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# Liberated Cognitive Behavioral Therapy: Liberating CBT From the Cognitive Distortions of White Western European Culture

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*It is no measure of health to be well adjusted to a profoundly sick society.*
—Jiddu Krisnamurti, Indian Philosopher

COGNITIVE BEHAVIORAL THERAPY (CBT) is a set of mental health interventions centered in the philosophy that psychological stress is maintained by cognitive distortions that lead to emotional stress and maladaptive behaviors (Beck, 1970; Ellis, 1962). According to CBT's original model of distress, automatic thoughts are triggered across specific situations that prevent well-being. Importantly, change in psychotherapy is a matter of altering "distorted" cognitions, leading to decreases in emotional stress and decreases in maladaptive behavior. Patients receiving CBT collaborate with therapists to challenge maladaptive cognitions, beliefs, and schemas, to change behavioral patterns (Beck; Ellis). CBT has shown strong support for anxiety disorders (Kindred et al., 2022; Lewis et al., 2020; Öst et al., 2023; Van Dis et al., 2020), depression (Cuijpers et al., 2019; Oud et al., 2019), eating disorders (Linardon et al., 2017), and a wide range of other conditions (Hofmann et al., 2012).

Recently, along with providing critical commentary regarding the cultural blindspots of CBT research, diverse researchers have sought to increase the cultural competence of CBT clinicians (Naz et al., 2019) and create culturally sensitive treatment adaptations that still maintain CBT's core treatment philosophy (Hinton & Patel, 2017; Naeem, 2019). Targeting ways to increase the cultural sensitivity within CBT is undoubtedly helpful, and acknowledging *specific* anthropological mechanisms of white supremacy in Western culture is necessary to create *specific* clinical tools. This paper will explore the cultural location of white Western European (WWE) *cognitive norms* within the context of the U.S., and how this context permeates the attitudes of U.S.-based CBT practitioners. CBT is useful, *and* it can operate from a culturally universal frame if its Western cultural location is acknowledged and compensated for with several easy-to-use treatment augmentations rooted in "cultural countertransference," to be outlined later.

It has been the goal of many scholars to highlight how the inception of Western psychology/psychiatry was rooted in white supremacist ways of being that discredited other cultural worldviews. The work of Fanon (2016) sought to underpin the psychological contagion that is white supremacist cognition, and similarly, Burch (2021) unpacked how psychiatric institutions attempted to erase non-white cultural cognition. Further, the seminal works of Cokley et al. (2019), Myers et al. (2018), and Jamison (2017) all wisely identify the trends of white supremacist cognition, and discuss the need to decolonize psychiatric institutions from white supremacist thinking.

As evidenced by the work of these diverse scholars, acknowledging WWE culture as certainly not "unbiased" is a strong step in the right direction. However, to integrate this anthropological acknowledgment into CBT specifically, we must centralize and identify specific WWE cultural cognitive norms. Further, as a product of those WWE norms, we need specific CBT-based modifications that aim to target the anthropological root of what may cause cultural bias in CBT practitioners located in the Western world, specifically the U.S.

This paper will discuss and offer solutions regarding the notion that WWE culturally specific cognitive styles have been globally normalized and used as a frame of reference for *the way people should think, behave, feel, relate to their surroundings, conduct/interpret research, and achieve well-being.* A metaphor for culturally specific cognitive styles in this case is that of saltwater and freshwater. It's not that saltwater is supreme to freshwater, saltwater is merely different, and comprehending saltwater's molecular structure helps us to understand its effect on fish. Let us begin our assessment of WWE cultural cognitive

styles with an important anthropological exploration into WWE cognitive inception. Following this discussion, we will then explore several clinical modifications.

### *Western Cognition*

It is harmful to gauge health based on culturally biased lifestyle norms, deeming what is universally "adaptive" as opposed to "maladaptive." CBT's political place within psychology is part and parcel with the Western medical model, that is, seeking to identify disease within individuals, rather than identify the diseased environment in which so-called "individual" disease arises. Liberation Psychology's creator, Martín-Baró (1994), outlined how individualism masks the operant conditioning that systems use to reinforce or punish culturally specific ideological reference points (e.g., capitalism, materialism, oppressive bias, etc.). More recently, Malherbe (2021) suggests that the role of psychotherapists is to assist clients in a process of *acultural* emotional integration that is beyond ideological reference points that systems cultivate.

Put plainly, without clinical tools filtering one's cultural assumptions, the CBT practitioner situated in Western culture may see Western systems as "universally healthy and normal." This translates into defining "mentally healthy individuals" as those who are best adapted to a system that is not "universally healthy." To expand upon the above explanation of operant conditioning according to Martín-Baró, the U.S. capitalist system creates individual lifestyle stress, and then offers what I call "institutionalized sedatives" for citizens to cope with the stress that the lifestyle creates (e.g., alcohol, social media, entertainment, materialism, food, etc.). Thus, wealthy companies then profit off these "institutionalized sedatives" without offering changes to the environment which necessitate the sedatives in the first place. In essence, WWE lifestyles cultivate a level of "socially conditioned dissociation" that increases stress and competition, which likely drives oppressive attitudes, a lack of emotional awareness, limited interpersonal connection and compassion, and likely many other markers of individual health that CBT practitioners seek to assist clients in achieving.

