



MARGINALIZED COUPLES IN THERAPY

Interventions for Healing
from Systemic Trauma

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INTRODUCTION

I want to gently invite you to imagine with me. Picture yourself traversing the wonderful yet tumultuous waters of love and intimacy under the relentless pressure of societal discrimination and oppression. Visualize the experience of sitting with a practitioner—the weight of confusion and overwhelm resting heavily upon your shoulders—attempting to dissect the disruptions in your relationship, while grappling with external forces that seem largely beyond your control. Now imagine being in a therapeutic space with a practitioner, whose efforts are not targeted to address the real cause of your pain: the system that inflicts it. For many BIPOC (Black, Indigenous, and people of color) and LGBTQIA+ (lesbian, gay, bisexual, transgender, queer/questioning, intersex, and asexual) folks, this is the disconcerting reality. These folks are marginalized, which means that they are disempowered, excluded, denied basic rights, oppressed, and treated as if they are insignificant.

There was a stage in my practice when I reached a pivotal point. I realized that I wasn't thoroughly prepared for working with clients who walk this painful truth every day. I was versed in various modalities, but I was not holding enough space for the assault my clients faced from the wider system. I needed to look not just deeper but wider. There was a dire need to broaden my lens. It was this quest that birthed this book, which illuminates the intersections of systemic trauma and relational privilege, specifically as they affect marginalized couples.

I view this book as a fulfilled commitment. The experiences of marginalized people are often devalued, even by helping professionals, and this text is my dedication to carving a space where we, as practitioners, can ensure that we are of service in a way that is rooted in the realities of our people. It is also a reflection of my obligation to marginalized couples and individuals. My sincere wish for them all is that they are never harmed in therapy but instead uplifted.

As a Black Caribbean woman who hails from Trinidad and Tobago, I also

know that my decision to write is an important statement. So often, voices from this part of the world are dismissed or relegated to lesser platforms. I have had the privilege of being able to serve clients from the Caribbean and from many other parts of the world. All of those voices have informed this work, and as I occupy this body, battling the ravages of postcolonialism, xenophobia, and racism, I am reminded of the importance of my voice in this world.

Divided into three parts, this text begins by exploring systemic trauma in Part I. Here, we discuss the pervasive effects of discrimination and marginalization on intimacy. Part II invites us to consider how to build a transformative therapeutic posture via the BIOME (bravery, intensity/intimacy, openness, microliberatory movements, epistemic embracing). The PRIDE model of intervention is also introduced in this part of the work. In Part III, you are escorted through distinct phases of working with marginalized couples. You are furnished with actionable methodologies, which are all supported by case examples and quotes in order to enrich your understanding and application of the work. In order to respect the privacy and anonymity of my past and present clientele, these case examples represent an amalgam of cases I have worked with over the years and pseudonyms have been used. The amalgam is deliberate so that stories are not identifiable. Additionally, pseudonyms have been used for some of the other direct quotes throughout this text. Essential concepts, such as relational curiosity, responsible externalizing, and building liberatory connections, are examined to equip you with what you need to support your clients. Finally, you are gently encouraged to sit in the discomfort we feel when some of our strategies do not work.

I have designed this book to provide guidance for therapists, social workers, counselors, and practitioners who either work with marginalized couples or wish to in the future. This book can also be used by current students of the aforementioned disciplines. It can support us all in appreciating the unseen complexities of intimacy that operate under the surge of systemic oppression. I hope that this book enhances your work and deepens your commitment for advocacy for social justice.

As a social worker, educator, trainer, and therapist, I have dedicated much of my practice, research, and teaching to address the needs of the communities I have written about in this text. My work in this field is ongoing and constantly unfolding. You are meeting me and this work in one phase of my journey. I am delighted to know that as I continue my work with so many communities,

I will continue to be nourished by additional insights. Some of these insights will shake the very foundation of where I am now. I am ready for that. I am also deeply grateful for the ways in which the voices of my clients have already had such a profound effect on my work. Their stories, which are highlighted in this text, have deeply inspired the body of work that I share with you now.

Please embark on the journey within this book in a way that feels right for you. Engage it with an authentic heart. Allow yourself to think critically about the work and to feel your own creativity. It is my sincere hope that this book emboldens you to do that. Be brave! Find and use your voice!

Together, let's explore the power that lies in humbly and wholeheartedly connecting with marginalized people. Together, let's work *with* them to create steps toward liberation and authentic relationship building.

Let's begin!

CHAPTER 1

A Prison With Invisible Bars

The Impact of Systemic Trauma on BIPOC and LGBTQIA+ Individuals and Relationships

It is not one moment. It is all the moments, and it is a system. It is a system of questions because you are never really sure what is happening to you.

—Yara, on dealing with racism and xenophobia in the United Kingdom

It is hard, every single day. It is like every single day, this is the fight. When you get up in the morning and you get dressed, it is a struggle to dress a particular way or look a particular way. It is exhausting.

