

Addressing Implicit, Unconscious, and Structural Bias Affecting LGBTQIA+ Patients in Behavioral Health Settings-20260603_143012UTC-Meeting Recording

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Simon-Ulysse, Phanide 0:06

Good morning, everyone, and welcome to Carelon's MBHP webinar presented in partnership with the Fenway Institute on addressing implicit, unconscious, and structural bias affecting LGBTQIA plus patients in behavioral health settings. We're so glad you could join us today, especially during Pride Month, a time when many of us are reflecting on how we can better support and affirm LGBTQIA plus community year round.

My name is Phanide Simon Ulysse and I'm the Health Equity Director at MBHP.

At NBHP, we are committed to advancing Health Equity by improving access to Behavioral Health Care so that all members, regardless of social, cultural, or economic background, have a fair and just opportunity to be as healthy as possible. Before we get started a few quick community agreement notes. You're currently in listen only mode with your mic muted.

open things during the Q&A and you'll have the option to unmute and turn your camera on then. Please feel free to use the chat to share questions as they come up.

Live captions are available in your meeting controls, and today's session is being recorded. CEUs are available for eligible disciplines. To receive credit, please plan to stay for the full session and complete the valuation survey we'll share at the end. With that, I'll turn it over to Kay Lambert. Kay, the floor is yours.



Ceil Lambert (he/him/his) 1:47

Thank you so much and good morning, everybody. It's really exciting to be here with all of you. My name is Kay Lambert. I use he, him, his pronouns. And today I'm going to be talking with all of you about addressing unconscious and implicit bias. So like we were talking about, this really very closely connects to the Massachusetts Behavioral Health Partnership mission statement which talks about exceeding expectations for consumers and their families, and pulling in that behavioral health need around who people are, those identities that define folks, and ensuring access to the proper services that promote rehabilitation and recovery, which includes having this kind of community and identity

awareness.

It's also about effectively and efficiently managing the resources that are at y'all's disposal. And we all know that a lot of those resources are in shift right now. So engaging with processes and skills building like this is a very important part of keeping that effective and efficient while we're kind of dealing with different access to resources. There's also the piece about managing linkages, fostering that consensus building and collaboration across agencies. So this is a collaboration. This is the Massachusetts Behavioral Health Partnership. It's the Fenway Institute. It's Carelon. All of these different pieces have come together to try to make it so that we can have this continuing education mode.

And also seeking to actively implement consumer, provider, other stakeholder involvement. That's exactly what we're going to be doing today is making sure that we're actually participating in that improvement process and strengthening links between all of you all as behavioral health and medical providers and support staff so that you're all on the same page, you have the same language to talk to each other, and hopefully enjoy the process of improving some of the ways in which we interact with our communities, and also increasing those healthcare innovations and best practices, which I would say implicit and unconscious bias awareness is definitely part of that best practice. We talked about the community agreements. So this event is meant to be as accessible and as inclusive as possible.

If you find yourself sort of lost, unable to access the chat, things like that, you can message someone from MBHP and they can get you more hooked up. If you have a question, you can pop it in the chat. They're going to be monitoring that for me so that I can make sure to get to questions. We will have formal time where I'll ask people, I'll stop sharing the slides, I'll ask folks to respond to case presentations, and then at the end we'll have time for question and answer sessions.

So a quick note, in the United States right now, part of what's happening is that we have an unprecedented creation of bias that's both conscious and unconscious. And for some people, there is a deliberate effort to harm, marginalize, and disappear lesbian, gay, bisexual, asexual, intersex, and particularly transgender and gender diverse people right now.

Transgender folks are one of the main targets of these bias campaigns. And so right now, not only are we having to combat implicit and unconscious biases that were formed maybe early in childhood, but it's happening every single day. As we move through the world as it is right now, there are people who are trying to make us think in biased ways. And so it's more important than ever to be able to notice where does this bias show up? Where did I get that from? And what can I do to make my own decisions and follow my own thought

processes? So we'll talk about that implicit and unconscious bias piece. We're also going to talk about conscious bias and the construction of misinformation, disinformation, and how that very purposeful construction leads to sort of the scaffolding that creates bias. And in my view, this is not a partisan issue. It's really a human rights issue. So LGBTQIA plus people, which is the very umbrella acronym that I'll use to talk about the queer, trans, and more expansive community broadly, have always existed as folks. We've always been here. And it's a natural expression of human diversity that actually adds a lot to our society. And so it's important to see how bias is not just affecting people with these identities and what you can do as a provider to interact and intersect with those biases affecting somebody, but also to understand that as a society, it makes sense for us to prioritize diversity because that's how we learn, how we grow, and how we become an even more innovative and cooperative society. So I really appreciate you all being here today.

Our roadmap, so we're going to talk about implicit and unconscious bias. Where does it come from? What does it look like? What do I even mean by those words? We're going to talk about what are telltale signs of bias? What are some really quick ways to sort of short circuit those biases? And then we'll also talk about long-term change. So part of what we're doing today is in discussing implicit and unconscious bias, we're rising it to the level of consciousness. And that's one of the first things that we need to do to start combating those biases, then having quick ways to make sure that we're not doing harm to other folks, and then progressively over time, working to undo those biases so that they no longer are our first reaction to people in front of us. We'll talk about misinformation and disinformation and how those contribute to bias and stigma. And we'll talk a lot about intersectional biases. I think that this is particularly important when talking about the LGBTQIA plus community because no one shows up to anywhere with only one of their identities. They show up as their full selves. So when I show up to a space, I show up as a person who identifies as a man. I show up as a transgender person. I show up as a queer person. I show up as a person who is from and lives in Colorado. I have all of these identities that matter to me, and I can't disentangle those things. So we'll talk about what that might look like both from a lens of sort of compounding bias and also from a lens of resilience. I think it's important to acknowledge that LGBTQIA plus people and other folks who are being marginalized and minoritized are actually in a position where because of those factors, we build resilience, we find ways to create community, And those are things that are both worth celebrating and also taking a look at as guidance for how we can move forward as a more productive society together. We'll also have throughout, I have a few case studies for us and discussion. And like I said, we'll have Q&A

at the end.

So what even is implicit and unconscious bias and what does that have to do with MBHP's mission to enhance behavioral health care and inclusive behavioral health care? So like we talked about in the mission statement, the goal of MBHP is to advance health equity by improving that access to behavioral health care so that all members, regardless of their social, their cultural, their economic background, have an opportunity to be as healthy as possible. And what that means is that every person who's engaging with providers needs to be able to come as their full self and identify themselves to that provider. Because who someone is and that identity component, particularly in the moment we're in right now, where someone's identity might be under threat or under attack, that's going to directly feed into whether or not that person is able to access proper health care, proper behavioral health care. And so what we're doing in the training, we're going to reinforce those culturally competent behavioral health care pieces by having an awareness of implicit and unconscious bias and how that fuels stigma, particularly towards folks who are LGBTQIA plus identified. We're also going to talk about whether we have a fair way of treating each other. And do we have a way of treating each other both as colleagues and also towards our patients in a way that is with dignity and where we're looking to reduce the amount of harm and ideally start to undo those biased ways of thinking, but at the very least not add to the harmful behavior. Thinking about what are member needs, not making assumptions about those identities or circumstances, and then moving forward by actually accessing the member needs and understanding our own biases.

And all of this will improve quality and accessibility to services, because it's going to emphasize that the work of combating bias as an ongoing practice is actually progressively feeding into that mission and making it so that we can provide better care to everyone, regardless of their identity.

Implicit and unconscious bias happens when our brains make incredibly quick judgments and assessments, and this is something that is a natural process. Because we are animals and we have brains that have evolved to respond to our surroundings, to respond to other animals, to respond to other human beings, our brains are trained to make fairly quick assessments of things at a subconscious level so that as we move through the world, if there's danger, if there's threats, all of these sorts of things, we can respond to it almost more quickly than we can even think that something is happening. If you think about how you move through the world and maybe someone opens a car door or maybe you see a crack in the sidewalk, You might not necessarily see that thing and think about it consciously, but over time, your body has started to give you information. How do I keep

myself safe? What sort of things do I need to be on the lookout for as I move through the world? And those are positive ways that those, what we could call unconscious biases, can make our lives more accessible.

