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Intersectional Queer Trauma

Effective Strategies for Treatment

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Colibri Center for Systemic Training

Before we begin



Content note

We will discuss violence, racism, homophobia, and transphobia, including harm that happens inside therapy.



Choice over depth, no disclosure required

Every exercise is by choice. You never need to share personal history: practice uses one composite case.



Support

Step out whenever you need to and I am available at the end.



Our starting point

Knowledge from Black, Indigenous, Queer, Asian, and other Global Majority communities is the standard here, not an add-on.

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Learning objectives

By the end of this workshop, participants will be able to:

1. **Differentiate** queer trauma, minority stress, double minority stress, race-based traumatic stress, PTSD, and complex PTSD.

2. **Construct** a systemic intersectional formulation that maps family and chosen family, community, institutions, ongoing threat, and power.

3. **Apply** five fit questions and clinical safety rules to evaluate a standardized trauma treatment, and select a culturally responsive adaptation or alternative, including relational, community, or somatic options.

4. **Demonstrate** a five-step repair of an in-session microaggression, using the Person of the Therapist decision loop to manage one's own reactions.

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Whose wisdom is the foundation?

Think of one trauma model you use. Who was it built with, and who was it adapted for afterward?

In threes: pick one model. Name one thing that would change if Queer, Black, and Global Majority knowledge were its starting point: who is in the room, what counts as trauma, or what counts as healing.

Small groups · 2 minutes

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Case thread 1 of 4: meet Malik & Andre

We return to this couple at every stage: formulation, fit, repair, and planning.

Malik (he/him), 29, Black, gay, middle-school teacher; raised in a Black Baptist church.

Andre (he/they), 33, Afro-Latino, bisexual, gender-expansive, nurse; his Catholic family calls his bisexuality "a phase."

- Four months ago, Malik was assaulted outside a gay bar by men shouting anti-gay slurs. Since then: nightmares, scanning crowds, heavier weekend drinking.
- His father cut contact when he came out at 17; his mother calls in secret. His ballroom house mother is his main support.
- A parent complaint that he is "promoting a lifestyle" is under review at his school. He has stopped going out and keeps Andre away from work events.

Andre: *"He's hiding us."* **Malik:** *"I'm trying to keep us safe."*

The system around them



Family of origin

Chosen family

Church

School & workplace

Community

Ongoing threat

Therapist: white, cisgender lesbian, 8 years licensed, who came out in a conservative church family.

Foundations

01 · Definitions, minority stress, racism as trauma

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Terms we will use

Precise language keeps us from treating LGBTQ+ people, or trauma, as a monolith.

Queer

An umbrella here for identities outside cis-heteropatriarchy. Some clients use "queer" as their specific identity; use each client's own words.

Sexual orientation ≠ gender identity

Distinct but interrelated. A person can be sexually diverse, gender diverse, both, or neither.

Minority stress

Excess stress from stigma, prejudice, and discrimination: outside events plus internal processes such as concealment.

PTSD

Requires a Criterion A event: actual or threatened death, serious injury, or sexual violence, plus symptom criteria.

Complex PTSD (ICD-11)

PTSD plus disturbances in emotion regulation, self-concept, and relationships, often after repeated or prolonged trauma.

Race-based traumatic stress

Emotional injury from racism, framed as injury rather than disorder. It may or may not meet PTSD criteria.

Sources: Menhinick & Sanders, 2023; APA, 2015; Meyer, 2003; Livingston et al., 2020; Benjamin et al., 2026; Carter, 2007; Williams et al., 2018

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A stress–trauma continuum

Queer trauma is cumulative, social, and tied to time, not only a single event.



Queer allostatic load

Chronic stress produced by white cis-heteropatriarchal conditions accumulates across a life.

Where it lands

Whether experience is stressful or traumatic depends on social supports, access to resources, and coping.

Traumatic temporality

Chrono-stress: threats against queer futures and the absenting of queer pasts.

Source: Menhinick & Sanders, 2023

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Risk is elevated, and uneven

PTSD risk is higher for LGBTQ people, and highest for trans and bisexual people.

