person might be cool." Like Audre, Leslie said, "she just seemed genuine when asked..." When therapists verbally and physically responded openly to participants' statements, participants felt like they had space to discuss matters of oppression. However, most therapists struggled to respond to these topics and "froze up" or "got stiff." When therapists stiffened at these topics, participants became concerned that they could not bring up race issues relevant to their PTSD/SUD. Eventually, however, these topics came up. Therapists' responses confirmed they had not adequately prepared for these conversations.

Microinvalidations

Race matters eventually came up in therapy. Sometimes, they came up after participants experienced discrimination that impacted their symptoms, and they wished to learn tools to prevent these issues from further activating symptoms. Other times, they were an integral part of why the participant had PTSD/SUD and was essential to the therapeutic conversation. However, when they brought up these matters, many from this group (*n* = 13) experienced microinvalidations from their therapist in response. These microinvalidations negatively affected participants' therapy experiences.

To illustrate, DeRay was in a grocery store, and a white clerk accused him of stealing a water bottle. However, DeRay brought the water bottle from home. The clerk called security, and DeRay strongly urged them to watch the film, fearing the situation could get deadly if police became involved. Fortunately, they watched the film, but rather than receive an apology, the clerk said, "People are always lying, so I couldn't trust you." However, DeRay saw other people drinking water and knew that because those other people were White, the clerk did not assume they were stealing. DeRay was angry the rest of the day and felt “out of it” the following day. He shared that events like this sometimes happen to him, noting his dark skin is regarded with suspicion wherever he goes. These experiences cause DeRay significant difficulty concentrating for days afterward, and he replays these moments in his head. DeRay relayed this to his therapist, hoping to process the fear he felt and the racism he experienced and learn how to cope with these experiences without feeling emotionally drained for days. But instead of helping, his therapist’s response was to ask DeRay if he was sure the clerk was being racist, sharing that perhaps it would help to think that the clerk was “just having a bad day.” “It just felt like she was making excuses for his [the clerk’s] behavior and questioning my view.” DeRay believed this interaction significantly negatively impacted his relationship with his therapist. He began searching for a new therapist and felt as though all the time and effort he spent getting into therapy was wasted.

In another example, David shared that he relayed to his therapist that he believed he had PTSD/SUD largely because of how Latine people are treated in the US. However, his therapist replied that his PTSD/SUD was likely a product of more complicated issues. David felt invalidated and was frustrated by his therapist’s response. Consequently, David decided not to share race matters with his therapist unless necessary. In a final example, Geena stated her therapist committed microinvalidations because of their implicit expectations of Asians. Geena shared that when she brought up her problems about her family’s expectations of her and how her parent’s Asian heritage uniquely shaped her transgender experience, “She [the therapist] looked at me and like, you know, like you're supposed to be smart. Like you don't belong here in a sense… when I shared, she didn't really put much thought in it and was like, oh, yeah, oh, that's unfortunate.” Geena shared that it seemed like her therapist nullified her distress because Asians are expected to be able to solve their dilemmas. This sense pervaded her therapeutic experience, and Geena also searched for a new therapist after becoming aware of this pattern.

Time after time, participants in this study reported similar circumstances, sharing that when they discussed how matters of race affected them, their racial realities were invalidated. Consequently, their hopes of processing racial issues and learning tools to lessen discrimination's impact on their PTSD/SUD were dashed. Most participants said they did not challenge their therapist's microinvalidation for fear of "making a big deal" out of the experience. However, Dolores did challenge her therapist, stating, "I know what racism looks like, and this was racism," yet her therapist did not acquiesce. Dolores was frustrated that she had to "convince" her therapist that racism affected her. Participants' experiences testing waters and with microinvalidations show that therapists have not been prepared to recognize and address matters of racial oppression. Further, when these circumstances are brought up, they commit harm in ways that diversity training could address. These results demonstrate that therapeutic interactions are structured by whiteness. This causes participants harm and alters their therapy path.

