FOR CLINICIANS

Roots & Lenses

A Therapist's Self-Reflection on Bias

Unconscious bias doesn't make you a bad therapist. It makes you human. What matters is whether you're willing to look.

What This Tool Is

This is a structured self-reflection tool designed to help therapists examine the biases, assumptions, and blind spots that can quietly shape clinical work. It is not a test. There are no right answers. The goal is honest inquiry.

Research consistently shows that therapists, like all humans, carry implicit biases related to race, gender, class, sexuality, body size, disability, religion, and more. These biases can affect diagnosis, treatment planning, therapeutic alliance, and outcomes. Awareness is the first step toward more equitable, effective care.

How to Use This Tool

Set aside uninterrupted time This is not a quick scan. Give yourself 20–30 minutes to sit with each section honestly.	**Write, don't just think** Journaling your responses activates deeper reflection than reading alone. Use the space provided or a separate notebook.
Return to it regularly Bias work is ongoing. Consider revisiting this tool every 6–12 months, or after challenging clinical moments.	**Use it in supervision** This tool works well as a starting point for conversations with supervisors, consultants, or peer groups.

A note on discomfort: *If something in this tool makes you uncomfortable, that discomfort is data. Sit with it rather than moving past it quickly.*

SECTION 1

Know Your Position

Understanding your own identity, privilege, and lived experience.

Before we can examine how our biases affect others, we need to understand who we are. Our identities, the ones we hold with privilege and the ones we don't, shape what we notice, what we normalize, and what we miss in the therapy room.

Identity Inventory

For each dimension below, briefly note your identity, any privilege it carries, and how it might show up in your clinical work.

- **Race / Ethnicity**
  How does your racial identity shape what you assume about clients' experiences of racism, discrimination, or belonging?
- **Gender Identity**
  What assumptions do you carry about gender roles, expression, or what's "normal" for men, women, and non-binary people?
- **Sexual Orientation**
  Do you default to heteronormative assumptions in couples work or when asking about relationships and attraction?
- **Socioeconomic Class**
  How does your class background (current or origin) shape your assumptions about money, work, ambition, or "good" choices?
- **Religion / Spirituality**
  Do you pathologize, dismiss, or over-romanticize clients' faith? Do you assume secular or religious frameworks?
- **Ability / Disability**
  What assumptions do you carry about bodies, mental illness, neurodivergence, or what a "functional" life looks like?
- **Age**
  Do you make assumptions about what clients at different life stages should want, feel, or be capable of?
- **Immigration / Nationality**
  How does your understanding of "American" or "normal" culture shape your clinical lens?

Reflection Prompts, Identity

- *Which of these dimensions do you think about most in your clinical work? Which do you rarely think about?*
- *Where do you hold the most privilege? How does that privilege make certain client experiences harder for you to fully see?*
- *Have you ever had a client whose identity was significantly different from yours in a way that felt challenging? What made it hard?*

SECTION 2

What Are You Diagnosing?

Examining how bias shapes clinical assessment and diagnosis.

Research shows that diagnostic bias is real and measurable. Black clients are more likely to be diagnosed with schizophrenia and less likely to receive mood disorder diagnoses. Women are more likely to be diagnosed with borderline personality disorder. LGBTQ+ clients are more likely to have their distress pathologized. These patterns don't happen because clinicians are malicious, they happen because we're human.

"Diagnosis is not neutral. Every diagnostic decision is filtered through the lens of the clinician who makes it."

Diagnostic Bias Checklist

- ■ **Over-pathologizing survival responses**
  Am I diagnosing trauma responses (hypervigilance, distrust, emotional dysregulation) as personality disorders in clients from marginalized groups?
- ■ **Under-diagnosing in high-functioning clients**
  Am I missing depression, anxiety, or trauma in clients who are articulate, successful, or "don't seem that bad"?
- ■ **Cultural misattribution**
  Am I interpreting culturally normative behaviors (spiritual experiences, communal decision-making, emotional expression styles) as symptoms?
- ■ **Gender-based assumptions**
  Am I more likely to diagnose women with BPD and men with antisocial traits for similar presentations?
- ■ **Race-based assumptions**
  Am I more likely to see Black or Brown clients as "resistant," "non-compliant," or "lacking insight"?
- ■ **Class-based assumptions**
  Am I attributing a client's circumstances to character deficits rather than systemic barriers?
- ■ **Confirmation bias**
  Once I've formed a clinical impression, do I seek evidence that confirms it rather than challenges it?
- ■ **Anchoring bias**
  Am I over-relying on a previous clinician's diagnosis without reassessing independently?

Reflection Prompts, Diagnosis

• *Think of a client you've diagnosed. What information most influenced that diagnosis? What information might you have weighted differently for a client of a different background?*

• *Have you ever revised a diagnosis after learning more about a client's cultural context? What changed?*

SECTION 3

Who Do You Connect With?

Examining bias in the therapeutic alliance and relational patterns.

Therapeutic alliance is one of the strongest predictors of treatment outcomes, and it is not immune to bias. We naturally connect more easily with clients who remind us of ourselves, share our values, or fit our implicit model of a "good client." The clients who challenge us most are often the ones who need us most.