2.20×

odds of PTSD for LGBTQ people vs. heterosexual / cisgender people (27 studies)

2.52×

odds for transgender people, the highest subgroup estimate

2.44×

odds for bisexual people; still 1.44× compared with lesbian and gay people

98%

of a transgender sample (n = 97) reported at least one potentially traumatic event

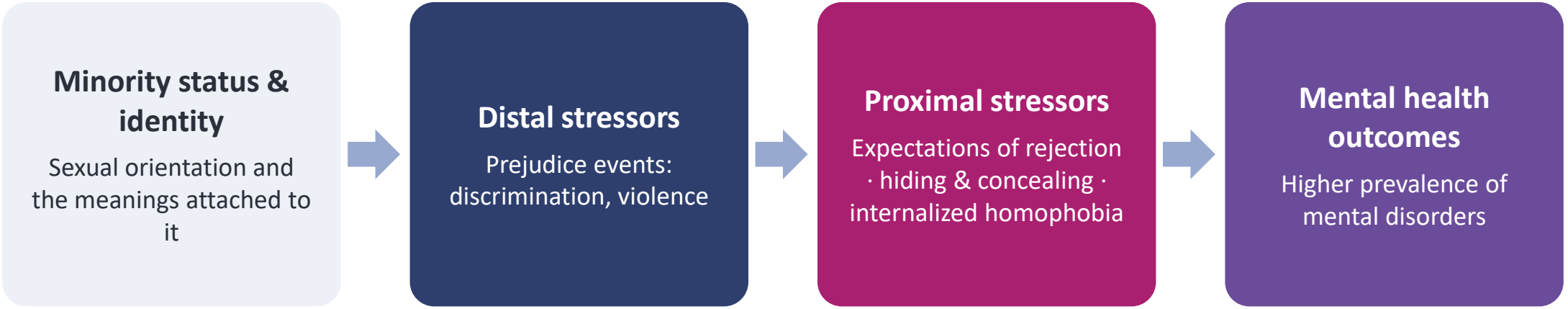
Odds are not destiny. Higher risk tracked exposure: more violence, more traumatic events, and earlier trauma (N = 34,653). Estimates also vary widely across studies and subgroups.

Sources: Marchi et al., 2023; Shipherd et al., 2011; Roberts et al., 2010

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The minority stress model

Stigma, prejudice, and discrimination create a hostile environment that causes mental health problems.



Ameliorative coping

Coping and social support can buffer the path from stress to distress.

Systemic lens

Family, faith communities, schools, workplaces, and institutions are part of the environment. Each can deliver distal stress or buffer it.

Source: Meyer, 2003. Systemic note: presenter's extension for MFT practice

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From mechanisms to treatable targets

Stigma gets under the skin through processes that existing treatments can change.

Internalized stigma

- Internalized heterosexism predicted PTSD severity in sexual minority women.
- Internalized homonegativity predicted PTSD for sexual trauma survivors.

Rejection sensitivity

- In one longitudinal study of 170 Black, Latino & multiracial GBM, racial discrimination × gay rejection sensitivity → emotion regulation difficulties → depression and anxiety → heavy drinking.

Emotion regulation

- Proposed framework: stigma-related stress raises emotion dysregulation (e.g., rumination), social isolation, and hopelessness, which in turn mediate distress.

Treatment implication: LGB-affirmative CBT (ESTEEM) and EQuIP were built to target these minority stress processes directly.

Sources: Hatzenbuehler, 2009; Dworkin et al., 2018; Solomon et al., 2021; English et al., 2018; Pachankis et al., 2015, 2020

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Double minority stress is an interaction

Not one stress plus another: racism and heterosexism shape each other, and the refuge for one can wound the other.

