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EMPIRICALLY GROUNDED CLINICAL GUIDANCE PAPER

# Considering the whole self: integrating identity(s), context and power into the declarative procedural reflective (DPR) model of CBT practitioner development

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## Abstract

The original declarative procedural reflective (DPR) model is a well-established model of therapist knowledge and skill development. To date, although it has been used to guide reflection and discussion around personal and practitioner selves, it has not emphasised the various intersecting identities of practitioners and how these interact within wider concepts such as power, society, service contexts and the patient and supervisory relationships. The learning, development and implementation of CBT skills does not occur in a vacuum or separate to the practitioner identities however relatively little has been written on this. This paper aims to expand the original DPR model to illustrate potential ways that social context, identity and power could be considered within CBT training, delivery and supervision. It delineates and explores the additional components of the model (i.e. practitioner identity(s), context/society and power) and then provides examples of how this framework could inform key CBT activities (including low-intensity CBT).

## Key learning aims

(1) We aim to (re-) familiarise the reader with the original DPR model of practitioner development and how this applies to CBT practitioners explicitly including low-intensity CBT practitioners (from novice learners through to expert).
(2) We aim to help the reader understand how the key elements of the original DPR model (declarative knowledge, procedural skills, reflective system and therapist stance) can be applied to specific content areas when working with individuals with minoritised identities.
(3) The reader will be introduced to an adapted DPR model which provides a framework for CBT practitioners to reflect on, and be able to conceptualise the influence of their own social identities, social context, power and how this may impact on their development and implementation of declarative knowledge, procedural skills and reflective skills.
(4) We aim to help the reader understand how an adapted DPR model can provide a helpful framework to guide skill development in working with difference and ensuring practitioners have the knowledge and skills required to provide sensitive and effective therapy, supervision and training to individuals with identities that may be different from the practitioner.

**Keywords:** equity; identity; LGBTQ+; power; racism; reflection; supervision; training

## Introduction

- When we are reflecting on our learning and development as CBT practitioners, do we always consider our various identities (e.g. ethnicity, gender[1], sexuality) and when these might be particularly salient? How can we consider identities of our patients and their impact on specific declarative knowledge and implementation of procedural skills?
- Do we always consider this as supervisors and trainers?
- How often do those of us with identities associated with privilege and power assume that the experience of others is similar to our own? For example, how many white CBT practitioners go through a whole day of clinical work without even thinking about their ethnicity?

CBT can often be accused of neglecting social context, identity and power (e.g. Ahuvia and Schleider. 2023; Proctor, 2008). Our hope is that this paper provides an initial framework to consider identities and their impacts within an established practitioner development framework. There has been a limited amount of discussion of this area in the past, and even less empirical research. By its very nature, this paper is speculative and draws on ideas from outside the CBT mainstream but aims to define them using CBT terms when possible and conceptualise them within an established CBT practitioner development model.

## The original declarative procedural reflective (DPR) model

The original declarative procedural reflective (DPR) model paper (Bennett-Levy, 2006) has been highly influential in the world of CBT. At the time of writing this paper it had been cited 193 times across a wide range of areas and had become one of the dominant practitioner development models within the field of CBT. In brief, the model delineates three main systems involved in practitioner development. **Declarative knowledge** is inert factual knowledge ('knowing that') such as knowing the CBT model of panic. **Procedural skills** are the rules and guidance which lead directly to the implementation of skills ('when to' and 'how to') such as knowing when and how to introduce a panic induction experiment with a patient. We could learn the former from a book, but the latter needs to be learned in a more experiential way, and reflected on afterwards to develop the clinical nuances and detail that leads to expertise. This involves the third system in the DPR model – the **reflective system** – which is a content-free system in which information and experiences are reflected on, transformed and turned into plans for action and ideally more nuanced procedural skills.

The DPR model has also made a distinction between the 'personal self' and the 'therapist self' (referred to as Practitioner Self[2] within this paper) with the former being the identity, knowledge and skills largely present before CBT training and the latter being the knowledge, skills, beliefs, stances and behaviours that develop as part of training (Bennett-Levy, 2019; Bennett-Levy and

[1]In this paper we use the usual mixture of descriptors commonly used to differentiate between people of the different sexes. This is deliberate because it reflects general usage, but we want to acknowledge that these words carry different meanings for different people. Generally, 'male' and 'female' are descriptors of biological sex, whereas 'man' and 'woman' are gender identities pertaining to socially imposed roles which are more or less accepted by the majority based on social norms. However, both sex and gender are constructs and are contested terms (Butler, 1990) often used interchangeably. When we add in that some people do not identify with any of these terms, being biologically (intersex) or gendered (non-binary, genderqueer, etc.) 'in-between' then we might understand that there is no simple answer as to what a person 'is', that they are best placed to tell you where they sit, and that the whole spectrum of sex/gender is a complex but wonderful thing if we can sit with some uncertainty and acceptance of others.

[2]Whilst the original DPR model referred to therapist development, the content applied equally to all CBT-based roles (and in fact other therapeutic modalities). Our intent is that the expanded model applies to the whole family of CBT practitioners (including what is referred to in many places as low-intensity CBT but also known by a range of other terms) and as such could be considered within initial training and further practitioner development for all CBT. Unless referring to the original DPR paper or using a specific CBT therapist example, we have used the term 'practitioner' rather than 'therapist' to make this clear.

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Haarhoff, 2019; Presley and Jones, 2024). Clearly there is an overlap between these two areas, as indicated in Fig. 1. There are parts of an individual's personal and practitioner selves (including identities) that are highly salient to their day-to-day practice of CBT and need explicitly referencing. These could influence their experiences within CBT, and the acquisition and deployment of knowledge and skills required to navigate interpersonal interactions such as a CBT session or a supervision session. Imagine the scenario of a white practitioner working with a Black patient presenting with PTSD where there has been a racist element to the index trauma event. It would be ill-advised for a white practitioner to engage in a discussion around racism and how this might be integrated into the formulation and treatment without acknowledging their own ethnicity, the ethnicity of the patient and how these may influence their outlook (Lawton *et al.*, 2025).

Black practitioners are often exposed to a range of microaggressions within therapy sessions (Williams, 2020) and clinical supervision when working with white supervisors. This can include displaying stereotypical assumptions about Black supervisees or making inappropriate treatment recommendations based on assumptions around Black patients (Constantine and Sue, 2007; O'Hara, 2014; Vekaria *et al.*, 2023). Supervisees from other minority groups, including those that may be less visible such as sexual minorities, also regularly report marginalisation, microaggressions and even direct homophobia (Satterly and Dyson, 2008).

The original model, and the later Personal Practice model (Bennett-Levy, 2019; Bennett-Levy and Finlay-Jones, 2018), referred to the individual identities and positionality of the practitioner and interplay with their development. It did not explicitly attempt to detail the declarative knowledge, procedural skills and therapeutic stance required to work effectively across cultures. However, the original DPR model did flag that the personal self included the many identities of the practitioner and later iterations have further emphasised that the practitioner self was built upon the personal self (Bennett-Levy *et al.*, 2009b). To the list of examples below we might also add social identities such as gender, ethnicity and sexuality.

> '*The self-schema is of course idiosyncratically related to personal history. For a given individual, this might include: personal experience in overcoming poor schooling or economic deprivation; attitude towards disability; experience of bereavement; skills in self-management, networking, or identifying community resources; perseverance, tolerance of ambiguity, and compassion.*'
>
> (Bennett-Levy, 2006, p. 65)

Despite the lack of explicit reference to identity in the original models, there have already been a range of examples of the DPR model being applied to practitioner identity including:

- Guiding practitioners to reflect on their own socio-cultural background (Haarhoff and Thwaites, 2016);
- Utilising personal identities within self-practice/self-reflection exercises (Bennett-Levy *et al.*, 2015);
- Using the DPR model in order to specify the knowledge, skills and reflective processes required to work effectively with patients from minoritised ethnicities (Churchard, 2022), However, this paper did not explicitly consider important factors such as power, and it would also have benefited from further conceptualisation of social identity.

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### *An increasing awareness of required CBT competencies*

The worlds of psychological therapies and CBT have begun to increasingly acknowledge the specific skills and stances required by practitioners to work effectively across a range of cultures. For example, the recently updated BABCP Minimum Training Standards (British Association for Behavioural & Cognitive Psychotherapies, 2023) refer to:

- 'Training and skills in promoting inclusion, an awareness of diversity and an understanding of the multiple and linked oppressions and discrimination associated with ethnicity, race culture, gender & gender diversity, sexual orientation, faith, age, disabilities, neurodiversity and individual differences and the impact these intersections have on mental health and therapy' (p. 8);
- 'Training in cultural competence, including cultural humility and promoting cultural safety' (p. 8);
- 'Demonstrating awareness of personal reaction to diversity and the implications of these reactions during sessions' (p. 9);
- Showing the 'ability and willingness to recognise your own background and culture, processes; personal and organisational context and implicit biases, and work to reduce their impact on therapy' (p. 9).

Within this paper we illustrate how the DPR model can be expanded to recognise these important developments and provide a framework to guide training, supervision and reflection around the domains of identity, diversity and cultural humility and inclusion.

### *Positionality of authors*

In the spirit of the newly adapted DPR model, we provide positionality statements for all authors below, acknowledging that these varying identities impact on our perspectives. Our positions and role influence our privilege and power, and what is, or is not, within our frame of reference. We speak from a diverse range of identities but it is important to acknowledge that this paper cannot possibly be informed by all potential identities (and intersectional identities)

Richard is a white, heterosexual, cis, able-bodied male. Other identities include being a CBT therapist, a photographer, a cinephile, a Carlisle United fan . . .

Alasdair is a mixed-race cis male with Afro-Caribbean heritage. He is able-bodied and heterosexual, and other important aspects of his identity include being a father of two, married to a woman of Jewish heritage, being a Buddhist, and enjoying spending time in nature.