It's part of being alive. But what happens is when those implicit and unconscious biases are constructed by a society where certain people are labeled as bad or other and put in a category, particularly a category where there are definitions that are negative, then those same biases that can protect us make it so that we might choose actions that are discriminatory and stigmatizing. For me, it's really important to focus on not self-blaming around implicit and unconscious bias. There's no need for shame. All of us walk through the world where we see something, we experience something, we meet someone, and something in our brain tells us, this is what I should think about that person. This is what I should think about this situation. Those thoughts aren't the problem. What we need to do is we need to be able to have those thoughts and then be able to look at them and say, wait a minute, is this actually what I believe or is this something that I've been programmed to believe?

And if it feels like it's something that you didn't put in your own brain, then it probably means that that's an unconscious bias and it's worth having a look at it. So this training and this kind of work is about surfacing things to the level of consciousness and then making very concerted choices about how we're going to act in the world.

Implicit and unconscious bias in terms of where they show up in thoughts aren't what is going to create marginalization and stigma. What creates marginalization and stigma is when we act on those implicit and unconscious biases in a way that marginalizes people. And so we'll talk a lot about what that action looks like. And at least in my experience, what I've found is The more that I address how I act to make sure I'm combating bias, the more those subconscious pieces, those thoughts start to go away or start to change. So it's a progressive and ongoing practice. And I think the more that you do it, the easier it will become.

Some signs of bias that I think are really useful to just know about so that if you're starting to look around and say, okay, how can I pick out where this implicit and unconscious bias piece is coming from? A lot of it looks like acceptance of governmental and institutional attacks on LGBTQ plus and particularly transgender people. A lot of you might have heard the phrase complying in advance. So there's a lot of medical systems, a lot of hospital systems who are reducing or removing care for LGBTQIA plus people and particularly gender affirming care for transgender individuals. And that's a direct response to fear about governmental and institutional attacks.

even if those governmental and institutional attacks at the moment don't have the power to force people to stop providing access to this care. So stopping providing access ahead of time is a sign that there's probably some bias going on in the background. Discrimination against queer folks in advance of direct threat like we were talking about. Another one is if you have two cases that are pretty similar, almost identical, but are treated differently when one patient identifies as being in the LGBTQIA plus community, that's another sign. So if one person's getting one treatment and another person's getting a different treatment because of their identity, it can be appropriate to acknowledge that identity. And perhaps the reason somebody is coming in is intersectional with that identity piece. But in terms of accessing care, if the person needs psychopharmacology, what are the barriers there? If there are increased barriers to access, that's a sign of bias.

A lot of the time you can see that cisgender and straight clients are given the benefit of the doubt. So if somebody walks in and says, I feel ill, I feel scared, I feel like I need to work on these different things. There's a lot of ways in which our society says a cisgender person, a straight person, a white person. These are individuals that we're going to just believe by default.

Meanwhile, LGBTQIA plus patients and patients of color particularly often have to provide exhaustive evidence for the things that they're trying to tell providers. So that's a way in which that barrier can show up and where it's distinctly different.

Cisgender and straight patients are offered often a harm reduction strategy, whereas LGBTQIA plus people and transgender and gender diverse individuals are often not offered an option that's about harm reduction. It has to be like a full cessation. Let's say for example, that you have a client who is smoking and who wants to reduce the amount that they're smoking and hopefully eventually quit smoking. Sometimes what can happen when bias is underlying is something like a cisgender or a straight patient might be offered a behavioral health strategy where you're talking to them and you're saying, okay, what are tools we're going to use so that you can smoke less and we're going to take it slow and progressive? A lot of LGBTQIA plus people, particularly folks who are looking for some kind of care that intersects with their identity are told, you have to stop smoking completely or we're not going to be able to move forward with any care for you. And that's a moment to stop and wonder, is that coming from a place where we're actually assessing the medical interactions between that behavior and access to care?

or recreating an artificial barrier that doesn't need to be there. And another one that we see is that providers might refuse to care for an LGBTQIA plus identified person, and they might cite all sorts of things like inexperience, an ideological difference between themselves and

the potential client. Somebody might say, not my area of expertise. And those are signs that two things are happening. Possibly there's an undercurrent of bias. And also it's okay to want to be educated. It's okay to access help. It's okay to ask for help. In fact, I would really, really strongly recommend if this is a growth area for you to find somebody that you can talk through these issues with, pretty openly and pretty bluntly, because that's going to help you make it so that when you're in front of your client, you're not going to be bringing your sort of figuring out of those identities to the client. You will have done that ahead of time. And really using that as a way to not making excuses. not make an excuse to refuse to see a client, but say, I need to do my own work in order to best serve that community. And part of that is addressing these undercurrents of bias. So specifically talking about behavioral health and bias, I think it's important to focus on the behavioral and mental health care provider and what bias looks like in those practices. So understanding where it shows up in therapy is really, really important. A lot of LGBTQIA plus people have had negative experiences with therapists in their pasts. And especially individuals who are queer folks of color will have probably had even more intense negative experiences with providers in the past. So a new client might be hesitant to talk about their identity. They might be hyper aware of discriminatory language. They might be very assertive in the clinical setting, whether that's with front desk staff or with a provider. And all of these things are not actually a personal attack on anybody, not on you as a provider, not on the front desk staff, but rather a symptom of somebody who has been mistreated by the system for a while. So when you're thinking about how am I going to support an LGBTQIA plus identified person in a behavioral health context, even opening the door and saying, hey, have you had experiences that haven't worked for you? What has worked for you? What hasn't? What brings you to this clinic at this time? You'll usually get responses from folks where they say, I tried to go to this other clinic and I wasn't able to get my needs met or I had this really negative experience or somebody called me a name or somebody refused to treat me. And once the person feels like they can be heard explaining what happened and that you are very receptive to that, that it seems like as a provider, you're doing the work, you're very interested in hearing that, you'll usually see that that sort of assertiveness, that guardedness, all of those different pieces that have happened for someone who's experienced bias will start to break down and will make it easier to provide therapeutic care. It's also important to incorporate elements of universal design. Everything that I'm talking about for serving LGBTQIA patients can be applied to any individual who might be experiencing bias and marginalization. So this is communities of color. These

are individuals who might be immigrants, documented and undocumented. These might be individuals who have a lower socioeconomic status than other individuals, folks who are unhoused. Bias shows up in all sorts of different places. And by doing this work around one community, we can often figure out what are the universal underlying elements that I can bring into all of the work that I do. And I would say with combating unconscious bias, even just knowing that every single day since we arrived here on the planet, We've been given messages about different groups that can help us to surface those pieces and then make it a practice where it doesn't matter what the identities are of the people that we're serving. We're going to be thinking through, am I reacting in a biased way? How? Am I offering the same opportunities to other people? How am I working in a clinical setting?

so that every single person, regardless of identity, can really access this care. I would also encourage patients, particularly with transgender clients. One of the things that you're going to see, if you aren't already, you probably already are, it has been true that for a lot of transgender individuals, there's a very high behavioral health requirement for accessing care. And what has happened in the past and continues to happen and is currently in what I would call a worsening state, particularly in the United States, is people need to go get lots of behavioral health evaluations in order to access hormone therapy, in order to access surgeries. For other individuals, they might need to have Behavioral health assessments to access fertility services if they're not able to conceive on their own. All of these are pieces where it's very, very frustrating for the individuals who have experienced this. And so again, we kind of come back to when the person comes into your space, comes into your room, and they're looking to you for help.

A lot of the time, you're the next person they've gotten to after going through a huge number of people. So being patient, listening to the person's whole story, the list of what they really need and why they need it, and then trying to reduce as many barriers to that. So just writing people the letters that they need, helping to check the...the boxes that insurance requires, all of those different pieces so that you have a better opportunity to work with the person most directly.

What can you do? So we talked a lot about sort of some of these risks, but there's a lot of things that you can do. So you can have an accountability buddy. This is what I was talking about in the beginning. I think this is so, so helpful. So if you have somebody inside your practice or a mentor who's outside of your practice, someone that you can talk to really openly and honestly, is very important. As we work through what our biases are and we start to identify like, oh, I might be carrying some stuff that I didn't necessarily ask for, but I saw a television show or I went to a school where this was what was told to me. Wherever

that bias happened to come from, sometimes I need to use language to talk about a bias I've identified in myself.