LGBT People of Color Microaggressions Scale: three subscales (18 items)

- **Racism in LGBT communities**
- **Heterosexism in racial & ethnic minority communities**
- **Racism in dating & close relationships**

Young Black gay men described homophobia and HIV stigma *"from churches and families within the Black community and from friends within the Black gay community, which otherwise provide support in the face of racism."*

Arnold, Rebchook & Kegeles (2014), "Triply cursed": 31 young Black gay men, 9 providers

Sources: English et al., 2018; Jackson et al., 2020; Balsam et al., 2011; Arnold et al., 2014

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Assess the joy, not only the wound

31% of days brought positive intersectional experiences, vs. 11% negative

Daily diaries from 131 Black LGBQ people.

Positive experiences predicted positive affect. Negative ones worked through identity conflict and rumination.

Clinical implication: ask what affirms clients at their intersections, not only what harms them.

Source: Jackson et al., 2020. Implication: presenter's

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Racism as trauma: RBTS and PTSD

Race-based traumatic stress is real injury, and it may not fit the PTSD criteria.

Race-based traumatic stress	DSM-5 PTSD
• Emotional injury from racism, including covert racism • Framed as a response to external, situational harm, not a disorder • May involve no Criterion A event	• Requires a Criterion A event plus symptom criteria • A diagnosis that guides treatment and access • Racism can meet it, but often does not

Case example in Williams et al.: racial trauma without a Criterion A event led to an adjustment disorder diagnosis; the UnRESTS interview still shaped the treatment plan.

Likely under-recognized

- Lack of clinician awareness
- Discomfort talking about race in therapy
- Lack of validated measures

Routine assessment prompt

"Have experiences of racism, at school, at work, online, or with police, affected you or your family?"

Black youth meet racism at school and in viral videos online.

Sources: Carter, 2007; Williams et al., 2018; Jernigan & Daniel, 2011; Tynes et al., 2019. Prompt wording: presenter's

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Treating racist-incident-based trauma

Eight counseling themes from Bryant-Davis & Ocampo.



Acknowledge



Share



Safety & self-care



Grieve



Shame, self-blame & internalized racism



Anger



Coping strategies



Resistance strategies

Named Caution: a conceptual approach illustrated with one case; the authors name its limits and call for more study.

Source: Bryant-Davis & Ocampo, 2006

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Adapt assessment and treatment to culture

Idioms of distress reveal what Western measures miss, and adapted treatment works better for PTSD.

CAMBODIA

Baksbat (bok-bye-it), “broken courage”: some symptoms are independent of PTSD.

SOUTH AFRICA · ZULU

A culture-specific screen elicited 19.4% more traumatic events.

INDIA

“I put a stone on my heart and kept going”: an emic model of distress.

Culturally adapted vs. non-adapted

SMD –0.67

PTSD symptoms · 7 RCTs, n = 213

Most common adaptations: socio-cultural integration, collaboration, psychoeducation, language, cultural matching, addressing stigma, provider training, practical supports.

No difference for depression or beyond post-treatment.

Sources: Chhim, 2012; Madigoe et al., 2017; Patel, Kovacevic, et al., 2022; Benjamin et al., 2026. Details in handout

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The systemic intersectional formulation

The spine of today's work: ten domains to map before you choose a treatment.

Individual trauma

Criterion A events and other harms

Minority stress

Discrimination, rejection expectations, concealment, internalized stigma

Double minority stress

Where racism and heterosexism or cissexism interact

Racism

Race-based stress at school, work, online, with police

Family acceptance & rejection

Specific accepting and rejecting behaviors; who knows what

Chosen family

Partners, friends, house parents: who shows up

Community

Connection and harm: faith, ballroom, LGBTQ+, cultural spaces

Institutions

School, workplace, health care, legal, religious

Ongoing threat

What is still happening; realistic risk; safety plan

Power & privilege

Client's and therapist's positions; what they make easy or hard to say

Presenter's synthesis tool drawing on Meyer, 2003; Balsam et al., 2011; Carter, 2007; Ryan et al., 2010; Livingston et al., 2020. Handout p. 1

Practice 1: map the system

1. **Form groups of 3–4.** Use the formulation tool (handout p. 1) and the case of Malik & Andre.

2. **Map all ten domains.** Put each detail from the case where it belongs. Note what you do not know yet.