—Jay, on facing homophobia in Trinidad and Tobago

Since transitioning, I've noticed a lot of people think I have a personality disorder. None of these people have ever been a therapist who has supported me, but they all know I am trans. So many people think I am a "crazy tranny." I've noticed that it's much easier to be taken seriously at work and in everyday life if people don't know that I am trans. I'm afraid of disclosing. I'm proud of who I am, but I am sick of being discriminated against.

—Elena, on being a trans woman in the United States

I remember what it felt like to sit with the three clients quoted above. I could sense their stifled, anxious, hypervigilant, and weary states. They were living in prisons with invisible bars, struggling to live fully, freely, and wholeheartedly. Their bodies were heavy with grief over the reality of a field that, even in its aim to be therapeutic, inflicts harm by not appreciating the true genesis of their painful narratives. For these clients, sitting with clinicians was difficult

and often, horrid. They were experiencing a profound sense of trauma, but often, their therapists did not understand how to provide support. Clinicians became additional perpetrators of harm, with assessments and treatment plans that paid tribute to the therapist's comfort and narrow etiologies.

We, as practitioners, sometimes ask the wrong questions when working with many of our clients. There is a deeper dive to be taken. There is a need for a wider scope and a form of clinical curiosity that stretches beyond the micro-contexts of our clients. Referring to the work of Thema Bryant, Linda Thai (trainer, mental health practitioner, and storyteller) notes: "Traditional psychology asks 'What's wrong with you?' Trauma-informed therapy asks 'What happened to you?' Culturally informed psychology asks 'What happened to your people?' Liberation psychology asks 'What continues to happen to you and your people?'" (Kelley & Marriott, 2023).

We are not doing the work if we are not asking the last two questions!

WHAT HAS HAPPENED AND WHAT CONTINUES TO HAPPEN? AN EXPLORATION OF SYSTEMIC TRAUMA

Systemic trauma can be defined as harm that emerges from components of the *wider* environment, cultural norms, and institutions. Perpetrators of systemic harm often include educational systems, economic structures, criminal justice systems, and religious institutions. For example, in Australia, a 2024 research report from the National Indigenous Youth Education Coalition School Exclusion Project points to the exclusion of Torres Strait Islander and Aboriginal people from the 19th century to present day in the country's public school system. The report goes on to demonstrate how Indigenous students are also treated differently in the educational system. Almost 7% of all expulsion is meted out to Indigenous children though they only represent approximately 2% of the student population. The criminal justice system has also presented its own challenges to marginalized people. Throughout the world, this system continues to horribly fail lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual, and other (LGBTQIA+) people. At the time of writing, in countries such as Trinidad and Tobago, as well as South Africa, many LGBTQIA+ complain about the lack of responsiveness from police to their various complaints of homophobic and transphobic violence (Naidoo et al.,

2023). The challenges that Black people in the United States experience at the hands of the police are also well known. This felt so vivid for me as I listened to the story of Lincoln, a Black man living in Florida. While discussing his experience of the police system as a taxpaying citizen in America, he said, “I’m paying them to kill me.” Sadly, the horrors do not end there for marginalized folks. Even religious institutions have been sources of harm. African slavery and genocide against Indigenous people are but two examples of the ways in which religious dogma has contributed to harm marginalized groups. For LGBTQIA+ people, there are countless stories of religious-based conversion practices as well as a loss of connection from their religious communities (Jones et al., 2022).

Features of Systemic Trauma

Why do we need to pay so much attention to the role of systemic trauma in the lives of marginalized people? Why do we need to pause and be with this type of trauma differently? It’s because there are four specific features of systemic trauma, which actually make it difficult to treat in therapy. Systemic trauma is *chronic and pervasive, disenfranchised, system induced, and unpredictable*. Its chronic and pervasive nature is evident by the fact that it continues to persist across time and space despite many efforts. Day by day, marginalized people have stories to tell about numerous microaggressions or larger infractions inflicted on them by those who hold more power in the world. From shopping in a store to navigating the judicial system, they live in a state of unsafety, surrounded by callous and unjust acts. Sadly, much of this is ignored or even invalidated by others who refuse to believe the experiences of marginalized people. The result of this lack of acknowledgment is disenfranchised pain, as their claims are often dismissed by those who hold more power and privilege in the world. Over time, this degree of systemic invalidation becomes self-invalidation, where marginalized people begin to doubt themselves and their experiences. As Jamie, a 25-year-old Asian transwoman shared:

“You are always asking yourself, ‘Did that just happen? Did I imagine that? Did they mean that or am I too sensitive?’ It destroys your nerves—always having to be on guard for harm, and then always wondering if you are perceiving the world right.”

Michael, a Caribbean immigrant living in Florida shared:

“After a while, you live in questioning. Questioning your sanity, questioning your thoughts.”

Sitting in the above realities results in persons living out of alignment with their own understanding of the world. This is one of the most violent pieces of systemic trauma: the way in which it forces you to step outside of your own reality in order to survive. Living your own truth becomes a privilege, accessed by those who hold power in the world. We explore more about this later in this chapter.