And that language could be harmful to an individual who holds those identities. So having an accountability buddy that I can go to and say, hey, I had this interaction and it didn't feel quite right, and I think there might be something going on for me. And then I can describe the entire situation. I can use very specific language that I might not use with a patient right in front of me. And being able to do that means that I can work through that bias, put it at the level of consciousness, but I'm not causing harm to the individuals I'm trying to help.

What we're doing today is very helpful. So having implicit and unconscious bias training, I do these trainings many, many times every single year.

And I actually learn more about my own thought processes and grow myself every time I give this presentation. I also attend implicit and unconscious bias trainings when I see them, because it's kind of one of those things that's an ongoing practice rather than a final result. So let yourself engage in the practice as you move through your life.

Let your client take the lead when it comes to defining their identities and what those identities mean for the client. So a lot of the time, if somebody were to come to you and say, I'm a transgender queer individual, that's informed my life in this way, your brain might serve up, okay, this is what transgender means. This is what queer means.

And a lot of the time, that's what we've been told, or maybe it has to do with an individual that we know or a few individuals that we know. But identity is hugely individual and specific. And so there's infinite words for those identity people use those words differently. And it can be really helpful to ask somebody like, I heard you say that you identify as transgender and queer.

What do those words mean to you? How does that show up for you? And how can it show up for us in the work today? And that allows the person to say, these are what those identity words mean to me. It builds rapport, it builds trust, and it also gives you an opportunity to make sure that you're not introducing bias into that relationship, but rather you're letting the client and the patient tell you how you want, how they want you to receive their identity. You can also own what you know and be willing to ask questions. It's very frightening, particularly when we're in positions of power, and there's a differential in power and a power dynamic between provider and patient that we just have. There's kind of no way to remove that power structure. But what we can do is say, all right, I know that this power structure exists. How can I demonstrate to my patient that I trust them to be part of this decision-making process, that I'm looking to them for guidance, that this is a collaborative engagement, and saying something like, maybe somebody introduces

themselves and shares that they identify as pansexual. Maybe you've never heard the word pansexual before. And asking that question rather than making an assumption can actually build trust as well. So the patient may have a different definition for pansexual. For me, pansexual means that my attraction has to do with an individual and that individual's particular circumstances and way that they move through the world. And it has very little to do with their gender. That's how I would define it, but somebody else might define it quite differently. And so understanding that person's definition is going to help the patient feel like you're not bringing bias into the therapeutic situation, you're asking them what they think. And then I would say, particularly right now, avoiding pathologizing identity. This can be very tricky for behavioral health providers. Like I was saying, particularly for transgender individuals, there's often a large barrier to care that has to do with getting behavioral health analysis, getting letters written, attending a certain number of appointments in order to access care. And some of those structural pieces are slower to change than the change that we can make in ourselves right now today. And so talking with the patient about what might need to happen, for example, in some insurances, you're going to have to have somebody have a diagnosis of gender dysphoria in order for them to access care. That diagnosis might feel really bad to a transgender person because being transgender is not a medical condition. It's an expression of human diversity. And so placing it inside that pathologized space reinforces bias and creates more bias. And we can't necessarily do anything about the insurance needing that code in order to provide care, but we can talk to our clients and our patients and say, this is what we know we need. These are the hoops we have to jump through. This is the red tape. This is the bureaucracy. I, as the provider, am going to be there with you, helping you to navigate this and trying to make it as easy as possible.

And saying right out loud, this isn't pathology. Having to do this is currently a red tape process, but your identity is not medicalized. There's nothing wrong with you and really focusing on that.

So the actual practice of combating bias, all of the pieces that we've talked about up to this point have been very much cerebral. What we're doing in our heads, how we're thinking about things, even in conversations, sort of how are we directing the conversation to ease the power that bias might have over folks. But the practice of combating bias is where we get to all of those thoughts coming into contact with now, how are we going to behave? So every single day that you're moving through the world, you're going to have an opportunity to combat that bias. If you can identify that biased thought, then all of a sudden you have a choice to make. And for me, a lot of the time what I need to do is just take a beat, slow

down a little bit, and give myself an opportunity to assess the situation and say, okay, am I revisiting preconceptions that I've held in the past? What preconceptions have I brought to this situation? What assumptions have I made about people's identity and therefore how they're going to behave? And is that right?

And should I bring that into this situation rather than waiting and seeing who this person actually is? Also thinking about how bias is intersectional. When you're meeting with a client, especially in a behavioral health context, often you're going to be seeing somebody more than once. And it may take time for that person to bring all of their identities to bear. And so having that consistent practice of every single time somebody brings up a part of their identity that you share, you don't share, that's new to you, whatever it happens to be, looking inward and saying, okay, what do I think about this? What was my gut reaction? Do I agree with my gut reaction? And do I want to proceed based on that gut reaction? Or do I want to proceed based on something that I've learned?

So we'll start with our first case study. I'm going to read the case study out loud and read the questions out loud. Then I'll stop my sharing and we'll take about a couple minutes, 3 minutes for questions and discussion of this case. All of the cases, if you want to keep talking about them, I'll probably have to move us along after a few minutes. But if you want to continue to talk about them, we have question and answer time at the end and we can bring the cases back up. Happy to continue and talk about them. So in this first case, we have a black transgender man who presents as a new patient in your clinic, and he's looking for help with depression, anxiety, and anger. The patient is frightened of how angry they sometimes become, and they feel shame about that anger, and that shame fuels their anxiety and fuels their depression.

When you ask about the client's anger, they talk about a deep distress with the current political action where it's attacking and dehumanizing transgender people. This is very worrisome to them. The client shares with you that they've started acting more prescriptively masculine and presenting in a more, rather than presenting in a more gender fluid manner which is actually more congruent with their identity. So this is a person who does identify as a transgender man. He uses he, him pronouns, but the way that he moves through the world is to use signifiers that as a society we might see as more feminine or more androgynous. And recently he's been feeling really pressured to fit inside that very small masculine mailbox. And that's pretty distressing when that's not actually your identity. So the client says that they're fearful of hate crimes and violence every time they leave their home. So the questions I would ask for you are what biases are present in society that likely created this situation for this patient where they are frightened, they're frightened of their

own anger, They're dealing with depression, anxiety, and they're feeling like they have to present themselves to the world in a way that's not authentic. How does the patient's multiple identities show up and how does that influence how they experience bias? And what else might be going on for this patient? In what ways do the social determinants of health, what we know about LGBTQIA plus people, what we know about transgender individuals, and their health outcomes play into this scenario. So I'll stop my share for now and see if there are questions. And you can put a question in the chat. I don't know that we can unmute folks. Irene, I see your hand. If you're able to unmute yourself, go ahead.



Simon-Ulysse, Phanide 33:01

Irene, if you're talking, you're still muted.



Cei Lambert (he/him/his) 33:09

And if you can't unmute yourself, you can type it into the chat and I can see if I can unmute you.

Okay, it seems like possibly the unmute function isn't working. So if folks have responses to the case discussion, you can go ahead and type them into the meeting chat. Like I said, we can also discuss things at the end when hopefully we can unmute folks.



Maria Jose Morales 33:58

Hello, can you hear me?



Cei Lambert (he/him/his) 34:00

Oh, yes, I can hear you. Go ahead, Maria.



Maria Jose Morales 34:04

Yes, I just, I'm confused because I'd rather put things on the chat, but my chat has been disabled. But since I'm speaking right now, yeah, I don't know why it's disabled. But yeah, but I don't like to speak too much like this. But I just wanted to say that this is very



Cei Lambert (he/him/his) 34:11

Oh, OK.



Maria Jose Morales 34:24

I'm very grateful that you are speaking about this. And so far what you've said, you said something very important to me, which is I work with colleagues that are

part of the community, LGBT community. And what you said about just straightforward asking them, because I know how they're different. And I mean, we have a great relationship, but I think it's a good idea to ask, you know, how would you like me to, you know, yeah, I think that was good. So I appreciate that.