Layla is a woman of mixed white middle eastern origin, able bodied, from the North East, CBT therapist, social worker, mother of two.

Debbie is a white, pansexual, genderqueer, able-bodied clinical psychologist living in the UK. Other aspects of identity include being 'northern', a socialist, a motorcyclist, a Liverpool fan . . .

Michelle is a Black female, mother, wife and academic who is able bodied and enjoys practising her faith as a Christian and loves travelling.

## A proposed expanded version of the DPR model

### *Overview*

The original DPR model *could* be applied to a range of content. We suggest that this new adapted model *should* consider content across declarative knowledge, procedural skills, reflective system and practitioner stance around working with patients with differing or minoritised identities. As previously discussed, this would support CBT practitioners in being consistent with the BABCP Minimum Training Standards (British Association for Behavioural & Cognitive Psychotherapies,

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2023). These same standards and the BABCP Standards of Conduct, Performance and Ethics (2024) are clear around the need for reflection on patient and practitioner identities.

The DPR model can provide a framework around how to identify gaps or deficiencies and then develop and implement knowledge and skills in specific areas. It has already been used to support white CBT therapists in working effectively and sensitively with patients from a minoritised ethnicity (Churchard, 2022). Both the original and this adapted model include practitioner stance/attitudes/beliefs as a key part of the DPR system. The beliefs and attitudes that CBT practitioners develop are entwined with their identities and life experiences. For example, a trans CBT practitioner could reflect on this specific part of their identity and explore:

> '*How does this aspect of my identity influence my beliefs around therapy? Does it help or hinder certain beliefs about working with particular patients e.g. trans patients? How does it affect my inclination to disclose my own identities? Might I collude with some trans patients? How might I feel working with gender critical patients? Would they trigger my threat system?*'

It is key to reflect on how our identities and experiences may be impacting on our stance towards specific patients and what beliefs or attitudes we hold. This is valuable content for the reflective system to work on, whether in self-supervision or supervision with a supervisor.

We also propose that the DPR model (see Fig. 1) can be updated to explicitly consider three new elements:

(1) Context and society;
(2) Practitioner social identity(s);
(3) Power.

We aim to explore and define these concepts and provide CBT-relevant explanations and examples. We refer back to non-CBT literature due to the very limited discussion of this within standard CBT models. We acknowledge that it is at times speculative, and we aim to be transparent about this.

### *Context and society*

None of the components of the original DPR model exist in a vacuum, they all exist in context and wider society. Context permeates therapy, and bringing two respective contexts together, through practitioner and patient, requires both awareness and knowledge of what is being influenced and how. Societal factors are not static, and attitudes shift over time in relation to significant cultural events.

One specific recent example is the #MeToo movement which was started in 2006 by Tarana Burke and 'went viral' on social media in 2017 with the aim of highlighting the prevalence of sexual assault (Me Too, 2024). The movement gained significant media attention with many celebrities sharing their personal experiences. It has been suggested that 'greater awareness of the prevalence of sexual assault may … embolden individuals to recognise and relabel their experiences' (Jaffe *et al.*, 2021; p. 6). As people gain awareness and potentially re-appraise and identify sexual assault in their history, their sense of belonging to the #MeToo movement could strengthen, and they may have experienced a sense of commonality with other women. This would apply to people seeking therapy and also practitioners. A broader awareness of sexual assault and associated media prominence set a different tone for the delivery of CBT and this change of context requires CBT practitioners to update and develop their declarative knowledge. While this movement has emboldened and given strength to many, it has been argued that women of colour have not been centred within it (Burke, 2017). While movements such as #MeToo can

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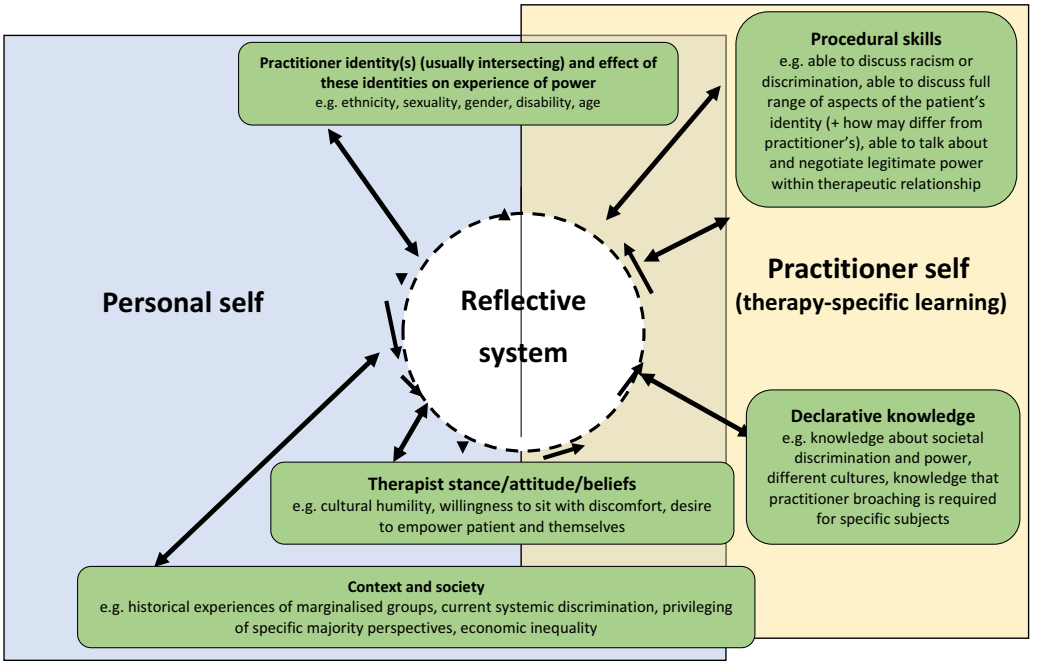


**Figure 1.** A perspective on the DPR model including updated sections around context and practitioner identities in green. Figure adapted from Bennett-Levy *et al*. (2009b). Republished with permission of McGraw Hill, permission conveyed through Copyright Clearance Center, Inc.

highlight particular perspectives, it is also important to note which perspectives could be sidelined or less visible.

There are movements and societal events that we may not be part of and take an observer stance towards, depending on whether we perceive a sense of commonality with the aims, or whether we discern ourselves to be different. This decision-making process of positioning ourselves as outside or inside a societal event, shapes how we define ourselves, and subsequently how we relate to our patients and supervisees.

Another recent example could be the attention and debate that exists around transgender people. The Office for National Statistics reports from 2021 that 0.5% of the population reported on the census have a gender identity different from their sex registered at birth, making this group a very small minority (Office for National Statistics, 2023). However, transgender issues are frequently and hotly debated in mainstream media. The debate is polarised, and positions are argued vehemently. This societal profile has an effect on how people feel about themselves, and how they feel about accessing services, and presenting their true selves to a new person. There are opportunities here for CBT practitioners to develop declarative affirmative knowledge relating to this group (Carvalho *et al*., 2022) to account for this context. Furthermore, they could identify and reflect on their own practitioner beliefs which will impact on their interpersonal procedural skills (see Bennett-Levy and Thwaites, 2007).

Minority stress theory (Meyer, 2003; Moorhead *et al*., 2024) describes the relationship between societal attitudes and our own internalised sense of identity. Originally proposed in relation to sexual minority groups, but with far broader applications, it theorises that minority groups experience excessive social stress through institutional stigma and societal prejudice. These messages can be internalised leading to experiences of shame and self-directed stigma regarding aspects of one's identity. It seems likely that shifting societal factors and events could contribute to our sense of ourselves, which aspects of our identity come with pride or shame, and which aspects

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present in the foreground or background and with what degree of salience. This theory and associated literature (e.g. Perry *et al*., 2017) can guide CBT practitioners in their acquisition of declarative knowledge and procedural skills which consider the interaction between identity and contexts.

Whilst there is no limit to possible examples of societal contexts that could impact on the delivery of CBT, these two specific examples demonstrate how cultural events and attitudes are relevant to both identity formation of the patient and practitioner, and the subsequent enactment of the DPR model in the delivery of individual CBT. Mainstream media coverage, viral topics on social media, or movements such as #MeToo, #BlackLivesMatter, or #WomenLifeFreedom, bring particular aspects of our lives and identities to the fore and may increase or decrease their relevance in the therapy room.

Jacobsen and Martell comment that 'when one looks at the demographics of depression, the importance of contextual factors external to the sufferer is clear' (Jacobsen and Martell, 2001; p. 258). In treating complex depression, Barton *et al.* (2017) note the multiple complex and interacting factors that need to be taken into consideration when formulating with a patient. They cite social factors such as culture, economics, employment and housing, and argue that it is important to map these factors and establish which sit alongside the presenting problem, and importantly which factors interact and contribute to it.

For the CBT practitioner, both wider societal and local contextual factors will play key roles and influence all aspects of the DPR model, e.g. if there are significant service pressures, how well supported they feel by their team and supervisor, whether they have access to adequate training and resources, as well as broader contextual issues such as their own geography. For example, declarative knowledge will be affected by context, a CBT practitioner's knowledge of the culture and customs of particular groups and clinical presentations will be influenced by the population the practitioner has routinely worked with. The experience of learning and training occurs within a context, both an immediate context of trainer and fellow learners but also a wider social context.