The unpredictable nature of systemic harm means that persons are often hypervigilant and are deeply concerned with survival. Irritability, mood disturbance, and changes in sleeping patterns present for persons who are always on the lookout for harm. In some cases, effects on the brain itself have been noticed. Research done by Fani et al. (2021) noted that Black women who indicated more experiences of racism also had more responsivity in brain regions that were responsible for vigilance and threat detection. Additionally, it was observed that there was greater response within the threat-inhibition networks in the brain, which indicates not only greater vigilance but “suppression of the threat response” (p. 1010). In other words, systemic trauma not only affects how vigilant one must be, but in order to survive this degree of harm and keep safe, one must overregulate how one responds to perceived threats. To gain a clearer understanding of how systemic trauma is truly unique and different from other types of trauma, see Table 1.1.

Type	Systemic trauma	Single-incident trauma
Source	Ongoing, pervasive, societal structures	Singular event (e.g., accident, assault)
Onset	Often insidious, cumulative, may go unnoticed	Sudden, clear onset
Impact on nervous system	Chronic dysregulation, hypervigilance, etc.	Acute stress response, posttraumatic stress disorder (PTSD) possible

Impact on emotional regulation	Difficulty regulating emotions, emotional numbing	Difficulty regulating emotions, flashbacks, nightmares
Impact on identity	Erosion of sense of self, shame, internalized oppression	Shock, confusion, potential for identity shift
Examples	Racism, sexism, homophobia, poverty, discrimination	Car accident, natural disaster, violent crime

Systemic harm causes considerable emotional, psychological, sexual, spiritual, financial, and physical distress to persons who are considered minoritized or marginalized in our societies. Let’s discuss these further.

Psychological and Emotional Harm

I feel like I am in an aquarium. I feel like I am behind glass in a museum. They are looking at me, just for their own entertainment. They are judging and laughing.

—Yara, on being Black in the United Kingdom

I’m tired a lot. Part of my battery gets used just existing, and part of that fatigue is because my nervous system is active all the time. Existing in this space is hard.

—Steph, on being Black in the United States

I sometimes find myself going into derealization. I feel like I often have to control who I am. For most of my life, I had to play a part because my gender expression was policed.

—Jess, on being a trans woman in the United States

Living in constant watch for harm is an unimaginable pain. Persons who exist on the margins of our society also *exist outside of the margins of the possibilities for their lives*. Being constantly vigilant places their nervous system in states that are not optimal for imagination, growth, creativity, flexibility, self-regulation, and coherent thinking. The state of the nervous system that allows for this is what I call the “window of possibilities,” an adaptation of the beautiful concept known as the “window of tolerance” developed by Dan Siegel (2020). I say “possibilities” because I believe that trauma traps us in a narrow range

of outcomes for our lives. It is a violent stripping of different ways of being in the world. Our repertoire of behaviors, ideologies, and decisions becomes smaller, or perhaps more restricted to our survival and not our growth. To understand more about this, let us look at the way that the autonomic nervous system (ANS) works and the impact of systemic trauma on the ANS. We will then look at the window of possibilities and Siegel's window of tolerance.

The human nervous system consists of two major parts: the central nervous system and the peripheral nervous system. The brain and spinal cord make up the central nervous system; the peripheral nervous system is composed of nerves that travel from the spinal cord and extend to the rest of the body. The ANS, which is a significant part of our upcoming discussion, is considered part of the peripheral nervous system. Consider the diagram in Figure 1.1 for further understanding.

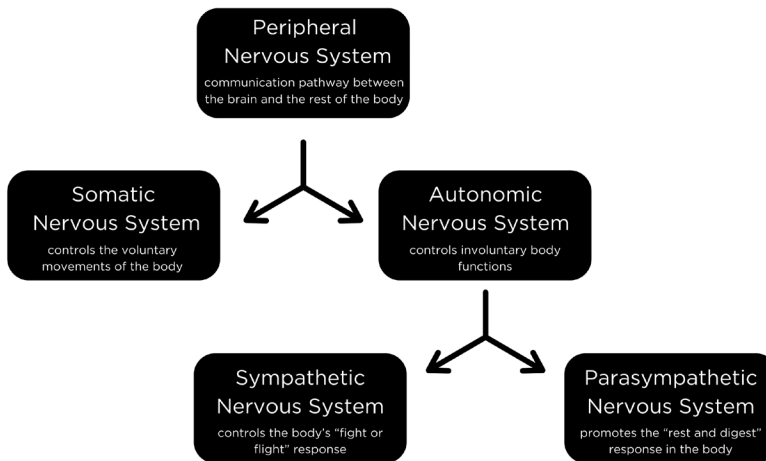


Figure 1.1: Understanding the components of the peripheral nervous system. Illustration by Nikki Shaheed.

The ANS helps us regulate our automatic bodily processes, such as breathing, sexual arousal, blood pressure, urinary functions, heart rate, and digestion. It also controls the involuntary responses of our muscles and glands to our internal and external environment. Additionally, as we live in the ever-changing realities of our environment, the ANS is one of the systems that assesses how

best to enhance our well-being and safety. When certain environmental cues are presented, this system organizes actions according to the cues.