CL **Cei Lambert (he/him/his)** 35:00

Absolutely. And thank you for sharing that. I completely agree. It has only happened to me a couple of times in 17, 18 years of doing work like this that somebody has been upset when I have asked for more information about their identity. I think it's one of the best ways to combat bias. So thank you, Maria, for highlighting that. I completely agree.

Just asking folks how they want to be treated, what words they want to use, it can make a huge difference.

Here in the chat, we have somebody who said, supporting clients facing racism and bias, especially when it's amplified by social or political climates, can be emotionally taxing and ethically complex. And the question is, are there any suggestions on therapist-centered ways to cope with continuing to provide effective care? Absolutely. Thank you so much for asking that question, because as the flight attendants like to tell us, we have to put on our own mask before assisting others, because if we pass out, we probably can't assist anybody. And that's sort of how I think about taking care of ourselves as providers and as support systems for these individuals. So I think it is. It's very emotionally taxing and complex for clients. I have a few different suggestions and some things might be more easy or less easy depending on what your practice structure is. One of the things that I've seen folks do is if they feel like there's a client who's coming in who maybe needs more time or something, it might be better for you as a provider to try to schedule that person in the morning, or try to schedule that person at the end of the day, depending on how you feel about your practice, just so that in terms of your own energy, because it is enormously energetically taxing to work with these issues with folks. If you can situate it when you have the most energy, or and or when you know that you're going to be able to take some time immediately afterward, you don't have to jump right into the next client. That can really help to ease, it helps me for sure to ease my mind when I'm working. I think also finding someone, it doesn't even necessarily need to be a therapist, although I always encourage people to engage with therapy. I think therapists, seeing therapists is a great idea. But have somebody that you can talk to about these particular questions. Maybe inside the clinic, if you have somebody who's like a team lead, a floor lead. I know that we've got folks from all different kinds of practice settings. And so that might look different for different

folks. But just having somebody that you can go to and say, wow, I just had to hold a lot for this client because they're really hurting, because it's really complicated, because they're facing bias, because I'm also addressing my own biases and working through it. Just talking about it can be very helpful. You can also be very transparent with your client. Keeping things professional, I found that it...can help a person to hear from the provider that they're actually holding that difficulty alongside the client. When we talk about activism and when we talk about specifically what it means to be an ally to a community, really what being an ally means is that you're stepping enough into the space of the identity that the person is holding, that you're actually going to probably feel some of that discrimination, marginalization, and bias. And so by being in that space, it can be tiring. And talking to your client about that and saying like, hey, I'm coming with you on this and I really feel. feel all the way deep down, how intense this is, that can feel relieving in the clinical moment and also build empathy and trust with the patient, with the client in a way that I think is helpful. So let me know. We can always circle back to that. We also have another piece here. Heather says that folks should be able to access the chat function and you can put your questions and comments in the chat. I think if you're looking at the Teams, if you go up to the top, there should be a little speech bubble that says chat, and that's how you can open up the chat. I'm going to move us along so we have enough time for the rest of the presentation. We'll have another case study, and then we'll also have time for Q&A at the end, and we can come back to this case study if folks want.

Okay, now that we've talked about unconscious bias, I think it's important to think about where does unconscious and implicit bias come from? And when it's created, sometimes the people who are creating the content, let's say it's a movie or maybe it's a piece of social media content, or maybe it's a published paper through a respected journal. All those sorts of places can be where bias shows up. It may be that the person who authored that piece of information or content that is creating bias doesn't know that it's creating bias. And a lot of the time, that's where we get misinformation. So misinformation is misleading and inaccurate information, and it's been disseminated, and it purports to be accurate. So that misinformation creates that stereotype and mental picture, the bias, and then that can lead to actions that are taken based on that bias, and those actions can cause harm. Importantly, we're also dealing, particularly right now, with disinformation. Disinformation is where people are intentionally misleading or creating inaccurate information that is then disseminated. And the goal is to direct public opinion and action in a specific way. This is very much what we're seeing for transgender people in the United States right now. We're seeing folks who are manufacturing completely fabricated data that is inaccurate about our

community. It's inaccurate about our satisfaction with our transition. They have a whole lot of papers that have been published by people who purport to be doctors. And as we go along, we're seeing that all of these pieces of disinformation that have been created are pretty easy to discredit.

So when you're dealing with disinformation, part of the job becomes a little bit more complex because the people who are creating this information that's causing the bias to show up in all of our minds knows exactly what they're doing. It's basically a propaganda machine. And so because that bias is intentionally created and it's intentionally created to cause harm, to reduce access to care, to target a specific community, single them out, and then discriminate against them. That means that actions that are taken based on that bias cause harm and further perpetuate the disinformation because it's creating an artificial trail of, quote, sources that can be cited.

This is particularly difficult right now as AI becomes more and more ubiquitous. AI can really only access information that it has been given by all of us, by people in the world who have created information and put it out there into the world. And so if somebody is using AI, for example, the people who have created disinformation have prioritized making it so that in many cases, the AI is accessing that disinformation when they're answering a question like, what does transgender mean? What is LGBTQIA plus? What are laws that are affecting transgender people?

And you might end up with an AI response that's drawing from disinformation. So how do we combat this? I think there's a lot of different ways that we can go about talking through misinformation and disinformation. One of the ways that I'm just going to talk about, it's very, very action oriented. If you're using AI in your work, which I think is probably going to be what's going to happen to most of us at some point or another, ask it to cite its sources very specifically. When I use AI, which I actually have used to make my research go much more quickly, what I ask it is every single sentence needs to have a live web link or a live link to whatever that source is and I go through and I click every link and I look at where is this pulling this information from? Can I trust it? Is it from an institution where I know that there's probably not underlying bias or an underlying political motivation that's creating this piece of information? And by doing that, I can start to...improve my brain's ability to identify that misinformation. Or in the case of AI, we're often talking about, you might have heard of AI hallucinating. AI does hallucinate. It makes up things completely randomly from like little bits of information. So holding your tools accountable while you're doing your research, while you're looking things up can really help to actually be an active way to combat that bias, particularly around disinformation. A lot of the time with disinformation, I

would also suggest if you find something and you're like, I think this might not be right, I think this might not actually be accurate, do your own research and search on that particular cited source.

And oftentimes, if something has been created for the purpose of harming the community, there will be a lot of conversation. And particularly, there will often be a response from a trusted institution like the American Psychiatric Association that says, what has been said over here is completely inaccurate. We don't endorse that. And that can be a good way to be like, OK, that piece was piece of disinformation over here I can probably trust these peer-reviewed articles and especially things that are written by the community for the community and look at those pieces.

Other ways to combat mis and disinformation, again, look for the peer review. I would love to say that that was a perfect solution. At this point, we're dealing with a situation where peer review doesn't always mean that the information isn't biased, unfortunately, but it's a good start. Looking for replicable data. So even if a piece of information or a paper has been peer reviewed, does it have data that's been replicated. And that usually means you're looking for information that has been done longitudinally over a decent period of time, has been replicated several times. And a lot of the time I look for what are multiple institutions who have researched, for example, caring for transgender people.

And what are their recommendations? Because a lot of the time, if multiple trusted institutions have done the same research and come to the same conclusion in this particular case, that providing gender affirming care is indicated and appropriate, then I know that this is probably a safe piece of information, as safe as it can be.

It's important to look at authorship and oversight of individuals who are working in the area of discussion. So there are a lot of publications, there are a lot of doctors who have been paid to create disinformation. And at least in the United States, sort of what's happening right now is there are people who are affiliated with...institutions that try not to have undercurrents of bias, that try to really be objective and fact-based and care-based, evidence-based. And then there are a whole lot of folks who warp everything so that it fits their model of the world. And so looking through that authorship, If you find an author and it seems like the paper that they've written or the piece of content that they've created is a little bit different than what you expected or what you have been led to believe by other sources, look up that author specifically and sort of see what are they, where are they coming from? Who are they affiliated with? And do those affiliations make it so that they're...potentially A biased source.

And just going through that authorship thing, look critically at authorship by individuals and

organizations who are not reliant on government funding. This can actually be a place to find more or less biased information, particularly in the current political climate, and look for authorship by individuals and organizations in countries other than the United States where the government in that country, it doesn't have the same level of anti-LGBTQIA plus sentiment. A lot of European countries in recent history have some pretty good papers on these things. Europe is also kind of teetering back and forth in terms of being affirming versus being discriminatory looking around and figuring out how you can combat that mess and disinformation.