### *Practitioner social identity(s)*

Social identities are influenced by context. A very specific example of this might be that in addition to the social identities that we identify with in different contexts, there is also the issue of identities that are imposed on us by the context, e.g. how the patient may view us. It might be that for some identities, there is a mismatch between self-identity and those imposed by society. For example, Adekoya (2021) has provided a detailed discussion of the complexities of being bi-racial in the UK and how someone who is of mixed ethnicity can find that being in white or Black spaces can fundamentally change the identity imposed upon an individual (and also impact on how they perceive themselves). For some identities, it might even be that some sections of society, including some therapists, do not believe in the validity of someone's self-identified gender or sexuality or even may think it can (and should) be changed by society in ways that are not commensurate with professional values and standards (BABCP, 2017; BABCP, 2024). We will discuss how identities are influenced by context and wider society. Consider the example we have mentioned of the transgender CBT practitioner and what might be passing through their mind as they prepare to meet their clinical supervisor for the first time? How much more might they be aware of their own social identities and the potential responses of the supervisor than for a practitioner with majority and privileged identities (whose gender and right to exist is not debated daily in newspapers and social media)?

Currently research does not tell us precisely how social identities become more or less salient for CBT practitioners or to what extent this is influenced by social context or the social identities of the patient sitting in front of us. Finally, it does not tell us how this might differ for practitioners identifying with majority identities compared with minoritised identities, or the particular challenges of a minoritised identity in a setting or geographical area where your identity is

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particularly minoritised (e.g. being a Black therapist in an area that is 97% white) and certain expressions of identity may not feel permissible or acceptable. Often in such situations people can even argue that a group is so minoritised that their needs do not even need to be considered.

Although there are recent examples of CBT training courses that have fully integrated considerations of equality, diversity and inclusion (Presley, 2023), anecdotal accounts suggest that this remains variable even for recent trainees, with many CBT therapists reporting not having received any training on this when they originally trained in CBT. All too regularly supervision does not consider this either (Vekaria *et al.*, 2023). What impact might this have on the wellbeing of CBT practitioners with minoritised identities? As a CBT practitioner, what might be the impact of never having a trainer or supervisor that shared mutual important social identities with you? For example, if you are a Black trainee Psychological Wellbeing Practitioner in an all-white or majority-white group with white trainers – what impact might that have? How might it feel for a transgender CBT therapist to have always had cisgender supervisors? What topics do not get discussed and what experiences might not be shared (or understood by the supervisor)? There is a lack of research on the impact of social identities on therapy but, given the complex and dynamic nature of practitioner identities and interaction with patient and team member identities, it is not surprising that most models (including the DPR model adapted here) would encourage ongoing reflection on these and explicit discussion when required. This paper will provide examples of when identity might need to be explicitly considered and referenced, plus guidance on how to do this.

There is more written about the professional identities of practitioners (e.g. Watkins, 2012) (especially within the world of CBT) than the wider range of social identities of practitioners. There is significant research on social identity largely going back to the seminal work of Tajfel and colleagues (Tajfel *et al.*, 1979). Social identity theory would suggest that self-concept is made up of both personal identity (e.g. personal attributes such as psychological traits and abilities) and also social identity in terms of social groups that the individual identifies with (e.g. '*I am a CBT therapis*t', '*I am a woma*n', '*I am Blac*k') (Ashforth and Mael, 1989). Social identity theory suggests that 'Social identities are relative, they differ in the extent to which individuals perceive them as psychologically meaningful descriptions of self (i.e. they are more or less central to our self-definition), and their function and meaning can change over time' (Haslam *et al.*, 2009; p. 6). The example below shows how the salience of identities can change over the course of a few hours:

> '*For example, while a client, Tom, may identify as "a depressed person" during a therapy session, later that day he may identify primarily as "an Everton fan" when watching a football match with a friend. While both social identities are part of Tom's self-concept, which one is salient (and thus more likely to shape his thoughts, feelings, and behaviour in the moment) depends on the social context*' (Cruwys *et al.*, 2023; p. 2)

There are several well-established models looking at a range of identities linked to power and privilege such as Social GGRRAAACCEEESSS (Burnham, 2012) or the ADDRESSING framework (Hays, 2013), specific identities such as Black identity (Cross, 1978), white identity (Helms and Carter, 1990) or sexuality (Cox and Gallois, 1996) or intersecting identities (Birdsey and Kustner, 2021), some of which have been criticised for not being transparent regarding their underlying assumptions (Krause, 2022). We are focusing on broader social identity theory to include all potential CBT practitioner social identities. The four components of social identity (Guan and So, 2023) will be familiar to all CBT practitioners (although we would include the evaluative component (appraisal) within the cognitive component and also consider additional physiological aspects) and we therefore use this as an amended working definition within this expanded DPR model: (1) a cognitive component, including (2) an evaluative component; (3) an emotional component; and (4) a behavioural component.

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So, in the relatively simple example of Tom above, whilst watching the Everton match, he would have awareness of being an Everton fan, he would have thoughts about this (e.g. a sense of whether this was a good thing or not), an emotional reaction to this (e.g. pride as he watches his team with his friends) and he might act in ways that are consistent with being an Everton fan (e.g. watching games with fellow fans). These components are clearly more complex for identities where there may be significant societal or internal oppression and discrimination, e.g. being Black, being Muslim, being transgender. For individuals not used to reflecting on their identity, the concept can sometimes be challenging to comprehend and apply. We propose that social identity as formulated within social identity theory provides an accessible and consistent way for CBT therapists to think about identity(s) (personal self *and* practitioner self) and start to reflect on how it might impact on the acquisition and implementation of CBT knowledge and skills.

### *Interaction between practitioner and personal identities*

Distinguishing between practitioner self and personal self can be a complex process and arguably at times impossible to separate. However, with an understanding that intersectionality (Crenshaw, 1990) seeks to embrace the complexity and interconnectedness of identities that exist within one person (Collins and Bilge, 2020), this does not make the individual fragmented but in fact human. An individual's personal identities might include their social identities, culture, sexuality, abilities, disabilities, 'race'[3], and ethnicity as well as their world view. However, intersectionality is not limited to these aspects and expands far beyond this remit. We need to always consider that clearly visible identities and less visible identities can be equally important to the development of the practitioner self and personal self. Also, whilst there may be some clearly visible identities perhaps such as race, gender or ethnicity, it also does not mean such identities are always the most relevant identity for the practitioner self in all interactions or contexts, or in fact are always salient across both practitioner and personal selves all of the time or at the same time. In fact, some aspects of the practitioner's personal identity may be less salient during working hours and so assumptions should not be made that just because the practitioner has clearly visible identities, that this aspect of their identity is the most relevant. It is therefore important to consider beyond the individual's external perceived attributes of the personal self to ensure appropriate self-care of both the personal and practitioner selves.

Both political and societal narratives can impact the level of safety the practitioner may feel in being able to confidently express identities associated with their practitioner self and personal self. For example, in the UK during the summer of 2024, racist riots took place across the country and were targeted against Muslims, people seeking asylum and racially minoritised communities (BABCP, 2024; Boukari and Devakumar, 2024). Whilst full discussion of these riots are beyond the remit of this article, the impact of the riots against people of colour negatively impacted communities leading to fear and defence. Such hostility against people in the UK is not necessarily new as it was visible during the 1980s (Fernando, 2017) as well as during Brexit with the rise in narratives centred on racism and xenophobia (Mintchev, 2021) and the hostile attitudes towards migrants (in particular people seeking asylum and refugees) (Dempster and Hargrave, 2022). Such societal experiences and contexts can cause the practitioner to need to disconnect with visible identities associated with their personal self, such as 'race' and ethnicity particularly during working hours or in work or therapy contexts as a way to distance themselves from identities that can be considered to make them feel vulnerable to attacks or rejection even within the room with their clients. For example, consider the experience of a Black CBT practitioner caught up in a white racist demonstration on their way to work and unable to follow their usual route without significant threat and uncertainty around their safety. It is hard to imagine that this does not have an impact on their professional self within their working day but also beyond this on their

[3]We use the term 'race' within inverted commas to acknowledge the fact that this is a socially constructed concept.

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personal self across the following weeks and months. Obviously, this would impact on individuals in very different ways, but it is a clear example of how the identities of the practitioner can exert a major impact on the wellbeing of CBT practitioners but also their implementation of procedural skills within therapy and supervision.

Such perspectives should also be considered from the patient perspective, that depending on the perceived identity of the practitioner (considering both visible and less visible attributes) this can lead to patients choosing not to bring their 'whole self' into the room, for example minimising personal characteristics (such as their sexuality, 'race' or gender) even when they might contribute to, or influence, their presenting problem. Political and societal narratives should be included when considering the challenges that practitioners or patients may have in bringing multiple identities into the therapeutic context.

### Power

Social identities and the concept of power are closely linked. Power is a complex theoretical construct and our aim here is to provide an initial exploration of how power relates to the practice of CBT. These ideas are explored in more detail elsewhere (Churchard, in preparation). We are not aware of any significant discussion of power in the mainstream CBT literature. This is despite explicit references to power in key policy documents. For instance, Health & Care Professions Council (HCPC) standard 2.13 for practitioner psychologists states that they must 'understand the dynamics of power relationships' (Health & Care Professions Council, 2023) and the BABCP minimum training standards state that 'Training and experience will include [ . . . ] opportunity to enhance awareness of power and privilege' (British Association for Behavioural & Cognitive Psychotherapies, 2024; pp. 10–11). It is therefore important to develop a better understanding of the various roles of power in the therapeutic relationship.

