You Love CBT, You Told me Last Week: A Hermeneutic Inquiry Into Client Claims of Gaslighting and Misutilization of the CBT Model

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Abstract

Cognitive-behaviour therapy (CBT) is a highly influential framework of psychotherapy that holds a unique position in the field of psychology, claimed to be the most “evidence-based” and “proven” theory. This quantitative story of effectiveness and certainty has recently been challenged by a rising tide of qualitative stories of gaslighting, invalidation, and unpleasant client experiences with the model and CBT practitioners. This manuscript attempts to bridge this dialectic by exploring the quantitative and qualitative accounts within the greater context of psychotherapy in the Western world.

Keywords: Cognitive-behaviour therapy, gaslighting, psychotherapy, evidence-based practice, power.

For my sister Shanelle, who always challenges me to look at life through different lenses.

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An underdog is often broadly revered in the hearts of onlookers due to its tenacity and relatability. They must beat the odds and scrap to the point of respectability, all the while being overshadowed by a more dominant adversary. This is a story often easily understood, as some may live their lives feeling as if every challenge is shortly superseded by the next. In movies, the story often ends at the point of the underdog capturing some form of power, status, or respect. What is left out are the after effects and the shifting psychological profile of the underdog. In its new state, how does the previous underdog react to novel power and how does the original adversary cope with such power slipping away? In this paper, I will explore the current state of a psychotherapeutic framework that began as an underdog and has risen to levels of utmost influence. I will question if proponents of the model are truly aware of its influence and if they are cognizant of how its resulting power interacts with other models in the field and the people it is meant to serve.

In the mid-1900s, Aaron Beck's (1991) cognitive behaviour therapy (CBT) was simply a thought in a respected psychologist's mind that paled in comparison to the dominant streams of behaviourism and psychoanalysis. Yet, A. Beck seemingly refused to catastrophize or fortune-tell when considering the minuscule odds of becoming a primary theoretical model. Over time this appeared to pay off, as in the eyes of many, CBT currently sits at the pinnacle of influence and support (David et al., 2018). CBT is a cluster of related therapies that prioritize the role of cognition in influencing an individual's life outcomes (A. Beck, 1991). There is considerable variance in the many iterations of CBT; in this paper, when CBT is mentioned, it will be referring to the second wave of CBT spearheaded by A. Beck's cognitive therapy. At times, the

concept of third-wave therapies will be noted; however, the distinction from the second-wave focus will be made clear. The main difference between these two iterations of the theory is in the second wave, the focus is mainly on changing a thought itself, whereas in the third wave, the focus is placed on changing a person's relationship to a thought (Hayes & Hofmann, 2021).

David et al. (2018) classified CBT as the gold standard of therapy and stated that although it is not perfect, it is clearly the top option in psychotherapy. I first read that article years ago as a fledgling master's student, and its influence on me was tangible, with such strong verbiage solidifying my previous beliefs about the seemingly unquestionable merit of the therapy. However, when I read it now, after years of study and reflection, I question the utility of making such brazen claims. My purpose in writing this paper is not to demonize CBT but to add nuance to the conversation around CBT's dominance in psychotherapy. In this endeavour, I classify myself as curious and as a learner. As someone with certain privileges that have sometimes reduced my care and attention to power, I wish to highlight the power of being the figurehead of any discipline and question if it is serving the entire field in its current form.

A Hermeneutic Phenomenological Approach

A hermeneutic phenomenological approach to research avoids making definitive claims about objective reality, mirroring philosophies of postmodern psychology (Madigan, 2019; Reiners, 2012). Standing in opposition to quantitative research, this line of inquiry acknowledges and accepts the presence of bias inherent in humans, who, at the core, are seen as a product of experience and cannot entirely remove oneself from such sweeping influence. Some qualitative research seeks to remove researcher bias through techniques such as bracketing, an intentional method by a researcher to remove all pre-conceived judgement of a phenomena (Creswell & Poth, 2017). Yet, in the spirit of Heidegger's (1962) interpretive hermeneutic philosophy, I will

embrace my role in research and explore my connection to the topic instead of attempting to hide it away in the metaphorical closet. Bias mitigation will be discussed further and is essential to the validity of such inquiry.

By including myself in this research through hermeneutics, I am mirroring the greater intention of this research: to bring individual voices to prominence in a field dominated by powerful voices. A primary component of CBT's influence is the robustness of the evidence base, which has been studied for decades (Westen et al., 2004). Evidence has been defined as something that "furnishes proof" (Merriam-Webster, n.d., para 1). Proof is necessary to understand what works and what fails in psychotherapy. However, hermeneutics claims that every piece of proof or evidence has an element of subjectivity and interpretation (Reiners, 2012). This is especially relevant when working in the domain of the social sciences, which has been described as inescapably interpretive (Sandage et al., 2008). A theme that will emerge through this paper is the grappling between those who make definitive claims about the superiority of CBT, and those like myself who adopt a hermeneutic, postmodern stance of alternative interpretations that sprout from the endless context of the conceptualization of mental health in the Western world. My goal is to carefully balance the merits of empiricism while questioning the dangers that arise from the claims that result from putting definitive quantitative numbers to the enigma that is the human psychological condition.

A sect of psychodynamic and postmodern therapists have felt discredited and silenced by the boastful claims of CBT that have been enabled by the quantitative "proof" (Shedler, 2019). These claims about the "truth" behind mental health recovery has become the dominant discourse and has resulted in power and influence for specific actors, and a lack of voice for others. Through a process of hermeneutics and curiosity of interpretation, I wish to analyze the

forgotten pixels of a quantitative picture that claims to be an unambiguous representation of reality. I wonder if lost in the vast evidence base for CBT is the voice of the individual. I seek to highlight this voice as having as much unique importance as a meta-analysis. In an arena of quantitative dominance, the qualitative underdog fights to be seen, heard, and respected. Through this research, I encourage a power shift through singular voices that bravely oppose the leviathan of claims about "what works" in psychotherapy.

Importance of this Research

Reducing Harm

CBT has an undeniable presence and is revered by many as a titan of psychotherapy (David et al., 2018). With such influence comes incredible responsibility to the clients served by the model. Ingrained in the Canadian Code of Ethics for Psychologists is the principle of responsible caring (Canadian Psychological Association, 2017). Points II.2 and II.3, respectively, require practitioners to be conscious and alert to the value of not causing harm to clients and accepting responsibility if such harm is to occur. Additionally, the CPA highlights a practitioner's responsibility to society and point IV.28 calls for psychologists to speak out for the benefit of society if the ways that the discipline of psychology is being utilized stand against the values of the code. In other words, if people are harmed at any point receiving psychological services, it is a failure on many levels, and action must be taken to fix any mistakes. This puts the onus on those in the psychology profession to be wary about work with their own clients, as well as broadened work in the field.

Recently, I have noticed a social media trend of individuals commenting about negative personal experiences with CBT. A quick Google search with the phrase "is CBT gaslighting," a

talking point I have observed even outside of my research, results in a litany of personal accounts and experiences hotly debating the topic. I have explored many of these articles and threads and observed themes that would indicate to me that some individuals have received treatment they defined as harmful. The existence of such a trend should startle novice and experienced therapists alike, regardless of theoretical grounding. Without defending or demonizing CBT broadly, we must seek to understand where this is coming from.

In the spirit of hermeneutic inquiry and the Canadian Code of Ethics for Psychologists, I have ascribed meaning to every person's subjective experience of harm (Canadian Psychological Association, 2017; Reiners, 2012). This includes forums, blogs, and social media threads as sources in this inquiry. For some, seeing a jestful username in an academic paper may immediately reduce the validity and importance of the work, and from a purely quantitative standpoint, that may be true. However, I challenge the reader to recognize the person behind the jestful username and focus on the personal impact and importance of the experience they are attempting to convey. In qualitative research, validity describes the appropriateness of the process, while reliability represents consistency (Leung, 2015). I would argue that in a space where existing qualitative research is lacking, surveying accounts available to the public is appropriate as a starting point for future research. The consistency factor is reflected in my process, including bias management, exploring academic research for themes found in social media, and attention to highlighting conflicting points about the topic.

When incorporating sources from blog sites and social media, anonymity on the internet can be seen as a strength and weakness for this type of research. Anonymity can provide a person the freedom to tell a true story without fears of being identified and shamed. However, this also reduces the likelihood of identifying the writer and verifying the story. I challenge the reader to

accept that the themes that emerge through these media sources likely cannot be checked for accuracy but to recognize the emotional significance of the experience being relayed. Healthy skepticism is encouraged in such endeavours; however, the themes in this paper have emerged multiple times during my exploration. If a single claim is true, it is the responsibility of psychology at large to validate the experience and grow. As the reader will see, there is far more than a single claim that supports this line of questioning.

Highlighting Voices

In a later section, I will explore evidence-based practice (EBP) in psychology in depth. I will provide a short primer here to encourage the reader to begin to note any potential differences in the amplification of individual voices compared to the research base. EBP is psychology's way of proving to itself and the world that the methods of therapy being used are safe and effective (Westen et al., 2004). Best practices are informed by an amalgamation of research that tests psychological methods with clients often in a clinical setting. While this has clear benefits, it begins to shape a monolithic narrative and create a natural hierarchy of the "usefulness" of therapies.

A hierarchy signifies power and a distinction between the people and frameworks at the top and bottom. Because CBT sits at the top, the average person may not have (or feel they have) enough social capital to present their negative experience in a way that is recognized by the profession, when the bulk of the research says that CBT is safe and effective (David et al., 2018). This is especially relevant as harm and adverse effects do happen in therapy but individuals do not report at an equivalent rate for various reasons, with one being a clear power differential between a client and a post-secondary trained professional (Duggan et al., 2014). Opportunities to relay experiences in a safe and confidential manner currently do not exist to the degree they

should, due to the lack of current qualitative research regarding people's negative experiences with CBT. Thus, I will highlight voices in a way that appears to make the most ethical sense.

I will directly cite usernames from comment threads from the social media platform Twitter, the discussion site Reddit, the public forum site Quora, and multiple comment sections under news articles, with all threads focussed on people's experiences with CBT. In these spaces, it appears that individuals are given a sense of safety to share through the courage of one person coming forward to start a discourse. I will also identify overarching themes in these threads because, as much as I would like to highlight every voice in such a way, that depth of direct quotation is not feasible. Any time a thread is referenced without a direct quote, see Appendix for the corresponding theme.

Corresponding to this topic, I will make a comparison to the *#metoo* movement that gained prominence in 2017, with individuals coming forward with their experiences of surviving sexual assault (Corbett, 2022). While the content of these situations is very different, a crucial and relevant aspect that the *#metoo* movement highlights is the influence of power differentials in an individual's perceived license to share. I will try to demonstrate through this paper that people who feel unheard, invalidated, and blamed when leaving therapy may be more likely to internalize these messages than directly question the treatment they received. After all, despite positive shifts, healthcare in the Western world was founded on the basis of patients having complete faith in the provider's knowledge, paired with little agency to question (Ubel et al., 2017). Fortunately, just like the *#metoo* movement, certain clients with shared experiences are beginning to question experiences that did not feel right, galvanized through community.

Direct citations will be utilized with the following intent and ethical justification. First, all information on the internet, unless otherwise stated, is public domain and accessible to

anyone (Simon Fraser University, 2022). Second, my primary goal is to highlight silenced voices, which I can do through the potential amplification of direct citations. Third, individuals in this inquiry have spoken about the pain of being silenced and the empowerment of having a voice noticed, validated, and amplified (Saltz, 2021). Therefore, I will often quote directly to ensure the writer's original voice is preserved as much as possible. I wish to take voices that have shouted out into the abyss of the internet, take them seriously, and assist them in assisting the field of psychotherapy in making positive change and reducing further negative experiences for people. Certain quotes have been cited in the body of this paper because of their relevance to the topic or power of writer voice, yet all convey significance, and further examples that have not been included in the body based on space and succinctness considerations rest in the Appendix. With my intentions for this research made clear, the following is the primary research question for this paper. Two sub-questions that have been formulated based on the trends I have observed in academic and non-academic literature will follow.

Research Questions

1. A primary component of CBT's influence in psychotherapy is the significant evidence base that backs it. In what ways, if any, has the evidence-base overinflated CBT's position, and with such power, how have qualitative accounts of negative experiences from individuals been validated and addressed as a part of the greater conversation?

2. Marginalized voices have traditionally been underrepresented in large-scale conversations in the Western world due to a lack of opportunity. In what ways have the marginalized groups covered in this review been amplified or silenced as they seek to co-exist in the mental health space alongside the powerhouse of CBT?

3. Do potential improvements to the implementation of CBT currently exist in the literature, or is it yet to be discovered?

Self-Positioning Statement

Personal Reason for Choosing Topic

I first learned about CBT the year before I applied to a master's of counselling program. Discovering CBT was empowering for me. As someone who had long defined myself as an overthinker, the cognitive model gave me a sense of agency over my thoughts and thought patterns. I learned about CBT through my own research and not through receiving therapy, so my initial impressions had to do with the model and not from being a recipient of a positive or negative experience as a client. My perception of CBT in the aftermath was notably positive as I saw beneficial impacts in my life and imagined sharing the same experience with others.