3. **Mark three things.** One ongoing threat · one source of community harm and one of connection · where power sits in the therapy room.

4. **Report one surprise.** What did the map show that an individual PTSD assessment would miss?

5 min mapping · 2 min debrief

Treatment Fit & Safety

02 · EMDR, TF-CBT, and culturally responsive adaptation

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Standard treatments help, but were not built with us

Effective treatments exist, but they were rarely tested with queer clients or their realities.

Untested identities

Cognitive processing therapy (CPT), prolonged exposure (PE), and SSRI/SNRI antidepressants help PTSD, but their evaluations did not examine LGBTQ identities.

Ongoing threat

Existing PTSD treatments do not account for ongoing threats to safety or pervasive minority stress.

Low reach

Of 2,685 SGM adults, 87% had been in therapy, including for trauma (56%), yet relatively few received evidence-based trauma treatment.

Thin evidence

A review of 16 CBT studies for LGBTQ+ mental health rated risk of bias high or critical/serious in every study.

Sources: Livingston et al., 2020; Artime et al., 2025; Tudor-Sfetea & Topciu, 2024

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Five fit questions, with decision rules

Run every standardized model through this checklist before you start it.

Fit question	If the answer is no…
1 Does it assess minority stress and racism alongside Criterion A?	Add those measures before choosing targets (UnRESTS, minority stress scales).
2 Does it account for threats still happening?	Safety plan first. Don't challenge accurate appraisals of risk or target ongoing threat as a memory.
3 Does it name race, sexuality, and gender directly, early, and more than once?	Build in explicit cultural assessment and check-ins from session one.
4 Can family, chosen family, or community be part of it?	Add a conjoint or community component or consider a couple format.
5 Has it been tested or adapted with people at these intersections?	Adapt and monitor outcomes or choose an alternative or refer.

Livingston et al., 2020; Williams et al., 2014; Owen et al., 2016; Sijercic et al., 2022; Benjamin et al., 2026. Handout p. 3

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Clinical safety rules

Non-negotiables when trauma and oppression are still happening.

No habituation to oppression	Never use exposure to racism, homophobia, or transphobia to habituate. On racism, Williams et al.: “The goal is not to have clients become habituated to racism.”
Ongoing threat is not a memory	Don’t make a current threat a desensitization target. Accurate appraisals of risk are not distortions.
Safety planning first	Assess suicide risk, substance use, intimate partner violence, and family violence before trauma processing.
Religious & spiritual abuse	Screen for it as trauma without pathologizing faith; faith can be both wound and resource.
Consent and choice	Target identity-based events only with a clear rationale and the client’s informed consent.

Williams et al., 2014 (racism); Livingston et al., 2020; Menhinick & Sanders, 2023; Díaz et al., 2001; Roberts et al., 2010

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EMDR

Strong PTSD evidence, thin evidence for queer clients of color.

What the evidence shows

- EMDR improved PTSD diagnosis and reduced trauma symptoms, and was effective across cultures (2 meta-analyses, 4 RCTs).
- Limits: small samples and short follow-up; authors call for research across populations and cultural contexts.
- Syrian refugees: EMDR (n = 37) reduced PTSD and depression more than waitlist (n = 33).
- **Neither source reports sexual orientation or gender identity data.**

Rules for fit

- **Do not target ongoing minority stress as a past memory.** A pending complaint or an unsafe home is a safety issue, not a target.
- **Target identity-based events only with a clear rationale and consent.** Past assaults or rejection may qualify.
- **Monitor outcomes.** Without SOGI data, you are the evidence check.

Sources: Wilson et al., 2018; Acarturk et al., 2016. Rules for fit: presenter's, informed by Livingston et al., 2020

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TF-CBT

A strong core for youth, an LGBTQ adaptation built around family safety, and limited adaptation evidence.

Core evidence

- Multisite RCT: 229 children (8–14) with sexual abuse-related PTSD.
- TF-CBT beat child-centered therapy on PTSD, depression, behavior, shame, and abuse attributions.
- Built for youth and caregivers.