Alliance & Countertransference Checklist

- ■ **Preferential warmth**
  Do I notice myself being warmer, more patient, or more engaged with certain clients than others? What do those clients have in common?
- ■ **The "good client" bias**
  Do I implicitly favor clients who are verbal, psychologically-minded, emotionally expressive, and motivated, and pathologize those who aren't?
- ■ **Avoidance of discomfort**
  Do I steer away from certain topics (race, class, religion, sexuality) because they feel uncomfortable for me, not the client?
- ■ **Rescue fantasies**
  Do I over-invest in certain clients in ways that serve my need to be helpful rather than their actual therapeutic goals?
- ■ **Premature termination bias**
  Am I more likely to see certain clients as "not ready" or "not a good fit" when the real issue is my own discomfort?
- ■ **Tone policing**
  Do I respond differently to clients who express anger, grief, or frustration loudly versus quietly, and does that differ by race or gender?
- ■ **Assumptions about motivation**
  Do I assume certain clients "don't want to change" based on their demographics, presentation, or affect?

Reflection Prompts, Alliance

- *Think of a client you've found challenging. What specifically was hard? What does that difficulty reveal about your own assumptions or discomfort?*
- *Think of a client you've found easy to connect with. What do they have in common with you? What might you be missing because of that ease?*
- *Has a client ever named a bias or assumption you held? How did you respond? What would you do differently now?*

SECTION 4

What Are You Treating Toward?

Examining assumptions embedded in treatment goals and interventions.

Treatment planning is where our values become most visible. What we define as "progress," "health," or a "good outcome" is shaped by our cultural lens. The goal of therapy is not to make clients more like us, it's to help them live more fully according to their own values.

> *"Whose definition of wellness are we using? Whose vision of a good life are we working toward?"*

Treatment Planning Checklist

- ☐ **Individualism bias**
  Am I defaulting to individually-focused goals when a client's culture values collective, family, or community wellbeing?
- ☐ **Emotional expression norms**
  Am I treating emotional restraint or stoicism as pathology when it may be culturally appropriate or adaptive?
- ☐ **Productivity bias**
  Am I implicitly measuring progress by a client's ability to work, be productive, or "function" in a capitalist sense?
- ☐ **Relationship norms**
  Am I imposing Western, nuclear-family assumptions about what healthy relationships look like?
- ☐ **Autonomy assumptions**
  Am I pushing independence and self-sufficiency as goals for clients whose culture values interdependence?
- ☐ **Evidence-based treatment bias**
  Am I applying interventions developed on predominantly white, Western, middle-class samples to clients with very different backgrounds?
- ☐ **Spiritual bypassing or dismissal**
  Am I either dismissing a client's spiritual beliefs as irrelevant or using them to avoid deeper clinical work?
- ☐ **Body and health norms**
  Am I treating clients' bodies, health behaviors, or medical decisions through a lens of what I consider "healthy"?

Reflection Prompts, Treatment

- *Think of a treatment goal you've set with a client. Whose values does that goal reflect, yours or theirs?*
- *Have you ever felt frustrated that a client wasn't making "progress"? What was your definition of progress? Was it shared?*

SECTION 5

See the System

Examining how structural and systemic factors shape clinical work.

Individual therapy does not exist in a vacuum. Our clients' distress is shaped by systems, racism, poverty, homophobia, ableism, immigration policy, and more. A therapist who only sees individual pathology, without seeing the systems that create and sustain it, is working with an incomplete picture.

Systemic Awareness Checklist

- ☐ **Individualizing systemic problems**
  Am I treating the effects of racism, poverty, or discrimination as individual psychological problems to be "fixed" rather than systemic injuries to be witnessed?
- ☐ **Pathologizing adaptive responses**
  Am I diagnosing hypervigilance, distrust of institutions, or anger at injustice as disorders rather than reasonable responses to real threats?
- ☐ **Colorblindness / identity minimization**
  Am I telling myself "I treat everyone the same" in a way that erases the real differences in clients' experiences of the world?
- ☐ **Institutional complicity**
  Am I aware of how my role as a mandated reporter, insurance-billing clinician, or institutional employee creates power dynamics with clients?
- ☐ **Advocacy avoidance**
  Am I staying silent about systemic issues because I believe therapy is "apolitical," when that silence itself is a political choice?
- ☐ **Access and equity**
  Am I examining how my fees, scheduling, location, and communication style create or remove barriers for marginalized clients?

Reflection Prompts, Systems

- *Think of a client whose distress is significantly shaped by systemic factors. How much of your clinical work addresses those factors directly?*
- *What systemic issues are you most uncomfortable naming in the therapy room? Why?*
- *How does your own relationship to institutional power (as a licensed professional, mandated reporter, etc.) shape the therapeutic relationship?*

CLOSING

The Ongoing Work

Bias work is not a destination. It's a practice.

Completing this tool doesn't mean you've "done" your bias work. It means you've started, or continued, a practice that requires ongoing attention, humility, and willingness to be uncomfortable. That willingness is itself a clinical skill.

Commitments to Carry Forward

I will name my identities and positionality in supervision. Not just when it's relevant, regularly, as a practice.	**I will seek consultation when I notice discomfort with a client.** Especially when that discomfort is about their identity, not their presenting problem.
I will read and learn about communities I work with. Not to become an expert, but to reduce the burden on clients to educate me.	**I will ask clients directly about their experience of our work.** "Is there anything about how I'm approaching this that doesn't feel right for you?"
I will repair when I cause harm. Not defensively, not with excessive self-flagellation, with genuine accountability and curiosity.	**I will return to this tool.** Bias work is not one-time. I will revisit these questions as I grow and as my caseload changes.

A Note From Dr. Ellis

I made this tool because I needed it myself. I have caught my own assumptions, about what "motivated" looks like, about whose pain I took most seriously, about what a "good outcome" meant. That catching didn't make me a bad therapist. It made me a more honest one.

The clients who sit across from us deserve clinicians who are willing to do this work. Not perfectly, but persistently. I hope this tool is one small part of that.

, Dr. Natalie Ellis, LCSW-QS