It was not until I began the master's and a notable portion of my original cohort had viscerally strong and negative reactions to CBT that I began to ponder the two potential sides to the story. This momentum continued after hearing about negative CBT experiences from my sister and a few others in my life. At this point, I still had generally positive views about the model and attributed the negative reactions as outliers. However, I had the nagging reflection in the back of my head that I had never seen someone have such a strong negative reaction to any other form of therapy. I did not receive a CBT therapy session until 2022 when I went to four. Without delving into details beyond what is necessary, I was grappling with fears about a severe medical diagnosis due to symptoms I was experiencing and was referred for treatment through a doctor's office. My experience was not terrible; however, I was left craving the concept of

therapeutic space in my sessions. More than anything, I desired the clinician to sit with my immense fears instead of providing me with tools.

Concurrently, from some of the doctors I was seeing, I was experiencing what I would define as *medical gaslighting*, a modern term that describes a healthcare professional dismissing or invalidating a patient's concerns (Onque, 2022). I had never experienced the misuse of power so blatantly in my life, as doctors encouraged me to ignore my intuition and symptoms based on a fixed belief that they had about what was going on, which ultimately put me in danger. At times I questioned myself, with particular messages threatening to take hold. Yet, thankfully, I had a degree in psychology that I could reflect on when considering the power of authority. Unfortunately, not everyone has that privilege, and some internalize messages about them being the problem instead of people in power being fallible. One Twitter commenter highlights their experience of internalization following CBT, saying, "I thought it was my fault for rejecting the idea that worrying about my finances was an 'irrational thought' or that I could solve my problems by going on a walk" (ItsMeLydiaa, 2021).

The interplay between my history with CBT and this personal experience of invalidation spurs the desire for this work. I am motivated to explore the voices of those who potentially have never been heard or recognized outside of a post on a social media platform, as I know the pain that can cause. Furthermore, as a future therapist, I wince at the idea of an individual leaving a session feeling unheard or blamed and taking that feeling forward with them. I am living proof that the CBT model can have a tangible positive impact on a person's life, yet this is balanced for me with the existence of an unfortunate trend that must be recognized in mainstream psychology and soon.

Biases

One may consider the multiple ways CBT has been intertwined with my life and see the potential for bias. As a hermeneutic researcher, I do not dispute this but choose to explore, examine, and reflect on how my biases intersect with the research (Reiners, 2012). I have biases that push in both ways. CBT was my first love in terms of theory, and to this day, I believe that the model has incredible merit. I personally credit it for helping me shed my self-described overthinker status for good. However, I and others close to me have had experiences receiving CBT that we would describe as less than preferred. In addition, at this point, I have read copious amounts of negative personal accounts. This leads me to a place of curiosity, not one in which my mind has been made. I have nothing to gain from writing off CBT as an inherently flawed model, nor do I gain from believing CBT is a perfect therapy. As someone who wishes to use cognitive techniques in my current and future practice, I have everything to gain from exploring the ways CBT may have missed the mark as well as emphasizing areas for improvement. My main interest is highlighting voices, enhancing my ability to be a competent practitioner, and broadening the conversation around a highly influential form of therapy.

Additional bias comes from the type of sources I come across. I have not formulated inclusion or exclusion parameters based on a hermeneutic philosophy of avoiding a hierarchy of importance in terms of experience (Reiners, 2012). My research in message boards has led me to papers about culture, which have led me to peer-reviewed research articles and vice versa. I am limited by the fact that I cannot read everyone's experience on the internet. However, this paper does not attempt to be descriptive of an entire population. This paper attempts to highlight a mosaic of a subset of experiences. My searches included everything from "the positives of CBT" to "the negatives of CBT" and many iterations in between. Additionally, my research prioritizes

individuals with access to computers and the internet. Furthermore, it captures a Western perspective due to an algorithm that prioritizes topics and people who share geographic and language similarities with me (Google, n.d.).

Bias Mitigation

Although hermeneutic research embraces the existence of bias and does not seek to eliminate it, it does seek to manage it (Reiners, 2012). The first part of this process has been engaging in the hermeneutic circle. Interpretive hermeneutic researchers view their own position in relation to the research being done and continuously revisit reflections about how the information interacts with their lived experiences. A tangible way I have done this is by keeping an ongoing notebook in which I write unfiltered responses to what I have read and consider how my interpretations of the text are influenced by my past experiences (Noble & Smith, 2015). Such reflections will appear throughout this paper with qualifiers that emphasize the subjectiveness of the interpretations. As I reflect on the comparison of my current thoughts after being exposed to torrents of information and my original ones when I first formulated the research question, one thing is clear to me. I have seen examples of what I believe to be masterfully composed cognitive interventions that validate and make space for clients, and I have seen examples of treatment that misses the mark for various factors.

In this inquiry, I will highlight and include both positive and negative perspectives into the conversation. Excluding examples of excellent CBT utilization would be a disservice to myself and the reader. I hope that the reader observes my biases throughout this exploration and feels they are reflected on and framed in a way that does not reduce the potential positives of CBT.

Privileges

Before beginning the exploration into this topic, it is important to note my intrinsic characteristics that either illuminate or make invisible my ability to innately understand the experience of others. As a white, cisgender, neurotypical male of average SES, I represent a similar phenotype of the type of person who created much of the evidence-base for CBT (Roberts et al., 2020). This includes those who conducted much of the research and with whom much of the research was conducted. If certain things I am reading fit my experience, it is likely because they were designed that way. It is with conscious intent that experiences that stand opposite to mine are valued, highlighted, and emphasized, as marginalized voices have had to fight to be heard (Hays, 2016). In addition, my work serves as an interpretation attempting to highlight the importance of the original individual experience. While my goal is to capture the content, themes, and feeling as much as possible, my representation is only one small piece of the entire picture. I encourage readers to access the blog posts cited in this paper to read these accounts expressed by the writers. Additional direct quotations are included in the Appendix.

Literature Review

History of Evidence-Backed Therapy in the Western World

The Art Versus Science of Psychotherapy

To understand CBT's current position in psychotherapy one must look back to see how things have come to this point. This journey will begin in the 1950s in an ecosystem in which behaviourism reigned supreme and Freudian psychoanalysis was gaining traction (Dworkin, 2012). While there was promise from other orientations, there was a clear hierarchy that looks much different than today. A debate that emerged around this time can be described as the art

versus the science of psychotherapy. Benjamin (2015) highlighted each side, noting the merit behind understanding the scientific mechanisms of change and using scientifically recognized methods while maintaining flexibility and continuously empowering the human side of the interaction. Others have been stricken by the exploration, framing their interactions "like works of literature which introduce us to characters with increasing complexity and depth, the psychoanalytic endeavour involves the analyst and analysand in a quest to understand a multi-layered inner world" (Orbach, 2016, para. 12). This source presents a voice from psychoanalysis, which through my observation has spearheaded the art side. Meanwhile, behaviourism, and eventually CBT, were to stake their claims behind empiricism and the scientific method (Westen et al., 2004).

The Influence of the Medical Model

Based on the framing of this research so far, it may be no surprise which side "won" this battle. The reigning approach towards mental health in the 1900s revolved around the *medical model* (Dworkin, 2012; O'Donohue et al., 2006). This approach focuses on biological deficits and prioritizes symptom reduction as a sign of recovery. This was reflected in the 1980s when the DSM-III adopted a symptom checklist which further established the view of how disorders originate and how they should be managed (Cosgrove & Shaughnessey, 2020). Around this time, CBT was emerging as an influential theory (A. Beck, 1991). CBT is based on the medical model and symptom recovery. It has been described as highly testable based on its short-term, structured approach and focus, paired with its attention to symptomology (Cosgrove & Shaughnessey, 2020; Gaudiano, 2008). Furthermore, CBT was met with initial success through a major study presenting it as a therapy that led to improvement compared to a placebo (Elkin et

al., 1989). While this may not sound astounding, at the time, faith in therapy was waning in favour of a surge in perceived pharmaceutical success (Dworkin, 2012).

Psychotherapy and Capitalism

The dominance of the medical model and the rise of pharmaceuticals can be observed within the greater economic system prevalent in the Western world. In a capitalistic system, results and productivity can be viewed as a primary goal, with the aim of streamlining various forms of treatment (Hinton & Maclurcan, 2017). This was observable in medicine but also in psychotherapy. In the 1990s, the concepts of evidence-based practice (EBP) and empirically supported treatments (EST) began to take hold. ESTs are treatments and interventions often designed and "proven" for specific populations and EBP is the use of these methods in the greater context of treatment planning and case conceptualization (Drisko & Friedman, 2019). ESTs fuel EBP and the standardization that can occur in which backing is placed behind specific therapies (Westen et al., 2004). Certain "testable" therapies were funded in the endeavour of putting levels of validity to existing psychological treatments. These ESTs were labelled as cost-effective and helpful for a range of psychological disorders, and CBT stood at the forefront (Cook et al., 2017; Shafran et al., 2009). Consistent in an economic system valuing efficiency, treatment became shorter and cheaper, with claims arising about fewer sessions needed to reduce symptoms (Westen et al., 2004).

This trend has continued into modern times, with the NHS (2014) in England pledging hundreds of millions of dollars into CBT programs to save the institution money in the long term through what they would describe as short-term quality therapy. Some have argued that the financial interests embedded in mental health recovery have resulted in a commercialization of therapy that values profit over the individual interests of those seeking treatment (Timimi, 2009).

One Twitter user described it as a “quick fix - meet for ten sessions, call it a day. This works well for insurance companies, not for living, breathing, hurting humans, who need time, love, validation and trust to heal” (Marguerite, 2020). The idea of a *quick-fix* was repeated multiple times in that thread, in addition to a news article on the topic (Hope, 2014; Saltz, 2020). This debate has also been explored by influential people in psychology, including the former head of the American Psychological Association, Dorothy Cantor (Cantor & Fuentes, 2008). Cantor has reflected on the rise in managed care, a system used to control healthcare costs. Managed care is fundamentally intertwined with EBP. In the late 1990s, Cantor feared that the quality of mental healthcare might dip due to the streamlining of treatment in a way most acceptable to insurance companies. This fear was actualized over the next decade, albeit with notable pushback from psychologists, with Cantor citing CBT as the figurehead of this movement. As it stands in the academic literature, CBT has been described as an ideal fit for the system, being seen as short, effective, and easy to learn (Johnsen & Friborg, 2015).

CBT as a Preferred Model

In addition to the NHS report, funding comes naturally to CBT and its proponents as the most studied form of psychotherapy, with certain practitioners benefitting from insurance models (Castor & Fuentes, 2008; McManus et al., 2010; Westen et al., 2004). In addition, some have brought forward the argument of overapplication. Cook et al. (2017) claimed that a tenet central to the credibility of EBP is the ability of an individual to choose an evidence-backed therapy that supports them best, the logic being that ESTs are often tested for a specific demographic, in a particular setting, with specific diagnoses. Therefore, clients should have ample explanation from practitioners, leading to an informed decision about choice of therapy.

Unfortunately, it does not seem this is always the case, with one person bringing up the NHS model and stating, “if you contact a GP for help and support with mental health you have to go on a waiting list and CBT is the only therapy on offer” (Chambers, 2022). This has been reinforced in the literature with people expressing a lack of options when considering ESTs and ending up receiving CBT treatment (Cook et al., 2017; Geraghty et al., 2019; Westen et al., 2004). Point II.18 in The Canadian Code of Ethics for psychologists highlights a practitioner’s duty “to provide and/or obtain the best reasonably accessible service for those seeking psychological services” (Canadian Psychological Association, 2017, p. 23). It continues to state the importance of tailoring a treatment to a client’s needs. Due to the evidence-base and availability of CBT, mental health providers may view CBT as the “best reasonably accessible service,” without considering its accessibility may overshadow individual client needs. This would likely disproportionately affect low-income or marginalized communities who may lack resources or support to access the wider range of options associated with private practice services (Bartram, 2019).

The Unspoken Dark Side of CBT’s Dominance

Is EBP Synonymous with CBT?

As a proponent of balance and nuance, the dominance of CBT, stemming from the popularization of EBP, naturally has me searching for the other side of the story. One does not have to look far to see concerns beginning to emerge, with one trend, in particular, warranting deeper reflection. While reviewing the literature, certain studies have used the terms EBP and CBT synonymously and seemingly without distinction between the two (Shafran et al., 2009; Waller & Turner, 2016). From an outside view, such generalizations hint at potential complacency and self-importance, considering that although cognitive therapies represent a

significant portion of ESTs, there are many accepted therapies from various philosophical backings (Cook et al., 2017).

One study title referred to the process of adapting psychological therapies for individuals with autism (Cooper et al., 2018). The article went on to claim it would assess the adaptation process with a variety of ESTs; however, the only ESTs discussed were from a CBT framework. In this case I wonder why the authors would not choose to frame the study assessing the adaptation process with CBT treatments, instead of the broad banner of psychological therapies and ESTs. It is more apparent to me why some individuals and groups within the realm of psychotherapy may harbour resentment towards the model when certain people within it equate CBT directly to EBP (Hope, 2014; Shedler, 2019). Certain writers have even claimed that other forms of psychotherapy have been deemed less worthy, with an insinuation these less studied models should be abandoned due to the futility of being compared to the giant of CBT (Shedler, 2019; Wampold et al., 2017; Westen et al., 2004).