Overall, seven participants have searched for a new therapist, and each shared that they are looking for a therapist of color because they believe a therapist of color would handle matters of race better than a White therapist. Others shared that they have not brought up matters of race with their therapist after their therapist committed a microinvalidation because they do not trust their therapist to validate their experience. Three participants stopped going to therapy immediately after they were microinvalidated. Interestingly, these three were also receiving medication from the same clinic for their PTSD/SUD and possibly felt comfortable ending therapy because they were still receiving some form of treatment. It is unclear if stopping therapy threatened their ability to continue receiving their medications. Additionally, two participants who experienced microinvalidation in therapy shared that their symptoms were exacerbated. Dolores felt like she wanted to drink after being invalidated by her therapist. She reported that she left feeling dejected and angry and that "a drink sounded like a good idea." Angela shared she felt "emotionally set back" and struggled to open up in future sessions. Thus, microinvalidations in the therapeutic setting can set back therapeutic goals like sobriety.

The Labor of Education

Nine participants reported that when they brought up race matters, their therapists provided "space" or "room" to discuss these topics. Five participants had a white therapist, and four worked with a therapist of color. Four who worked with a white therapist believed that their therapist was underprepared to discuss matters of race and they had to spend valuable time in the therapy session educating the therapist. They reported that when they brought up matters of race, their therapist asked them to explain the issue so they could understand the experience. Rosa captured the sentiment of these participants succinctly by stating, "It's great she wants to see where I'm coming from… but I have to sit down and tell her why I see something as discrimination… it's exhausting… it takes the whole time to help her [the therapist] get it…". Rosa and the other participants expressed frustration that their therapist was not trained or did not make their own time to learn about matters of race.

Importantly, two participants had unique experiences. Fannie worked with a therapist of color; however, she shared that her therapist was originally from India and that her therapist was not clued into the unique racial circumstances Black women face in the US. She also had to spend considerable time in therapy educating her therapist about racism and its impact on her PTSD/SUD. In fact, despite her therapist's receptiveness to discussing matters of race, Fannie left therapy after a few months, declaring that she felt like she had to explain too much to her therapist and got too few therapeutic tools out of their engagements. Next, Audre mentioned that her White therapist handled matters of race and gender well and was knowledgeable about the impact of racism on behavioral health. Audre shared that she learned that a Black woman supervised her therapist and that she took several diversity trainings. Audre believed that her therapist's exposure to diversity training allowed her to be responsive to race matters.

Discussion

Our findings add to the mounting literature that structural oppression impacts PTSD and SUD (Bird et al., 2021; Farahmand et al., 2020) , and we are the first to link structural oppression with the incidence of PTSD/SUD. Specifically, we found that various forms of oppression intersect and influence the nature of marginalized people's traumas and substance use. Moreover, participants recognized that oppressive forces were relevant to their PTSD/SUD and wished to discuss these issues in therapy. Further, consistent with intersectionality (Cho et al., 2013; Crenshaw, 1991), we found that these intersecting forces differed by gender. Women's traumas typically stemmed from gender-based violence made permissible by patriarchy, and their substance use was often a coping mechanism they engaged in because they did not want to discuss their victimization and risk being victim-blamed. Currently, some research has investigated treatments for PTSD/SUD caused by gender-based violence, and authors have concluded that these interventions are efficacious (e.g., see Myers et al., 2015). However, White women are the majority group included in this research (42% of the entire sample). Yet, women of color have a higher prevalence of gender-based violence than White women (≤ 46%:≤ 34%; Stockman et al., 2015) and often endure more severe violence during gender-based attacks and often endure both racial and gender violence simultaneously (Bent-Goodley, 2009). Therefore, it is unclear how efficacious existing interventions are for women of color. Further, despite a long history of research linking victim-blaming with women's substance use patterns (Follingstad et al., 1988; Sáez et al., 2020), and evidence that Black women are more likely to be blamed for victimization than White women (Linhares et al., 2023), none of the PTSD/SUD clinical research has addressed victim blaming. Therefore, our findings demonstrate the importance of a) including more women of color in clinical research targeting gender-based violence and b) taking an intersectional approach to designing PTSD/SUD interventions by targeting victim blaming and gender-based violence among women of color.

