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Therapist Positionality: A Cornerstone of Antiracist Clinical Practice

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Abstract

Therapist positionality is a foundational principle of antiracist clinical practice, yet it remains underemphasized in practitioner education, training, and ongoing professional development. Positionality refers to the interplay of a therapist's intersecting identities, including race, gender, class, sexuality, ability, and professional status, and how these shape power, perception, and relational dynamics. This article examines the role of positionality across clinical, collegial, and supervisory relationships, offering strategies to promote reflexivity, cultural humility, and relational accountability. Using positionality, clinicians can move beyond cultural competence into an ongoing, embodied practice of cultural humility, ethical engagement, and cultural responsiveness, particularly with clients and colleagues from marginalized communities.

Keywords

Therapist Positionality, Antiracist Practice, Reflexivity, Cultural Humility, Power and Privilege, Intersectionality

1. Introduction: Why Positionality Matters

In antiracist clinical practice, awareness of systemic inequities is essential but insufficient if practitioners do not also examine their own roles within these systems. Clinical positionality recognizes that no therapist enters the therapeutic encounter as a neutral observer; rather, we are shaped by, and participate in, the same systems of oppression that clients navigate (Pettyjohn, Tseng & Blow, 2020; Wright, et al., 2025). Bhatia and Ram (2009) assert that the therapist's gaze is never impartial; it is filtered through a lens of cultural history, identity, and institutional power.

Many therapists have been professionally socialized to believe that clinical interactions should center solely on client(s). The concept of the "neutral therapist" is historically rooted in classical psychoanalysis, where Freud conceptualized the

therapist/analyst as a "blank screen" onto which clients project unconscious conflicts. Sigmund Freud, and later ego psychology, emphasized neutrality, invisibility, objectivity, and detachment as indicators of clinical competence (Comas-Díaz, 2014; Freud, 1912; Greenson, 2018; Singh, 2019; Wright, et al., 2025). The underlying assumption was that neutrality would allow for the pure unfolding of the client's intrapsychic material, untainted by the therapist's countertransference. From this lens, acknowledging the therapist's own positionality—such as race, gender, class, or other intersecting identities—is viewed as a distraction from client-centered work, or even a boundary violation. However, this stance also emerged within a broader sociocultural context that privileged whiteness, heteronormativity, and other dominant positionalities as normal or universal, thereby rendering these identities invisible and unexamined (Altman, 2000; Comas-Díaz, 2014). As a result, the purported neutral position often functioned less as an absence of identity and more as the centering of dominant norms, marginalizing clients whose lived experiences diverged from these assumed universals.

Critics of this stance argue that such neutrality is both illusory and harmful, as it ignores the ways power, privilege, and systemic inequities inevitably shape the therapeutic relationship (Brown, 2008; Pettyjohn, Tseng & Blow, 2020; Tervalon & Murray-García, 1998; Wright, et al., 2025). By failing to name or acknowledge their social location, therapists may unintentionally uphold dominant cultural norms and invalidate clients' lived experiences through misattunement, invalidation, or projection, especially when working with clients experiencing racial trauma, cultural marginalization, or systemic injustice (Kivlighan III, et al., 2019; Singh, 2019). In contrast, antiracist and culturally responsive frameworks assert that reflective engagement with one's positionality enhances, not detracts from clinical effectiveness by fostering authenticity, trust, and relational accountability (Hook et al., 2016; Pettyjohn, Tseng & Blow, 2020; Singh, 2019; Wright, et al., 2025).

2. Defining Positionality: More Than Identity

Positionality encompasses a clinician's intersecting identities (e.g., white, Afro-Latine, queer, cisgender, working class, disabled, immigrant), the social meanings attached to them, and includes consideration of how these identities afford privilege or oppression in various contexts (Bowleg, 2012; Crenshaw, 1991). However, positionality is more than a checklist of identity factors; positionality also speaks to how these identities are interpreted and enacted relationally within power and privilege dynamics.