Superiority of Symptoms

This conversation is further complicated by the observation that the consensus of CBT's superiority may not be as agreed-upon as certain writers would claim (David et al., 2018). The first criticism that will be highlighted comes from the medical model debate. One writer on a forum expressed their belief that "their entire framework (CBT) lies around symptoms, and absolutely nothing more" (Weinblatt, 2020). Some do not take issue with this, seeing the goal of treatment as the reduction of symptoms, yet some see symptoms as one piece of a much larger and more complex puzzle (Cook et al., 2017; Geraghty et al., 2019; Weston et al., 2016). To allude back to the art versus science debate, certain writers have expressed their distaste towards the symptom recovery view, noting that the complex emotional needs of a person may be

overshadowed by their symptom profile (Geraghty & Blease, 2016; Hofmann et al., 2012; Wampold et al., 2017).

Additionally, critics have stated that the claim of CBT's massive evidence base is bloated based on the view that even successful treatments only lead to minor symptom relief (Shedler, 2019). Hofmann et al. (2012) supported this claim through an extensive review of each meta-analysis published since 2000 that measured CBT's efficacy with different disorders. Results of this review indicated small to inconclusive results in all disorders reviewed other than anxiety and specific phobias, which resulted in moderate improvement. An additional study comparing CBT with psychoanalysis found that although CBT led to quicker symptom reduction, the results were similar over time (Leichsenring et al., 2014). Wampold et al. (2017) critiqued the power of the claims of CBT's effectiveness, claiming that science must agree on what *statistically significant* means, observing that the term has been used in the absence of real recovery. From my research, I have found the following anecdotal finding. Often, while better than placebo, the therapy will lead to marginal improvements in the domain being tested, which is contrasted by the takeaway from the study authors who state that the therapy was effective with that group (Geraghty & Blease, 2016; Westen et al., 2004; Weston et al., 2016).

A Long-Term Solution?

An additional criticism of the power of the evidence base revolves around a sense that the symptom reduction of CBT is not long-lasting (Hofmann et al., 2012). In a news article, Hope (2014) reported a sense in the field from non-CBT practitioners that over an extended period, the effectiveness of CBT drastically declines, and it can be viewed as short-term symptom management. Indeed, research on long-term outcomes of CBT is lacking (Hofmann et al., 2012). The research that does exist is mixed.

One cluster of studies found that symptom reduction from CBT tends not to last for periods much longer than a year (Johnsen & Friborg, 2015; Leichsenring et al., 2014). Meanwhile, von Brachel et al. (2019) observed a notable number of patients reporting higher symptom remission rates at follow-up than immediately after treatment. However, many patients in this study reported no improvement at all, during or after treatment.

Interpretation of Scientific EBP Literature

A final note has to do with the benefit of healthy skepticism when interpreting scientific literature results, even in the presence of seemingly significant findings (Shedler, 2019). In a survey of 117 published and unpublished studies, Cuijpers et al. (2010) found that researchers were much more likely to post results if they showed significant positive findings. This was true for both CBT as well as other psychological treatments. The writers of this study interpreted these results as a suggestion of commercialization, with groups having special interests in promoting the therapy they have chosen. I do not believe these results are an indictment of CBT alone, as it seems many therapies benefit from this. However, by proxy, it does encourage me to continually question the power of EBP. With CBT's influence in the field, I must consider how it may benefit from the potential positive effects of large interest groups hoping and expecting to see the efficacy of the model "proven" through research. These findings also lend credence to the idea of subjectivity and interpretation in all knowledge, including thus that claims to be scientific (Sandage et al., 2008).

Questions about the Rigidity of CBT

A Side Opposing Strict Adherence to Manuals and Protocol. When debating the efficacy of CBT, individuals have gone back and forth about whether strict adherence to manuals

and protocol helps or hinders the practice of CBT (Parker & Waller, 2017; Webb et al., 2010). One blogger indicated that when receiving CBT therapy, his therapist would strictly rely on protocol and technique, and he felt blamed when it did not work (Heisler, 2019). Meanwhile, the use of manuals has been hotly debated, with two studies conducting meta-analytic reviews and finding negligible evidence for the claim that adhering to manuals leads to competence by the therapist or positive outcomes for clients (Rapley & Loades, 2018; Webb et al., 2010). Okamoto et al. (2019) made the case that collaboration and empiricism are essential mechanisms of CBT that are lost when treatment feels too structured or robotic. Following this line of thinking comes the term *therapist responsiveness*, defined as a therapist's willingness to react to what is happening in the session instead of sticking to a pre-determined plan (Webb et al., 2010). Such responsiveness may appeal to the *art* side of therapy mentioned previously. It can also be interpreted as an ethical responsibility of therapists to be attuned to a client's needs, providing flexible care even if it falls outside a prescribed treatment plan (Westen et al., 2004).

Additional beliefs are founded in the sense that manualized techniques may be used too often, with a meta-analysis showing that therapists who strayed from an A. Beck manual achieved better treatment outcomes with clients (Johnsen & Friborg, 2015). The authors interpreted these positive outcomes as resulting from increased therapist confidence to draw on past experience. Olatunji et al. (2009) claimed that certain exposure-related techniques should be used much more by therapists, who avoid them because of negative perceptions.

A Side Supporting Strict Adherence to Manuals and Protocol. A collection of writers further argued that CBT techniques in general, not just exposure ones, are commonly withheld from clients due to therapist anxiety and therapist drift, which poses a threat to EBP (Hoyer et al., 2017; Levita et al., 2016; Parker & Waller, 2017; Shafran et al., 2009; Waller & Turner,

2016). A common belief in this stream of thinking is that the manuals are not the issue, the blame is on the therapists who refuse to follow manuals (Hoyer et al., 2017). Waller and Turner (2016) stated that therapists' preconceived beliefs and, by extension, their egos lead therapists away from EBP, a term referred to as *therapist drift*. These writers went as far as to say that some practitioners may be unfit to administer psychotherapy due to their tendency to insert themselves into an established protocol. Waller and Turner then proposed that therapists could benefit from practicing cognitive techniques on themselves, such as cognitive restructuring, when debating about straying from manuals.

I question the ways these beliefs towards strict adherence can co-exist with therapist responsiveness and the potential merits of flexibility and intuition. This line of reasoning can be seen as restrictive, especially considering the nuances in evidence-based research and the likely reality that ESTs are not applied to individuals of every background and experience profile (Cook et al., 2017). It has been found that negative beliefs about technique lead to less CBT adherence (Parker & Waller, 2017). However, that is taken alongside the findings that adherence often does not lead to better outcomes (Webb et al., 2010). Young clinicians must decide whether their inclinations to veer from protocol in times of inspiration is a flaw to be worked through or an asset to be manicured.

Comorbidities in Manualization. Further consideration of manualization and protocol is highlighted within the comorbidity conversation. Manuals have been supported based on their standardization and perceived generalizability of care (Westen et al., 2004). While this may increase their testability, one study found that in addition to manuals not being superior to a non-manual test group, in two studies, manual groups resulted in poorer outcomes (Truijens et al., 2018). Cook et al. (2017) also raised the question about the feasibility of practitioners learning a

new manual for every new comorbidity, stating that the addition of every new diagnosis will complicate the integrity of the design of the manual.

Is CBT Withheld from People?

CBT advocates have argued that on top of therapist drift, a primary concern for the field is that ESTs like CBT are not being offered at the rate that they should (Hoyer et al., 2017; Maddox et al., 2019; Shafran et al., 2009). This opposes the earlier observation about CBT being overapplied and, at times, the only option for individuals (Geraghty et al., 2019). Proponents have argued that because of its evidence base, CBT should be offered to everyone seeking therapy because of its proven efficacy with a wide range of psychological disorders (Shafran et al., 2009).

Such claims perfectly sum up my intention for this section. While I do not deny CBT should be offered to many who seek treatment, I believe an array of mental health treatments should. Furthermore, these treatments should be accompanied with a thorough explanation and consent process so individuals know what to expect, and can do their own research about a type of therapy (Olatunji et al., 2009). In this section, I wish to show that real and lively debate exists about the superiority of one therapy over another. When Shafran et al. (2009) insisted CBT should be the go-to option in most psychology clinics because it is well-studied, I must point at the multiple literature reviews and meta-analyses that claim CBT boasts no superiority to other established treatments (Hofmann et al., 2012; Lechsenring et al., 2014; Wampold et al., 2017). CBT is effective with certain people, yet as presented, it also holds an advertising advantage over slower moving therapies due to managed care (Castor & Fuentes, 2008). In our society that prioritizes productivity and quick “recovery,” two years of reflection-based humanistic or insight-based psychodynamic therapy are not as appealing as four sessions of CBT. As this paper

proceeds with an increased focus on individual voices, I encourage the reader to question how CBT's power in the psychotherapy space may muffle any dissenting voice with an alternate opinion, purposely or not.

The Empowerment of the Individual to Share Their Story

The Balance of Power

My research has suggested that the manifestations of client disempowerment and discomfort with CBT are multifaceted but, on a larger scale, are more about the system that discourages CBT from being reflective than the model itself. Holding power and influence, as CBT does, is not a crime. Yet, power has been described as a tool used by a dominant group to influence discourse and behaviour, and those in power often seek to maintain it at the expense of individuals who lack a voice in major decisions (Foucault, 1984; Vogel et al., 2020). In 2017, Cristea et al. (2017) wrote a rebuttal to the meta-analysis conducted by Johnsen and Friborg (2015) previously cited in this paper, that refuted the finding that the effectiveness of CBT is falling. A year later, the top two authors credited, both CBT practitioners, wrote the infamous CBT as "the gold standard of therapy" paper mentioned in this discussion (Albert Ellis Institute, n.d.; Cristea et al., 2016; David et al., 2018). While these authors included a conflict of interest note in the gold-standard paper, no mention was made of how these conflicts intersect with their research and no comment was made in the rebuttal (Cristea et al., 2016; David et al., 2018).

I believe that with CBT holding the status it does, the current time presents an excellent opportunity for proponents of the theory to reflect. Yet, I have observed a tendency to be defensive about preserving the model's reputation. Currently, I see the primary focus of CBT research as adding to the already robust quantitative evidence base. The most helpful route could

emphasize more qualitative research, empowering the less scientifically prominent voices who have taken a stand against CBT.

Gaslighting. I hope the power of CBT on a macro level has been made evident at this point as I turn to highlight power imbalances in isolated therapy settings through the term gaslighting. Gaslighting is a term first popularized in the 1900s through film, in reference to the dramatization of a man controlling his partner by leading them to question the reality of their own thoughts and experiences (Docto, 2022). This form of psychological abuse has increasingly appeared in media since its introduction. Its appearance through media has seemingly led to victim empowerment, with calls to domestic violence hotlines being correlated with gaslighting themes appearing in TV show debuts (Haider, 2019). Likewise, with the rise of social media, individuals seem to be empowered to share their stories more than ever (Leetaru, 2018).

Regarding past CBT experience, one Reddit user stated, “honestly I feel like I’m gaslighting myself … any unpleasant or negative thought must be a ‘distortion’… that experience I had wasn’t painful. I just perceived it as painful. In reality it was fine. I’m exaggerating” (flimsypeaches, 2021, paras 6, 7, 9). Similar experiences and labelling such experiences as gaslighting were frequent in my survey of social media and discussion threads (average_vibe, 2021; Quora, 2020; Saltz, 2020). While I do not believe that the CBT model was designed with an intention to discredit individuals and their experiences, these personal accounts show a clear potential for that to materialize, spawning from an orientation that labels the practitioner as the expert and a model that claims that given thoughts are innately irrational (J. Beck, 2021). Whether it is personal characteristics of the therapist and their delivery of information, a misunderstanding of the model, or other factors mentioned throughout this paper, something has gone astray in these instances resulting in harmful power imbalances that have left

clients leaving therapy with the impression that their thoughts, and by extension, them, are inherently wrong or invalid (average_vibe, 2021; Quora, 2020; Saltz, 2020). Emotional safety is imperative in the field of psychotherapy and serves as a base for psychological growth (Briere & Scott, 2014). This discussion highlights the ethical obligation noted earlier to ensure emotional safety for clients, and further illuminates a point echoed throughout this paper about the need for future research to clarify the specific factors or combinations of factors that result in these experiences (Canadian Psychological Association, 2017).

I believe this is an effective point in the review to highlight some negative discrepancies when utilizing the model, and compare them to my perception of strong utilization of principles. The message I have interpreted that many have heard in CBT sessions is that the client has a wrong/negative thought which is hurting them, so they should stop thinking it. In contrast, the message I have observed in what I would refer to as effective CBT is that clients have thoughts that make sense or serve to protect them when it was formed, which is entirely reasonable and rational, but that thought does not serve the client anymore (Olatunji et al., 2009; Richey & Pointer, 2022).