Men of color’s PTSD/SUD incidence was also linked with intersectional oppression, namely the criminalization of circumstances relevant to their lives and cultural stigma precluding men from discussing behavioral health issues. Importantly, around 40% of PTSD/SUD research focuses on addressing PTSD/SUD from combat trauma (Reid & Buchanan, 2024). Yet, only around 12% of those with PTSD/SUD have the disorder because of combat trauma. Rather, the most common traumas related to PTSD and SUD for men are exposure to adverse childhood experiences, enduring neighborhood, gang, or gun violence, or witnessing violence (Roberts et al., 2013). Moreover, men of color are most likely to experience adverse childhood experiences, or exposure to neighborhood, gang, or gun violence and subsequently develop pathology from the experience (Roberts et al., 2013). Therefore, the systematic lack of attention in PTSD/SUD research to issues relevant to men of color may not only sustain their suffering but may also sustain their concerns of criminalization and stigma around seeking treatment. By not charting studies to address the PTSD/SUD issues to men of color, we perpetuate the legal systems’ involvement in their traumas rather than the healthcare system. Moreover, a lack of research into these issues maintains a gap in knowledge around these issues, which may make it more difficult for men of color to feel comfortable speaking up about how these issues affect them. Therefore, PTSD/SUD researchers must address these issues if men of color are going to have options for help and feel comfortable seeking these options.

Although men and women in this sample endured unique traumas, they both coped with their traumas with substances for similar reasons. In both cases, social forces silenced them from speaking out about their traumatic experiences, which encouraged their substance use. These findings indicate that PTSD/SUD scholars must also recognize and address the role that culture and oppression plays in promoting substance use as a coping mechanism for trauma among people of color.

Further, many participants shared that discrimination aggravated their PTSD/SUD symptoms by prompting substance use cravings or causing them to dwell on past traumas. These findings build on existing scholarship identifying a link between discrimination, PTSD, and SUD (Bird et al., 2021; Desalu et al., 2019; Fani et al., 2021; Sibrava et al., 2019). Yet, as with the issues above, there are no PTSD/SUD studies targeting racial discrimination. The lack of investigation of the effects of discrimination negatively affected clinicians' ability to address the topic appropriately (discussed more below).

Next, we found that clinics were structured by whiteness as they curated an environment that centered the visibility of White people and made oppressed groups feel unwelcome. White people were the most visible group among posters, staff, brochures, and security personnel, and participants' unambiguous takeaway was that they were unwelcome. These results corroborate research findings that environmental macroaggressions create an unwelcoming environment by creating questions about whether institutions will be receptive to oppressed groups' needs (Purdie-Vaughns et al., 2008; Solorzano et al., 2000). This finding is a logical consequence of the pervasive inattention to diversity and health equity in psychological spaces (Hardy, 2022; Huff, 2021; Roberts et al., 2020). Because participants felt uncomfortable in clinic spaces, they altered their appearance and speech to go unnoticed in these settings. They felt this was necessary because they felt sticking out in White spaces put them at risk for discrimination.

Yet, despite altering their appearance and speech, participants often endured microinsults when speaking with staff. Although they could not give concrete examples of racially biased statements staff made, they argued that the *way* staff spoke to them was racially discriminatory. Interestingly, staff seldom discriminated against participants whose skin color passed as White. Among participants who did not pass for White, they shared that their interactions with clinic staff resembled “subtle racism” rather than overt racism. This subtlety is a key feature of microaggressions (Sue and Spanierman, 2020), and the enactment of microaggressions against people of color is deeply problematic for many reasons. Yet, importantly for this group, researchers have found that microaggressions can aggravate PTSD symptoms (MacIntyre et al., 2023). Although no participant remarked that their encounter with clinic staff aggravated their symptoms, they could have. Therefore, microaggressions from clinic staff risk aggravating the very disorder that participants are seeking to treat. These issues must be addressed by clinics and staff trainings, and health equity scholars like Monnica Williams have begun developing protocols to ensure clinics foster welcoming environments for oppressed groups (Williams et al., 2024). These suggestions include integrating oppressed groups into practices like the design of settings and training on interpersonal interactions between different racial/gender groups. Each of these practices may reduce the likelihood that clinics are structured by whiteness and client-staff interactions by subtle racism.