Because positionality is inherently shaped through relationships, it must be conveyed and experienced as genuine and embodied, rather than as a performative display. In the context of antiracist clinical practice, performative engagement with positionality refers to superficial or scripted acknowledgments of one's social location that lack genuine reflexivity, relational accountability, or meaningful impact on clinical practice. This often manifests as rehearsed statements about identity that are presented to signal awareness or allyship but are disconnected from

actual shifts in power dynamics, therapeutic stance, or systemic analysis (Ahmed, 2020). Performative acknowledgments can function as an assurance of comfort or a form of self-protection, allowing the therapist to appear culturally attuned without confronting their complicity in oppressive systems or making substantive changes in their behavior, decision-making, or institutional advocacy (DiAngelo, 2018; Sue, 2010). In contrast to authentic engagement, which is ongoing, uncomfortable, and action-oriented, performative engagement is static and self-referential, often centering the therapist or their image rather than the client's lived experience. Therefore, authentic positionality must be more than a declarative statement; it must be an embodied, accountable, and evolving practice.

As highlighted by D'Cruz, Gillingham, and Melendez (2007), positionality is both a reflective stance and a practice of accountability. Intrapsychic reflexivity requires clinicians to examine the identities they hold and how those identities shape their assumptions, emotional responses, and clinical judgments. Interpersonal reflexivity encourages clinical providers to be curious about how the client(s) views them and explore power dynamics that will likely influence therapeutic efficacy (Pettyjohn, Tseng & Blow, 2020). Positionality is a clinical skill set for intersectionally diverse clinicians of every race and should not be limited to when the client(s) phenotypical presentation is visibly different than the practitioner. However, explicitly naming positionality in the presence of significant privilege differentials is essential, as such disparities are often unspoken yet profoundly influence perceptions of safety, relational intimacy, and emotional vulnerability within therapeutic settings.

For example, a white therapist might reflect (intrapsychically) on how their racial privilege impacts their interpretation of a Black client's symptoms, anger or distrust. This same therapist may engage the client (interpersonally) with curiosity about prior experiences with white authority figures, and express willingness to explore and unpack racial dynamics in the clinical context (Pettyjohn, Tseng & Blow, 2020). A clinician with citizenship privilege might examine (intrapsychically) how their lived experiences impact their perception of the fear or terror of a client navigating community US Immigrations and Customs Enforcement (ICE) raids. This same clinician may be curious (interpersonally) about the clients' experiences with individuals with citizenship (or residents without immigration history), and inquire about their concerns in being seen, heard and understood by the therapist. This kind of reflexive interrogation supports clinicians in remaining responsive rather than reactive, clarifies to clients that therapists are aware of culturally relevant power dynamics in therapy, and creates scaffolding for exploration and deconstruction of racially charged dynamics in mental health treatment.

3. Clinical Implications: Showing up with Awareness

Therapist positionality becomes especially salient in therapeutic settings where cultural dissonance exists. As Phelps (2013) notes, clients often assess safety based on visible and perceived aspects of therapist identity. Thus, a lack of awareness,

acknowledgement or silence around positionality may trigger mistrust or rupture the therapeutic alliance. To address cultural dissonance and provide culturally responsive services, therapists must consider how their presence influences clinical interpersonal dynamics. For example:

- A cisgender clinician working with a transgender teen must be attuned not only to pronoun usage but also to how cisnormative assumptions may show up in language, posture, or conceptualization.
- A therapist from a dominant faith tradition might need to reflect on how their spiritual framework shapes interpretations of a client's indigenous or ancestral spiritual practices.
- A Black clinician working with a white client may need to navigate dynamics of racial projection, fragility or defensiveness, especially when addressing race explicitly.

Acknowledgement of positionality is not performative. When therapists acknowledge positionality as an ongoing relational stance, therapy becomes a more transparent space where power can be named, negotiated, and rebalanced.

4. Acknowledging Positionality Interpersonally

1) With Clients

While positionality names the therapist's intersectional identities, it does not center their perspective and hijack treatment. Acknowledgement of positionality allows therapists to welcome and normalize dialogue about diversity, difference, power and privilege into therapy settings (Pettyjohn, Tseng & Blow, 2020). Therapists can acknowledge positionality through direct, grounded statements that affirm the impact of identity without derailing the clinical focus. An example is:

"*As a straight, white, able-bodied clinician, I want to acknowledge that my role as a therapist affords me some power and privileges. I am aware that my lived experiences may limit how I understand some of what you're sharing or what you have been through. I don't want my lack of understanding or ignorance to cause you to feel shut down, unsafe, or unheard in our work together. I invite you to let me know if something I say doesn't feel right or needs unpacking.*"

Conversely, a performative positionality disclosure might sound like: "*I just want to say that I'm an ally, and I really value diversity. I try to treat everyone the same.*" While this statement may be well-intentioned, it centers the clinician rather than acknowledging how their identities shape the clinical relationship. It offers no concrete invitation for dialogue, does not address power dynamics, and risks minimizing the client's lived experience by implying that identity can be generalized or dismissed. Anchored positionality acknowledgements explicitly name power, acknowledge potential limitations, and create space for accountability and repair.