So for our next case study, we're going to talk about management of clinicians and sort of what does it look like to be not just in a situation with patients, but what does it look like to be in a situation with colleagues? So in this particular case, I invite you to pretend that you are a manager who's supervising several clinicians and these clinicians have very large caseloads.

Most of your direct reports have come to you over the past few months to discuss how they can support transgender clients, lesbian, gay, and bisexual clients, and other clients who have diverse sexual and gender identities. Some of the clinicians really, really know a lot about LGBTQIA plus culture, language. A lot of them might even be members of the community themselves.

Other folks are still learning on how to work with this population. There have been a couple of comments and feedback from clients who are concerned about clinicians having bias, and you, as the manager, have been asked to meet with the clinicians broadly to discuss LGBTQIA plus identity and what the expectations are for clinical support and having diversity literacy.

The questions that I would ask you to answer, and I'll do the same thing we did before, where I'll stop sharing and we can talk about it a little bit, is what support and education do you need to best guide the clinicians who are reporting to you in this scenario? How do you balance safety and support of the clients in the clinic alongside that learning curve for clinicians?

And what plans can you make to ensure that the clinical competence that you need around LGBTQIA plus identity happens for all clients? And what would you do if the clinician that you are supervising is unwilling or unable to support an LGBTQIA plus identified client? What are your organization's rules and regulations regarding support for clients with these identities?

So I'll stop sharing now and we'll go back. Like before, you should be able to unmute yourself. You should also be able to place things in the chat.

While we're waiting, I'll make a suggestion that I have found to be helpful for folks in the past. And also, this suggestion comes with some caveats. And this is kind of when we get into the gray area of doing this work. So when you are in a setting like this and you're looking for how can we support these patients, how can we make sure that all of the clients who are coming through the door are having the same level of care regardless of identity, a lot of the time it can be helpful if you have an internal institutional team member who's willing to take a leadership role who holds those identities. I was just asked to share the questions from previous slide again. Let me see if I can do that.

It's a little bit of a funny situation. I'll do my best. But if you have an internal champion inside your organization who's willing to talk to folks, it looks like I'm not able to paste the questions into the chat. I'll keep trying.

But if you have somebody who can be an internal champion inside the organization and is willing to do that work, two things about that. One, it can be very, very helpful. And also, it means that there's a lot more work that's being asked of that individual. And so when we're thinking about having an internal institutional champion or champions. Employee resource groups are also a really good way to address these concerns. But making sure that those individuals are also being supported, that if possible, they're being compensated for the extra time they're taking to train other team members, that sort of thing. But we've got something in the chat. I'm still working on figuring out how to paste those questions in the chat.

This question is, I'm wondering if there are ways or techniques to support and influence staff in addressing bias regarding working with this community. I have a staff member who's really struggling to separate her strong religious background and get past that barrier to accepting the client as they are in order to build rapport. And it's really become a barrier in supervision.

Thank you so much, Bianca, for sharing that question. I think that's extremely important. So in my interpretation, and this is very much my view, everybody gets to believe what they want to believe. But in the same way that somebody who has a gunshot wound comes into the ER, nobody in the ER is going to be asking what that person's religion is. No one's going to be asking themselves, am I in personal alignment enough with this person to take care of that gunshot wound? They're going to be jumping in and taking care of that gunshot wound. And it becomes more complicated when we're in a situation where it's not a life-threatening emergency, or at least it doesn't feel like the same level of life-threatening emergency. But I make the analogy to say that provision of care, particularly when it is peer reviewed, when it is evidence supported, when we know beyond a shadow of a doubt,

from all of the major medical and behavioral health institutions that providing this care is correctly indicated. Really what we're doing is we're not asking anybody to change their beliefs. We're asking them to provide the same level of care as they would for anybody following clinical guidelines. So this person doesn't have to change their religious views. In order to say the clinical guidelines say it is appropriate to provide hormone therapy. It is appropriate to affirm this person's gender while they're in my clinical space. And that can be a tough thing to hold. I've found that with a lot of individuals, it requires a discussion that's kind of ongoing and from a supervisory perspective, helping somebody return over and over again to do what we're doing is we're providing care and we're going to run into people in our practices that we don't agree with, that we don't like, that we don't want to have anything to do with necessarily, but that's the nature of the job. The nature of the job is...someone needs help, we are trained to provide that help, and it is ethically correct to provide that help, and just having that framework. I've got a couple other questions here. Sort of a multi-part question here. One is, what support and education do you need to best guide the clinicians that are reporting to you?

I think it can be a lot of different things. I think attending sessions like this is part of it, talking to somebody who's a supervisor or a manager. Also, with a tentative asterisk of be careful, the internet is not a bad place to find education and guidance. Just be really choosy about where you're getting that education and guidance.

I would strongly, strongly suggest looking up folks who are providers inside the space. Out in Massachusetts, actually, in Western Mass, I'm forgetting where he is. There's a provider named Sebastian Barr, and he is a trans man who does this work all day, every day.

And so it can be very, very helpful to have someone like him. And you can, he's got a sub stack, he's got a lot of writings, he has many published papers that are about exactly this, and goes into very specific detail with lots of cases about how do you navigate like this particular type of presentation. Similarly, Fenway Health also has a lot of resources through the National LGBTQIA Plus Health Education Center, which is inside the Fenway Institute. And that's where we're coming in to partner with folks here. And there are webinars, there are papers, there are pamphlets, there's lots of different pieces that have been generated. To sort of address specific questions. So I hope that helps. We can definitely, I can also send more resources folks this way. Another question, how do you balance the supportance?



Simon-Ulysse, Phanide 56:32

Hey, just wanted to let you, I just want to let you know we did put your questions in the chat, the question from the case study, just as an FYI.

CL **Cei Lambert (he/him/his)** 56:40

Oh, perfect. Thank you. Oh, there we go. That's what's going on.

I was like, this is interesting. It feels like it's, we're right there talking about the questions.

Thank you. Another question, could I share tips for how to invite others to grow in their learning if they already feel they are knowledgeable, but they show signs of bias? Thank you so much for asking this question. This is where things get particularly challenging.

What I would say is one of the ways that you can invite somebody in and sort of gently say, I see what you're doing and I see how much work you've put in and I'm seeing these other pieces. Start by talking about what you're seeing that's positive. Start by talking about, I see that you're knowledgeable about things. I see that you're passionate about these things.

and then bring up a very specific example. So have it rooted in a specific moment of action, a specific interaction, and say, you know, based on what I know of you, this interaction feels a little funny. Can we talk about this? Can we talk about the language that you used? What's going on there? Help me understand and giving the person kind of an open-ended way to say, this is how I was thinking about it, can give you insight into how they were thinking.

And it can be very helpful for saying, I think there might be bias there. And if this person has sort of self-identified as knowledgeable about these pieces, continuing to say like,

Okay, I know because you're knowledgeable about this and because you've done the work, I can say this to you and I can be really honest with you. This thing didn't land quite right with me. Can we talk about that? This thing feels like it might be rooted in bias. Can we talk about that and make it an invitation rather than a criticism?

Hold on, we also...There's a really great comment here. Thank you, Elena, for sharing this. So Elena shares that this is my personal sentiment. So this person's personal sentiment, who believes in God and believes that those who choose to follow God and work with the community should recognize it, that they are meant to live in God's image. God would never turn away a person.

That's in literature and it's the nature of humanity. I think that's a fantastic insight and way to talk about to people while acknowledging their identity as a person of faith. I think that that's really, really meaningful. So I appreciate that comment very much. There's also a book recommendation called *Outside the Lines, How Embracing Queerness Can Transform Your Faith*. I have actually read that book. It's also, it's definitely fantastic. Can recommend, particularly if you are thinking through how does your faith intersect with this work or you know somebody who's going on that journey. So thank you so much for sharing that piece of information.

The question here, what would you do if the clinician you are supervising is unwilling or

unable to support an LGBTQIA plus identified client? This gets really complicated. So I'm going to say that like me as an individual, as a consultant doing this work with you today, I can't tell you what you can and cannot do because every organization is different and has different rules and regulations. Things have also changed a lot over time and in recent years. And so I would say the first thing to look at is, will you have organizational support for holding people accountable for providing care to these communities?