LGBTQ adaptation

- Safety comes first and continues throughout.
- Parental rejection is validated as a significant trauma.
- Goal: acceptance, “not to change families’ deeply held beliefs or values.”
- Limit or end caregiver involvement if a caregiver is actively unsafe or physically harmful.

Evidence limits

- The LGBTQ adaptation is a practice manual; no outcome trial is reported in the sources reviewed.
- Culturally modified TF-CBT for Latino youth: a pilot of 10 youth, no control group.

Sources: Cohen et al., 2004; Cohen, Mannarino, Wilson & Zinny, 2018; de Arellano & Danielson, NCTSN fact sheet

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Cultural adaptation decision tree

When to proceed, adapt, choose another path, or refer.

Is the client safe right now?

→ No → stabilize: safety plan, advocacy, connection. Hold trauma processing.

↓

Yes → Is the target a past event or ongoing oppression?

→ Ongoing → no exposure to the oppression itself. Build coping, affirming context, community, advocacy.

↓

Past event → run the five fit questions

→ **All yes → proceed with consent**

→ **Some → adapt**

→ **No → alternative or refer**

At any point: outside your competence with this model or these identities? Consult or refer to an affirming specialist.

Options with early evidence

- **Affirmative CBT** (ESTEEM, EQuIP): targets minority stress
- **Intersectional group CBT**: GBM of color felt less alone
- **Culturally adapted CPT and CA-CBT**: large PTSD effects in small trials
- **IPT**: a non-exposure option, noninferior to PE
- **Couple formats** (e.g., CBCT): reduce PTSD, improve relationships

Presenter's decision aid drawing on Livingston et al., 2020; Benjamin et al., 2026; Markowitz et al., 2015. Options: Pachankis et al., 2015, 2020; Jackson et al., 2022; Pearson et al., 2019; Jalal et al., 2020; Sijercic et al., 2022

Case thread 2: does it fit?

Session 2. Malik asks for EMDR “to get the attack out of my head.” The clinic’s trauma track offers individual CPT. Andre asks, “What about us?”

1. **In pairs,** run the five fit questions (handout p. 3) on EMDR for Malik.
2. **Decide:** proceed, adapt, or choose another path, such as a couple format.
3. **Name** the first safety step you would take, and what is not a processing target.

Pairs · 5 minutes

Harm & Repair

03 · Microaggressions, missteps, and the alliance

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The cost: outcomes, alliance, and dropout

Unacknowledged culture is not neutral. It is linked to whether therapy works.

Missed opportunities

Missed chances to discuss cultural identity were linked to worse outcomes with less culturally humble therapists.

Microaggressions → alliance

Perceived microaggressions related to lower well-being, mediated by the working alliance.

BIWOC clients

Microaggressions were linked to poorer outcomes through lower cultural humility and alliance.

Dropout disparities

Therapists' racial/ethnic comfort was associated with disparities in unilateral termination.

Trauma clients may be most exposed: among 2,685 SGM adults, those treated for trauma reported more barriers and microaggressions than others in therapy. Overall, microaggressions were low and satisfaction high.

Sources: Owen et al., 2016; Owen et al., 2011; DeBlaere et al., 2023; Owen et al., 2017; Artime et al., 2025

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Seven sexual orientation microaggressions

What 16 LGBQ clients experienced, and what to do instead.

Microaggression clients reported	Do instead
Assumption that sexual orientation is the cause of all presenting issues	Ask what brings them in, and how identity relates, if at all
Avoidance and minimizing of sexual orientation	Name it and invite it in when it matters
Attempts to overidentify with LGBQ clients	Center their experience; disclose only if it serves them
Making stereotypical assumptions about LGBQ clients	Ask about this client's meanings and communities
Expressions of heteronormative bias	Use inclusive language for partners, family, and sex
Assumption that LGBQ individuals need psychotherapeutic treatment	Treat the presenting concern; identity is not the problem
Warnings about the dangers of identifying as LGBQ	Plan for real external threats without discouraging identity

Source: Shelton & Delgado-Romero, 2011. "Do instead" column: presenter's clinical translation

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Eight missteps with trans clients

What each looks like, and a repair response.