By attempting to treat individual mental "illness" within a cultural system that causes illness, "health" means assisting clients in adapting to a system that is unhealthy. I identify this not to cause despair or hopelessness, but to highlight our cultural location as CBT practitioners in the U.S. and identify our need to acknowledge our cultural bias as those living a Western lifestyle, which is normalized in our national environment. To understand the implications of WWE cultural cognition in our understanding of applied CBT, anthropology can enlighten us to the fact that WWE thought is *not acultural or objective*. Anthropology is defined as "the science that deals with the origins, physical and cultural development, biological characteristics, and social customs and beliefs of humankind" (Dictionary.com). WWE cultural cognition began centuries ago, and the age of any culture may have us forget that culture shifts and changes over time—there are *no* universal styles of thinking or behaving.

Outlined by African anthropologist Mariam Ani (1994), WWE culture holds a particular momentum, certain "cognitive assumptions about the nature of reality" or the term *Utamawazo* in Afrikan anthropological language. Ani outlines the primary Utamawazo of WWE culture as rooted in the assumption that WWE culture needs to be spread across the globe, as a "universally correct" style of thinking, behaving, and living. This particular WWE cognition, which we might identify as a cognitive distortion, developed into behavior that became intent on spreading its values, beliefs, and territories to other lands—often by brute force. Ani details the violent practice of conquering or colonization as culturally substantiated by the WWE cognitive distortion that others *should* adopt similar views, even by force. This cognition led to feelings of superiority, then leading to violent behavior that allowed the Roman State to spread not only its physical territories, but its *psychological territories*. By *forcing one's cognitive styles* on cultures, WWE cultures identified their behavior as "civilizing" or "correcting" the irrational thoughts and behaviors of non-WWE cultural lifestyles.

Importantly, WWE goals of "civilizing" others was maintained by an additional culturally specific distortion: *the nonfalsifiable presence of what "reason" or "objective thinking" is, versus not*. We can start to see the parallel between WWE culture and the risk we run as Western CBT practitioners deeming certain thoughts as "realistic" or "unrealistic." As Ani (1994) discusses, WWE culture aimed to physically and cognitively conquer territory, then coupled this aim with presenting its harmful actions as acultural, "logical," "universally true," or "virtuous." In essence, this is the distortion that WWE cognition or thoughts are objective, untouched by cultural imprinting, context, history, or lifestyle. The distortion manifests such that: "Since I am objectively correct beyond reproach due to my WWE cognitive style, then I can force others to adopt what I want them to, and still see myself as a benevolent person."

Centuries later, via ongoing physical and cognitive conquering, WWE cultural cognition and behavior has curated the surrounding environment in a way that supports WWE cognitive distortions—beyond falsifiability. Thus, reality now reflects what WWE says reality is when we look around, as WWE culture has forced others to adopt its own cognitive styles, and punished those who do not reflect its own distortions via operant conditioning. As mentioned, Burch (2021) outlined this WWE phenomenon, identifying how WWE psychiatry attempted to erase non-WWE cultural cognition through the use of WWE institutions. Importantly, cultural norms are absolutely not inherently a negative or harmful thing, which is why CBT practiced with self-awareness of its own WWE cultural location is of utmost importance. Without cultivating self-awareness within the practice of CBT with specific alterations (to be detailed later), CBT practitioners run the risk of carrying out the WWE Utamawazo and potentially labeling *non-WWE thinking as "maladaptive" or "unhealthy"*—without acknowledging whether the environment itself is healthy. *The intention is not to overhaul CBT*, but to assist its ability to acknowledge cultural context of thoughts, emotions, and behaviors.

Not acknowledging the WWE cultural limitations within CBT may further promote hegemonic thinking, and grandiose attitudes. To make the case that CBT must include "cultural filtration" tools for WWE cultural distortions, acknowledging a definition of narcissistic thinking may help us see the issue with not utilizing clinical tools that operate as cultural bias "filters." Briefly, narcissism is seeing one's own reality as fundamentally correct without falsifiability, and then forcing others to adopt that reality with forceful physical and cognitive coercion, regardless of victim resistance (American Psychiatric Association, 2013; Skodol et al., 2014). While we as CBT practitioners are certainly not intent on victimizing those we serve, our WWE cultural location has a particular cognitive history that may cognitively coerce if we are not careful in acknowledging our Western Utamawazo.