I believe this distinction is crucial, as the former sentence has the potential to put the blame on the client and situate them as "wrong." In contrast, the latter sentence highlights the person's rationality based on their past experience, which fundamentally situates them as "right." Due to a lack of qualitative research, it is unclear to me why this distinction occurs. Research about therapist training in the model is mixed, with one study finding more training led to better outcomes and one not discovering a correlation (Hoyer et al., 2017; McManus et al., 2010). Also, outcomes generally reflect symptoms and not client feelings about the sessions, further highlighting the need for qualitative research. Personally, I wonder if certain practitioners feel

time restraints resulting from only having a few sessions guaranteed through insurance, so they opt to focus on surface-level distortions instead of exploring core beliefs and the emotion behind the automatic thoughts.

Power Imbalance and Judgement. An additional concern that has been highlighted is the feeling of the presence of a power imbalance in CBT sessions (average_vibe, 2021; Quora, 2020; Saltz, 2021). I will note that I did not explicitly find this theme in the academic literature other than the earlier observation that individuals have not always been empowered in their therapy choices (Geraghty et al., 2019). Concerning power imbalance, I will highlight the presence of the cognitive model as a potential culprit if explained poorly. One commenter described one of their therapists as "extremely arrogant and liked to tell me he was the professional and I most definitely was not" (O'Flynn, 2022). This could be one isolated incident where therapist and client clashed. However, reading into this comment further and considering other comments about the model, I am curious if there is the potential for a sense of arrogance being relayed when a practitioner presents the model as factual and a clear "answer" to the struggles of the person. One may view the magnitude of their issues as more significant than an interconnection between thoughts, feelings, and behaviours and may desire to be heard before being explained to. This query is highlighted by a tweet saying, "the therapist wouldn't let me get a word in and I couldn't remember the barrage of information she gave" (koren_nkm, 2021).

Others have claimed that cognitive distortions are inherently judgemental (Heisler, 2019). Additionally, various voices have expressed a sense of self-blame associated when the treatment was unsuccessful (average_vibe, 2021; flimsypeaches, 2021; Geraghty & Blease, 2016; Saltz, 2021). One Reddit commenter expressed their frustrations by saying that "the

therapist just blames clients who don't get better as 'not being ready' rather then [sic] considering their own incompetency" (Judoxing, 2022).

One last note is the claim that depressed people are more accurate in their perceptions about the likelihood of future events than their non-depressed peers, directly disputing some of Aaron Beck's (1991) early claims of how depression distorts reality, and combatting the cognitive distortion of *fortune telling* (Ratnayake, 2022). Such a claim could explain certain attitudes towards the therapy if individuals believe CBT therapists are discounting the judgement of those who potentially see the world clearer than anyone. The research on this hypothesis is mixed, with Moore and Fresco (2012) finding little effects of bias in depressed individuals and positive bias for non-depressed individuals. One could continue this line of thinking and question if there is merit in a positive bias or if that itself presents a distortion; however, I believe that is a philosophical query irrelevant to this conversation. What I would highlight is the importance of hearing the perceived futility in a person's story who may have endured immense hardship, with no reason to expect better, and spending time framing cognitive distortions in ways that are not discounting to a person's lived experience.

Invalidation and Marginalized Groups. A common trend I have observed is individuals recognizing others' experiences of CBT invalidation through message forums and comment threads. In response to an original thread, one person stated, "with your tweet...it all makes sense. I felt invalidated and tricked in a bad way" (CultureCurves, 2021). A feeling of invalidation is the most recurrent theme I have found through social media sources (average_vibe, 2021; flimsypeaches, 2021; Quora, 2020; Saltz, 2020, 2021). I have especially noticed this in marginalized groups, consistent with the finding that marginalized groups are more susceptible to invalidation and may be more alert to perceived invalidation (Mitchell et al., 2021). Benitez et

al. (2019) recognized validation as a prominent intervention in psychotherapy and highlighted the importance of not insisting clients feel a specific emotion or pathologizing a client's experience. Nicola et al. (2021) further emphasized the importance of this construct by highlighting the potential adverse outcomes of invalidation, including guilt, shame, and self-doubt. Their research was done with chronic pain sufferers, a community that will be highlighted later in this session. An important note is that I will only cover the marginalized groups I have encountered in my searches. Additional qualitative research that includes BIPOC, LGBTQIA+, and other marginalized groups is necessary to discern if similar themes emerge.

Trauma Survivors. Trauma survivors may be uniquely attuned to danger due to nervous system hyperexcitability formed in response to past experiences of harm (Briere & Scott, 2014). This adds an emphasis for practitioners to meet the client where they are at and establish a strong sense of rapport and trust that aligns the practitioner with the client. A potential breach of trust that has emerged is the invalidation of client intuition and cognitive reframing with the intention of reducing the client's worries.

One harrowing account of a client describing a long-term abusive relationship presented such worries and eerily presented similarly to the concept of gaslighting. In reference to their boyfriend (he) and their therapist (she), this client explained that "instead of asking why his behavior made me uncomfortable, she ordered me to use scripts to push away the 'irrational thoughts.' I was supposed to tell myself 'He loves me very much and would never hurt me'" (Hedges, 2022). I believe this example presents more of an ethical concern in which the therapist was not adequately attuned to their client's needs. However, it seems that an ethical issue like this can be enabled through the CBT model if the practitioner is using it without mindful awareness. It is essential for practitioners to realize that even though CBT categorizes "helpful"

and “unhelpful” thoughts, it is through collaboration with the client that these distinctions are to be made (J. Beck, 2021). J. Beck noted that an unhelpful thought is not a value judgement by the therapist but an agreement based on past information that has been acquired.

Another compelling point is people’s personal experiences that make life feel unfair (Saltz, 2021). In these instances, highlighting cognitive distortions may not feel genuine, at least not for some time. However, it can reasonably be a goal to build up the idea that life can be safe, or at least safer than how it has been (Olatunji et al., 2009).

Chronic Pain and Fatigue Community. Chronic pain and chronic fatigue are separate but often related conditions that can have debilitating effects on an individual, depending on the severity (Eccles & Davies, 2021). These are invisible disabilities that are not always recognized by others but persistently felt by those afflicted. Saltz (2021) explained her experience of living with chronic pain for decades and finding no relief. She explained that, to her, at times, life has been unbearable. However, instead of a practitioner attempting to help in a journey of reaching acceptance, she talked about how she experienced sessions as times when her therapist would try to talk her out of the impact of her reality. Saltz recounted “pushing back when therapists told me my pain was exaggerated” (para. 10).

While the philosophy of CBT has been effective for many, I wonder if the emphasis on “things getting better” is appropriate for every situation. As a future therapist, it seems paralyzing to me not to attempt to instill hope in a client, and likewise, instilling hope is a tenet of modern CBT (J. Beck, 2021). Yet, I believe Saltz (2021) was telling the reader that she was yearning for someone to face the immense grief of potentially living with chronic pain for the rest of her life. A companion who holds profound space instead of an instructor who informs them of a model that “should decrease their pain.” Saltz explained that the only modality she has

found some relief with is acceptance and commitment therapy (ACT), based on its principles around coping and finding agency in times of hardship. ACT, a third wave form of CBT, has been classified as a strongly supported treatment for chronic pain, with less focus on symptom reduction, and increased focus on the acceptance of the experience around the chronic pain sufferer (Feliu-Soler et al., 2018). This has the potential to create space for experience, without putting a burden of healing on the client.

When reviewing the literature regarding CBT and chronic pain, I noticed a trend that continues to arise. Ehde et al. (2014) brought back a familiar term, citing CBT as "the gold-standard of pain therapy" (p. 161) and stating it is the clear-cut best option. Yet, one of the primary sources they cited was a large-scale review assessing CBT's efficacy that found small initial positive effects on mood, no effects on pain, and no improvement in any dimension at a 12-month follow-up (Williams et al., 2012). What is most startling about that review is that the authors concluded that because CBT's efficacy "has been proven," there is no further reason to compare CBT's effectiveness to other treatments. Ehde et al. (2014) did not dispute this and instead used it as additional fuel into the evidence-base of CBT. Meanwhile, the following is an individual's personal account:

> I have treatment-resistant chronic pain and when they made me do CBT it felt super gaslighty – like they were saying that if my pain didn't improve it's because I didn't try hard enough, not because CBT is just not going to do much to lower physical pain. (theizzEB, 2021)

There is a connection between pain and the cognitions people have about pain (Ehde et al., 2014). However, the leap that is taken to claim that CBT is established as the best available treatment highlights the main issue I have been presenting through this paper. Furthermore, it

seems that clients risk believing they are the problem when they do not see improvement after being told CBT is efficacious with their diagnosis, even though studies show minor improvement at best. I suggest practitioners be wary and honest about instilling hope in similar cases.

A similar but likely more damaging example comes from the chronic fatigue community. In England, a combination of CBT and graduated exercise therapy was approved as the primary treatment for chronic fatigue based on a belief rooted in the cognitive model that chronic fatigue is a psychological disorder maintained through negative beliefs and avoidance of exercise (Geraghty & Blease, 2016). This choice of funding and application was made even though chronic fatigue has been accepted as a neurological condition not rooted in psychology (Missailidis et al., 2019). Individuals were led to believe that their issues were based on their own thinking and behaviour instead of the function of neurological misfirings. Even though nearly half of the clients reported the belief that CBT was inappropriate for their needs, the trial went forward (Geraghty et al., 2019). Individuals involved in these trials described blaming themselves for not improving as they were led to believe it was an issue of effort and cognition (Geraghty & Blease, 2016). Wilshire et al. (2018) reported that although the improvement was negligible, the organization that conducted the research (PACE) used the results of this trial to claim the treatment was a fit, in turn, adding to CBT's evidence base.

In a follow-up, not only did participants not improve, a portion of the participants physically declined, with some experiencing malaise as a result of forcing themselves to exercise in the presence of their bodies lacking the energy to do so (Wilshire et al., 2018). While the physical harm has been attributed to graduated exposure therapy, the encouragement to not listen to oneself was rooted in the CBT philosophy of the mind creating the issue. This example illuminates multiple issues on top of the clear harm done.

First, it illustrates the power of the therapist and those choosing ESTs to define and decide for a client how to view their own illness. On a Twitter thread questioning CBT's use in treating myalgic encephalomyelitis (ME), one commenter asked, "But it's still the cure for ME, isn't it?!" (UrgleyClark, 2021). In a later comment, she mentioned that CBT and graded exercise were her only treatment options after being diagnosed. Not only are the treatments an issue, but the fact she referred to it as a "cure" also concerns me if this was what was communicated to her. There is no evidence of a cure for ME, CBT or otherwise (Geraghty & Blease, 2016). Second, it dilutes the validity of EBP, considering that this treatment pairing was viewed as an EST for chronic fatigue, and supported even after this trial. In reality, it is a complete misapplication, seemingly based on CBT's claimed effectiveness with various disorders (Wilshire et al., 2018).

Neurodivergence Community. Neurodivergence is an ever-evolving term used to describe individuals with unique cognitive profiles than what is seen as typical, in the past frequently conceptualized through the medical model idea of dysfunction, but more frequently accepted as non-pathological human diversity (Chapman, 2020). Neurodivergent individuals share many of the same concerns about being misunderstood by practitioners, which may be representative of numerous other aspects of their lives living in an ableist society (Price, 2022). This is something practitioners must be alert to, as the experience of a neurodivergent individual could be drastically different than for a neurotypical client. One self-identifying autistic individual in a comment thread explained their experience by saying, "our brains are receiving too much information to process rapidly, then the extra effort required by CBT methods is really another load" (Patricia, 2021). Practitioners must be wary that for individuals on the autism spectrum, feelings often cause thoughts instead of thoughts causing feelings (Price, 2022). While J. Beck (2021) emphasized the interrelationship between thoughts, feelings, and behaviours, a

primary focus is how thoughts create a person's experience. For an autistic person, basic survival and rest needs may lead to a state of dysregulation that will not be solved by any cognitive intervention but a basic need being tended to (Price, 2022).

Another fundamental misunderstanding that has caused damage to the autistic community is the belief that autism has to be "fixed" (Price, 2022). When considering the medical model CBT is based on, behaviour that violates social norms is often pathologized. One Quora poster explained that "the way we act is our normal. You are essentially making your child uncomfortable so that you can be comfortable. We stim to make ourselves calm. We don't make eye contact because it is uncomfortable. We are highly sensitive" (Goldman, 2020). These attempts likely stem from a motive to "help a person fit in," but they insinuate that autistic behaviours, often self-regulatory, are inherently wrong.

Weston et al. (2016) studied the reduction of "autistic-related symptoms" in people on the spectrum using a CBT treatment method. The researchers found that self-report data from the autistic participants indicated zero change. However, observer and practitioner data indicated moderate symptom reduction. The researchers suggested multiple interpretations of this data, including potential communication difficulties on behalf of the participants. Based on the Quora conversation and the reality that autistic people often mask natural functioning to fit in with neurotypical people's expectations, I would like to offer a different interpretation (Price, 2022). I wonder if the participants noticed zero reduction in symptoms, as they did not view specific behaviours as symptoms to be reduced. In contrast, observers and clinicians noted decreases in behaviours they viewed as problematic symptoms. I want to highlight the potential emotional trauma of describing autistic symptoms as non-preferred behaviours (Price, 2022). Studies like Weston et al. (2016) openly claimed support for behaviour extinction strategies such as ABA,

even with current understandings of how such therapies encourage autistic people to mask for the comfort of others (Price, 2022).