There are two branches of the ANS: the sympathetic nervous system (SNS) and the parasympathetic nervous system (PNS). We will first spend some time discussing the PNS by leaning on the Polyvagal Theory by Stephen Porges (2011). According to this theory, there are two branches of the PNS: the ventral vagal branch and the dorsal vagal branch. When we feel safe within our bodies and in our environments, the ventral vagal branch—which is connected to many body parts including our larynx, face, inner ear, and neck—is activated. Our inner middle ear muscles become engaged, which increases our ability to hear the human voice and filter it out from other background sounds. Our facial muscles also have increased capacity to make communicative expressions, and the larynx is able to produce a soothing vocal tone and a modulated vocal patterning. These changes support our ability to rapidly communicate our internal state of calm and security, as well as our availability for connection to others and social engagement. Perhaps this is the state we often notice when marginalized persons are in safe affinity spaces. These spaces are designed for persons with shared identities to feel a sense of ease while sharing stories, ideas, and connection.

However, these spaces exist because so much of our reality extracts us from this state of calm. The rest of the world is often a space of both real or imagined threats. These threats lower our vagal tone. Our SNS is activated to prepare for defense. When this happens, we can begin to feel immense panic and possibly, even rage. The body is preparing to fight or run. In order to facilitate these responses, the heart rate quickens and the pupils dilate. More blood is steered to parts of our body that need oxygen so that we can protect ourselves from danger. The muscles in the middle ear lose their tone and perceiving the human voice becomes difficult. Instead, we become more responsive to high- and low-frequency sounds, which essentially are predatory sounds. The nerves that manage our speech are inhibited and so there is less regulation of tone or voice pattern. *This is not a state of connection.* In this state, connection and bonding behaviors are not physiologically supported. In fact, as the presence of threat continues with no relief in sight, this can move from fight and flight to a state of terror and freeze, which is actually a blend of responses from two separate systems: the SNS, and now, the dorsal vagal system, which activates to

support additional strategies for protection. We turn now to understand more about this branch: the dorsal vagal branch.

The body cannot sustain that degree of terror and freeze for a long time. As such, if the threat continues, the dorsal vagal system eventually takes full control. When we perceive danger that is inescapable, this branch, which is another part of the PNS, activates to support immobilization. This increases the possibility of survival. When the body is in this mode, other changes are noticed. This could include a flatter facial expression, less access to vocabulary, and less vocal prosody. Persons in this state experience fatigue, incoherent thinking, and numbness. They feel less connection to their emotions, to other people, and the environment. Often, people in this state have reported experiencing despair and shame. We speak more about the impact of shame on marginalized partnerships in Chapter 2.

The activity of the ANS can also be easily understood, using Dan Siegel's window of tolerance. The window of tolerance refers to an optimal zone of ANS arousal, in which we can experience the state of connection described earlier. Siegel notes that when there is increased activity of the SNS, which is known as hyperarousal, we are taken outside of our window of tolerance. In this state, we experience hypervigilance, anxiety, and anger. Conversely, we can also experience hypoarousal, which is the dorsal vagal state mentioned earlier. It protects us through numbness, flat affect, and feelings of despair. Because the window of tolerance is the space where we feel safe, curious, and open, I also refer to it as the window of possibilities. An image of the window of possibilities is shown in Figure 1.2.

In the window of possibilities, people experience more creativity and imagination. They live in the fullness of their human potential, and can engage in human relationships with flexibility and depth. Because of the chronic nature of systemic trauma, marginalized people are often not allowed to live the true breadth of their lives. Their psyches are battered, torn, and worn by living in a world that considers them less than human. As such, many of them battle intense mental health challenges. As one Black woman living in Portugal once said to me: "It feels like I am always at war!" Indeed, this sounds similar to the phenomenon of racial battle fatigue, a concept that explains the psychophysiological reality of Black people who move through White spaces (Smith et al., 2011). From anger, shock, depression, and anxiety, Black adults in the United States live in psychological realities that make them more likely

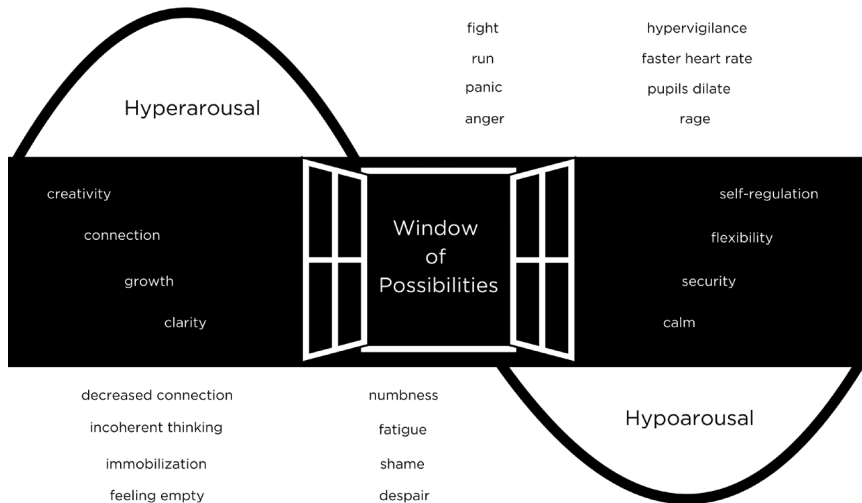


Figure 1.2: In the window of possibilities (inspired by Dan Siegel’s window of tolerance), people experience more creativity and imagination. They live in the fullness of their human potential, and can engage in human relationships with flexibility and depth. Illustration by Nikki Shaheed.