In some clinics, in some cases, they will say, if you want to work here at this clinic, you will provide care to these people and you will provide the same level of care to these communities as you would anybody else, or you can't work here. So that is what some organizations do. That is very, very difficult, particularly in the current political climate, it's very difficult if you work in a federally qualified health center or if you're taking Medicare, Medicaid, you often don't have that leeway to just say, this is a requirement for working at our clinic. A lot more private clinics are able to do that. If somebody is unwilling and unable to support somebody, I would say in terms of harm reduction, it can be appropriate to reassign a patient to a different provider who is supportive. I think it still makes sense to then talk to the provider on staff and say, we have a significant number of people or we need to be able to rely on our providers to provide care regardless of the identity of the people that we're caring for.

And I think this kind of comes back to the discussion around spirituality and religion. No one is being asked to change their personal beliefs. They're being asked to do a clinically indicated job. And the clinical indication that's supported by science is provision of care for these individuals.

So kind of coming back to that, but I do think it can be appropriate to move a patient to a different provider if possible when somebody is not willing or unable to do the work because we don't want to cause harm to our clients. Another question here, I might have to cut us a little bit short and move on with the presentation. So I'm going to do one more question.

Then we're going to move on and then we'll circle back to everything in the question and answer. The question here, at what point would you recommend transferring a client to a new clinician? Yeah, okay, so this feeds in directly, particularly if the person is unable to meet that person's needs. What should that look like for the client? I think a lot of the time... The client will probably know if the person that they came and met with or that they maybe had several sessions with is unable to support them in what they particularly need. And so again, it depends on your organizational structure, how easy it is to transfer care from one provider to a different provider.

ID **Isabella Delgado** 1:02:22

Yeah.

CL **Cei Lambert (he/him/his)** 1:02:31

And you're always welcome. I have my email address at the end of this. You can send me your very specific case scenario and I can try to navigate it with you from an organizational perspective. So if you do have to move somebody to different care, typically that person's going to know that the clinician they've been seeing isn't quite a good fit they'll probably feel similarly. And that's a nice way to be able to transfer care easily. You can also make it kind of not about the patient and say, this person needs to have a different schedule, so we need to find a way to hook you up with a different provider. Talk to the patient very specifically about, you know, what are you looking for in a provider? I'm going to try to connect you with a person who's going to be a really good fit for you and just kind of make it about that. Someone added to this conversation here. I'll just read this one little bit. I'd like to add that if a clinician is unable to provide unbiased care to a certain human for whatever reason, they should be able to transfer that client to another provider as the care could be unconsciously harmful. Absolutely. I completely agree.

Oh, thank you. I love BOLO ties. I have a whole collection. I'm glad you like BOLO ties. I am from Colorado and live in Colorado and I really like Western wear. So, okay, I'm going to move us back to the presentation. But like I said, we can continue to have this conversation at the end about this case and about sort of the conversation generally. Let's see here.

Okay, now that we've talked about what unconscious and implicit bias is and how we can combat it, and we've also talked through some cases of very specific unconscious and implicit bias, and we've talked about how mis and disinformation create those biases, I want to talk about two sort of concordant pieces of where bias might show up for a hypothetical client, particularly around intersectionality and how intersectional identities can compound the difficulty that someone is experiencing if they're experiencing bias around multiple parts of their identity. So in this example, which is entirely fabricated, We have an individual who identifies as a transgender woman. This person's religious identity is as a Muslim, and this person's racial identity is black and specifically African-American. So in this Venn diagram, in the intersection of gender identity and racial identity, a transgender woman might experience sexism and transphobia in a lot of spaces, Also, including from other people inside the community, a lot of the time people in lesbian, gay, bisexual, and other spaces that are about sexual orientation might actually have bias against transgender individuals. And that can be very difficult because it can be hard to find community if your community

includes people who have biases against you.

A woman of color might also experience discrimination from numerous groups, including from inside the LGBTQIA plus community. So one of the things that's important about intersectionality is to understand how different communities may or may not be perpetuating bias, even if they are an organization representing A minoritized identity. And that's definitely something.

Many communities of color might be more welcoming of Muslim people than perhaps other communities, but they might not be as supportive of LGBTQIA individuals. A Muslim individual may experience discrimination inside the LGBTQIA community because there's a frequent connection between organized religion and community and stereotypes about Islam, and discrimination towards the LGBTQIA plus community. So for this individual, what this might look like is the person might feel like they can only show up to certain spaces with part of their identity. And as we were talking about in the beginning, none of us is just one identity.

And none of us can show up as just one identity. We bring our whole selves to a space, even if we're having to hide part of ourselves. And the act of hiding, the act of masking those identities that are part of what makes us ourselves is very detrimental to our mental health and also our physical health, since that mental health and physical health piece is really connective. So this individual might be very stressed or challenged and feeling like they might have to sacrifice one identity in order to have space in another identity or vice versa. And just thinking about how those different things interact could be very helpful as a provider for working with this particular individual.

One of the questions I might ask an individual like this is, where would you like to receive support? Where would feel most uplifting? Where are you feeling like you're not getting a lot of support? And maybe this person says, you know, I really would like to find a religious space where I can practice my religion in community and feel safe and accepted.

And so maybe for them, the focus is on accessing that religious community, and we'll work on that, and we'll work on finding a place that's affirming of transgender individuals, that is doing anti-racist work, all of those different places. So going to the client and saying, I see that you have infinite and multitudinous identities, as do all of us, Where do you need help? Where can I help you prioritize or figure out how to find community and support?

And in so doing, one of the things that I think is really important to remember when we're doing this work is to not just focus on the negative. We live in a world where bias and stereotypes are created, and that's not going to change overnight. One of the things that happens when people have an experience of multiple marginalized identities, or even a

single marginalized identity, is we develop resilience. And that resilience can look like a lot of different things. And that resilience can also give us an opportunity to create spaces of more and deeper support than we might otherwise have had. So this same individual who is a transgender woman who identifies as Black and African American and also as a Muslim. So this individual might be supported by the Black community and might even find that there are LGBTQIA plus BIPOC affinity groups and meetups that are specific to those intersectional identities. A transgender woman might be welcomed and supported by a Muslim congregation that is progressive. And I know several organizations mostly on the East Coast and in Colorado, but I can, I know a lot of folks who do national stuff as well. There's actually a lot more affirming religious spaces than people might think there are. And so it might be that this person, because they have run into this confluence of their identities, finds a very supportive space where they can practice their religious identity and be in a space that also acknowledges their other identities. And many Muslim groups are also very involved with supporting the Black and African American community, and some of those groups are also welcoming of transgender people. So I do know that because of this resilience, people have built spaces and built ways of working together around identity that prioritize that intersectionality. And when we're thinking about the clinical context, I think it's just as important to acknowledge the resilience that a person has and how that could have made it so that they can build community, build relationships, and support themselves in addition to talking about how things are hard. In my experience, when I just focus on the things that are hard and when I just focus on the things that it's like, oh my goodness, the news and somebody said this thing and it's inaccurate and somebody said that thing and this person behaved that way and all of that can feel very, very heavy even if we're sort of reinforcing and affirming how somebody is experiencing their day-to-day life, also helping them see, you know, I see that you have found this group. I see that you have made this choice. All of those things are resilience to those negative inputs that you're seeing, and that's worth celebrating. And I find that to be a very therapeutic conversation.

This is our last case study and then we'll start moving forward towards the end of the presentation. We'll try to put the questions, if someone could try to put these questions in the chat, that would be awesome. I have not figured out how. So in this case, you have Sam. Sam is your client and has been your client for about two years. Sam is originally... came to you for help with substance use disorder and depression. Today, Sam came to their appointment wearing lipstick, a dress, a full beard, and recently styled curly hair. Sam has not previously presented their identity outside of a stereotypically male lens. Sam seems happy and also a little nervous. Sam tells you that they still go by Sam as their name, but

that they are using they, them pronouns, and have begun to express their gender more authentically in the past weeks. So in this case, what are some questions that would be appropriate to ask Sam? What questions might be inappropriate? What are some possible biases that could impact your work with Sam, especially in their new identity expression? And where can you find more information about gender fluidity and gender expansive identities?