Instead of using CBT as a tool to change behaviour and encourage neurodivergent people to believe that they are not being judged by others, even though there is likely a strong chance they have had such an experience, I wonder if it is possible to reframe the conversation. A self-described autistic person on a Reddit thread described that for them, “anxiety and depression are rooted in social alienation, which is a very real and scathing thing. I can trace the origins of these feelings to the high school lunch room, where I’d have nobody to sit with” (atavisticautist, 2021). Behaviours common to autistic individuals are not the problem, however, core beliefs such as unworthiness may develop based on a lack of acceptance by peers. It is my belief that through a lens of cultural competency, this would be the prevailing view. However, I wonder if more traditional conceptions of CBT that have roots in behaviourism have not fully caught up.

As this section on power in the therapy context concludes, the theme becomes no less germane. Claims of gaslighting and power differentials in individual therapy sessions reflect singular experiences that build up, becoming representative of, and being enabled by a greater discourse that states “CBT works and is safe.” This statement is seemingly benign, with aspects of truth packaged in a tsunami of alternate unique individual experience.

Additional Issues Noted in CBT Therapy

In addition to gaslighting, the term *toxic positivity* has been used to describe CBT therapy (average_vibe, 2021; Saltz, 2021). This means keeping a positive attitude in every situation, no matter how difficult or potentially dire (Cherry, 2023). A Twitter user commented that CBT is “incredibly positive mindset oriented rather than acknowledging and validating emotions which

are completely valid, wherever they come from" (Carpydiem85, 2021). Baker et al. (2011) acknowledged that CBT has historically placed more weight on cognition than emotional processing as a mechanism of change. However, I will note that in the resulting study, they found participants improving in the measure of emotional processing while receiving CBT treatment. That said, the criticism re-emerges in dialogue from McManus et al. (2010) who criticized the cognitive therapy scale, the most-used scale of measuring CBT therapist competence, for not emphasizing emotion. As mentioned earlier, J. Beck (2021) described the cognitive triangle as thoughts, behaviours, and emotions, but it seems they may not be weighted equally in practice.

An additional issue noted is a sense that CBT therapy "treats the surface feature, thoughts, rather than the life story, emotional states and relationships of the person that give rise to those very thoughts" (Gilham, 2022). Some individuals have reported addressing automatic thoughts and cognitive distortions but lacking further exploration into the etiology of such reactions (average_vibe, 2021; Quora, 2020; Saltz, 2020). I believe that J. Beck (2021) significantly emphasized the role of core beliefs in treatment. However, I wonder if core beliefs are sometimes neglected due to abbreviated therapy (Westen et al., 2004). If so, this would be a notable failure, as J. Beck (2021) stressed the importance of such beliefs as the foundational pillars for many current actions. On the surface, CBT states that people are influenced in conscious and unconscious ways by their thoughts, feelings, and behaviours. However, on a penetrative philosophical level, CBT states that people make judgements about the world often based in early development and pivotal emotional moments in their lives, when they did not have the experience or knowledge to think any other way. The latter philosophy recognizes the depth

of individual experience, and has potential to normalize current thought and action if expressed in a setting that lacks judgement or urgency.

Positive Reflections about CBT

While there is no shortage of threads highlighting people's negative experiences with CBT, there are troves of people defending CBT on these threads and acknowledging what has worked for them (average_vibe, 2021; flimsypeaches, 2021; Saltz, 2020). One commenter said, "I suffered from my relationship with my minds [sic] Automatic negative and fearful thoughts for quite a few years … it was definitely a horrible and very controlling experience … thankfully I now recognise them for exactly what they are, just thoughts" (Green, 2022). This frequently appeared, with some users acknowledging it worked for them but may not be universal.

Additionally, the user who created the Twitter thread that many of these thoughts came from, a self-described therapist, relayed that CBT has many challenges but has great merit with specific phobias and generalized anxiety (average_vibe, 2021). While some other claims are disputed, this is one area I have found consistent support for the effectiveness of CBT (Kazantzis et al., 2018; Westen et al., 2004). Westen et al. (2004) claimed this may be due to the well-understood mechanisms of these disorders in relation to the cognitive model. Specifically, with a certain phobia, it represents the link between a particular stimulus and behavioural response that can be isolated with more confidence than other disorders. Other mechanisms of CBT do not seem to be nearly as well understood (Rapley & Loades, 2018).

In terms of precisely what works, one writer on Reddit highlighted the importance of "Good CBT practitioners with warm attitude, good interpersonal skills" (JunichiYuugen, 2021). They further explained that they felt the issues fall into therapist training and systemic issues. In

a study measuring the development of CBT skills and interpersonal effectiveness in a diploma training course, the practitioners who took part improved CBT skills more than interpersonal effectiveness. In a related but distinct thread of exploration, Webb et al. (2010) concluded that the therapeutic alliance trumps adherence to manuals and general competence in CBT skills as a predictor of change. Meanwhile, Waller and Turner (2016) claimed that technique leads to change and that therapist overreliance on the alliance is a safety mechanism for therapists anxious to use "adequate" levels of technique and adherence.

An important takeaway is that even in the presence of substantial evidence for the relationship as a primary predictor of change, there is a prevailing belief among some cognitive therapists that the therapeutic alliance is not a mechanism of change (Zlotnick et al., 2020). One may wonder if these beliefs lead to a style that emphasizes a rigid, technique-driven environment instead of prioritizing warmth and the relationship. One dimension I have noticed agreement about the importance of, is collaboration and empiricism in CBT interventions (Cook et al., 2017; Kazantzis et al., 2018; Okamoto et al., 2019). Okamoto et al. (2019) reinforced the importance of these processes in CBT as essential values that serve to reduce power differentials and reinforce client agency and self-belief.

The focus of this inquiry has been based on how the second wave has been applied. However, I must note aspects of the third wave seem to address criticisms of the second, with validation as a mechanism of change in DBT, acceptance as a primary aim in ACT, and mindful exploration in mindfulness-based interventions (Cook et al., 2017). While certain third-wave therapies have gained in popularity, by large, they are viewed as less evidence-based than second-wave CBT (Gaudiano, 2008). Furthermore, while certain aspects of the third wave have been incorporated into more traditional approaches, much of the work being done is still rooted

in philosophies and methods that are seen as descriptive of the second wave (Hayes & Hofmann, 2021).

Revisiting Research Questions

1. A primary component of CBT's influence in psychotherapy is the significant evidence base that backs it. In what ways, if any, has the evidence-base overinflated CBT's position, and with such power, how have qualitative accounts of negative experiences from individuals been validated and addressed as a part of the greater conversation?

I will not claim to what extent the evidence base has overinflated CBT's position, as I believe that would miss the point of this inquiry. However, I think the power and influence generated due to the accumulation of mixed research findings gives CBT an undue sense of superiority over other popular theoretical models. I also believe CBT has been overgeneralized and overapplied because of the evidence base, with people equating a large amount of research in specific areas as a justification to use it on others. In my opinion, the claims around CBT and EBP have left some individuals with care that does not adequately address their needs. The etiology of this issue takes many forms, but I would like to highlight the commercialization of treatment and shorter treatment times, with a greater emphasis on the model than the human in the room. I fear this may lead individuals to feel they have no other options, that a particular version of CBT is representative of all therapy, and that deep psychological healing is a commodity. At times during this research, I have wondered if the clients were getting what they need from the system, or if the system was getting what they need from the clients.

2. Marginalized voices have traditionally been underrepresented in large-scale conversations in the Western world due to a lack of opportunity. In what ways have the marginalized groups

covered in this review been amplified or silenced as they seek to co-exist in the mental health space alongside the powerhouse of CBT?

My most optimistic reflection would be that, at best, marginalized voices have not been amplified. What I believe to be a more realistic reflection would be that voices have been silenced, as ableism, close-mindedness, and dedication to a protocol and theory have taken precedence. Saltz (2021) has been a repeated voice in this paper, and what I have yet to mention is that she had an article critical of CBT prepared for the New York Times, and it was scrapped with insufficient explanation to her.

The peer-reviewed literature I have seen that includes marginalized voices has not amplified voice but made interpretations of CBT's effectiveness. It is my reflection that research has been done quantitatively to add to the evidence-base instead of being done qualitatively to see what works and what does not with diverse populations. I believe more work must be done to increase the conversation around adapting the model for those with different cultural factors and personal traits.

3. Do potential improvements to the implementation of CBT currently exist in the literature, or is it yet to be discovered?

My research on this subject has frustrated me at times. Still, it has rewarded me with the belief that good, effective, thoughtful CBT exists and can be beautiful in transforming negative, difficult thoughts into ones that empower an individual. What I believe is imperative is recognizing the validity around the context in which thoughts were created, and eventually empowering the client through empiricism to realize that those thoughts no longer serve them. Instead of labelling a client's irrationality and flexing the practitioner's supreme sense of

rationality gifted to them through training and the model, a practitioner may aim for so much more. A client-practitioner tandem can work together to identify a client's core beliefs instilled upon them by a society that often lacks the ability to accept individuals for their genuine self and work to build beliefs that highlight the client's strengths and internal worth, underscored by the evidence in their life. Additionally, therapists must be responsive to what methods are working, attuned to what is not, and humble in admitting when what they are trying may not be a good fit. I question if strong, effective, and responsive CBT can be accomplished in a four-session model for complex issues and if such growth is even the goal of four sessions, or if short-term symptom reduction will do for the people making funding decisions. I believe J. Beck (2021) has laid out a healthy and culturally competent format for future practitioners. However, I do not think that is the treatment everyone receives.

Implications for Counselling Psychology

The Influence of EBP and the Western Economic Model

At this point, practitioners must accept the power that EBP has in defining the perceived effectiveness of therapies. Practitioners likely still have a choice about preferred modality, but this has the potential to be influenced by discourse spurred through an EBP lens (Cook et al., 2017). At the forefront of this is CBT, which to some in academia, has already been "proven" to the point that the concern now is less about proving efficacy and more about spreading the therapy so it is widely available (David et al., 2018; Shafran et al., 2008; Simons et al., 2013). Simons et al. (2013) framed certain criticisms that have come up in this paper, like treatment rigidity, de-emphasis of the therapeutic alliance, and issues around comorbidity and manuals as "urban myths" (p. 182). Additionally, certain writers have framed therapist skepticism about

EBP as a threat to safe and responsible practice (Levita et al., 2016; Lilienfeld et al., 2013; Parker & Waller, 2017; Shafran et al., 2008; Waller & Turner, 2016).

While espousing this belief, Lilienfeld et al. (2013) took a novel approach to the topic, attempting to empathize and find common ground with practitioners and psychology students hesitant about EBP. Unfortunately, this was attempted by classifying those hesitant towards EBP as a problem group with beliefs stemming from "several deep-seated sources, such as naïve realism and misconceptions regarding human nature and group probabilities" (p. 895). This faux empathy does not seek to understand genuine concerns about EBP, but instead insists many psychologists are misinformed and fall victim to rudimentary psychological principles such as confirmation biases and cognitive distortions. Lilienfeld et al. called for "psychologists interested in promoting EBP to think more like psychologists" (p. 897), claiming once one understands the biases of those opposed to EBP, they will have a stronger chance to convince EBP-hesitant psychologists and students of the supremacy of EBP and scientific understanding.

While it is likely bias plays a role in belief, the above argument makes the logico-scientific claim of supremacy for the superiority of one system (Bruner, 1986). Foucault (1984) described his belief that the claim of absolute supremacy of any one belief system is a method of social control. This claim is observed in certain post-modern psychological frameworks that reject the finality of conclusions about human dysfunction or human recovery (Madigan, 2019). Therefore, the above-cited Lilienfeld et al. (2013) article may be interpreted as a dominant actor seeking to influence discourse from a Eurocentric, logico-scientific position, by labelling EBP as absolute truth, while labelling those with hesitations as bad actors from virtue of their own ignorance. The authors pleaded that "students learn about the lengthy history of errors in medicine, including psychiatry" (Lilienfeld et al., 2013, p. 896) in regards to the dangers of

cognitive biases, without taking into account the construction of mental illness in the Western world, in which certain diagnoses and ESTs of the past have shifted dramatically based on public perception, a cogent example being the inclusion of homosexuality in the DSM until 1974 (Madigan, 2019). Madigan observed that EBP is one complex system of understanding human recovery that has been formed through the scientific standards of a given time period, but influenced by dominant voices, economics and politics, claims about what makes any individual psychologically normal, and a bias towards a medical model. This greater context of the etiology and continued dominance of EBP has not been included in the literature I have reviewed discussing hesitancy of EBP (Lilienfeld et al., 2013; Parker & Waller, 2017; Shafran et al., 2008).