Misstep	What it looks like	Repair response
Education burdening	The client has to teach you about TGNC issues	Seek training and consultation; stop making the client teach
Gender inflation	Exaggerated focus on gender over the rest of life	Follow the client's agenda across all of life
Gender narrowing	Fitting the client into a preset "formula" of gender	Use the client's own language and meanings
Gender avoidance	Not addressing gender enough	Invite gender in when it matters to the client
Gender generalizing	Assuming all TGNC people are the same	Individualize
Gender repairing	Treating identity as a problem to fix	Affirm; never try to change identity
Gender pathologizing	Labeling gender variance as illness or the cause of all problems	Separate distress from identity
Gate-keeping	Overfocus on controlling access to gender-affirming care	Keep therapy on client goals; be transparent about letters

Source: Mizock & Lundquist, 2016 (45 TGNC participants).

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A five-step repair

When a microaggression lands, repair it out loud. The alliance carries the outcome.

1	**Acknowledge**	*"Last session, when you talked about your father, I said I knew exactly how you felt."*
2	**Take responsibility**	*"That was about me, and it put my story in place of yours."*
3	**Inquire**	*"What was that like for you? What did it make harder to say?"*
4	**Repair**	*"I want to hear your experience, as a Black gay man in your family and church, on its own terms."*
5	**Change behavior**	*"I'll keep my story out unless it serves you, and I'm taking this to consultation."*

Owen et al., 2011, 2016; DeBlaere et al., 2023

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Person of the Therapist: the decision loop

Know your history, access it in the moment, and use it on purpose. Run the loop at the first cue in session.

1 → Notice

Catch the cue in body, emotion, or behavior.

2 → Name privately

What is stirred, and which values or invisible scripts it touches.

3 → Check the aim

Whose need would a response serve: the client's or mine?

4 → Check the power

How do our positions shape what this response means?

5 → Choose

Use it, hold it, or repair.

Shared identity can deepen attunement or replace it. Clients name overidentification as a microaggression. The loop is recursive: after every shift, re-access the self.

Aponte & Kissil, 2014; Pennant & Shamoon, 2023. Overidentification: Shelton & Delgado-Romero, 2011

Case thread 3: repair in the room

Session 3. As Malik describes his father, the therapist says, “I know exactly how you feel. My church rejected me too.” Malik goes quiet. He cancels the next session, then returns.



Therapist: Run the loop silently, then repair with the five steps.



Malik: Respond honestly to what the therapist offers.



Observer: Track the five steps and the loop. Give one strength and one edit.

Triads · 5 min role-play · 2 min debrief

Relational, Community & Somatic Healing

04 · Family, chosen family, community, and the body

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Relational treatment: the evidence

Couple and group formats reduce PTSD. The evidence is young, and family-based trials for adult PTSD are missing.

Clinical framework

EFT for trauma

Interpersonal trauma violates human connection, so healing attachments matter.

A 1998 conceptual paper: the authors note very few empirical studies and do not present couple therapy as sufficient on its own.

Meta-analysis
12 couple, 7 individual studies

Both formats: moderate-to-large PTSD reductions, small gains in relationship functioning. No family-based treatments for adult PTSD were identified.

Cochrane review
4 trials

Evidence insufficient, but CBCT (cognitive-behavioral conjoint therapy) beat waitlist for PTSD (low-quality evidence).

Decade review
31 systemic studies

Strongest evidence for youth–caregiver, group, and couple treatments; youth–caregiver approaches rated probably efficacious.

Sources: Johnson & Williams-Keeler, 1998; Sijercic et al., 2022; Suomi et al., 2019; McWey, 2022

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Family & chosen family in practice

Turn identity into a strength instead of a fault line and keep safety first.

Two models

EMBRace: racial socialization between Black parents and adolescents as a cultural strength; five 90-minute sessions that target racial stress and trauma.

Family acceptance (TF-CBT LGBTQ): include rejecting, not abusive, caregivers; aim for acceptance, not changed beliefs.