to report psychological distress than White adults (U.S. Department of Health and Human Services, 2025). Other racial minorities also face a dismal reality. According to the American Psychiatric Association (2017), American Indians and Alaska Natives experience disproportionately higher rates of mental disturbance than the rest of the U.S. population. In the mid-17th to early 20th centuries, they were removed from their lands and had to endure government-run boarding schools. This removed them from their families and spirituality, which has contributed to higher rates of suicidality, substance abuse, and traumatic stress. Within the U.S. Latinx community, adults are more likely than youth to experience psychological distress due to acculturation and immigration in the United States.

In the United Kingdom, people from Black and minority ethnic groups are more likely to have psychotic symptoms than other racial groups (National Health Service, 2016). In fact, Black men present a higher likelihood of experiencing psychosis than any other group. This startling reality, which presents in both African and Caribbean men in the United Kingdom, does not occur for Black men in predominantly Black spaces. This clearly suggests that this is

due to the context of feeling unsafe in largely White communities (Khan et al., 2017). Additionally, Black women in the United Kingdom experience a greater likelihood of having common mental health challenges when compared to White British women and non-British White women. Much of these aforementioned challenges can be attributed to racism, which has been connected to an increased probability of developing delusions, hallucinations, depression, and posttraumatic stress.

The relative lack of access to support exacerbates the reality for Black, Indigenous, and people of color (BIPOC). For instance, Asian American and Pacific Islander communities face obstacles such as language barriers and the lack of culturally competent providers within the mental health system (Mok, 2023). There are also considerable financial barriers. Almost 10% of African Americans do not possess health insurance when compared to approximately 5% of non-Hispanic White persons (Keisler-Starkey & Bunch, 2020). This severely compromises the ability to access counseling support and/or pharmacotherapy. Additionally, issues such as a lack of transportation and not knowing where to go to access care reduce the ability and willingness to obtain care (Alang, 2019). Furthermore, there is growing fear and mistrust of treatment as engaging with the mental health system can sometimes lead to involuntary hospitalization and inclusion of the criminal justice system (Alang, 2019).

Fear of experiencing discrimination, experiences of actual harm and micro-aggressions within the system, as well as high levels of internalized queerphobia are just a few of the factors that prohibit the LGBTQIA+ community from accessing services. Horrific experiences, such as being misgendered or being asked invasive and inappropriate questions about their sexual practices, also deter LGBTQIA+ folks from reaching out. These experiences are dehumanizing and further traumatizing. What results is a reluctance to engage the system or early dropout. This is unfortunate given that members of the LGBTQIA+ community experience high rates of mental health concerns. In 2021, a study conducted by Ramchand et al. revealed that gay, lesbian, and bisexual individuals have increased suicide risk in the United States. Furthermore, LGBTQIA+ persons are more than twice as likely as heterosexual people to suffer with depression, anxiety, and substance abuse. Similar findings also exist in countries such as New Zealand. Stats NZ (2021), an official database agency in New Zealand, revealed that people who were LGBTQIA+ were over twice as likely

to experience day-to-day feelings of depression and anxiety than their non-LGBTQIA+ counterparts. These statistics also revealed considerable physical health disparities as well.

Physical Harm

I try my best not to go to the doctor. I only go if I absolutely have to.

—Samuel, a 57-year-old gay man in Florida

The sentiment expressed above represents so much about how queer people feel when interacting with the health care system internationally. There are also many reports of being harmed by nurses and pharmacists, whose glaring blind spots show up as systemic violence of the highest order. When compared to non-LGBTQIA+ adults, LGBTQIA+ adults in the United States report adverse health care experiences at a higher rate (Montero et al., 2024). Furthermore, 6 in 10 LGBTQIA+ adults admit that they prepare themselves to be insulted by medical practitioners when seeking medical care. Many also believe that they must alter their physical appearance to receive just treatment in the health care system (Montero et al., 2024). Similar reports pervade in the Caribbean. Many members of the LGBTQIA+ community can attest to the struggles while accessing health care. According to 33-year-old Femi, a gay man living in Trinidad who refused to access care: “I was afraid of being made a spectacle, of being laughed at.” Shanti, a 40-year-old trans woman in Trinidad, echoed similar sentiments as she divulged: “Accessing health care is a ritual that I never want to perform!”

It is heartbreaking to acknowledge that so many health care providers provide such a tiresome experience for the LGBTQIA+ community. Some of this is spurred on by a lack of awareness. Clients who I have interacted with have shared that some health care providers do not even understand the difference between sex and gender, while others evade the issue of gender altogether. Some professionals also ask invasive and irrelevant questions about the clients’ sex lives, gender transitioning, or their physical bodies. All of these gruesome occurrences serve as undeniable hindrances when community members need help.