A primary factor in the context of EBP are financial incentives for providing "quick" and "effective" treatment associated with a symptom recovery model (Castor & Fuentes, 2008; NHS, 2014). On a micro level as a practitioner, but also a macro level considering the discipline of psychology, people are put in the position of deciding if it is reasonable, or responsible, to expect psychological change to consistently occur in precise and efficient ways (Bolen & Hall, 2007). Precise and efficient change is a worthwhile and aspirational goal, but it may minimize the complexity of the change process. Bolen and Hall questioned the ethics of a society that values quick, surface-level change, compared to long-term self-development through therapy and core shifts in functioning. They claimed while it may take longer to see "results," the long-term benefits will be an enduring improvement for clients, which will even have long-term economic benefits.

Some core values of EBP are to find "what works" and to protect individuals from unhelpful pseudoscience (Cook et al., 2017). These are both valuable aims and a collection of

studies analyzed together within a greater context can begin to tackle these issues. Yet, discussions around EBP have evolved beyond those issues and increasingly have been used to make generalized claims about entire theories of counselling and change and what that can consistently look like (David et al., 2018). I propose that practitioners neither entirely accept nor reject the field of EBP but instead consider the broader context of using a specific treatment with a particular person. This consideration includes analysing the research from a lens that honours context, assessing the desires and beliefs of the client with as much importance, and evaluating the fundamental ideas about change the practitioner holds. These recommendations are fueled by evidence that therapists are more likely to discontinue an EBP if their beliefs do not align with the practice or if they feel that the EBP is a mismatch with the client (Lau et al., 2020).

The Therapeutic Relationship or Technique

While proponents of EBP highlight the importance of matching specific clients to specific treatment plans, the reality is that both clients and therapists are unique individuals with biases and tendencies towards certain paths of change. A notable philosophical difference I have previously noted is psychodynamic therapy and CBT. Psychodynamic therapists view change as a more protracted process in which a person resolves longstanding childhood wounds (Corey, 2017). In contrast, CBT therapists generally focus on how current thoughts and behaviours are adaptive or maladaptive for a client. Further distinctions between therapies include a fundamental belief in using techniques to empower the client in CBT, opposed by the belief that the therapeutic relationship, over time, can help facilitate a profound healing process in a client, as claimed from a person-centred orientation. These fundamental differences about ideas of change will alter what treatment will look like and can also affect how psychopathology is measured. For example, narrative therapy generally refutes diagnosis and symptom measurement

as the sole indicator for change, standing in the face of what makes up much of EBP (White & Epston, 1990).

Before exploring the relationship or technique debate in greater depth, I will briefly state my biases about the topic. At the core, I believe in the sanctity of the therapeutic relationship as setting the foundation for change. Yet, I value technique, specifically in ways that empower clients to act on their behalf to lead to change. I struggle with the idea that solely relationship, or technique, would be sufficient to encourage change for everyone. In a discussion about therapist training in EBP, Frank et al. (2020) stated that their primary goal is increasing intervention use in psychotherapy, and they equated therapist skill with the frequency in which they use interventions. They also emphasized adherence to pre-planned structure and interventions. Clearly, this mindset diametrically opposes orientations like narrative and person-centred therapies, which are client-led and resistant to structure (Madigan, 2019). This focus on intervention also carries additional connotations considering the subjective experiences covered in this paper about feeling secondary to interventions in CBT sessions (Heisler, 2019).

A fascinating exploration of this topic is contained in the Hara et al. (2017) study that measured how increasing empathy in CBT sessions may or may not increase homework compliance with clients. This study explored relationship and technique, but more importantly, if and how the two constructs are linked. CBT critics may take issue that the study's focus emphasized the therapeutic relationship only as a mechanism to enhance the impact of an intervention, yet others may view the rationale as congruent with the model as CBT does value intervention and technique as a primary process of change (Waller & Turner, 2016). The study in question found that therapists with higher levels of empathy were associated with better treatment outcomes and increased homework compliance, highlighting the importance of

therapist empathy (Hara et al., 2017). Meanwhile, in a similar study that measured if Socratic questioning improved therapeutic activity engagement, Heiniger et al. (2018) found that it did not, but did lead to higher observer ratings of the therapeutic alliance. Socratic questioning is a method crucial to CBT that seeks to enhance collaboration by exploring a client's problems in depth by asking a multitude of questions about them, without the therapist ever stating their beliefs about what is right. In opposition to the previous study, although Socratic questioning did not increase engagement in an intervention like homework, one can argue it still has inherent value based on the gains of the therapeutic alliance.

Certain CBT advocates may claim that the Heiniger et al. (2018) findings prove that Socratic questioning is a non-essential process in CBT because it does not facilitate further engagement in interventions, which can be seen as a primary process for change (Waller & Turner, 2016). However, Haug et al. (2016) claimed that treatment-specific factors like intervention do not have a strong consensus for change, in the same way process-specific factors like the therapeutic alliance do. These findings that pointed to the importance of empathy, collaboration, and the therapeutic alliance in CBT bring me to the idea of an increasingly person-centred CBT, a concept called for in the dated article from Josefowitz and Myran (2005) but one that may not represent the current state of CBT as it is practiced (Zlotnick et al., 2020). The idea of person-centred CBT promotes the significance of Rogers' (1961) core conditions of unconditional positive regard, congruence, and empathy within the CBT framework.

I will highlight two rebuttals to promoting person-centred CBT as some form of a new standard. The first is a recurrent theme in areas of the literature that the therapeutic alliance and relationship is a less important process as compared to technique, and may even inhibit growth when emphasized in favour of technique (Waller & Turner, 2016). This is an example of a

different philosophical view of change to myself and much of the existing literature (Hara et al., 2017; Johnsen & Friborg, 2015; Webb et al., 2010). The second is that CBT practitioners already do this, and the belief they do not is an urban myth (Simons et al., 2013). To proponents of this beliefs credit, in the most recently published version of the cognitive therapy handbook, Judith Beck (2021) outlines the importance of including the three core conditions within the CBT framework. However, it was my impression that although it was mentioned, there was no extensive exposition about how to do this through a CBT lens. Furthermore, I will make the claim that the evidence in this paper likely outlines some form of absence in practice. This is backed up by the Westra et al. (2016) study that showed when combined with a motivational interviewing (MI) framework, CBT therapists were rated as significantly more empathetic than those practicing just CBT. Moreover, these high empathy scores were observed alongside no significant cost to the use of CBT interventions. These findings are impactful in a quantitative sense that the difference was that notable. It also raises questions about how clients would qualitatively observe the difference in each of these sessions.

Third-Wave CBT

CBT seems to be in a transition period in which certain therapies and ideas towards treatment are being "modernized," whereas others are rooting themselves in the traditions of classical CBT more than ever (Hayes & Hofmann, 2021; Waller & Turner, 2016). Third-wave CBT therapies such as DBT, ACT, and MBCT have embodied a shift that prioritizes the context and function of thoughts over their content (Hayes & Hofmann, 2021). To elucidate further, traditional, second-wave CBT views maladaptive thought as the key to the formation of psychopathology and more adaptive thinking as the answer. This prioritizes the content of the thoughts as a primary factor that must be changed from maladaptive to adaptive. Meanwhile,

third-wave CBT therapies are less concerned about changing specific thoughts and more about changing a person's relationship to the thought. Instead of changing it to something more "adaptive," a person may learn to accept the existence of the thought but reduce their reactivity to it.

This shift has the potential to reduce certain criticisms that have been brought up in this paper. For example, the concept of *therapeutic space* and room for emotionality would ideally be present in third-wave CBT with the prioritization of a person's holistic experience (Hayes & Hofmann, 2021). In a modality like DBT, validation of experience and sitting with painful emotions are viewed as essential aspects of therapy, meaning the focus lies more in understanding and acceptance as opposed to challenging. Furthermore, this philosophical shift might represent a reality in which people do not feel judged for their "illogical" thinking, as there is less pressure to define and categorize thought in third-wave CBT therapies. There is also less pressure on defining symptoms in terms of the medical model, as clients may be viewed in increasingly idiosyncratic ways, with the value placed on the complex personal relationships to experiences, instead of diagnostic labels.

I do not claim that third-wave CBT has "figured everything out." However, clinicians must understand the fundamental differences in philosophy between second and third-wave CBT therapies and where the belief about what causes change lies, whether in the thought itself or the person's relationship to the thought. I also believe this conversation highlights the importance of conceptualizing treatment based on the human who enters the room instead of the diagnostic label placed on them. To call back to the Westra et al. (2016) study about combining CBT and MI: for individuals ambivalent about change, it appears that traditional CBT led to even more resistance as individuals did not feel heard about why they were hesitant to change in the first

place. Instead of the practitioner trying a different traditional CBT intervention, one of these clients may benefit from a more person-centred approach where their thoughts are reflected back to them without judgment. Or, a third-wave technique could be drawn from a therapy like DBT, in which the client can carefully explore both sides of the dialectic (Hayes & Hofmann, 2021).

Recommendations for Practice

Clarifying Personal Beliefs

A consistent theme emerging in this inquiry is a call for practitioners to explore their personal beliefs about humans and change before carelessly adopting a CBT approach because that is what the "evidence points to." As demonstrated, even within the umbrella of CBT, distinct philosophical differences completely alter a practitioner's approach toward a problem (Hayes & Hofmann, 2021). The therapeutic experience is a delicate and flexible endeavour, which calls for malleability at points through therapist responsiveness (Rapley & Loades, 2018). There are hundreds of therapies to be chosen from, and I believe that the one a person chooses is not a "right" or "wrong" decision but more so an indication of the therapist's beliefs towards change. However, different beliefs about change and ways of showing up in the therapy room will be effective on a sliding scale, depending on the client (Hayes & Hofmann, 2021). EBP seeks to distill and simplify this decision but cannot operate as absolute authority on a case-to-case basis.

Reframing Expectations

When I consider the assumptions EBP has made about CBT as quick and effective for most disorders, I am left with the following reflection (David et al., 2018). These expectations may lead practitioners to put lofty expectations on themselves and their clients to see rapid "improvement." In reality, improvement itself is an abstract concept based on a personal

definition and may not be realistic for every client in a short time span (Bolen & Hall, 2007). I encourage CBT therapists to become more comfortable with not "seeing change" immediately and accepting that even highly tested techniques have limitations. I wonder if the association of toxic positivity and CBT has anything to do with overinflated beliefs about what rapid change can or should look like for people. For some, like Saltz (2021), who has dealt with intense chronic pain for her entire life, change may look vastly different and, as she noted, may never look like solving a problem in a medical model sense. Ingrained in the CBT model is a strong belief that people have the key to their own change (J. Beck, 2021). The concept of hope is essential, and J. Beck noted the importance of instilling it early on with clients. However, we also must accept the limitations placed on us through living in an unjust world. A therapist unwilling to accept reality rejects an individual's experience.

Cultural Competence

For some clients, the unjustness of the world may be heightened based on physical or cultural characteristics that affect their experiences through pain or prejudice (Richey & Pointer, 2022). For certain individuals, what may be seen as a cognitive distortion through a Western lens, could be a cultural reality or based on potent real-life experience, highlighting the importance of collaboration more than ever (Okamoto et al., 2019). Collaboration is more than simply inviting the client to speak, but recognizing that even in a model like CBT that promotes the practitioner as the expert, their expertise lies in the model, not the client's worldview. Okamoto et al. (2019) noted that collaboration seeks to shift the control to the client as much as possible, which is essential in a world where each person has a distinct cultural reality and an intersection of identities. A White practitioner could classify a person of colour's fear of homogenous crowds as the cognitive distortion of *overgeneralizatio*n. While the person of colour

may be remembering a specific event in which they were ostracized for looking differently in such a setting, a White practitioner may have never been in a situation in which they were clearly distinct from the dominate group, and may categorize the likelihood of something bad happening in such a situation as unlikely. Likewise, to a man, the fear of walking home at night could be classified as a safe event, yet a woman may have an entirely different perspective. However, these classifications may be ignorant or even dangerous when considering the realities of the society in which we live.

Individuals have claimed that CBT can be culturally sensitive as it aims to bring agency to those who have felt a lack of agency due to structural inequities (Kelly, 2019). However, Kelly noted that unless the practitioner takes the time to adequately understand and validate these concerns, there will be a disconnect between the client's thoughts and the practitioner's attributions about those thoughts. Like other aspects in this inquiry, although CBT has room to be culturally sensitive, it comes down to the practitioner to ensure this is embodied, which comes from a thorough understanding of the model and its limitations.

I would also like to highlight the impact of socioeconomic status when it comes to availability of diverse therapy options and access to treatment in general. A contradiction highlighted in this inquiry is the emphasis on choice and fit when it comes to client's deciding on an EST treatment, and the reality that this is not always the case (Cook et al., 2017). The NHS (2014) in England has claimed that with additional funding, treatment will be quicker and more effective than in the past. This is necessary, as the previous system required a referral from a general practitioner and a mean wait time of several months before receiving treatment, which is usually CBT (Jokela et al., 2013). Jokela et al. (2013) found that those with higher financial security are more prone to access private psychological services where the choice is in the hands

of the client, and these individuals on average have better treatment outcomes. It is an unfortunate reality in the Western economic system of managed care that the individuals who often need therapy the most must wait for extended periods of time, and then accept the treatment modality offered at the public institution they eventually get in to, with little choice about if this form of therapy resonates with their presenting problem (Bolen & Hall, 2007; Jokela et al., 2013).