The first step is to reach an adequate definition of power that fits within CBT. Discussions of power have acknowledged that this is such a complex construct that no single definition is likely to be final (Lukes, 2018), so in line with Haugaard (2010) we are seeking to define power in a way which is good enough for the specific context of CBT. We acknowledge the extensive discussion of power in other fields of psychology (e.g. Boyle, 2022; Smail, 2005), but these definitions of power are very complex and part of a wider body of theory which is not always easy to reconcile with standard CBT theory and practice. Instead as a starting point we will use the following definition of power from the sociological field, as this provides a relatively simple conceptualisation which is easier to link to the practice of CBT:

> '*At its most general "power" simply means the capacity to affect outcomes, and, more specifically, in the context of social relations it means the capacity to affect significant social outcomes, whether positively or negatively.*'
>
> [Lukes, 2018; 'Power' section]

Power can therefore be thought of as the ability to have an impact, either positive or negative, on other peoples' lived experience. If we are to understand how power operates in a therapeutic relationship where there are differences in social identities, we need to add some additional elements to this definition of power. This discussion draws on Proctor (2017), who is highly critical of CBT but provides some important ideas that need to be considered. Firstly, we assume that power is present in all relationships, therapeutic or otherwise, and it is not possible to reach a stage where power disappears from the therapeutic relationship. Secondly, in line with what Lukes (2018) writes about how power can affect outcomes either positively or negatively, CBT practitioners can act in ways which either empower the patient, or conversely exercise power over

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the patient and force them to comply with what the practitioner thinks is best. The key question then is not how to get rid of power, but rather how to ensure this is used in a way which is legitimate rather than illegitimate, where the practitioner empowers the patient rather than exerts power over them. It seems likely that there is a higher risk of this illegitimate use of power when the practitioner has more privileged social identities than the patient (Beck and Naz, 2019; Pieterse, 2018). There is also the additional risk in this case that a practitioner neglects to use their legitimate power in ways that might be helpful for the patient (e.g. not asking about experiences of racism or discrimination or failing to include them in formulations when relevant (Beck, 2019).

The mainstream CBT literature, which generally does not consider social identities, asserts that the practitioner should empower the patient. This is clear in discussions of collaboration in CBT, with for instance Westbrook (2014; p. 22) writing that CBT therapists have a duty 'to encourage clients' active participation, to take seriously their ideas and to respect their independence'. The idea of empowerment is also implicit in other key parts of CBT such as agenda-setting, Socratic questioning and formulation. However, there is an awareness that empowering the patient is not a straightforward process. For instance, Gilbert and Leahy (2007; p. 10) state that the 'concept of collaboration becomes hazy in the shadow of the power dynamics' and Katzow and Safran (2007) argue for the importance of continued negotiation, with associated issues of power, in the therapeutic alliance. None of these discussions, however, consider why different social identities in therapy might create more of a risk of the practitioner exerting illegitimate power over the patient.

While there are obvious examples of the illegitimate use of power by CBT practitioners such as open expressions of prejudice or discounting of the patient's experience (e.g. a practitioner querying whether a patient was correct in their identification of specific incidents as racist or homophobic), we believe a larger issue is practitioners from majority social identities unconsciously exerting illegitimate power over patients from a marginalised identity (or failing to helpfully use legitimate power). Consider the case example of a white CBT therapist assessing a minority ethnic service user who has developed PTSD following a traumatic incident involving racism. Despite clear guidelines on working with people from racialised minorities (e.g. Beck, 2019; Beck *et al*., 2019) the CBT therapist does not think to ask the patient about their experiences of racism and the patient does not feel confident to talk about these experiences without prompting. The therapist then proceeds to offer a course of CBT which does not effectively treat the PTSD because some of the key trauma meanings were never identified or addressed. This shows how practitioners from more privileged identities can, through their inaction, force compliance, in that the patient was not enabled to disclose a key part of their experience and was not empowered to address the racial traumatic event they had experienced. More broadly, CBT which does not consider the social identity(s) of the patient may proceed with assumptions that are specific to a white, Western, university-educated and middle-class culture, and which therefore force compliance with the assumptions of that culture rather than empowering the patient to develop an understanding consistent with their own identity, experiences and beliefs (Beck, 2016; El-Leithy, 2014).

Legitimate power by contrast is based around actively working with the patient to empower them, and this will necessitate explicit attention to how the identities of the practitioner and patient interact. In line with the existing CBT literature (e.g. El-Leithy, 2014; Katzow and Safran, 2007; Kennerley, 2014), practitioners need to take care to build up a therapeutic alliance which acknowledges the particular experiences and needs of the patient, which in this case will include what they feel comfortable to disclose to the practitioner and what the practitioner will need to sensitively ask about (Beck, 2016). In this regard it may be important for the practitioner to consider some level of appropriate self-disclosure (Miller and McNaught, 2018) and explicit reflection on differences in identities. The practitioner will also need to consider how to incorporate the relevant experiences of the patient, which may be entirely outside their personal

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knowledge and what they were taught in their CBT training, into the formulation and intervention.

Putting this understanding of legitimate and illegitimate power in the terms of the DPR model, we can identify key areas of declarative knowledge, procedural skills and reflection that need to be addressed to build up practitioner competence in this area. Therapists need to have declarative knowledge about power itself and how this relates to their own social identities and those of the patients they work with. For instance, a white British practitioner working in an ethnically diverse area would be well-advised to find out more about the social and historical context of the specific ethnic minority communities, so they can have a better sense of how they might be viewed by a patient from a minority ethnic background. Practitioners will also need declarative knowledge about when and how to appropriately adapt CBT, so the therapy is experienced by the patient as empowering and not something that they have to comply with.

Key procedural skills for CBT practitioners to develop are how to broach differences in social identities and experiences related to these, how to raise issues of power in a sensitive way with patients, and how to manage the therapeutic process so that they are using their power legitimately rather than illegitimately. Day-Vines *et al.* (2020) provide a helpful guide to broaching difference and Beck (2019) discusses how experiences of racism can be addressed by practitioners. Power should be raised with patients from the first session, in line with Kennerley's (2014) identification of transparency as at the core of the development of a good working alliance. Normal features of the beginning of therapy such as gaining consent, assessment and psychoeducation all provide opportunities to discuss power within CBT terms and how to work with this. With regard to managing the therapeutic process so this remains empowering for patients, Katzow and Safran (2007)'s conceptualisation of the therapeutic alliance as a process of 'ongoing negotiation' may be helpful. Understanding the therapeutic alliance as something that requires continual attention, and discussion means that power is never treated as something that has been 'dealt with', but rather something that needs to be considered throughout the entire course of therapy.

Reflection will be a central part of this process, in that practitioners will need to carefully consider whether they are empowering their patients or exerting illegitimate power. This carries significant intellectual and emotional demands, given the complexities of how power is linked with social identity, but also challenging feelings such as anxiety and guilt which are likely to emerge when difficulties associated with social identities are focused on (Rosen *et al.*, 2019; Sue, 2013). Practitioners are likely to benefit from a space to reflect not just on power dynamics in relation to their patients, but also on their own identity in itself and how this has been linked with power over the course of their lives.

Finally, it is important to acknowledge that power goes both ways in the therapeutic relationship, so practitioners from marginalised identities will at times experience the negative effects of power. Consider for instance when practitioners from marginalised identities have difficulties either with patients or supervisors from majority identities. What impacts may experience of direct discrimination or silence around identity have on these practitioners? Legitimate power may look quite different in this context, as it is important that practitioners from minoritised identities feel empowered to take steps to keep themselves safe if they experience prejudice. There are also questions about how far practitioners can draw on aspects of their own experience to inform their therapeutic work, and not feel compelled to comply with a particular understanding of CBT which does not consider social identity as a factor.

## Examples of practical implications for the adapted model

Whilst we have provided brief examples within the paper so far, we are aware that many of these concepts have not previously been integrated into standard CBT practice and it might be useful to provide some very clear and practical examples of what, and how, we might do differently considering the new elements of this adapted DPR model. Within this section we provide

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examples of how the adapted model has informed, or could inform, the provision of CBT interventions, supervision and training.

### How could the adapted model inform how we apply standard evidence-based CBT models?

Both the original and this adapted model focus on practitioner development and how we develop declarative skills and knowledge. One part of this is developing nuanced procedural skills via reflecting on routine practice and integrating new learning into our CBT practice. The example below illustrates how the adapted model could inform the delivery of cognitive therapy for PTSD where racism is part of the traumatic incident (Lawton *et al.*, 2025) but any of the evidence-based models could have been discussed in this way.

#### *Example of how the adapted DPR model could inform the delivery of cognitive therapy for PTSD (CT-PTSD) where racism is part of the traumatic incident*

Whilst the NHS England Positive Practice Guide for Black and Asian patients encourages practitioners and services to proactively engage with racially diverse communities (Beck *et al.*, 2019), anecdotally some practitioners have reported anxiety around asking about racism (Beck, 2019) and as such this then limits a full understanding of the meaning of a traumatic event for someone from a minoritised ethnicity where racism has been part of the traumatic event. This is likely to impact on the patient's experience and also lead to worse clinical outcomes. The expanded DPR model could helpfully conceptualise this and guide how this could be addressed.

#### *Declarative knowledge*

What declarative knowledge does a therapist need to be able to ask appropriate questions around racism, integrate this into the formulation and ensure relevant meanings are addressed during CT-PTSD? As a minimum, they need to have an understanding of the widespread nature of discrimination and racism (Ellingworth *et al.*, 2023), the role it can play in anxiety disorders (MacIntyre *et al.*, 2023) and have the awareness that asking about this may be relevant to the understanding of a PTSD presentation (Lawton *et al.*, 2025). They would need to know that often the patient may not feel able (or not have the power) to raise the issue of racism due to a fear of how the practitioner (especially when they are white) may respond. As such the practitioner holds the responsibility for broaching the issue (Day-Vines *et al.*, 2007) and making it clear this is something that can be incorporated into CT-PSTD.

The practitioner may need culture-specific knowledge, specific information about societal context (Naeem *et al.*, 2023) or at the least the knowledge that they need to infuse their questioning with cultural humility and curiosity (Hook *et al.*, 2013). The supervisor or trainer could help the practitioner to understand declarative knowledge gaps and guide the individual to appropriate sources of information. However, the challenges of applying the declarative knowledge in practice and developing associated procedural skills can be conceptualised as a separate issue.