Finally, because the clinics were structured by whiteness, participants were unsure if they could discuss matters of oppression or discrimination with their therapists. Thus, before they brought up these experiences to therapists, they searched for signs that diversity-related issues were welcome in the therapy session. They often noted rainbow flags in their therapists’ offices, which was encouraging. However, therapists never remarked about diversity before participants did, and when participants brought up the subject, most therapists appeared uncomfortable. This caused participants to be reticent to discuss diversity matters unless they were relevant. However, because matters of oppression and discrimination were laced into oppressed groups' PTSD/SUD experiences, they eventually discussed these matters in therapy.

When participants brought these issues up, their therapist either invalidated their experience or encouraged the participant to share about the topic. Most participants' therapists invalidated their experience. They shared that when they brought up an instance of discrimination and its effects on their symptoms, therapists asked them if they were sure the experience was racially motivated or asked them to think about the experience from a different logic (i.e., put themselves in the perpetrator's shoes). These microinvalidations harmed the therapeutic relationship participants had with their therapists. Most shared that they could no longer trust their therapist, and many began searching for a new therapist– preferably a therapist of color. Clinical scholars have found that the quality of the therapeutic relationship is one of the most significant predictors of therapeutic success (Flückiger et al., 2018). Because microinvalidations caused the therapeutic relationship such harm, it is possible that participants' chances of recovering from PTSD/SUD using therapy were lowered. The juxtaposition of these findings is particularly distressing given that researchers have found microaggressions are pervasive in therapy (Lee et al., 2018; Sue & Spanierman, 2020). Further, microinvalidations caused some participants to stop attending therapy altogether. Importantly, PTSD/SUD literature indicates people of color often terminate treatment early. Scholars have theorized that this is because people of color have worse symptoms, which make it more difficult for them to attend treatment (Lester et al., 2010; Ruglass et al., 2016). However, our findings suggest that the damage microaggressions caused to the therapeutic alliance caused early treatment termination.

Contrary to most participants' experiences above, some therapists validated participants' experiences and encouraged them to discuss the matters. However, although these therapists took an important first step by validating participants' experiences and encouraging them to talk about discrimination, these therapists were underprepared to discuss matters of discrimination and oppression. Participants shared that when they discussed these matters, they had to educate their therapist about racial dynamics and why circumstances were discriminatory. They found it laborious to have to educate their therapists about these issues consistently, and one participant found the matter so frustrating that she left treatment. Therefore, validating participants' experiences with discrimination is only one step in helping them overcome these issues. Although psychological scholarship is still growing in this area, current scholarship urges therapists to educate themselves about discrimination, take cultural competence training, and receive feedback on their related interventions (Buchanan & Wiklund, 2020; Hardy, 2022; Sue & Spanierman, 2020). This is imperative because researchers have found that therapists' practices usually do not improve over time regardless of their frequency of work in a topic area (Erekson et al., 2017). Rather, their skills tend to improve when they receive education, training, and feedback on their work (Erekson et al., 2017).

One final point, contrary to expectations, we found that gender was not a salient issue in therapy for most participants regardless of whether they were cisgender or transgender. This may be because most therapists were women, and most clinics demonstrated sensitivity to LGBTQ+ people by displaying rainbow flags. However, there were still several important takeaways related to gender. Both transgender participants had historically experienced discrimination in healthcare settings and made significant efforts to "pass" as cisgender women through the duration of their treatment. They may have experienced discrimination if they did not make these efforts. Additionally, men shared that they were more comfortable working with a female therapist due to the stigma of men sharing feelings with other men. This suggests that gendered experiences are operative in PTSD/SUD treatment and must be explored in future studies.

In sum, we found that matters of oppression and discrimination are deeply woven into oppressed groups' PTSD/SUD. Consequently, these issues will most likely need to be addressed in treatment. However, whiteness structures clinic settings and therapeutic engagements, and this had negative consequences for oppressed groups' ability to address matters of oppression and discrimination in therapy. This cycle of oppression is alarming and must be addressed to address PTSD/SUD among the oppressed.