Working with CBT-Hesitant Clients

After highlighting the voices in this paper and certain academic distrust of the model, I believe it is entirely expected and valid that individuals seeking therapy may have negative preconceived notions about CBT. When Lilienfeld et al. (2013) considered what EBP to use with a client, they highlighted the research base as the single most important factor, taking priority over client preference and clinical expertise. While I understand the justification of the therapist being the "expert" and client being influenced by potentially less reliable sources, I believe client concerns must be validated as a pre-cursor to treatment. The two CBT principles of collaboration and psychoeducation are vital to this process (J. Beck, 2021).

If clients are hesitant about CBT, they likely know someone with a bad experience or have seen similar accounts to the ones highlighted in this paper. Collaboration serves as a starting point to understand where these beliefs came from and recognize the impact that hearing about those experiences may have had on the potential client, especially if the client shares characteristics with individuals harmed. A practitioner can use this opportunity to encourage their voice, validate the courage in highlighting concerns to an "expert," and actively reduce the power dynamic. Next, psychoeducation can explain a practitioner's beliefs about the potential merit of CBT, and how CBT can look different based on various factors (Hayes & Hofmann,

2021). While hope is essential in CBT, and J. Beck (2021) relayed the example of explaining to a person that CBT has shown to be effective with depression, it is also important to note that psychological treatment is not a prescriptive or exact science (Benjamin, 2015). Richey and Pointer (2022) provided a strong example of collaboration and psychoeducation by explaining to clients why a four-session CBT model could be beneficial. They described the pros and cons of such treatment and the reality that a longer form of treatment could be preferable, but their intention of working through pressing automatic thoughts that are actively distressing these individuals. No unrealistic claims were made, and the practitioners expressed that engagement in homework in a shorter method like this would be essential. Clients were not shamed if they could not meet this standard but instead referred out.

In summary, CBT is not a "straightforward" approach, and to say it is would be to say that mental health treatment is simple, which is not the case. It is my observation that EBP may exaggerate CBT's effectiveness to the point of perceived ease, which is a disservice to everyone. I encourage practitioners to clarify their personal values of change, reflect on how therapeutic alliance formation is actively facilitated, be curious about cultural intersections with CBT, and be open to client beliefs about any mental health treatment, including CBT.

Next Steps for Research

Is CBT Actually Proven?

I will begin this section by urging psychology to move past the idea that CBT is so proven that further research is simply a formality (Simons et al., 2013). The closest finding to a consensus in the literature is CBT's effectiveness in treating panic disorder and phobias

(Hofmann et al., 2012). Notably, the processes of change are very well understood with these disorders. Beyond that, the research is mixed (Wampold et al., 2017). While more attention has been recently placed on understanding which processes of CBT work and why, this area still requires much more exploration (Haug et al., 2016; Heiniger et al., 2018; Kazantzis et al., 2018). On a broader scale, in the debate between absolute truth and empiricism and unlimited interpretations and postmodernism, if a balance is to be struck in which the field accepts something close to a truth, it is careless for this truth to be based on mixed results and marginally above statistically significant findings.

Qualitative Research

I would also like to address the lack of qualitative research. Qualitative research often highlights areas in which further quantitative research is required (Creswell & Poth, 2017). With CBT being the foregone conclusion that it is in the eyes of many, it appears that researchers have noted less of a need for these forms of inquiry. However, mirroring some of the qualities of third-wave CBT therapies, qualitative research additionally serves to attempt to understand the experiences of individuals (Creswell & Poth, 2017; Hayes & Hofmann, 2021). While qualitative research may not be as "generalizable" to large groups of people, some of the issues highlighted in this paper have stemmed from the perceived generalizability of CBT research used in harmful and short-sighted ways (Geraghty & Blease, 2016). In resistance to the influence of EBP, individual accounts of what feels helpful and unhelpful in CBT sessions may be more impactful than another study that claims symptom reduction for a group of people.

Marginalized Voices

Additionally, marginalized voices must be included in CBT research in ways that highlight their experiences without using them as a pawn to increase the robustness of the evidence base. The Quora (2020) thread that highlighted stories from multiple autistic individuals provided me with more information about understanding how a CBT model may help or hinder an autistic person than a study which claimed to be effective in reducing affective and "autistic" symptoms in the population (Weston et al., 2016). While these two sources are vastly different in intention and vigour, it highlights the need for qualitative or mixed-methods research that explores treatment use with this population. For example, what do the individuals believe are "autistic symptoms," and are these even things that anyone has business defining as symptoms that need to be changed?

Practitioner Values

Much research has been done on why therapists struggle to stick to a pre-planned CBT intervention, often through manualized treatment plans but not always (Levita et al., 2016; Parker & Waller, 2017; Shafran et al., 2008; Waller & Turner, 2016). Therapist drift is described as undesirable, and practitioners' values are seen as roadblocks that a practitioner must overcome (Levita et al., 2016). Bias and countertransference are inevitable truths that will come up for every therapist and serve as learning opportunities (Corey, 2017). However, values towards change will inevitably guide a therapist, starting with their choice of therapeutic model (Lau et al., 2020). I encourage additional research about potential internal discrepancies therapists feel when using a model that feels incongruent with their beliefs. Does this impact their ability to be genuine in session and embody the person-centred core condition of congruence (Rogers, 1961)?

If so, how have potential incongruencies been forced in a climate that may pigeonhole practitioners into “empirically-proven” therapeutic modalities?

Self-Statement

As I noted at the beginning of this inquiry, I have biases for and against CBT. As I re-consider the same point now, I am left feeling this sentiment of co-existing admiration and hesitancy with even greater reason. At its core, I see the cognitive model’s incredible power to assist people in redefining their thoughts in ways that encourage agency and empowerment. The cognitive model does reflect a great belief in the strength of a person, which I am now realizing is both a blessing and a curse. Significant progress can be made for those in changeable situations with adequate support and a therapist who collaboratively and empathically observes automatic thoughts and core beliefs in the context that spawned them. Furthermore, CBT tools can empower people to personally maintain change beyond what the therapist can help with (J. Beck, 2021). However, for those in less malleable and more complex situations, who experience a therapist who rigidly adheres to a treatment protocol and frames unhelpful thoughts as deficiencies in an individual, I see the glaring harm that could be done. Time and money pressures, cultural considerations, and additional therapist variables influence both hypotheticals.

I am left to consider the complexity and uniqueness of every person, the cumulation of their experiences, and the importance of each of their voices in this conversation. I am thankful that spaces have been created to discuss unjust experiences; however, these spaces must be expanded to the dominant scientific discourse on the subject. I am also struck by the potential devaluation of humans by their symptom profiles. I do not wish to entirely disparage the DSM-5 as a categorical tool for grouping general clusters of behaviour and affect in ways that seek to simplify the diversity in mental health (American Psychiatric Association, 2023). However, I

closely align with the viewpoint espoused by Hayes and Hofmann (2021) that situates the context as the most essential and humanizing factor in why individuals develop into who they are. With great force, I reject the commercialization of therapy and the idea that individuals are left disregarded in favour of the concept of an entirely efficient mental healthcare system.

Lastly, I want to acknowledge the CBT practitioners embodying many of the positive traits I have highlighted through this paper for your beautiful work. Furthermore, I want to validate the struggles of the practitioners who have not, based on pressures from a workplace, pre-chosen insurance "recovery" plans, or a lack of knowledge stemming from the belief instilled that CBT is effective in all its forms. I doubt there is a perfect way to do anything. Still, we can aspire towards excellence with the consistent accumulation of knowledge and the acceptance of the flaws we have engaged in, in the past. To individuals with negative attributions based on unfortunate or harmful experiences, your voice and your experiences matter, and your bravery in sharing your story is remarkable. Change is slow, but it is accelerated by every person who comes forward.

Conclusion

It is impossible to view CBT, or any other form of therapy, without considering the context in which it came to prominence. CBT has had inherent advantages in the Western system of psychotherapy based on its adherence to the medical model, testability through symptomology, and perceived efficiency (Dworkin, 2012). It rose to prominence as the figurehead of EBP in a society that values standardization and generalizability. At a certain point, questioning its omnipotent utility became the minority opinion in psychological research (Simons et al., 2013). Unfortunately, with this level of power and influence came complacency that has had far-reaching consequences. As individuals have become more encouraged and able

to share their experiences, a different side of CBT has revealed itself to those actively looking. This side has been defined as gaslighting, by toxic positivity, invalidation, judgement, power imbalances, overapplication, cultural insensitivity, and as the only choice for many people (average_vibe, 2021; flimsypeaches, 2021; Quora, 2020; Saltz, 2020, 2021). While not descriptive of CBT as a whole, these concerns are salient and indicative of significant issues in the use of the model.

Fortunately, the answer to this problem exists partly in the current psychological landscape and partly in future research that would accept the fallibility of the model. Unfortunately, the conversation around the answers constitutes far from a consensus. Some have encouraged the embracement of a person-centred CBT that increasingly promotes the therapeutic relationship as a factor for change, while some rejected the need for such a shift and point to technique (Parker & Waller, 201; Westra et al., 2016). Some have highlighted the importance of adherence to manuals and structure, while others embraced the ambiguity of change and the need for therapists to be flexible and responsive (Levita et al., 2016; Rapley & Loades, 2018). Some viewed short-term symptomatic improvements as a worthy goal in the overall functioning of society. In contrast, others viewed meaningful personal change and enduring shifts in how people view themselves as an ethical and moral obligation (Bolen & Hall, 2007). I have my own beliefs with each debate, but I also recognize that every side has its own ideas about what works. I will let the reader absorb the qualitative accounts highlighted through this inquiry and decide what form of CBT treatment would honour those individuals and their experiences. In the future, I hope for additional qualitative and mixed-methods research that recognizes these voices, potentially shifting how CBT is viewed on a macro scale in psychological literature.

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Appendix

Synthesis Matrix of Direct Quotations From Non-Academic Sources

Theme or Themes	Citation	Direct Quote	Used in Paper?
Gaslighting	flimsypeaches [u/flimsypeaches] (2021, March 22). *CBT feels like gaslighting myself.* [Online forum post]. Reddit. https://www.reddit.com/r/TalkTherapy/comments/mb1rto/cbt_feels_like_gaslighting_myself/	"honestly I feel like I'm gaslighting myself … any unpleasant or negative thought must be a 'distortion'… that experience I had wasn't painful. I just perceived it as painful. in reality it was fine. I'm exaggerating"	Yes.
Gaslighting	worldofhawk [@worldofhawk]. (2020, July 31). *I've done CBT three times now. The second one was gaslighting from beginning to end, but the first was well balanced*. [Tweet]. Twitter. https://twitter.com/worldofhawk/status/1289345705077690369	"I've done CBT three times now. The second one was gaslighting from beginning to end, but the first was well balanced"	No.
Gaslighting	SpiralFractal [@SpiralFractal]. (2020, July 31). *I have a brain tumor. For years, Docs told me I was suffering "anxiety." By the time they finally found tumor*. [Tweet]. Twitter. https://twitter.com/SpiralFractal/status/1289356128392843266	"I have a brain tumor. For years, Docs told me I was suffering 'anxiety.' By the time they finally found tumor (which was clearly visible if anyone had ordered a complete MRI), I was in terminal stages"	No.

Gaslighting, self-blame	Woodward1503 [@Woodward1503]. (2021, April 5). *Felt to me like I was supposed to blame my own brain and perceptions for my trauma, not my attacker*. [Tweet]. Twitter. https://twitter.com/Woodward1503/status/1379122837043220481	"felt to me like I was supposed to blame my own brain and perceptions for my trauma, not my attacker"	No.
Gaslighting, trauma insensitivity	Reed, G. [@mrgrahamreed]. (2021, April 6). *CBT doesn't work for people who have been in abusive, gaslighting relationships. This is because CBT attempts to change your methodology*. [Tweet]. Twitter. https://twitter.com/mrgrahamreed/status/1379401370646765573	"CBT doesn't work for people who have been in abusive, gaslighting relationships. This is because CBT attempts to change your methodology of thinking."	No.
Gaslighting, trauma insensitivity, invalidation	Hedges, K. (2022). *Instead of asking why his behavior made me uncomfortable, she ordered me to use scripts to push away the "irrational thoughts."* [Comment on the online forum post *Why do those in the autism community dislike CBT (cognitive behavioral therapy)?]*. Quora. https://www.quora.com/Why-do-those-in-the-autism-community-dislike-CBT-cognitive-behavioral-therapy	"instead of asking why his behavior made me uncomfortable, she ordered me to use scripts to push away the 'irrational thoughts.' I was supposed to tell myself 'He loves me very much and would never hurt me'"	Yes.