#### *Procedural skills*

Once the practitioner knows why they need to ask about racism and integrate relevant experiences into the formulation, this leads onto the next step, putting this into action, which brings its own challenges. Does the practitioner need to develop the specific skills of how to ask about experiences of racism? Can they practise this in supervision? Or is the barrier to implementing this specific skill related to confidence or anxiety? CBT practitioners and supervisors can use their usual strategies to test out practitioner beliefs around feared catastrophes and identify barriers to implementing specific procedural skills (Haarhoff and Thwaites, 2016).

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Practitioners may feel they have the skills to ask about racism but may identify gaps in knowing how to integrate these experiences into models that have not previously referred to this or may feel anxious about doing this. For example, some practitioners have reported feeling they are doing something wrong or deviating from the model (Brooks-Ucheaga, 2023). Clinical supervision should ideally be a place to reflect specifically on this and develop skills in the integration of racist experiences (both during the index trauma and also prior experiences) into a standard PTSD formulation (Lawton *et al.*, 2025).

### *Reflective system*

Although the DPR model is clear that reflection can either be more general or more self-specific, we will focus here on the practitioner reflecting on their own racialised identity and considering what role this might play in the implementation of their knowledge and skills. For example, for a white practitioner, to what extent are they able to reflect on their own white identity and consider how their identity may impact on the patient's willingness to discuss their experiences of racism or culture without specific broaching behaviours? When are they able to reflect on their own ethnicity and that of the patient in supervision (plus potential interactions)? How can the supervisor create the optimum conditions where this reflection can be facilitated? Also, the less familiar concept of power, what might the patient feel that they have the power to do, or more importantly feel they lack the power to do? (e.g. raise the issue of racism in their traumatic event to a white practitioner).

## ***How could the adapted model inform how we provide and receive CBT clinical supervision***

It has been suggested that 'new supervision approaches and models that incorporate ways to discuss power differentials, intersectional identities, and systemic forms of oppression' are required (Tarshis and Baird, 2021; p. 36) and we suggest the updated DPR model has the potential to be a model for such discussions and a guide to the content and process. The example below illustrates how the adapted model could inform the delivery of sensitive and effective clinical supervision in a specific context.

### *Example of how the adapted DPR model could inform the delivery of culturally responsive supervision*

Cross-cultural therapy and supervision can create excellent opportunities but can also create potential challenges when trying to understand identities that may influence the practitioner self (Charura and Lago, 2021; Vekaria *et al.*, 2023; Williams and La Torre, 2022). This adapted DPR model provides a framework for culturally responsive clinical supervision which supports the practitioner in developing skills in considering context, identity and power. Consider supervision dyads where the therapist is Black and the clinical supervisor is white; consideration of all the domains of the adapted model can allow the supervisor to work with the supervisee to explore clinical issues (whether this is with respect to formulations or interventions) concerning 'race' and ethnicity within a helpful framework. It can also be helpful to consider when an issue arises that has impacted either (or both) the practitioner self and personal self, for example systemic societal racism but also more specific examples such as the earlier example of the Black CBT practitioner caught up in racist riots on the way to work (although we need to acknowledge that threat levels were significantly elevated in many people from minoritised ethnicities even if not directly exposed to the riots).

Another example of specific societal events is the murder of George Floyd, a Black man and human being, whose murder created a global movement that included support from international human rights organisations (Beckett and Hankins, 2021; Eichstaedt *et al.*, 2021). The impact of racial trauma, in particular secondary trauma (of watching George Floyd's murder for example via

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social media and the news) may have impacted many people; however, those who identify as Black may have found this not only distressing but also may have experienced PTSD symptoms (Roberts *et al*., 2011) in particular 'race-based trauma' (Chin *et al*., 2023). Such societal issues represent a shifting context and are most likely going to impact the personal self and the practitioner self. The absence of a safe place to discuss issues around race in clinical supervision can cause therapists to feel vulnerable and unsupported (Brooks-Ucheaga, 2023). This adapted DPR model can provide a framework to consider what knowledge and skills might need to be learned and implemented to ensure that clinical supervision is both safe and effective.

### *Declarative knowledge*

University courses and continuing professional development (CPD) courses should clearly identify the specific declarative knowledge that supervisors require as an initial starting point to enable practitioners, regardless of their ethnicity, to feel equipped to embrace discussions about 'race' and culture. A key element of clinical supervision is the creation of a safe space where both the supervisor and supervisee can helpfully discuss issues occurring in the wider societal context that have the potential to significantly impact the practitioner self and/or the personal self (Vekaria *et al*., 2023) – what declarative knowledge might the supervisor need to hold in mind? Examples of such declarative knowledge required for CBT supervisors can include that we all have an ethnicity and a culture (just some are more dominant or visible than others), factual information about racism, discrimination and microaggressions, knowledge around specific cultures and norms, an understanding of why our CBT formulations should include relevant cultural background and context but also why it may be important to include discussions of supervisee and supervisor identity within clinical supervision.

### *Procedural skills*

Whilst the clinical supervisor needs to have the declarative knowledge around why discussions around supervisee and patient identities may be relevant, they also need to have procedural skills and the confidence to implement these in supervision at moments where emotions may be heightened and there is a fear of 'saying the wrong thing'. Practising conversations in relation to ethnicity and 'race' can feel like a 'safe' way to prepare for potentially challenging or complex discussions where procedural skills need to be implemented.

Discussions as well as formal training and workshops around ethnicity and 'race' are helpful, but practitioners should also be mindful that assumptions are not made because a visible identity such as 'race', sexuality or ethnicity may be present; this might not be an aspect the supervisee chooses to bring to supervision. The development of procedural skills around *when* to ask about aspects of identity, but also the more subtle nuances around *how* to introduce discussions around, for example, potential racism can be helpful. This is important in creating safe spaces in clinical supervision so that both the supervisee and supervisor have a choice of what aspects of their practitioner self they choose to bring but ultimately working towards them feeling safe to bring their whole identity to such spaces such as clinical supervision (Iwamasa *et al*., 2019).

Practical organisational steps could include additional training for supervisors explicitly on culturally sensitive supervision and evidence of supervisor implementation of this could be included within the supervisory accreditation process, not as a punitive measure but as a supportive process. In addition, within services supervision of supervision should also be a recognised process to support additional training to consider ethnicity and 'race' when supporting supervisees from different communities.

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### *Reflection*

The reflective aspect of training both practitioners and clinical supervisors should encourage the use of exploring their own culture and ethnicity inclusive of family and friends, community and country where they reside or were born. This can allow practitioners to not feel as if a 'them and us' vacuum exists concerning culture or 'race' once we understand that culture is not about 'race' but includes our upbringing and lived experience. It also allows a decentring of whiteness by helping white therapists to understand they also have an ethnicity to reflect on which influences their viewpoints and experiences of the world. This approach will lend itself to being open to discussions of culture and not assume that culture is only aligned with some ethnicities or 'races' and not with others. Ideally such practices will also develop the ongoing reflective capacity of the clinical supervisor and supervisee reflect on their racialised identities 'in action' and be aware of how these may be impacting on interpersonal and therapeutic processes (Schon, 1991).

## *How could the adapted model inform how we plan and deliver CBT training?*

Using the DPR model as a framework for the development of training makes intuitive sense. Declarative and procedural knowledge are long-established elements of any training to 'do' something. However, a reflective element can help trainees to empathise, to see how they might contribute to power imbalance, to cement knowledge and fine-tune procedural skills. This is demonstrated by levels of processing theory (Craik and Lockhart, 1972) whereby practising 'deep processing', which involves meaningful analysis of information, improves retention. The original DPR model has also encouraged a range of different learning methods to address different aspects of the model (Bennett-Levy *et al.*, 2009a). The following example is based on training for working with LGBTQ+ people, but many of the general principles apply for working with any minoritised group. The recently published NHS LGBTQ+ Positive Practice Guide (LGBT Foundation, 2024) asserts that all staff members, regardless of role, should attend LGBTQ+ specific training and it provides useful case studies and information which informs content in the realms of declarative and procedural knowledge.

## *Example of using the expanded DPR model to inform training around working with LGBTQ+ people*

### *Declarative knowledge*

Examples of declarative knowledge about LGBTQ+ people that training might include would be: who they are, how they experience the world and more particularly, how they experience healthcare and therapy. Important topics, although not an exhaustive list, might also include knowledge about identities and terminology, biopsychosocial components of gender, prevalence and visibility, history, social norms and queer theory. Knowledge of pathology and depathologisation, health inequality, prejudice, discrimination and the minority stress model (Brooks, 1981; Hendricks and Testa, 2012; Meyer, 1995; Meyer, 2003) and identity affirmative therapy (e.g. Austin *et al.*, 2017; Lelutiu-Weinberger *et al.*, 2024) are also important topics. Training should also cover intersectionality and relevant aspects of the law (e.g. in the UK, Equality Act, 2010). It will also be helpful to highlight specific experiences of therapy by LGBTQ+ people, and what we can learn from them, e.g. that LGBTQ+ people often report that their identity becomes the focus of the therapist, when in fact they have accessed therapy to deal with something quite separate, or conversely that their identity is an important part of their formulation which the therapist does not address (Hunt, 2014).

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### Procedural skills

The updated model can be used to explicitly guide a framework of what procedural skills are required. For example, it would be critical to address the difference between affirmative therapy (which does not prohibit exploration but is clear that this needs to be on the patient's terms) and conversion therapy, and to consider when useful exploration of identity becomes therapist agenda-led – either for or against the client's presenting identity. This can be conceptualised around the specific procedural skills required; one way of developing these might be to take the form of a series of short clinical vignettes with roundtable discussion of what each situation represents and what would have to change in order for the work to become affirmative. How might questions be phrased, what specific statements might the practitioner make and how might this influence key tasks such as goal setting or formulating.