2) With Colleagues

Positionality also matters in interdisciplinary or racially diverse teams. Without awareness, therapists may unconsciously replicate hierarchies of dominance in

consultation spaces by speaking over others, questioning lived experiences, or defaulting to white normative standards of professionalism (Akinyela, 2005; Kivlighan III, et al., 2019).

Acknowledging positionality with colleagues or peers might involve:

- Naming how titles, professional status or academic privilege may silence colleagues with less institutional power
- Asking for feedback and perspectives from those with lived experience in the communities being discussed
- Taking accountability for harm when microaggressions or invalidations occur

3) In Supervision

Supervision is a powerful space for modeling reflexivity. Supervisors must address clinical content while also navigating dynamics of power and identity that show up in the supervisory relationship (Pettyjohn, Tseng & Blow, 2020). According to Mattar (2024), culturally responsive supervision includes an explicit discussion of racial identity, power and privilege dynamics, and intersectionality as core elements of case conceptualization, reflexive self-awareness, cultural responsiveness and ethical practice.

Supervisors can foster this by:

- Modeling crafting positionality statements with supervisees
- Training supervisees on the importance of positionality and encouraging practice in supervision sessions
- Using critical questions (e.g., "Whose voice is centered here?" "What assumptions are we making?")
- Exploring emotional reactions as clues to unconscious bias or internalized norms

5. Intersectionality: Expanding the Frame

Positionality and intersectionality are inseparable. As Crenshaw (1991) asserts, individuals are not simply oppressed or privileged; they experience both, simultaneously, across different axes. A queer, disabled, middle-class Latina therapist, for example, holds a unique vantage point that includes cultural, bodily, and economic intersections. Culturally responsive treatment requires that clinicians remain internally and interpersonally curious about the nuanced ways in which intersectionality manifests in therapeutic work. As Singh (2019) emphasizes, this includes attending to how multiple identities influence emotional labor, professional expectations, and burnout, particularly for Black, Indigenous, Asian, Latino/a/x/e, and people of color (BIALPOC) clinicians.

Intersectional reflexivity necessitates therapists to consider:

- Where do I hold both power and vulnerability in this relationship?
- How do institutional structures (e.g., academia, licensing boards, workplace bureaucracy) reinforce or diminish my positionality?
- How might unacknowledged intersections of identity reinforce mistrust or disengagement in supervision spaces?

- How might unacknowledged intersections of identity reinforce client mistrust or disengagement?

Strategies for Integrating Positionality

1) Create and Revisit a Positionality Statement

Clinicians are encouraged to reflect on and intentionally articulate their intersectional identities and social location in writing as a means of deepening self-awareness and promoting ethical, antiracist practice. Disclosures should be grounded in personal safety and professional relevance, beginning with aspects of identity that feel less vulnerable or more accessible. It is essential to anchor any positionality statement in a clear purpose, such as fostering antiracist and anti-oppressive care, enhancing cultural humility, or supporting culturally responsive supervision. Clarifying the intention behind the disclosure helps contextualize its use and reduces the likelihood that it will be misinterpreted or perceived with suspicion or malintent.

Acknowledging potential therapist resistance to this practice is equally important. Some clinicians may experience discomfort related to fears of self-disclosure, concerns about boundary violations, uncertainty about how clients will respond, or internalized beliefs about the therapist's role as neutral. These tensions are expected and can become meaningful sites of reflexive practice rather than barriers to engagement. Supervisors should be prepared to model the development of positionality statements in supervision; addressing dynamics of intersectionality, power and privilege require explicit guidance and training (Wright, et al., 2025). As identity and professional context are not static, clinicians should revisit and revise their positionality statements regularly to reflect ongoing growth and awareness.