Family acceptance in adolescence was linked to better mental health in LGBT young adults (n = 245).

Systemic steps

1. Map who counts as family: genogram plus chosen family and house parents.
2. Name specific accepting and rejecting behaviors, including silence and secrecy.
3. Invite family or chosen family into conjoint sessions only when safe.
4. Set the safety boundary: limit contact with anyone actively unsafe.
5. Rehearse identity and race conversations the client wants to have.

Sources: Anderson, McKenny & Stevenson, 2019; Cohen et al., 2018; Ryan et al., 2010; Arnold & Bailey, 2009. Steps: presenter's clinical application

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Community as a clinical intervention

Belonging is treatment. Map it, refer to it, and strengthen it.

Map it
Draw an ecomap of chosen family and communities. Mark each as connection, harm, or both.

Refer to groups
Warm referrals to affirming groups. GBM of color in group CBT felt less alone.

Strengthen connectedness
Connectedness was linked to lower anxiety among LGBTQ+ survivors.

Honor kinship systems
Ballroom houses give kinship and health guidance that biological definitions of family miss.

Radical healing

Five anchors for communities of color

- **Collectivism**
- **Critical consciousness**
- **Radical hope**
- **Strength & resistance**
- **Cultural authenticity & self-knowledge**

Bedford et al., 2023; Jackson et al., 2022; Arnold & Bailey, 2009; French et al., 2020; Arnold et al., 2014. Actions: presenter's clinical application

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Somatic & ancestral pathways

Healing through the body, through ceremony, and through time.

The body

- **CA-CBT** treats somatic sensations with yoga-like stretching and meditation.
- **Trauma-focused yoga**: 52% vs. 21% no longer met PTSD criteria (64 women).
- **Somatic Experiencing**: PTSD effects d = 0.94–1.26 vs. waitlist (n = 63).

Ancestors & time

- **Historical unresolved grief** crosses generations; healing combines ceremony, communal grief rituals, and elders teaching history.
- **Queer care across time**: address the erasure of queer pasts and threats to queer futures.

Trauma-informed safety: offer choice and invitational language, never touch without consent, let clients keep eyes open, and stop if they dysregulate. These trials did not test effects for queer clients of color.

Sources: Jalal et al., 2020; Eskici et al., 2023; van der Kolk et al., 2014; Brom et al., 2017; Brave Heart & DeBruyn, 1998; Menhinick & Sanders, 2023. Safety note: presenter's guidance

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Case thread 4: the next-session plan

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Safety first	Screen drinking and suicide risk. Plan for safety at school and when going out.
Formulation	Share the ten-domain map with both partners and correct it together.
Treatment path	Couple format plus individual trauma work on the assault, with consent. The complaint is not a target.
Repair & alliance	Open with the repair. Check in on race, sexuality, and bisexuality every session.
Community & body	Bring the house mother into the plan if Malik wants; add grounding and somatic resourcing.

Planning template: handout p. 4

Key takeaways

1. Queer trauma is cumulative and systemic: map family, chosen family, community, institutions, and ongoing threat.
2. Double minority stress is an interaction. The communities that heal one wound can enact another.
3. Test every model’s fit, and never treat ongoing oppression as a memory to habituate to.
4. Repair is a clinical skill: acknowledge, take responsibility, inquire, repair, change.
5. Healing is relational: couples, families, chosen family, community, and the body belong in the plan.

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Questions & answers

Before you leave, write one change you will make in your next session.

10 minutes

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References & handout

Everything cited today is in the handout packet.

Handout packet contents

- **p. 1** · Systemic intersectional formulation tool
- **p. 2** · Systemic assessment questions and chosen-family & community mapping
- **p. 3** · Five fit questions, clinical safety rules, and the adaptation decision tree
- **p. 4** · Five-step repair, decision loop practice card, and next-session plan
- **p. 5** · The composite case: Malik & Andre
- **pp. 6–7** · Evidence tables and assessment toolkit
- **pp. 8–10** · Full APA reference list
- **p. 11** · Support resources

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Thank you

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