And their need for help is quite real! LGBTQIA+ people are disproportionately affected by many illnesses, such as cervical cancer, anal cancer, and breast cancer (Baker, 2020). Specifically, same-sex-loving women and

bisexual women are more susceptible to cardiovascular disease and obesity whereas bisexual men report a higher degree of diabetes (Fredriksen-Goldsen et al., 2013). Aging LGBTQIA+ persons face higher rates of disability and HIV diagnoses when compared to their heterosexual counterparts (Emlet, 2016). Perhaps the most disheartening point to note is that in many cases when LGBTQIA+ persons are diagnosed with various conditions, there is also a lack of culturally appropriate responsiveness by medical professionals. In addition, LGBTQIA+ people also lack the financial resources to care for themselves in many of these circumstances.

Financial Harm

I am so tired of this, being unable to find work. No one wants to employ you when you are dressed like this. So just to find work, I have to betray who I am and wear a suit and pretend.

—Clara, on trying to find employment as a trans woman in the Caribbean

The economic and employment barriers faced by racial and sexual minorities are unfathomable. Even in countries that have shifted away from institutionalized segregation in so many ways, these are sizable impediments to economic inclusion. Black and LGBTQIA+ South Africans can attest to this harm. In a 2022 World Bank Report on inequality in Southern Africa, South Africa was deemed to be the most unequal country in the world, with its Black populace being the poorest group in their society (United Nations, 2024). This report notes that income disparities are directly attributed to race and racism in South Africa. The United Kingdom shows a similar reality where there is a large income inequality between ethnic groups. In the United Kingdom, Pakistani, Bangladeshi, and Black persons have the lowest median household incomes (House of Commons Library, 2020). In the United States, White people still have far more wealth than their Black counterparts. According to the Federal Reserve Survey of Consumer Finance (2023), though there has been growth in income for Black households, their income still is just a fraction of that of White households. In Australia, Aboriginal and Torres Strait Islanders have lower employment rates when compared to non-Indigenous people (National Indigenous Australians Agency, 2022). Significant barriers to education, as

well as entrenched discrimination in the criminal justice system, all contribute to these.

In many ways, this is also the reality for queer folks: Lack of access to formal education or rampant discrimination in the education system often render them with limited opportunities in the job market. I have heard so many stories of young LGBTQIA+ individuals who were unable to complete their high school education due to disturbances in their adolescence and early adulthood that were directly tied to their sexual orientation or gender identity. For example, Luke, a 40-year-old LGBTQIA+ activist from Guyana openly noted: “From an early age, my parents put me out of the house when they realized I was trans. Who could find the time to study or become anything when you have nowhere to live and nothing to eat?” Additionally, being on the receiving end of merciless taunting and homophobic discrimination by school colleagues and faculty makes it very difficult for many queer persons to thrive academically and become qualified in their desired fields.

Even when fully qualified, LGBTQIA+ persons are often denied full participation in their economic environments and job markets, as they are denied jobs or promotional opportunities. So attests Videsh, a 47-year-old Indian gay man from Trinidad and Tobago. In one of his sessions with me, Videsh disappointingly shared, “I was in line for the promotion, but they called me and let me know that I couldn’t get the job, because they knew about my orientation, and they were afraid of how that would look!” His is one of many stories of rejection and injustice that goes unnoticed and unnamed.

Another form of harm that is often invisible is the effect on human relationships. We turn our focus here now, which is the central essence of this book.

Relational Harm

After a while, you don’t even want to be touched.

—Stacy, a Black woman, on the impact of racism on her relationship

As a Black Guyanese migrant in London, Stacy began to realize that her interactions with her male partner, Shaun, were slowly shifting. She was becoming hypervigilant, less interested in sex, aggressive, and even withdrawn at times. She struggled to connect with Shaun and didn’t always understand the reasons for this. However, she did indeed sense that something else was at play.

She understood that her inability to be emotionally and physically intimate was because her body was being assaulted in other ways. This Black woman was under the onslaught of racism and xenophobia, and there was little to no redress for this degree of harm.

Despite this, Shaun didn't comprehend Stacy's behavior toward him at all. He found her temperamental, and he was becoming impatient with her low sexual interest. When she complained about her daily experiences of race-based prejudice and discrimination, he just saw her as being overly sensitive and belligerent. During one of his declarations that she was unnecessarily reactive, he complained, "She is beginning to see things that don't even exist." She felt gaslit and not seen. He felt helpless and believed that he could do nothing right to appease her.

Neither of them could effectively name what was destroying their relationship, though Shaun felt that it was all due to Stacy's trying personality. This is how he understood it. In his eyes, she was just *difficult*. Racial activist and somatic abolitionist Resmaa Menakem often says that trauma that is decontextualized can look like personality (Fragoso, 2020). And here it was, decontextualized trauma, masking itself as personality and ruining meaningful connection. Their love was not playing by the rules. Despite all the insight they had into each other's own foibles, preferences, and familial traumas, they could not seem to shift what was really happening to them.