2) Integrate Positionality into Clinical Activities

Given that most graduate programs do not include positionality as a core component of clinical training, clinicians intentionally practice sharing their positionality statements with clients to build confidence and increase comfort with addressing racial dynamics in therapeutic settings. Integrating curiosity about intersectionality into supervision is equally essential (Wright, et al., 2025). Power and privilege are active forces in supervisory relationships, shaping whether questions are posed, how feedback is offered, and how direction is received. As Lipscomb and Ashley (2017) assert, effective culturally responsive care and supervision require consideration of the "triple process" that examines the intersecting identities of the client, clinician, and supervisor. This layered awareness fosters relational accountability and enhances the capacity for ethical, equity-informed clinical practice.

3) Anchor Disclosure to Power, Not Performance

Clinicians should share aspects of their identity only when it serves the therapeutic process, such as validating unspoken racial dynamics or enhancing relational safety, not as a means of seeking validation or performative critical consciousness (Sibbald, et al., 2025). An ideal time to offer a positionality statement

is at the conclusion of the initial session, as part of a reflective discussion about the therapeutic alliance and next steps. However, positionality can and should be acknowledged at any point in the therapeutic relationship when it becomes clear that the therapist's intersectional identities are influencing clinical engagement or effectiveness. Positionality acknowledgement promotes cultural humility in therapy, which maintains therapeutic rapport and can assist in repairing cultural ruptures (Mosher, et al., 2017).

4) Use Reflexive Questions Routinely

Incorporating reflexive questions such as "*What might I be missing*?" or "*I wonder how my identity may influence how you hear or receive my feedback*?" should become a routine aspect of clinical practice. These inquiries signal a therapist's ongoing commitment to cultural humility and relational accountability. Positionality is not a one-time statement or performative gesture; rather, it is an evolving practice that requires continual attention and engagement (Sibbald, et al., 2025). Clinicians bear the responsibility to initiate and sustain dialogue that invites the exploration of racialized dynamics within the therapeutic relationship. Proactively acknowledging the potential for racial misattunement, cultural dissonance, or identity-based power imbalances creates space for clients and supervisees to name experiences that may otherwise remain unspoken (Mosher, et al., 2017; Wright, et al., 2025). This practice not only strengthens the therapeutic alliance but also helps mitigate harm and fosters a more equitable and responsive clinical environment.

5) Model and Normalize Accountability

Racial dynamics and disruptions are an inherent aspect of clinical practice, particularly within intersectional and antiracist frameworks. When racial misattunement or harm occurs, it is essential that clinicians validate the damage, take responsibility, offer a sincere apology without defensiveness, and engage in a collaborative process of repair (Mosher, et al., 2017). In many sociocultural and sociopolitical contexts, accountability is neither modeled nor widely practiced, which contributes to a general lack of expectation or skill in navigating it (Wright et al., 2025). Within this landscape, it is especially powerful for clinicians to model relational accountability in therapeutic settings. Doing so not only strengthens the therapeutic alliance but also demonstrates cultural humility, fosters trust, and affirms the client's lived experience, which are key components of equitable and ethical clinical care.

6. Moving forward: Courage, Accountability, and Justice

Therapist positionality is not a one-time reflection or a checkbox in cultural competence training. It is an ongoing, relational, antiracist commitment to practicing with integrity, humility, and cultural responsiveness. In an era of heightened visibility around racial trauma and systemic inequity, the refusal to examine one's positionality is no longer neutral, it is harmful. Therapists who center positionality in their clinical, collegial, and supervisory relationships help build the condi-

tions for trust, safety, and transformation. Clinicians who engage in accountability and reflexivity model the practices they seek to cultivate in others. As equity centered practitioners, we are charged with locating the courage to engage in deep self-examination, and the humility to repair, learn, and grow when we inevitably fall short. Courage in this context is not abstract. It involves confronting real risks, such as challenging institutional norms, disrupting entrenched power dynamics, and potentially facing professional resistance, criticism or opposition, interpersonal tension, or personal discomfort. Choosing to act with integrity in these moments reflects a commitment to antiracist practice that prioritizes justice and relational accountability over self-protection or professional comfort.

Conflicts of Interest

The author declares no conflicts of interest regarding the publication of this paper.

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