Systemic Intersectional Formulation

Page 1 · Map all ten domains before you choose a treatment. Note what you do not know yet.

Domain	Prompts	Notes for this client
Individual trauma	Criterion A events (actual or threatened death, serious injury, sexual violence) and other harms. When? By whom?	
Minority stress	Discrimination and violence; expectations of rejection; concealment; internalized stigma.	
Double minority stress	Where racism and heterosexism or cissexism interact. Which spaces feel unsafe for which identity?	
Racism	Race-based traumatic stress: school, work, online, police, health care. Covert as well as overt.	
Family acceptance & rejection	Specific accepting and rejecting behaviors, including silence and secrecy. Who knows what?	
Chosen family	Partners, friends, house parents, mentors. Who shows up? Who would they want involved?	
Community	Connection and harm: faith, ballroom, LGBTQ+ spaces, cultural community. Which hold both?	
Institutions	School, workplace, health care, legal, immigration, religious institutions.	
Ongoing threat	What is still happening? Is the client's appraisal of risk accurate? What is the safety plan?	
Power & privilege	The client's and the therapist's positions. What do they make easy or hard to say in the room?	

Meyer (2003); Balsam et al. (2011); Carter (2007); Williams et al. (2018); Ryan et al. (2010); Arnold & Bailey (2009); Bedford et al. (2023); Livingston et al. (2019, 2020); and the Person of the Therapist power check.

Systemic Assessment Questions

Page 2 · A question bank for couples, families, chosen family, communities, and institutions. Adapt to your voice and the client's words.

System	Questions
Couple/Intimate Partners	• How does each of you experience the threat, and the other's way of coping with it? • Who knows about your relationship at work, at church, and in each family? How do you decide? • When one of you is hurt by racism or homophobia, what does the other do that helps? That hurts?
Family of origin	• Who in your family knows your sexual orientation or gender identity? What did they do when they found out? • What accepting or rejecting behaviors happen now, including silence or secrecy? • What did your family teach you about race, and about sexuality and gender?
Chosen family	• Who shows up for you? Who would you call in the middle of the night? • Would you want any of them involved in therapy?
Community	• Where do you feel fully yourself? Where do you hide part of yourself? • Which communities support one part of you and harm another? • Has religion or spirituality been a source of harm, support, or both?
Institutions	• Have school, work, health care, police, or legal systems treated you differently because of race, sexuality, or gender? • What is still happening now?
Safety	• What would make you safer this week? • Ask directly about suicidal thoughts, substance use, and violence at home or from a partner.
Power in the room	• What about me, my identities or my role, might make it harder to tell me some things?

Chosen-family & community mapping

Draw the client at the center of a page with three rings: closest, regular contact, and further out. Place every person, chosen family member, and community on the map, then mark each one in the table below.

Person or community	Connection, harm, or both?	What they offer or cost	Involve in treatment? How?

Ryan et al. (2010), Arnold & Bailey (2009), Arnold et al. (2014), Bedford et al. (2023), and Livingston et al. (2020).

Treatment Fit & Safety

Page 3 · Run every standardized model through these checks before you start it.

Five fit questions, with decision rules

Fit question	If the answer is no...
1. Does it assess minority stress and racism alongside Criterion A events?	Add those measures before choosing targets (e.g., UnRESTS, minority stress scales).
2. Does it account for threats that are still happening?	Safety plan first. Do not 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.

Clinical safety rules

- **No habituation to oppression.** Never use exposure to racism, homophobia, or transphobia to habituate. As Williams et al. (2014) put it, "the goal is not to have clients become habituated to racism."
- **Ongoing threat is not a memory.** Do not make a current threat a desensitization target. Accurate appraisals of risk are not distortions (Livingston et al., 2020).
- **Safety planning first.** Assess suicide risk, substance use, intimate partner violence, and family violence before trauma processing.
- **Religious and 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 informed consent.

Cultural adaptation decision tree

1. Is the client safe right now? If no: stabilize with a safety plan, advocacy, and connection. Hold trauma processing.

2. Is the target a past event or ongoing oppression? If ongoing: no exposure. Build coping, an affirming context, community, and advocacy.

3. Past event: run the five fit questions. All yes: proceed with consent and monitor. Some: adapt (language, collaboration, psychoeducation, addressing stigma, cultural integration). No: choose an alternative (affirmative CBT, intersectional group CBT, culturally adapted CPT or CA-CBT, IPT, a couple format such as CBCT) or refer.