Limitations and Future Directions

This study is the first to examine the relationship between race and gender and PTSD/SUD and to explore the effects of how these matters are addressed in clinical spaces for oppressed groups. This novel study has several limitations, many of which are common to qualitative studies. First, our sample size was modest, which may lead to questions about the generalizability of our findings. However, this is the only study to our knowledge exploring these issues pertaining to PTSD/SUD, and qualitative research is meant to prioritize depth over breadth when uncovering relatively new phenomena. We did not necessarily aim to produce generalizable findings, but instead to provide a detailed and nuanced understanding of the experiences of oppressed groups as it related to PTSD/SUD to inform future research. By conducting 28 in-depth interviews, we gathered rich and detailed data that can be used to develop and inform future quantitative studies with larger samples. Additionally, despite a modest sample size, we achieved data saturation whereby data provided by participants and interpretations of that data converged over time, which ensured that our findings were comprehensive. Also, we interviewed participants across several states and three different geographic regions in the U.S. This allows us to be confident that our findings apply to more than one region or clinic setting.

Next, these interviews provided self-report and retrospective information, and participants' individual retrospective accounts may be inaccurate. However, participants across race and gender groups recalled many startlingly similar experiences related to oppression, discrimination, and treatment in clinical settings. In other words, participants' experiences are triangulated across interviews, enhancing our findings' credibility. However, future studies should interview therapists and clinic staff to determine their perspectives on how matters of race and gender are relevant to PTSD/SUD, how they address these matters in treatment, and how they should assess their cultural competence.

Another limitation may be that participants have interpreted phenomena as raced and gendered, whereas clinic staff and clinicians would not. Conflicting interpretations may complicate these findings. However, as covered in the literature review, oppressed groups are often more aware of the dynamics of oppression and are more readily able to identify these dynamics. Our purpose was to build knowledge specifically from the interpretations of oppressed groups. As such, asking about their interpretations of these experiences is most appropriate.

Similarly, although we aimed to build knowledge from oppressed groups' perspectives, it is possible that our interpretations of their experiences and perspectives may be inaccurate. We used several strategies to combat this limitation. First, we created a research team with people with different identities and situatedness. Although one researcher carried out most interviews, the second researcher participated weekly in discussions about the interviews, helped write analytic memos, assisted with developing approximately 50% of codes, and helped construct categories from the themes. Additionally, we continuously reflected on and shared our biases and how they may influence the research (reflexivity). Finally, we shared our transcripts and interpretations of the data with participants as the study progressed. No participants disagreed with the interpretations, and all five who participated in member-checking (secondary) interviews concurred with our interpretations. However, despite this work, future research should conduct focus groups with participants from oppressed groups and allow them to discuss their shared/differing experiences and construct their meaning together rather than rely on researchers to construct meaning.

Moreover, future research should use mixed methods approaches and send quantitative surveys based on interview findings to clinic staff, clinicians, and clients of color in behavioral health settings to validate findings. Despite these limitations, this study was conceptually unique for the PTSD/SUD field and was rigorously undertaken. Qualitative research limitations were attended to and addressed. This research provides new directions for PTSD/SUD scholars to promote health equity.

Conclusion

Matters of oppression and discrimination are deeply woven into oppressed groups' PTSD/SUD incidence and exacerbate their symptoms. Oppressed groups are aware of the relationship between oppression, discrimination, and their PTSD/SUD and want to address these issues in therapy. Yet, when oppressed groups enter the clinic setting, they are made to feel unwelcome, and staff commit microaggressions that have the potential to aggravate PTSD/SUD symptoms further. Moreover, when oppressed groups engage in therapy and attempt to discuss matters of oppression or discrimination, their therapists often invalidate their experiences, and as a result, the therapeutic relationship is significantly ruptured. Members of oppressed groups begin seeking other therapists, vow not to discuss these issues with their therapists again or terminate treatment early. Sometimes, but less frequently, therapists validated participants' experiences with discrimination, which was an important first step in making participants feel comfortable bringing these issues up in therapy. However, participants often then had to spend significant time and energy educating their therapist about the dynamics of race and how and what discrimination looked like and did to them. This labor was intensive, and one participant terminated treatment with her therapist because each time she brought up issues with discrimination, she had to spend significant time educating her therapist about these issues. Because matters of oppression and discrimination are woven throughout oppressed groups' PTSD/SUD, clinics must enhance visible diversity in their clinics (e.g., in staff, posters, brochures) and make their environment welcoming for diverse groups(Buchanan & Greene, 2024; Buchanan & Wiklund, 2024). Further, staff and therapists must engage in cultural competence training to ensure their interactions with oppressed groups do not risk aggravating PTSD/SUD symptoms or causing people to cease engaging in therapy.

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