Gaslighting, overapplication, self-blame	theizzEB [@theizzEB]. (2021, April 6). *I have treatment-resistant chronic pain and when they made me do CBT it felt super gaslighty - like they were*. [Tweet]. Twitter. https://twitter.com/theizzEB/status/1379424576313131013	"I have treatment-resistant chronic pain and when they made me do CBT it felt super gaslighty - like they were saying that if my pain didn't improve it's because I didn't try hard enough, not because CBT is just not going to do much to lower physical pain"	Yes.
Overapplication	UrgleyClark [@UrgleyClark]. (2021, April 6). *But it's still the cure for ME, isn't it?!* [Tweet]. Twitter. https://twitter.com/UrgleyClark/status/1379365402069843970	"But it's still the cure for ME, isn't it?!"	Yes.
Overapplication	Sergonova, O. [@olgasergonova]. (2021, April 6). *I think the problem is how overused it is. It is proven helpful for a certain group of symptoms but somehow.* [Tweet]. Twitter. https://twitter.com/olgasergonova/status/1379366557147672581	"I think the problem is how overused it is. It is proven helpful for a certain group of symptoms but somehow people took that to mean you should put everyone in it - even those whose symptoms will severely worsen with it."	No.
Trauma insensitivity, invalidation, judgement	Kueblerwolf [@kueblerwolf]. (2020, August 1). *Finally left a CBT therapist when I described an abusive incident & they told me flat out, that isn't abuse.* [Tweet]. Twitter. https://twitter.com/kueblerwolf/status/1289539558392991746	"Finally left a CBT therapist when I described an abusive incident & they told me flat out, that isn't abuse, you are thinking about this incorrectly- it was the 1st time I really understood that this person was just judging me & telling me I was wrong about my entire life"	No.

Invalidation	CultureCurves [@CultureCurves]. (2021, April 6). *With your tweet...it all makes sense. I felt invalidated and tricked in a bad way* [Tweet]. Twitter. https://twitter.com/CultureCurves/status/1379361672142409736	"with your tweet...it all makes sense. I felt invalidated and tricked in a bad way"	Yes.
Invalidation	SparklingGirafffe. (2021, March 22). *It felt like anything I was nervous about was labeled 'irrational' and needing to be adjusted which is just so dismissive* [Comment on the online forum post *CBT is gaslighting*]. Reddit. https://www.reddit.com/r/therapyabuse/comments/tga1cq/cbt_is_gaslighting/	"It felt like anything I was nervous about was labeled 'irrational' and needing to be adjusted which is just so dismissive"	No.
Invalidation, toxic positivity, lack of emotions	Carpydiem85 [@Carpydiem85]. (2021, April 5). *Incredibly positive mindset oriented rather than acknowledging and validating emotions which are completely valid, wherever they come from* [Tweet]. Twitter. https://twitter.com/Carpydiem85/status/1379271470170451969	"incredibly positive mindset oriented rather than acknowledging and validating emotions which are completely valid, wherever they come from"	Yes.
Toxic positivity, neurodivergence	KaipokuWolf [@KaipokuWolf]. (2021, April 6). *I felt the toxic positivity pretty heavily towards the end post-discovery of my neurodivergent self.* [Tweet]. Twitter. https://twitter.com/KaipokuWolf/status/1379406516453711872	"I felt the toxic positivity pretty heavily towards the end post-discovery of my neurodivergent self."	No.

Invalidation, toxic positivity	Saltz, A. (2021, November 11). How CBT harmed me: The interview that The New York Times erased. *Disability Visibility Project.* https://disabilityvisibilityproject.com/2021/11/11/how-cbt-harmed-me-the-interview-that-the-new-york-times-erased/	"pushing back when therapists told me my pain was exaggerated"	Yes.
Invalidation, power imbalance, unfairness of life	Saltz, A. (2021, November 11). How CBT harmed me: The interview that The New York Times erased. *Disability Visibility Project.* https://disabilityvisibilityproject.com/2021/11/11/how-cbt-harmed-me-the-interview-that-the-new-york-times-erased/	"I always knew there was something medical going on. I told them that I was suffering. It didn't matter. They still thought they could convince me my pain wasn't real, or that I was choosing to suffer from it even if it was real"	No.
Power imbalance	O'Flynn, N. (2022, January). *Who was extremely arrogant and liked to tell me he was the professional and I most definitely was not* [Comment on the online forum post *Why do those in the autism community dislike CBT (cognitive behavioral therapy)?*]. Quora. https://www.quora.com/Why-do-those-in-the-autism-community-dislike-CBT-cognitive-behavioral-therapy	"extremely arrogant and liked to tell me he was the professional and I most definitely was not"	Yes.
Power imbalance	Koren_nkm [@koren_nkm]. (2021, April, 6). *The therapist wouldn't let me get a word in and I couldn't remember the barrage of information she gave* [Tweet]. Twitter. https://twitter.com/koren_nkm/status/1379391686451867648	"the therapist wouldn't let me get a word in and I couldn't remember the barrage of information she gave"	Yes.

Self-blame	ItsMeLydiaa [@ItsMeLydiaa]. (2021, April 6). *Omg. I needed to hear this. I had 16 lots of CBT in 2020 and felt the same if not worse* [Tweet]. Twitter. https://twitter.com/ItsMeLydiaa/status/1379397813713444873	"I thought it was my fault for rejecting the idea that worrying about my finances was an 'irrational thought' or that I could solve my problems by going on a walk"	Yes.
Self-blame	Judoxing. (2022, March 17). *Especially if the therapist just blames clients who don't get better as "not being ready" rather then considering their own incompetency* [Comment on the online forum post *CBT is gaslighting*]. Reddit. https://www.reddit.com/r/therapyabuse/comments/tga1cq/cbt_is_gaslighting/	"the therapist just blames clients who don't get better as 'not being ready' rather then considering their own incompetency"	Yes.
Self-blame	Toksvig [@toksvig]. (2021, April 6). *Which just reinforces the message that I got from CBT: that I am a failure for not making it work.* [Tweet]. Twitter. https://twitter.com/toksvig/status/1379343386033987585	"which just reinforces the message that I got from CBT: that I am a failure for not making it work."	No.
Judgement	Heisler, Q. (2019, January 17). *Cognitive behavioural therapy needs to adapt or die*. The Medium. https://medium.com/healthy-mind-healthy-life/cognitive-behavioral-therapy-needs-to-adapt-or-die-af504c5fe30	"When those reductive, remedial, and rusty tools failed to remedy the problem, I was made to feel, perhaps unintentionally, that I had not tried hard enough and that I was to blame"	No.

Focus on surface issues, neurodivergence	ADHDeeds [@ADHDeeds]. (2021, April 6). *My other issue with all of my CBT therapists, even if they were good, was they didn't address the details of the.* [Tweet]. Twitter. https://twitter.com/ADHDeeds/status/1379369571816202241	"My other issue with all of my CBT therapists, even if they were good, was they didn't address the details of the "how." So my ADHD barriers to journaling and meditating left me essentially in self-help land"	No.
Focus on surface issues	kioni24 [@kioni24]. (2021, April 6). *One thing I noticed between different CBT therapists is the ones relying on just CBT never actually think about why.* [Tweet]. Twitter. https://twitter.com/kioni24/status/1379368156028928003	"One thing I noticed between different CBT therapists is the ones relying on just CBT never actually think about why/the specifics/ or just any deeper than the surface for issues and treat life like it's school w/ a single correct answer"	No.
Focus on surface issues	Adam Gilham. (2022). *Treats the surface feature, thoughts, rather than the life story, emotional states and relationships of the person that give rise* [Comment on the online forum post *Why do those in the autism community dislike CBT (cognitive behavioral therapy)?*]. Quora. https://www.quora.com/Why-do-those-in-the-autism-community-dislike-CBT-cognitive-behavioral-therapy	"treats the surface feature, thoughts, rather than the life story, emotional states and relationships of the person that give rise to those very thoughts"	Yes.

Symptoms focus	Weinblatt, S. (2020). *Their entire framework lies around symptoms, and absolutely nothing more. Worse still, any symptoms addressed are worked on merely by telling the patient* [Comment on the online forum post *Why do those in the autism community dislike CBT (cognitive behavioral therapy)?*]. Quora. https://www.quora.com/Why-do-those-in-the-autism-community-dislike-CBT-cognitive-behavioral-therapy	"their entire framework (CBT) lies around symptoms, and absolutely nothing more"	Yes.
CBT only option	Liz Chambers. (2022, February). *If you contact a GP for help and support with mental health you have to go on a waiting list* [Comment on the article *CBT is wrong in how it understands mental illness*]. The Conversation. https://theconversation.com/cbt-is-wrong-in-how-it-understands-mental-illness-175943	"if you contact a GP for help and support with mental health you have to go on a waiting list and CBT is the only therapy on offer"	Yes.
CBT only option	SparklingGirafffe. (2021, March 22). *I thought CBT was the only option so I was really losing hope but it turns out there's many therapists* [Comment on the online forum post *CBT is gaslighting*]. Reddit. https://www.reddit.com/r/therapyabuse/comments/tga1cq/cbt_is_gaslighting/	"I thought CBT was the only option so I was really losing hope but it turns out there's many therapists out there that use modalities other than CBT"	No.

CBT only option, commercialization	probable_witch [@probable_witch]. (2021, April 6). *Most of the therapists I know who practice "good" CBT (including my current therapy supervisor) don't actually practice pure CBT.* [Tweet]. Twitter. https://twitter.com/probable_witch/status/1379390525137117186	"Most of the therapists I know who practice "good" CBT (including my current therapy supervisor) don't actually practice pure CBT. But that's all the insurance companies want to pay for"	No.
Quick-fix, commercialization	Marguerite, K [@katemarguerite1]. (2020, August 1). *CBT is thought of as a "quick fix" - meet for ten sessions, call it a day. This works well for insurance.* [Tweet]. Twitter. https://twitter.com/katemarguerite1/status/1289442192457596929	"quick fix - meet for ten sessions, call it a day. This works well for insurance companies, not for living, breathing, hurting humans, who need time, love, validation and trust to heal"	Yes.
Adjustment of model for cultural considerations, neurodivergence	atavisticautist. (2021, May 15). *Anxiety and depression are rooted in social alienation, which is a very real and scathing thing. I can trace the origins of these feelings* [Comment on the online forum post *Beware of CBT 'therapy'*]. Reddit. https://www.reddit.com/r/autism/comments/nd57nl/beware_of_cbt_therapy/	"anxiety and depression are rooted in social alienation, which is a very real and scathing thing. I can trace the origins of these feelings to the high school lunch room, where I'd have nobody to sit with"	Yes.

Adjustment of model for cultural considerations, neurodivergence	Patricia. (2021, November 19). Our brains are receiving too much information to process rapidly, then the extra effort required by CBT methods is really [Comment on the article *Cognitive behavioral therapy may be only mildly effective for anxious, autistic children*]. Spectrum. https://www.spectrumnews.org/news/cognitive-behavioral-therapy-may-be-only-mildly-effective-for-anxious-autistic-children/#comment-5614436184	"our brains are receiving too much information to process rapidly, then the extra effort required by CBT methods is really another load"	Yes.
Adjustment of model for cultural considerations, invalidation	Goldman, R. (2020). *The way we act is our normal. You are essentially making your child uncomfortable so that you can be comfortable* [Comment on the online forum post *Why do those in the autism community dislike CBT (cognitive behavioral therapy)?*]. Quora. https://www.quora.com/Why-do-those-in-the-autism-community-dislike-CBT-cognitive-behavioral-therapy	"the way we act is our normal. You are essentially making your child uncomfortable so that you can be comfortable. We stim to make ourselves calm. We don't make eye contact because it is uncomfortable. We are highly sensitive"	Yes.
Positives of CBT	Gibbonsgibbons2 [@Gibbonsgibbons2]. (2021, April 6). *CBT really helped me! Aware that I'm an anecdote and not a statistic here, but people's mental health issues/ do vary.* [Tweet]. Twitter. https://twitter.com/Gibbonsgibbons2/status/1379324892093485056	"CBT really helped me! Aware that I'm an anecdote and not a statistic here, but people's mental health issues/ do vary...perhaps it just needs to be used in the right way/context"	No.

Positives of CBT	Emilycantsing [@emilycantsing]. (2020, August 1). *I understand what you are saying. I was lucky to have good therapists and went through CBT as a constructive and healthy process.* [Tweet]. Twitter. https://twitter.com/alanasaltz/status/1289187388913139714	"I understand what you are saying. I was lucky to have good therapists and went through CBT as a constructive and healthy process. I also suffer from chronic pain and my therapist and family were always the one people who understand. But I see now how it can be used negatively"	No.
Positives of CBT, what works with CBT	Green, J. (2022). *I suffered from my relationship with my minds Automatic negative and fearful thoughts for quite a few years* [Comment on the article *CBT is wrong in how it understands mental illness*]. The Conversation. https://theconversation.com/cbt-is-wrong-in-how-it-understands-mental-illness-175943	"I suffered from my relationship with my minds Automatic negative and fearful thoughts for quite a few years … it was definitely a horrible and very controlling experience … thankfully I now recognise them for exactly what they are, just thoughts"	Yes.
Positives of CBT, what works with CBT	JunichiYuugen. (2021, March 23). *Good CBT practitioners with warm attitude, good interpersonal skills* [Comment on the online forum post *CBT feels like gaslighting myself*]. Reddit. https://www.reddit.com/r/TalkTherapy/comments/mb1rto/cbt_feels_like_gaslighting_myself/	"Good CBT practitioners with warm attitude, good interpersonal skills"	Yes.