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

Livingston et al. (2020), Williams et al. (2014), Owen et al. (2016), Benjamin et al. (2026), Sijercic et al. (2022), and Markowitz et al. (2015).

Repair, Reflect, Plan

Page 4 · Practice tools for the role-play and for your next session.

Five-step repair

Step	What it sounds like (fictional composite case)
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."

Workshop repair framework (presenter). Why repair matters: microaggressions affect outcomes through the working alliance (Owen et al., 2011; DeBlaere et al., 2023), and cultural humility moderates the harm of missed cultural opportunities (Owen et al., 2016).

One loop this week (practice card)

The decision loop: Notice → Name privately → Check the aim (whose need would this serve?) → Check the power → Choose: use it, hold it, or repair. After every shift, return to step one.

1. **Know.** Name one moment this week that stirred you. Write it as a cue (what happened, where you felt it), not a story.
2. **Access.** In your next session, notice where it registers in your body. Run the loop.
3. **Use.** Use it briefly in service of the client system, hold it for consultation, or repair if it has already landed.
4. **Bring it.** Take it to supervision or consultation, and note what changed.

My cue	One value or invisible script it touched	My decision: use / hold / repair

Colibri Person of the Therapist Supervisor Edition (Colibri Center for Systemic Training, 2026), adapted here for the clinical room. The Know / Access / Use framework draws on Aponte & Kissil (2014) and Pennant & Shamoon (2023).

Next-session plan

Area	My plan for Malik & Andre (fictional case) or my own client
Safety first	
Formulation to share	
Treatment path and adaptation	
Repair and alliance	
Community and body	

The Case: Malik & Andre

Fictional composite written for teaching. Not a real client.

Malik (he/him), 29, is Black and gay. He teaches middle school and was raised in a Black Baptist church. **Andre** (he/they), 33, is Afro-Latino, bisexual, and gender-expansive, and works as a nurse. His Catholic family calls his bisexuality "a phase."

- **Presenting concern.** Four months ago, Malik was assaulted outside a gay bar by men shouting anti-gay slurs. Since then he has nightmares, scans crowds, and drinks more on weekends.
- **Family and chosen family.** Malik's father cut contact when he came out at 17. His mother calls him in secret. His ballroom house mother is his main support.
- **Ongoing threat.** A parent complaint that Malik is "promoting a lifestyle" is under review at his school. He has stopped going out and keeps Andre away from work events.
- **The couple.** They seek couple therapy at a community clinic. Andre: "He's hiding us." Malik: "I'm trying to keep us safe."
- **The therapist.** A white, cisgender lesbian, licensed for 8 years, who came out in a conservative church family.

Case thread prompts

Thread 1 · Practice 1 (map the system). Map all ten domains. Mark one ongoing threat, one source of community harm and one of connection, and where power sits in the therapy room.

Thread 2 · Practice 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?" Run the five fit questions on EMDR and name your first safety step.

Thread 3 · Practice 3 (repair). Session 3: as Malik describes his father, the therapist says, "I know exactly how you feel. My church rejected me too." Malik goes quiet, cancels the next session, then returns. Run the loop, then repair in five steps.

Thread 4 · Integration. Write the next-session plan on page 4.

Evidence Tables

Pages 6–7. Most treatment evidence comes from small, often waitlist-controlled samples.

Risk and prevalence

Finding	Source
LGBTQ people: OR 2.20 for PTSD vs. heterosexual/cisgender peers (27 studies; I^2 = 91%; low-quality evidence). Transgender OR 2.52; bisexual OR 2.44 (1.44 vs. lesbian and gay peers).	Marchi et al., 2023
U.S. representative sample (N = 34,653): excess PTSD risk among sexual minorities largely accounted for by violence exposure, more traumatic events, and earlier trauma.	Roberts et al., 2010
Transgender sample (n = 97): 98% reported ≥ 1 potentially traumatic event; 42% of those exposed reported a bias-related event.	Shipherd et al., 2011
912 gay and bisexual Latino men, past 6 months, felt at least once or twice: depressed mood 80%, anxiety 44%, suicidal ideation 17%. Homophobia, racism, and financial hardship predicted symptoms.	Díaz et al., 2001
131 Black LGBQ people: positive intersectional experiences on 31% of days, negative on 11%.	Jackson et al., 2020