The same degree of despair was felt by Jay and Ronnie, two men who had been romantically involved for 10 years. As Jay noted,

"I don't understand this covering thing. He never wants to hold hands. He hides me. I get no affection in public. He lets other people determine how we live. I want to live together, and he is rejecting me. Even that he doesn't want!"

Ronnie perceived Jay to be unreasonable and ridiculous. He lamented over Jay's lack of consideration and the fact that Jay seemed to not care that Ronnie would lose his family, friends, and community from being open about his orientation. Here were two men who desperately wanted to make their relationship work, but they were managing the impact of queerphobia quite differently. In fact, they were also destroying each other emotionally in the process.

I've been with many of these stories, both directly and indirectly. I've sat with BIPOC and LGBTQIA+ partners who are struggling with the impact of

racism and queerphobia, respectively, or in some cases concurrently. When systemic trauma seeps into relational dynamics, it leaves a trail of chaos. So many of us have been taught that there is a clear path to intimacy. This path includes trust, accountability, responsiveness, compassion, and interdependence. However, systemic trauma disrupts this path because it muddles these very components that we need to enable true connection. These seemingly attainable components are, in fact, tied very closely to our social location in the world. In other words, the characteristics of intimacy in our *private* relationships are affected by the amount of power and privilege that one holds in one's *wider context*. Intimacy, as we currently understand it, does not operate outside of one's wider economic, educational, legislative, judicial, religious, and cultural contexts.

It is important to note here that the harmful relationship between marginalized couples' intimacy and the wider social system is not just a contemporary phenomenon. It is also not an accidental connection. There have been well-organized mechanisms that have deliberately harmed the relationships of those who hold less power in our world. Such was certainly the case for African slaves in the Americas. Hill (2005) asserted:

Slavery destroyed the African heritage of blacks, claims Kenneth Stamps, and left them living in "cultural chaos" since the family patterns of whites were "meaningless and unintelligible" to them. Moreover, the definition of slaves as property was one of many efforts to negate their humanity and deny the significance of their personal and family lives. Slaves' property status precluded them from entering a legal marriage contract, as the law recognized no form of marriage among slaves, "whether they 'take up' with each other by expression of their owners, or from mere impulse of nature, or in obedience to the command to 'multiply and replenish the earth.'" With no standing before the law, slave marriages could be and were ended at any time at the discretion of slave owners. (pp. 58–59)

Though same-sex marriage is, at the time of this writing, legal in 36 countries in the world, there are still many spaces where this is not so. In countries where there are well-entrenched and established systems that formally diminish, and in many cases, criminalize same-sex relationships, there is undeserved strain on these partnerships. In my practice, I have seen the different ways in which the nonrecognition of these unions cause breakdowns and conflict.

Delegitimizing same-sex love forces many partners to view intimacy as risky and unsafe. In addition to a fear of public displays of affection, the strain placed on the relationship to maintain safety even stifles the partners in the privacy of their own homes. Jacinth, a 56-year-old lesbian woman, notes, “It’s like a noise in my head. I can’t turn it off, and so even when we are trying to be intimate, I just can’t. It’s right there . . . between us.” The challenges are further amplified if both partners have different assessments of risk. Many arguments ensue over safety measures, with one partner often deeming the other to be either too uptight or restrictive, while the other is accused of being reckless. Additionally, many of these relationships are not entitled to the same privileges of heterosexual couples. For example, social security “spousal” benefits are typically nonexistent for persons who exist in illegitimate unions. This adds additional fears about financial safety and security. In some countries, even being able to find housing for partners can become a harrowing and daunting experience, often with no real success in the end. Living in this constant state of disquietude does not augur well for connection.

We cannot forget that it is not only our ability to be connected and intimate that is affected by our systemic reality. Our capacity for navigating the vagaries of intimate relationships on a whole is compromised by systemic harm. Yes, being in a romantic relationship necessitates deep intimacy. However, relationships also require the partners to know how and when to practice healthy boundaries, when to engage in deep self-trust, when to be one’s own advocate, and quite frankly, when to disconnect. Due to structural oppression and systemic discrimination, marginalized people do not always have experiences that foster what is necessary to maneuver the ebb and flow of intimate relationships. As Ola, a 25-year-old nonbinary client shared, “I learnt from my experiences in the world that I should not trust myself. If I begin to trust myself, then I would be angry all the time, so I just can’t do that.”

The belief that one is not worthy of one’s own trust in the wider system can certainly spill over to other domains in one’s life. This lack of self-trust can prevent major life decisions that are critical to preserving well-being during difficult moments in intimate relationships. Additionally, marginalized people do not always have the resources required to seek their own interest when relationships are either harmful or no longer desirable. For example, some partners find it practically impossible to end relationships that they no longer wish to be in because they do not have sufficient financial resources to be alone

and independent. This limits their relational possibilities. Caribbean sex and gender analyst Isaiah Alexander, who is also a gay man, shared:

“Sometimes, it is hard leaving a relationship because being in a relationship with a good-looking man gives you social capital that you just don’t have as a queer person. Sometimes, you even put up with an abusive relationship because you have no financial security, and financial security overrules emotional security. Standing on your own is scarier than existing in a loveless relationship.”