More specifically related to CBT it will be important to highlight specific presentations and whether there may be particular considerations and/or adaptations. So, for example, consider working with social anxiety disorder where some patient fears about 'the world' are more likely to be realistic – and how that might affect engagement with therapy and personal safety. Practitioners would need to develop the procedural skills (WHEN and HOW) relating to asking specifically about experiences of judgement or hostility from majority groups plus integrating these into standard CBT formulations. Another example might be understanding the procedural skills to ask about and explore the traumatic reactions arising from regular, and ongoing, experience of microaggressions over a protracted period of time, how that might relate to – or differ from – current standard PTSD models (Livingston *et al.*, 2020), the prevalence of hypervigilance and the possibility that this might not feel like 'real trauma', either to the patient or the therapist. In both cases it could be useful to ask participants to formulate based on a clinical vignette and put together a potential treatment plan, followed by a group discussion considering gaps in procedural skills required or fears and anxieties about implementing current procedural skills.

## Reflection

### Self-reflection

Butler, a systemic trainer, cites the importance of a reflective element to training, and how reflexive exercises can help practitioners to ask different questions and come to different formulations by reflecting on their own privilege and oppression (Butler, 2015). Thus, this element of training should include exercises which encourage trainees to reflect on their own sexuality and gender identity, how these identities arose, whether disclosure was necessary, how they align with societal norms and whether they might actually be more complex than first imagined. Also to think about how it might be to be 'different' – and whether in fact they conform less than they realised. The aim of these reflective exercises is to build empathy, but also to consider whether LGBTQ+ people are actually as different from cisgender/heterosexual people as might be imagined, whether in fact we might all share characteristics we did not realise. An example of these reflective exercises would be to ask people to consider their own sexual desires and fantasies and to think about how ready they are to share them with the group – how acceptable it would feel to be open about them more generally – and whether or not we even dare to realise everything we might think about when pleasuring ourselves or having erotic thoughts.

### Reflecting on personal and practitioner self

It would seem pertinent to consider the impact of practitioner identity on the training and how they might work with LGBTQ+ patients in future including how their identity affects their understanding and acceptance of the patient (Benson, 2013; Bess and Stabb, 2009; Hunt, 2014; Raj, 2007).That might mean an LGBTQ+ practitioner reflecting on whether they might collude with

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the patient in any way or perhaps generalise their own experiences to those of the patient. On the other hand, a practitioner with a particular social or religious stance might need to consider how they can separate their world view from the work, or indeed whether they might need to refer some patients on if they conclude that they cannot do so. The hope would be that all trainees would become more aware of how their own identities and beliefs might impact their work with LGBTQ+ patients.

## Conclusions

Most of us have not covered the concepts within this paper in any detail during our training or during continued professional development. There are often societal (including service) barriers as well as internal barriers to reflecting on and discussing differing identities and how these impact on our professional activities. As such this is an area that most of us are always learning and improving in, rather than feeling highly skilled and confident. A key conclusion to keep in mind is that this cannot be done perfectly or be exactly correct – but they are important considerations that should influence our approach and decision-making. Initially trying to integrate these kinds of approaches may seem clunky and time consuming at first – but in line with the DPR model – they will become integrated into our practice and make it more balanced, contextually-linked and sensitive to identity and power dynamics.

We hope that the expanded DPR model is clear to readers, addresses potential gaps or makes explicit some of what was left implicit within the original model. Our fundamental hope is that it provides an initial framework to consider context, identity and power within CBT skills acquisition and implementation whether in clinical practice or during training or supervision. We welcome feedback on this initial step and recognise that we are often speculative or drawing from related fields and evidence bases. Although some of the concepts in the model would be hard to measure directly, perceptions of these can be measured and their relationship with other elements explored. We would suggest that the new elements of the expanded DPR model require empirical exploration (i.e. context and society, practitioner social identity(s) and power) but could serve as a useful framework to widen the inclusivity of all forms of CBT. Given the early stage of this thinking in CBT and the need to ensure our models remain evidence based, we would suggest commensurate research such as small *N* design or qualitative studies that could start to explore the relationships, for example, between identities (matching and non-matching) in CBT interactions whether supervisory or training.

### Key practice points

(1) The expanded DPR model provides an initial framework to conceptualise and make explicit concepts such as identity, societal context and power which have not adequately been defined within a CBT context.
(2) It provides a framework which reminds us to consider our various identities within interactions but also those of our colleagues, supervisees and patients. The various social identities of the CBT practitioner cannot be separated from practitioner self (whether with respect to their procedural skills and knowledge) or with respect to how others may respond to them. This may be a more novel idea for practitioners with largely majority identities where discrimination has not been part of their experience.
(3) This expanded framework specifically provides a way for individual CBT practitioners to consider their various identities and the impact they may have had on their development as a practitioner and how they deliver CBT, supervision and training. It provides a potential 'map' to guide reflection and identify gaps in declarative knowledge and procedural skills and also how supervision and training can address these.

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## Further reading

**Bennett-Levy, J.** (2006). Therapist skills: a cognitive model of their acquisition and refinement. *Behavioural and Cognitive Psychotherapy*, *34*, 57–78.

**Bennett-Levy, J., & Finlay-Jones, A.** (2018). The role of personal practice in therapist skill development: a model to guide therapists, educators, supervisors and researchers. *Cognitive Behaviour Therapy*, *47*, 185–205. https://doi.org/10.1080/16506073.2018.1434678

**Churchard, A.** (2022). How can psychotherapists improve their practice with service users from minoritised ethnicities? An application of the declarative-procedural-reflective (DPR) model of clinical skill development. *the Cognitive Behaviour Therapist*, *15*, E1. doi: 10.1017/S1754470X21000386

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## References

**Adekoya, R.** (2021). *Biracial Britain: What It Means To Be Mixed Race*. Little, Brown Book Group (Constable).

**Ahuvia, I. L., & Schleider, J. L.** (2023). Potential harms from emphasizing individual factors over structural factors in cognitive behavioral therapy with stigmatized groups. *the Behavior Therapist*, *46*, 248–254.

**Ashforth, B. E., & Mael, F.** (1989). Social identity theory and the organization. *The Academy of Management Review*, *14*, 20–39. https://doi.org/10.2307/258189

**Austin, A., Craig, S. L., & Alessi, E.** (2017). Affirmative cognitive behavioral therapy with transgender and gender nonconforming adults. *Psychiatric Clinics of North America*, *40*, 141–156. https://doi.org/10.1016/j.psc.2016.10.003

**Barton, S., Armstrong, P., Wicks, L., Freeman, E., & Meyer, T. D.** (2017). Treating complex depression with cognitive behavioural therapy. *the Cognitive Behaviour Therapist*, *10*, e17.

**Beck, A.** (2016). *Transcultural Cognitive Behaviour Therapy for Anxiety and Depression: A Practical Guide*. Routledge.

**Beck, A.** (2019). Understanding Black and Minority Ethnic service users' experience of racism as part of the assessment, formulation and treatment of mental health problems in cognitive behaviour therapy. *the Cognitive Behaviour Therapist*, *12*, e8.

**Beck, A., & Naz, S.** (2019). The need for service change and community outreach work to support trans-cultural cognitive behaviour therapy with Black and Minority Ethnic communities. *the Cognitive Behaviour Therapist*, *12*, e1.

**Beck, A., Naz, S., Brooks, M., & Jankowska, M.** (2019). Black, Asian and Minority Ethnic Service User Positive Practice Guide. https://babcp.com/Therapists/BAME-Positive-Practice-Guide-PDF

**Beckett, B. I., & Hankins, S. K.** (2021). 'Until we are first recognized as humans': the killing of George Floyd and the case for Black life at the United Nations. *International Journal of Human Rights Education*, *5*, 4.

**Bennett-Levy, J.** (2006). Therapist skills: a cognitive model of their acquisition and refinement. *Behavioural and Cognitive Psychotherapy*, *34*, 57–78.

**Bennett-Levy J.** (2019). Why therapists should walk the talk: the theoretical and empirical case for personal practice in therapist training and professional development. *Journal of Behavior Therapy and Experimental Psychiatry*, *62*, 133–145. https://doi.org/10.1016/j.jbtep.2018.08.004

**Bennett-Levy, J., & Finlay-Jones, A.** (2018). The role of personal practice in therapist skill development: a model to guide therapists, educators, supervisors and researchers. *Cognitive Behaviour Therapy*, *47*, 185–205. https://doi.org/10.1080/16506073.2018.1434678

**Bennett-Levy, J., & Haarhoff, B.** (2019). Why therapists need to take a good look at themselves: self-practice/self-reflection as an integrative training strategy for evidence-based practices. In S. Dimidjian (ed), *Evidence-Based Practice in Action: Bridging Clinical Science and Intervention* (pp. 380–394). Guilford Press.

**Bennett-Levy, J., McManus, F., Westling, B. E., & Fennell, M.** (2009a). Acquiring and refining CBT skills and competencies: which training methods are perceived to be most effective?. *Behavioural and Cognitive Psychotherapy*, *37*, 571–583. https://doi.org/10.1017/S1352465809990270

**Bennett-Levy, J., & Thwaites, R.** (2007). Self and self-reflection in the therapeutic relationship: a conceptual map and practical strategies for the training, supervision and self-supervision of interpersonal skills. In P. Gilbert & R. L. Leahy (eds), *The Therapeutic Relationship in the Cognitive Behavioral Psychotherapies* (pp. 255–281). Routledge/Taylor & Francis Group.

**Bennett-Levy, J., Thwaites, R., Chaddock, A., & Davis, M.** (2009b). Reflective practice in cognitive behavioural therapy: the engine of lifelong learning. In Dallos, R., & Stedmon, J. (eds), *Reflective Practice in Psychotherapy and Counselling* (pp. 115–135). Open University Press

**Bennett-Levy, J., Thwaites, R., Haarhoff, B., & Perry, H.** (2015). *Experiencing CBT from the Inside Out: A Self-Practice/Self-Reflection Workbook for Therapists*. Guilford Press.