Affirming and culturally adapted treatments

Model	Who	Key finding	Source
LGB-affirmative CBT (ESTEEM)	Young gay and bisexual men (n = 63)	Reduced depression, alcohol problems, sexual compulsivity, condomless sex vs. waitlist	Pachankis et al., 2015
EQuIP	Sexual minority women (n = 60; 43% trans or nonbinary)	Depression d = 0.85, anxiety d = 0.86 vs. waitlist	Pachankis et al., 2020
Intersectional group CBT	Young Black and Latino GBM (pilot, n = 21)	Feasible; 17 of 20 outcomes moved in the expected direction; felt less alone	Jackson et al., 2022
Culturally adapted PE	African American clients	Front-end rapport sessions; ask directly about race; safe exposures only (case examples)	Williams et al., 2014
Culturally adapted CPT	Native American women (n = 73)	Large reductions in PTSD and high-risk sexual behavior vs. waitlist	Pearson et al., 2019
CA-CBT	Sepedi South Africans (n = 20); Syrian refugee women (n = 23)	PTSD d = 2.11 completers / 1.27 ITT vs. relaxation; d = 1.17 vs. usual care	Jalal et al., 2020; Eskici et al., 2023
IPT (non-exposure)	Chronic PTSD (n = 110)	Response 63% IPT, 47% PE, 38% relaxation (n.s.); IPT noninferior to PE	Markowitz et al., 2015
Adapted vs. non-adapted (meta-analysis)	Adults from racial and ethnic minority groups (21 studies)	PTSD SMD −0.67 (7 RCTs); anxiety SMD −1.92 (5 RCTs); no difference for depression	Benjamin et al., 2026

Harm, alliance, and relational evidence

Finding	Source
Missed cultural opportunities linked to worse outcomes only with therapists seen as less culturally humble (247 clients, 50 therapists).	Owen et al., 2016
Perceived microaggressions linked to lower well-being, mediated by the working alliance (232 clients, 29 therapists).	Owen et al., 2011
288 BIWOC clients: microaggressions linked to poorer outcomes through cultural humility and alliance (cross-sectional).	DeBlaere et al., 2023
Therapists' racial/ethnic comfort associated with disparities in unilateral termination (177 clients, 23 therapists).	Owen et al., 2017

Finding	Source
2,685 SGM adults: trauma-treated clients reported more barriers and microaggressions; microaggressions fully mediated the gender identity–satisfaction link.	Artime et al., 2025
Couple and individual PTSD treatments: moderate-to-large PTSD reductions; small relationship gains; no family-based treatments identified.	Sijercic et al., 2022
Couple therapies: evidence insufficient; CBCT beat waitlist for PTSD (low-quality evidence). CBCT = cognitive-behavioral conjoint therapy, 15 sessions in three phases.	Suomi et al., 2019
Systemic interventions 2010–2019 (31 studies): strongest evidence for youth–caregiver, group, and couple treatments.	McWey, 2022

Assessment toolkit

Tool	What it captures	Format	Systemic use
LEC-5 · PCL-5	Lifetime Criterion A exposure · PTSD severity	Self-report (16 · 20 items)	Baseline and progress monitoring
Everyday Discrimination Scale	Type and frequency of everyday discrimination	Self-report (9 items)	Track institutional and community stressors
Gender Minority Stress & Resilience Measure	Discrimination, rejection, victimization, non-affirmation, internalized transphobia, concealment, community connectedness, pride	Self-report (58 items)	Pair stress and resilience domains in the formulation
Minority stress measure	Violence and victimization, outness, community connectedness, internalized homophobia/transphobia	16 yes/no items	Quick screen of connectedness (Goldbach et al., 2015, as cited in Bedford et al., 2023); items not yet empirically validated
LGBT People of Color Microaggressions Scale	Racism in LGBT spaces; heterosexism in communities of color; racism in dating	Self-report (18 items)	Map double minority stress across communities
UnRESTS	Ethnoracial identity development and racism-related experiences, within DSM-5	Clinician interview	Name racism in the case conceptualization
Family acceptance measure	Retrospective family accepting behaviors toward LGBT adolescents	Self-report	Name accepting behaviors to build on (Ryan et al., 2010)
Culture-specific screens	Locally meaningful events and idioms of distress	Culturally adapted	e.g., Zulu trauma questionnaire; adapted HTQ (Madigoe et al., 2017; Patel, Newman & Richardson, 2022)

Measures listed in Livingston et al. (2020, Tables 1–2), Balsam et al. (2011), Williams et al. (2018), Bedford et al. (2023), and Ryan et al. (2010). Item counts are as reported in those sources. Not every measure listed is validated for every population; check psychometrics before use.

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Support Resources

Step out whenever you need to. You are welcome to speak with the presenter at the end of the session.

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