And are there specific biases that might impact non-binary individuals in a political context? So I'll stop my share for a moment. And look, yes, and the questions are in the chat.

And Katharine, in answer to your question, yes, that is how Sebastian spells his name. It's Sebastian Barr with two R's.

This is also an important comment. Kathy says, I've had luck focusing on the clinician's intent. Most of us have been made to feel a way that's not good about ourselves and can identify that feeling of not good. And we wouldn't want to make the client experience that feeling of not good. And so I think bringing that empathy piece can be very helpful in the clinical context.

So in this case, yeah, Kyle is spot on a question that you should not ask is, are you going to cut your beard? Because that assumes that Sam in this case wants the beard gone. And if they wanted the beard gone, they probably would have taken the beard off. And assuming that they don't want the beard is putting Sam in a place where we're making assumptions about their gender identity and how they want to express that gender.

And it can be that for Sam, the most expressive way that they feel their gender is in a dress with a beard, with makeup, using elements that are all social constructs for gender, makeup, dresses, facial hair. All of these are things that we assign gender, but they don't necessarily need to be assigned to a specific gender.

Deb says, a question can be, tell me more. Absolutely. Don't ask if they've started using again or whether they're high in that session. I think that's a really, really good comment. So not bringing in, Sam came to you and you probably have had lots and lots of conversations about the substance use, what's going on there. And but if you bring in like, are you using again? Sam might feel like, oh, you're criticizing my gender expression as a symptom of maybe being high or something that I might do if I were using again. Whereas probably what's happening is Sam has started to feel comfortable with you as a provider and has decided that they're safe enough in this space with you to be their full authentic selves. So it's really good to meet them with that same energy.

We also have, if the person does not bring up the change in their appearance, is it appropriate to ask? I would say it's another one of those gray areas that's a little bit difficult.

I wouldn't start by asking, hey, you look completely different. What's going on? You might just start your session the same way you would start any other session.

And then as time goes on, it probably, if Sam is making a choice to express their gender identity in this specific way with you, a few things are probably happening. One might be that Sam does want to bring it up and talk to you about it. And so as long as you leave an opening for that, they might talk to you about that in that session. Another thing that could be happening is Sam might be sort of testing the waters. What happens in the clinical context if they show up as their full selves with their own gender expression that really feels authentic? How are they received by the clinician? And I would say in that case, it can be really helpful to just move on with your clinical interaction the same way you always have. And if Sam wants to talk about their gender expression, they'll bring it up.

And like I said, it's a gray area and probably I think trust your instincts. If you have been working with somebody for a little while, you probably have an idea whether the person needs to be sort of coaxed out and brought into a space where they feel safe to share and whether you need to say something to do that or whether this is a person who will share as long as they feel like they're in a safe space.

Um...We've got a comment here, a couple comments. Someone saying you could ask, tell me more about what this experience is like for you. Absolutely. If Sam starts talking about this, inviting them to talk about like, how has this experience been? When I was in Boston working at Fenway Health, I talked to a lot of clients who would actually change once they got to the clinic space because they didn't feel safe riding the train or taking transport or even taking an Uber, presenting their gender the way that felt authentic. And so it was very helpful in the clinical context to have that conversation. Like, what about being here feels safe? What about being out there feels unsafe? And how do you want to make things different, make changes along what timeline? What would feel good? This person also says that they want to acknowledge that it can be hard being steeped in the binary for decades to fully step out of it. Absolutely. This person says, Leslie says, we're not used to seeing a beard and lipstick together.

So it can cause confusion or discomfort seeing them together and then keeping that to yourself or sharing with your accountability buddy. Absolutely. You don't want to harm the client with your discomfort or questions. I think this is really important to acknowledge. It's okay if in a specific situation you feel a little uncomfortable or unsure of what to do next or...unclear of where people's boundaries are, those sorts of things. But I think the suggestion of keeping those things to yourself and trying to show up for Sam as much as possible to be with Sam in their process as the clinician supporting them, then going to

someone else and saying, this happened and it was difficult for me. What are things that I can do? so that the next time Sam comes in, it feels less difficult. And I think, at least in my experience, in these situations, it's true. That is one of the unconscious and implicit biases we usually all get, which is, this is what man looks like. This is what woman looks like. There's only two. And it has to do with like very specific things and frankly, the way that we decide male and female is a doctor's visual inspection of genitals and then it's like set in concrete and men do these things and women do these things and we hear those messages over and over and over again. So to be in an interactive space with somebody who is breaking that binary and taking it to a different place can be very difficult. And that's real. That's part of doing the work of taking away those implicit and unconscious biases. A question here is, would it be appropriate to mention that you appreciate their appearance, saying something like, you look great and more like yourself? You can. I think again, that's kind of a gray area. One of the things I would avoid, I say something like, I really love that necklace or that dress looks really good or whatever it happens to be, but be careful not to push the person in one direction or another. So something, and this was discussed earlier on, so saying, Oh, if you're looking for a more feminine look, you're really getting there, but you should change your hair, you should cut your beard, avoiding those sorts of things. And generally, I try to avoid making comments about individual's appearance, but you know your client best. So if your client comes in and you have a casual rapport that helps to build that trust, Saying something like, love that necklace, love your nails, whatever it is, can feel really affirming to someone. Going through here, just a couple more, and then I'm going to move on, and then we'll have our questions and answers at the end. We can dive more in. Someone would say, I'd be careful of my facial expression when I first see Sam. I think that's helpful. Yeah, because when we see something that we're not expecting, that is definitely where the implicit and unconscious bias shows right up.



Lorenzo, Zetmara 1:20:14

Goodbye.



Cei Lambert (he/him/his) 1:20:14

Our reptile brain gives us something.

No.

Lorenzo, Zetmara 1:20:19

Yeah.

CL **Cei Lambert (he/him/his)** 1:20:19

Someone asking a question.

Oh, Dawn.

Lorenzo, I think you're not coming through completely if you were trying to make a comment I couldn't hear.

Okay.

Super. So I'm going to move on. Thank you for everybody who jumped into the chat. There's some really great stuff there. So if you're looking through the chat, make sure to read everyone's comments. I really appreciate everything that everyone's saying. Y'all are really on it. I love it.

Okay.

I want to talk about the power differentials and bias. I promise I'm not going to read this whole slide, but I think it's important to just name it out loud. When a provider sees a patient, whether that's in a behavioral health context, a medical context, whatever it happens to be, there is an automatic power differential, particularly in the United States, where people are reliant on the provider, not just to take care of them, but also to make sure that the insurance is processed correctly, that the payment process goes correctly, all of these different things. So when the patient arrives, the patient is already in a situation where the provider has a lot more power than they do.

So some of the things that you can look for in terms of how is that power differential perhaps exacerbating bias is look for these signs. Are you assuming that a patient is lying about symptoms and experiences? Are you not really trusting the patient as the historian of their own experiences?

Are you adding barriers? Some of this is really repetitive from what we were talking about before, but thinking about those things and specifically thinking about any of those things being a moment to hit the brakes and say, okay, is this about a power differential? Is this about my own biases? What is this actually about? And what you can do is you can be aware of that risk factor about that power differential and work on participating in collaborative decision making. I think that one of the best things you can do to break down bias, and especially unconscious bias, with any community, and this is where we get to kind of the universal applicability of this sort of training, is making it a collaborative decision making process to the best of your ability and within what's appropriate clinically, having the person right alongside you making those decisions. And in so doing, when you invite the person into that decision-making process, a lot of the time they will say, oh, I have this identity, I have this feeling, I had this experience.