**Benson, K. E.** (2013). Seeking support: transgender client experiences with mental health services. *Journal of Feminist Family Therapy: An International Forum*, *25*, 17–40.

**Bess, J. A., & Stabb, S. D.** (2009). The experiences of transgendered persons in psychotherapy: voices and recommendations. *Journal of Mental Health Counseling*, *31*, 264–282.

**Birdsey, N., & Kustner, C.** (2021). Reviewing the Social GRACES: what do they add and limit in systemic thinking and practice? *American Journal of Family Therapy*, *48*, 429–442. https://doi.org/10.1080/01926187.2020.1830731

**Boukari, Y., & Devakumar, D.** (2024). Far-right riots in the UK: the culmination of years of rhetoric and policies. *Lancet*, *404*, 931. https://doi.org/10.1016/S0140-6736(24)01713-6

**Boyle, M.** (2022). Power in the power threat meaning framework. *Journal of Constructivist Psychology*, *35*, 27–40.

**British Association for Behavioural & Cognitive Psychotherapies** (2017). Leading UK psychological professions and Stonewall unite against conversion therapy. https://babcp.com/About/News-Press/Leading-UK-Psychological-Psychotherapeutic-and-Counselling-Organisations-Unite-Against-Conversion-Therapy

**British Association for Behavioural & Cognitive Psychotherapies** (2023). *Minimum Training Standards*.

**British Association for Behavioural & Cognitive Psychotherapies** (2024). BABCP Standards of Conduct, Performance and Ethics. https://babcp.com/Standards

**British Association for Behavioural & Cognitive Psychotherapies** (2024). Violence across the UK. https://babcp.com/About/News-Press/Violence-across-the-UK

**Brooks, V. R.** (1981). *Minority Stress and Lesbian Women*. Lexington Books.

**Brooks-Ucheaga, M.** (2023). A qualitative exploration of black psychotherapists' personal experience of racism and the challenges that exist for black therapists who work with clients in therapy who have also experienced racism. A pilot study using interpretive phenomenological analysis. *the Cognitive Behaviour Therapist*, *16*, e14.

**Burke, T.** (2017). Me Too was started for black and brown women and girls. They're still being ignored. *The Washington Post*, 9 November 2017. https://www.washingtonpost.com/news/post-nation/wp/2017/11/09/the-waitress-who-works-in-the-diner-needs-to-know-that-the-issue-of-sexual-harassment-is-about-her-too/

**Burnham, J.** (2012). 'Developments in the Social GGRRAAACCEEESSS: Visible-invisible and voiced-unvoiced', in Krause, I. (ed), *Culture and Reflexivity in Systemic Psychotherapy: Mutual Perspectives*. London: Karnac.

**Butler, C.** (2015). Intersectionality in family therapy training: inviting students to embrace the complexities of lived experience. *Journal of Family Therapy*, *15*, 583–589. doi: 10.1111/1467-6247.12090

**Butler, J.** (1990). *Gender Trouble: Feminism and the Subversion of Identity*. Routledge.

**Carvalho, S. A., Castilho, P., Seabra, D., Salvador, C., Rijo, D., & Carona, C.** (2022). Critical issues in cognitive behavioural therapy (CBT) with gender and sexual minorities (GSMs). *the Cognitive Behaviour Therapist*, *15*, e3.

**Charura, D., & Lago, C.** (2021). *Black Identities + White Therapies: Race, Respect + Diversity*. PCCS Books.

**Chin, D., Smith-Clapham, A. M., & Wyatt, G. E.** (2023). Race-based trauma and post-traumatic growth through identity transformation. *Frontiers in Psychology*, *14*, 1031602.

**Churchard, A.** (2022). How can psychotherapists improve their practice with service users from minoritised ethnicities? An application of the declarative-procedural-reflective (DPR) model of clinical skill development. *the Cognitive Behaviour Therapist*, *15*, E1. doi: 10.1017/S1754470X21000386

**Churchard, A.** (in preparation). *How Can We Conceptualise and Work with Power in CBT?* Oxford Institute of Clinical Psychology Training and Research, University of Oxford.

**Collins, P. H., & Bilge, S.** (2020) *Intersectionality*. John Wiley & Sons.

**Constantine, M. G., & Sue, D. W.** (2007). Perceptions of racial microaggressions among black supervisees in cross-racial dyads. *Journal of Counseling Psychology*, *54*, 142–153. https://doi.org/10.1037/0022-0167.54.2.142

**Cox, S., & Gallois, C.** (1996). Gay and lesbian identity development: a social identity perspective. *Journal of Homosexuality*, *30*, 1–30. https://doi.org/10.1300/J082v30n04_01

**Craik, F. I. M., & Lockhart, R. S.** (1972). Levels of processing: a framework for memory research. *Journal of Verbal Learning and Verbal Behavior*, *11*, 671–684.

**Crenshaw, K.** (1990). Mapping the margins: intersectionality, identity politics, and violence against women of color. *Stanford Law Review*, *43*, 1241–1299. https://doi.org/10.2307/1229039

**Cross, W. E.** (1978). The Thomas and Cross models of psychological nigrescence: a review. *Journal of Black Psychology*, *5*, 13–31.

**Cruwys, T., Lee, G. C., Robertson, A.M., Haslam, C., Sterling, N., Platow, M. J., Williams, E., Haslam, S. A. & Walter, Z. C.** (2023). Therapists who foster social identification build stronger therapeutic working alliance and have better client outcomes. *Comprehensive Psychiatry*, *124*, 152394. https://doi.org/10.1016/j.comppsych.2023.152394

**Day-Vines, N. L., Cluxton-Keller, F., Agorsor, C., Gubara, S., & Otabil, N. A. A.** (2020). The multidimensional model of broaching behavior. *Journal of Counseling & Development*, *98*, 107–118.

**Day-Vines, N. L., Wood, S. M., Grothaus, T., Craigen, L., Holman, A., Dotson-Blake, K., & Douglass, M. J.** (2007). Broaching the subjects of race, ethnicity, and culture during the counseling process. *Journal of Counseling & Development*, *85*, 401–409. https://doi.org/10.1002/j.1556-6678.2007.tb00608.x

**Dempster, H., & Hargrave, K.** (2022) *Understanding Public Attitudes Towards Refugees and Migrants*. ODI.

**Eichstaedt, J. C., Sherman, G. T., Giorgi, S., Roberts, S. O., Reynolds, M. E., Ungar, L. H., & Guntuku, S. C.** (2021). The emotional and mental health impact of the murder of George Floyd on the US population. *Proceedings of the National Academy of Sciences*, *118*, e2109139118.

**El-Leithy, S.** (2014). Working with diversity in CBT. In A. Whittington & N. Grey (eds), *How to Become a More Effective CBT Therapist: Mastering Metacompetence in Clinical Practice* (pp. 44–61). Wiley Blackwell.

**Ellingworth, D., Bécares, L., Šťastná, M., & Nazroo, J.** (2023). 4: Racism and racial discrimination. In *Racism and Ethnic Inequality in a Time of Crisis*. Bristol, UK: Policy Press. https://doi.org/10.51952/9781447368861.ch004

**Equality Act** (2010). Available at: https://www.legislation.gov.uk/ukpga/2010/15/contents

**Fernando, S.** (2017). *Institutional Racism in Psychiatry and Clinical Psychology: Race Matters in Mental Health*. Palgrave Macmillan/Springer Nature. https://doi.org/10.1007/978-3-319-62728-1.

**Gilbert, P., & Leahy, R. L.** (eds) (2007). *The Therapeutic Relationship in the Cognitive Behavioral Psychotherapies*. Routledge.

**Guan, M., & So, J.** (2023). Social identity theory. In *The International Encyclopedia of Health Communication* (eds E. Y. Ho, C. L. Bylund, J. C. M. van Weert, I. Basnyat, N. Bol and M. Dean). https://doi.org/10.1002/9781119678816.iehc0667

**Haarhoff, B., & Thwaites, R.** (2016). *Reflection in CBT*. London: SAGE.

**Haslam, S. A., Jetten, J., Postmes, T., & Haslam, C.** (2009). Social identity, health and well-being: an emerging agenda for applied psychology. *Applied Psychology: An International Review*, *58*, 1–23. https://doi.org/10.1111/j.1464-0597.2008.00379.x

**Haugaard, M.** (2010). Power: a 'family resemblance' concept. *European Journal of Cultural Studies*, *13*, 419–438.

**Hays, P. A.** (2013). *Connecting Across Cultures: The Helper's Toolkit*. Los Angeles: Sage.

**Health & Care Professions Council** (2023). *Standards of Proficiency: Practitioner Psychologists*. https://www.hcpc-uk.org/standards/standards-of-proficiency/practitioner-psychologists/

**Helms, J. E., & Carter, R. T.** (1990). Toward a model of the white racial identity development. In J. E. Helms (ed), *Black and White Racial Identity: Theory, Research, and Practice*, pp. 49–66. Westport, CT: Greenwood Press.

**Hendricks, M. L., & Testa, R. J.** (2012). A conceptual framework for clinical work with transgender and gender noncomforming clients: an adaptation of the minority stress model. *Professional Psychology: Research and Practice*, *43*, 460–467. doi: 10.1037/a0029597

**Hook, J. N., Davis, D. E., Owen, J., Worthington, E. L., & Utsey, S. O.** (2013). Cultural humility: measuring openness to culturally diverse clients. *Journal of Counseling Psychology*, *60*, 353–366. https://doi.org/10.1037/a0032595

**Hunt, J.** (2014). An initial study of transgender people's experiences of seeking and receiving counselling or psychotherapy in the UK. *Counselling & Psychotherapy Research*, *14*, 288–296.