In fact, some even believe that finding happy relationships is extremely rare. James, a same-sex-loving male client in Jamaica confessed: “I was in love once, and for me that was like a needle in a haystack. There is no way that I can find that love again, not in this country!” A similar sense of despair is felt by some clients of color. When speaking of his relationship with his White female partner, 37-year-old Tahj admitted, “The truth is that this relationship’s been over a long time ago, but where will I go?” His experience is one of many stories that indicate the severe limitations placed on marginalized people.

Oppression can place unique stressors on relationships as partners may experience both *individual-level* and *couple-level minority stress*. Individual-level minority stress refers to extreme levels of stress experienced by minoritized people that are directly tied to their wider social reality. This type of stress usually results in adverse physical and mental health outcomes. Couple-level minority stress, on the other hand, refers to hardships that couples and partnerships face because the *relationship form* itself is marginalized. This is often the case for interracial or same-sex partnerships, whose relationships undergo considerable devaluation, discrimination, and painful scrutiny (LeBlanc et al., 2015). As you will see ahead, current literature gives us critical insight into the impact of both individual- and couple-level minority stress on couples.

Lavner et al. (2018) investigated the relationship between racial discrimination and couples’ relational health. In their study, which focused on 344 rural, low-income heterosexual African American couples, they found that partners who experienced high levels of racial discrimination outside of their relationship reported increased physical or psychological aggressive tendencies between them. Other research has presented a similar picture. In a sample of 330 Latinx newlyweds, it was revealed that male partners’ experience of discrimination negatively affected wives’ marital quality (Trail et al., 2012).

These findings suggest that BIPOC partners construe their relational experiences within the context of their systemic reality (Goldberger & Veroff, 1995). LGBTQIA+ couples also report the same challenges. Some research in this area has indicated that increased experiences of minority stress are connected to lower relationship quality for same-sex partnerships (Doyle & Molix, 2015; Frost & Meyer, 2009; Otis et al., 2006; Todosijevic et al., 2005). This is undoubtedly heightened when these partners experience couple-level minority stress where their relationship form is stigmatized, thus leading to additional strain on the relationship (Frost et al., 2017).

The impact of systemic trauma on these relationships can be understood using the concepts of stress spillover and stress crossover. The spillover of stress from one facet of an individual's life to another is known as "stress spillover," whereas stress crossover refers to the crossover of stress from one person to another (Bolger et al., 1989). Martin, 26 years old, can certainly vouch for the experience of stress spillover. As a Black man in America, Martin often felt that he was "being drowned." He wasn't just drowning. He was *being* drowned by something outside of him that he could identify but couldn't shift. "I can't pull myself up," he cried. He said that he felt his relationship with his wife, Leanne, was becoming "a lot" because that was the way everything felt. There was no distinction for him, and even being asked to construct one felt unfair and tedious. He experienced night terrors and would yell at Leanne often. She bore her pain in silence, though noticeably aching in session. As the stress crossed over to her, Leanne became a shadow of herself. She lost her sense of interest in life, invested only in ensuring that Martin was okay.

I want to be clear though, that not every single marginalized person experiences the circumstances described above. I am not attempting to universalize or generalize the experiences of minoritized people. We are quite vast and different. We are not all having the same experiences. There are, indeed, many individuals who withstand the pangs of daily prejudice and harm, and still have healthy relationships. There are many who are able to trust themselves, maintain a sense of ego integrity, and develop beautifully intimate and resonant interactions. However, if we are to stay true to the integrity of the helping profession, we must be with the fullness of *all* experiences. We must hold, with tenderness and deep curiosity, the realities of those for whom the system has anchored its weight. This helps us truly be of service.

All of the stories above point us to a need to widen our understanding of intimacy, and to excavate the definitions of intimacy and relationality from homogenizing forces that do not hold the myriad circumstances of LGBTQIA+ and BIPOC partnerships. When we truly grapple with this, we can provide services that are authentic and most importantly, not damaging. It was this quest to serve in this way that drove me to conceptualize the idea of “relational privilege,” a concept that we explore further in Chapter 2.

Practitioner’s Reflection

This is an invitation to reflect on the four features of systemic trauma and the many ways in which marginalized people are harmed. As you process how these features can show up for your clients, what are you noticing within you? Take note of any feelings, images, thoughts, sensations, or joint and muscle activation that may result. As you sit with these, reflect on your current ways of working with trauma. What would you like to continue doing? What would you like or feel the need to change given how systemic trauma is experienced for marginalized people? Can you think of any other features of systemic trauma that may be useful for you to reflect on?

CHAPTER RECAP

- *Systemic trauma* can be defined as harm that emerges from components of the *wider* environment, cultural norms, and institutions. Perpetrators of systemic harm often include educational systems, economic structures, criminal justice systems, and religious institutions.
- Marginalized people, such as LGBTQIA+ and BIPOC individuals, disproportionately experience systemic harm, which affects their psychological, physical, and financial well-being.
- The intimate relationships of BIPOC and LGBTQIA+ folks are negatively affected by systemic trauma. Systemic trauma disrupts their ability to stay connected.