And it'll give you a lot more information about that person's identity and how they've experienced their identity in medical and behavioral health settings in the past. Like we talked about, ask your colleagues to talk through your clinical approach. Bring in recent examples and see if other folks spot things that you don't necessarily spot. An approach. caring for LGBTQA plus folks with a harm reduction mindset. We've been talking about this in the conversation, and I think that this is something that y'all really seem to understand, that the first thing that we want to do is try to do no or as little harm as possible. We don't want to add to the problem. And so if that means we sort of hit the brakes and take a beat, even if it might slow down some of our progress, or it feels like we're slowing down some of our progress, taking that time is actual progress in and of itself. So making sure that you feel comfortable taking a step back and reassessing the situation before proceeding. I think that in terms of that power differential, Another gray area I've run into is naming the power differential with the client. And I think that it can sometimes be helpful, particularly, let's say you have a client who's coming to you and you're seeing them as a therapist, you're seeing them in supporting their mental and behavioral health, but you also might be asked to write a letter for gender affirming care, something like that just knowing and acknowledging to the person out loud saying, I see that you need me to write a letter. I can write this letter for you. I also want you to know that I support your bodily autonomy. I support your ability to make these decisions on your own. I know that this is a piece of red tape, that this is a hurdle that you have to jump. I see that there's a power imbalance here sharing that with the patient can be appropriate. And again, it's a bit of a gray area, whether that's a good idea to share, but I find that naming things can often soften pieces that we can't change, insurance, for example. So that's the conclusion of the presentation. I've got my email address here, as well as my website and my LinkedIn handle. Interestingly, my other job is as a tattoo artist. So if you want to see what I do when I'm not doing this, you can go to my website and check that out. I'm also always happy to talk to folks. Send me an email. We can even set up a Zoom chat and work through some things. But I'm going to stop my share now and open into the group for questions, comments, and I'll try to get to folks that we didn't get to before.

See here.



Simon-Ulysse, Phanide 1:25:42

But we do have a raised hand if you don't.



Ceil Lambert (he/him/his) 1:25:44

Okay, thank you.

Yes, is it Shipley? Can you unmute? There you go, Shibilila.



Simon-Ulysse, Phanide 1:25:49

Yeah.



Shibilila, Kelsey 1:25:49

Uh, Kelsey.



Cei Lambert (he/him/his) 1:25:51

Oh, Kelsey, alright, and seeing your last name. Thank you.



Shibilila, Kelsey 1:25:52

Hi. Yep, yep, that's okay. This has been wonderful. Thank you so much. I'm wondering if you can talk a little bit about suggestions on infrastructure for organizations, just from a leadership perspective, how we can ensure that folks are getting quality care in the community.



Cei Lambert (he/him/his) 1:26:13

Absolutely. I think that's a great question. What I would recommend is I like a top-down approach. I like the idea if you have influence inside your organization and you have access to the different hierarchical layers of management, look and see are people across the spectrum of management engaged with the same training practices



Shibilila, Kelsey 1:26:14

Thank you.



Cei Lambert (he/him/his) 1:26:35

and conversations that the clinical staff are being asked to participate in. And if not, one of the big things you can do is say, hey, we're doing all of these trainings. It would mean a lot if the CEO, if the medical director, whoever it happens to be, the Behavioral Health director, if those people show up to the same trainings, It may be that those individuals have already done training, but I think it can be extremely impactful for folks to do training all together. So bringing in front desk staff, bringing in clinical staff, bringing in the C-suite and administrators and all of those individuals and making sure that everyone is speaking the

same language.

And that's usually how I phrase that invitation to different parts of the organization, especially people kind of at the top, is I say, this is really about rapport building with your team so that they know that whatever is going on with them, the type of clients that they're seeing, that the top of the organization also sees those conversations and is supportive of those practices so that everyone is literate. That's where I would start for sure. And then also, if you find yourself in a situation where you feel like there are different levels of support inside the organization, trying again to figure out, are there people in the organization who are capable of...being leaders in this way? Can you form an employee resource group? A lot of the time, a collective of individuals who want to push this work forward can get the attention of people in executive positions more easily than a single individual. It really just depends on the organizational structure. Did that answer your question?



Shibiliala, Kelsey 1:28:20

Yes, thank you so much.



Ceil Lambert (he/him/his) 1:28:22

Thanks.



Simon-Ulysse, Phanide 1:28:24

And there was a question that may have gotten buried. It says, I'm a licensed, I'm an independently licensed clinical social worker in primary care. I have some trans clients who get started at by patient in the waiting room. Does my silence imply bias? Do I mention it in session?



Ceil Lambert (he/him/his) 1:28:27

Okay. Mm.



Simon-Ulysse, Phanide 1:28:44

who gets scared at by the patient in the waiting room.



Ceil Lambert (he/him/his) 1:28:45

That is.

Yes, this is an excellent question and I really appreciate you asking this. So one of the things

that can be very challenging is we don't have control over how other patients behave. And typically in a clinical context, at least in my experience, unless somebody is doing something that is pretty disruptive, we're not going to ask somebody to leave a care situation where the other patient also needs care.



Simon-Ulysse, Phanide 1:29:07

Yeah.



Cei Lambert (he/him/his) 1:29:13

but that patient might have biases. So one of, I can think of a few different things. And again, it depends on what sort of tools you have available at your disposal. Small things like affirming signs, are you able to put up rainbow and trans flags? They don't have to be big. If they're there, a lot of the time that signifies to people enough of that safety that they know, okay, there's going to be biased people in the world. And most folks have almost certainly run into somebody who has expressed bias, who has treated them poorly, whatever it is. It's not fun to have a patient in the waiting room be discriminatory.



Jennifer Dixon 1:29:48

Hi, how are you, Georgia? Good.



Cei Lambert (he/him/his) 1:29:52

No. Sorry, I thought somebody was talking. Okay. So in the waiting room, if the client is able to see signals that the organization is supportive of their identity, it can help them to just sort of sit with that space and be like, okay, I can't control the actions of that person and probably neither can the clinician but I see that this is a safe organization. This is a safe clinic. And when they come to you and talk to you about being stared at, about whatever might have happened in the waiting room, really validate that experience and say, yeah, I really hear that. That makes sense. And if it reaches a certain point, if...If there's another patient in the waiting room who is saying hateful things, who is taking action, who is actively harassing a person, that's a moment to step in. And again, it depends on how your organization deals with those situations. When I was working at Fenway Health, if we had a patient who was becoming aggressive, who was starting to make physical motions towards an individual, who was using hate speech, we would call a code green, and that would make it so that providers, front desk staff, administrative staff would all come to the space where the incident is occurring. And depending on what we were able to get done, we would

either ask the person who's the aggressor to please sit down and stop harassing other people or if they feel like they can't stop harassing other people, we would have them leave. And it did happen a couple of times where we had somebody who was really detrimental to the experience of others, and we had that person escorted away from the building by security. That's a pretty extreme example. Ideally, that's not what's going to be happening, but it is something to talk about.



Simon-Ulysse, Phanide 1:31:28

Okay.



Cei Lambert (he/him/his) 1:31:35

with your other staff and whoever is in charge of how you manage those situations. It's pretty similar. If you're in a room with an individual who becomes aggressive, if you have a protocol for dealing with that so that you stay safe as a clinician, it can work the same way in the waiting room structure.

But I think acknowledging it for a client can be also an opening to have a conversation about how do you deal with this kind of discriminatory behavior in your day-to-day life? What are some ways that you and me as a clinician and patient can work to help build your resilience and give you some tools for managing other people who we just can't control some of the time, which is...which is not always fun. So thank you for asking that. Yes.



Simon-Ulysse, Phanide 1:32:18

Bing.

Thank you, Kyle. Yes, we are at, okay, we are at the top of our, just want to make sure folks have the evaluation. So,



Cei Lambert (he/him/his) 1:32:22

Oh. Yes.



Simon-Ulysse, Phanide 1:32:31

Thank you again, Kay, for such a thoughtful and informative training. And thank you to everyone for spending part of your day with us, especially during Pride Month. Before we do sign off, just a quick reminder, CEU is available for eligible disciplines. Please make sure to complete the evaluation survey that is in the chat.

Also, we value your feedback. So if there's anything you'd like to see more in the future

session, please share it in the survey. Also, lastly, on behalf of Kayla and ABAMBHP and the Fanway Institute, thank you for joining us today. Have a great rest of your day. Thank you. Bye.

 **Cei Lambert (he/him/his)** 1:33:06

Thank you so much, everyone. Happy Pride. Have a wonderful rest of your day.

 **Simon-Ulysse, Phanide** 1:33:10

Let me cry.

 **Mike Ramey, MSW/LCSW** 1:33:10

Thank you.

 **Maria Jose Morales** 1:33:12

Thank you so much.

 topped transcription