**Iwamasa, G. Y., Regan, S. P., & Sorocco, K. H.** (2019). Culturally responsive cognitive behavior therapy clinical supervision. In G. Y. Iwamasa & P. A. Hays (eds), *Culturally Responsive Cognitive Behavior Therapy: Practice and Supervision* (2nd edn, pp. 317–332). American Psychological Association. https://doi.org/10.1037/0000119-013

**Jacobsen, N.S., Martell, C.R., & Dimidjian, S.** (2001) Behavioural activation treatment for depression; returning to contextual roots. *Clinical Psychology: Science and Practice*, *8*, 255.

**Jaffe, A.E., Cero, I., & DeLillo, D.** (2021). The #MeToo movement and perceptions of sexual assault: college students' recognition of sexual assault experiences over time. *Psychology of Violence*, *11*, 209–218.

**Katzow, A. W., & Safran, J. D.** (2007). Recognizing and resolving ruptures in the therapeutic alliance. In P. Gilbert & J. D. Safran (eds), *The Therapeutic Relationship in the Cognitive Behavioral Psychotherapies* (pp. 90–105). Routledge.

**Kennerley, H.** (2014). Developing and maintaining a working alliance in CBT. In A. Whittington & N. Grey (eds), *How to Become a More Effective CBT Therapist: Mastering Metacompetence in Clinical Practice* (pp. 31–43). Wiley Blackwell.

**Krause, I.-B.** (2022). Can we teach race and equity? *Journal of Family Therapy*, *44*, 157–170. https://doi.org/10.1111/1467-6427.12361

**Lawton, L., Thwaites, R., & Warnock-Parkes, E.** (2025). Using cognitive therapy for PTSD when racism was part of the traumatic event(s): case illustrations and practical considerations for therapists and supervisors. *The Cognitive Behaviour Therapist*, *18*, e31. https://doi.org/10.1017/S1754470X25000182

**Lelutiu-Weinberger, C., Filimon, M. L., Chiaramonte, D., Leonard, S. I., Dogaru, B., Pana, E., Pruneanu, C., & Pachankis, J. E.** (2024). A pilot trial of an LGBTQ-affirmative cognitive-behavioral therapy for transgender and gender expansive individuals' mental, behavioral, and sexual health. *Behavior Therapy*. https://doi.org/10.1016/j.beth.2024.10.005. (https://www.sciencedirect.com/science/article/pii/S0005789424001552)

**LGBT Foundation** (2024). NHS talking therapies for anxiety and depression: LGBTQ+ positive practice guide. https://lgbt.foundation/wp-content/uploads/2024/07/LGBTQ-Positive-Practice-Guide-20248_DIGITAL_FINAL.pdf

**Livingston, N. A., Berke, D., Scholl, J., Ruben, M., & Shipherd, J. C.** (2020). Addressing diversity in PTSD treatment: clinical considerations and guidance for the treatment of PTSD in LGBTQ populations. *Current Treatment Options in Psychiatry*, *7*, 53–69. https://doi.org/10.1007/s40501-020-00204-0

**Lukes, S.** (2018). Power, truth and epistemic closure. *Praxis 13/13*. https://blogs.law.columbia.edu/PRAXIS1313/STEVEN-LUKES-POWER-TRUTH-AND-EPISTEMIC-CLOSURE/

**MacIntyre, M. M., Zare, M., & Williams, M. T.** (2023). Anxiety-related disorders in the context of racism. *Current Psychiatry Reports*, *25*, 31–43. https://doi.org/10.1007/s11920-022-01408-2

**Me Too** (2024). *History and Inception*. metoomvmt.org

**Meyer, I. H.** (1995). Minority stress and mental health in gay men. *Journal of Health and Social Behavior*, *36*, 38–56. https://doi.org/10.2307/2137286

**Meyer, I. H.** (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychological Bulletin*, *129*, 674–697. https://doi.org/10.1037/0033-2909.129.5.674

**Miller, E., & McNaught, A.** (2018). Exploring decision making around therapist self-disclosure in cognitive behavioural therapy. *Australian Psychologist*, *53*, 33–39. https://doi.org/10.1111/ap.12260

**Mintchev, N.** (2021) The cultural politics of racism in the Brexit conjuncture. *International Journal of Cultural Studies*, *24*, 123–140.

**Moorhead, B., Lewis, H. K., & Arnull, L.** (2024). LGBT sexuality and gender minority experiences of minority stress: a comparison of models and theories. *Quality & Quantity*. https://doi.org/10.1007/s11135-023-01771-z

**Naeem, F., Sajid, S., Naz, S., & Phiri, P.** (2023). Culturally adapted CBT – the evolution of psychotherapy adaptation frameworks and evidence. *the Cognitive Behaviour Therapist*, *16*, e10. doi: 10.1017/S1754470X2300003X

**O'Hara, C.** (2014). *The Relationships among the Experiences of Racial Microaggressions in Supervision, Traumatic Experiences, and the Supervisory Working Alliance in Professional Counselors and Counselors-in-Training*. Dissertation, Georgia State University. https://doi.org/10.57709/5677091

**Office for National Statistics** (2023). *Gender Identity, England and Wales: Census 2021*, released 6 January 2023, ONS website, statistical bulletin.

**Perry, N. S., Chaplo, S. D., & Baucom, K. J. W.** (2017). The impact of cumulative minority stress on cognitive behavioral treatment with gender minority individuals: case study and clinical recommendations. *Cognitive and Behavioral Practice*, *24*, 472–483. https://doi.org/10.1016/j.cbpra.2016.12.004

**Pieterse, A. L.** (2018). Attending to racial trauma in clinical supervision: Enhancing client and supervisee outcomes. *The Clinical Supervisor*, *37*, 204–220.

**Presley, V. L.** (2023). Addressing equality, diversity and inclusion as part of CBT training: a course evaluation study. *the Cognitive Behaviour Therapist*, *16*, e30. doi: 10.1017/S1754470X23000235

**Presley, V. L., & Jones, G.** (2024). 'Crossing the reflective bridge': how therapists synthesise personal and professional development from self-practice/self-reflection during CBT training. *the Cognitive Behaviour Therapist*, *17*, e18. doi: 10.1017/S1754470X24000175

**Proctor, G.** (2008). CBT: the obscuring of power in the name of science. *European Journal of Psychotherapy and Counselling*, *10*, 231–245. https://doi.org/10.1080/13642530802337975

**Proctor, G.** (2017). *The Dynamics of Power in Counselling and Psychotherapy* (2nd edn). PCCS Books.

**Raj, R.** (2007). Transactivism as therapy: a client self-empowerment model linking personal and social agency. *Journal of Gay & Lesbian Psychotherapy*, *11*, 77–98. doi: 10.1300/J236v11n03_05

**Roberts, A. L., Gilman, S. E., Breslau, J., Breslau, N., & Koenen, K. C.** (2011) Race/ethnic differences in exposure to traumatic events, development of post-traumatic stress disorder, and treatment-seeking for post-traumatic stress disorder in the United States. *Psychological Medicine*, *41*, 71–83.

**Rosen, D. C., Kanter, J. W., Villatte, M., Skinta, M. D., & Loudon, M. P.** (2019). Becoming an antiracist White clinician. In M. T. Williams, D. C. Rosen, & J. W. Kanter (eds), *Eliminating Race-Based Mental Health Disparities: Promoting Equity and Culturally Responsive Care Across Settings* (pp. 147–168). Context Press/New Harbinger Publications.

**Satterly, B. A., & Dyson, D.** (2008). Sexual minority supervision. *Clinical Supervisor*, *27*, 17–38. https://doi.org/10.1080/07325220802221462

**Schon, D. A.** (1991). *The Reflective Practitioner*. Ashgate Publishing.

**Smail, D. J.** (2005). *Power, Interest and Psychology: Elements of a Social Materialist Understanding of Distress*. PCCS Books.

**Sue, D. W.** (2013). Race talk: the psychology of racial dialogues. *American Psychologist*, *68*, 663.

**Tajfel, H., & Turner, J. C.** (1979). An integrative theory of intergroup conflict. In W. G. Austin, & S. Worchel (eds), *The Social Psychology of Intergroup Relations* (pp. 33–37). Monterey, CA: Brooks/Cole.

**Tarshis, S., & Baird, S. L.** (2021). Applying intersectionality in clinical supervision: a scoping review. *The Clinical Supervisor*, *40*, 218–240. https://doi.org/10.1080/07325223.2021.1919949

**Vekaria, B., Thomas, T., Phiri, P., & Ononaiye, M.** (2023). Exploring the supervisory relationship in the context of culturally responsive supervision: a supervisee's perspective. *the Cognitive Behaviour Therapist*, *16*, e22.

**Watkins, C. E.**, Jr (2012). On demoralization, therapist identity development, and persuasion and healing in psychotherapy supervision. *Journal of Psychotherapy Integration*, *22*, 187–205. https://doi.org/10.1037/a0028870

**Westbrook, D.** (2014). The central pillars of CBT. In A. Whittington & N. Grey (eds), *How to Become a More Effective CBT Therapist: Mastering Metacompetence in Clinical Practice* (pp. 17–30). Wiley Blackwell.

**Williams, M. T.** (2020). *Managing Microaggressions: Addressing Everyday Racism in Therapeutic Spaces*. Oxford University Press. ISBN: 9780190875237

**Williams, M. T., & La Torre, J.** (2022). Clinical supervision in delivering cognitive behavior therapy across race, ethnicity, and culture. In E. A. Storch, J. S. Abramowitz, & D. McKay (eds), *Training and Supervision in Specialized Cognitive Behavior Therapy: Methods, Settings, and Populations* (pp. 265–287). American Psychological Association.

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