Put simply, we don't always acknowledge how the umbrella of the above anthropological details of WWE cognitive-cultural bias influences our lifestyles, treatments, research questions, or values within academic institutions. Concluding our exploration of WWE cognitive anthropology, we see that the psychology of WWE aimed to spread its cognitive style until the globe was no longer "distorted" in its thinking—according to its own culturally biased reasoning. While it is important to acknowledge the harm this global crusade has caused people and the earth itself (in the form of climate disaster), it is outside of the scope of our discussion. What is within scope is identifying the appropriate clinical tools we can use to assist CBT professionals to limit WWE cognitive distortions negatively impacting clinical work. Prior to exploring clinical modifications, let us identify a primary WWE cognitive distortion and its operationalization, based on our anthropological discussion:

**WWE cognitive distortion:** WWE ways of life and beliefs are fundamentally objective, acultural, and beyond the need to gauge falsifiability.

**WWE cognitive operationalization:** Given WWE's "objective" cognitive reasoning, anyone who cognizes differently must have their cognitions "corrected" by WWE norms, because they are unable to do so without WWE teaching them to.

I will now explore these cognitive mechanisms, which will then lead to the introduction of clinical modifications reflecting "Liberated Cognitive Behavioral Therapy" (CBT-L).

## Cultureblindness and Cultural Gaslighting

Readers may be familiar with the notion of *racial* colorblindness, described as the denial of racial difference altogether, to minimize and deny the harms of racism and white supremacy (Apfelbaum et al., 2012). Here I am using the term "cultureblindness" to extend this definition to include the distortion of "universality" of WWE cultural norms. This is an important distinction, intended to capture the anthropological essence of WWE momentum described above that exists *not only in white-identified individuals*, but also in people of color who have adopted WWE norms, and particularly, those trained in WWE psychology training institutions. I define *cultureblindness* as:

*The cognitive distortion that WWE cognition and behavior is acultural, universal, and not culturally unique, but a reference point for what are "normal" cognitions, behaviors, and lifestyles for all human beings.*

As outlined in our anthropological discussion with Ani (1994), this claimed "universality" of WWE culture has significant incentives driving its motivation, such as the expansion of land, expansion of preferred cognitive styles, and preferred style of intellectual analysis (detached reasoning which incorrectly side-steps cognitive-cultural imprinting and bias). One highly relevant example of cultureblindness in CBT

is the intellectual, detached "reasoning" prevalent in academic systems, treatment protocols, and academic journals that WWE systems self-select for.

As a Black-identified man (representing roughly 2% of clinical psychologists; Beasley et al., 2015), by wanting this paper to be accepted, I am forced to adopt a style of detached communication not native to my cultural identity. The words read on this page reflect the incorrectly assumed, acultural notion of "professionalism," or "coherent" expression, devoid of curse words, Afrocentric slang, or other expressive styles that reflect emotionally integrated personality states, which convey completely valid information. The experience of having non-WWE cultural imprinting, yet the challenge of needing to adopt it to be seen as "normal," is thoroughly outlined by W.E.B. DuBois as "double consciousness" (DuBois, 1903), sometimes known as "code switching." Inasmuch, what is defined as "coherent" is within cognitive-cultural framing, and those who do not understand detached reasoning are not "unintelligent," just perceptually different. If we were to unpack notions of neurodivergence (Sonuga-Barke & Thapar, 2021) and the WWE definition of what makes one "neurotypical," we would stumble upon the same cognitive distortion of cultureblindness.

The embodiment of this cultureblindness distortion has significant cognitive implications. Specifically, acting as if WWE is not a *unique cultural perspective*, but instead a fundamentally correct perspective, any harm done on behalf of WWE behavior is rationalized as a normal or objective way to be. This side-steps any harm done to non-WWE cultures, and leaves no room to highlight its lack of falsifiability as a cultural philosophy. Cultureblindness then becomes operationalized in its assumed acultural, air-tight objectivity. Specifically, since one's ideas are "objective" and not driven by one's cultural imprinting, unconscious motivations, needs, or desired self-image, any harm caused is excused. The operationalization of cultureblindness is mechanistic, which I call "*cultural gaslighting*," defined as:

> *Ongoing rationalization of harm done to individuals or communities as "objectively correct," functioning to gaslight victims into internalizing the cognitions that WWE culture defines for them. This forces victims of systemic harm to psychologically accept the cognitions of WWE culture as the needs of oneself, one's community, and the globe.*

Cultural gaslighting affords cognitive avoidance of shame or guilt related to one's "correct thinking." This leads to seeing oneself in the light of all-pervading-correctness, benevolence, and saviorism. The more harm that is done to others or the earth in this vein, may lead to further cognitive avoidance to compensate for the continued escalation of harm done. The parallels to narcissistic pathology (American Psychiatric Association, 2013; Skodol et al., 2014) here are striking, specifically related to an all-good and impossibly-never-wrong self-view. However, this pathology is being acted out on a collective psychological scale in WWE culture, and not specific to racial categories or individual actors, but to a culturally momentous, systemically celebrated cognitive frame, rooted in capital gain and hyper-individualism which masks systemic reinforcement. By framing WWE as a "normal" way to be, then avoiding one's direct experience of negative affect related to harm done, WWE behavior cloaks its culturally biased roots. Therefore, it becomes difficult to identify its cognitive distortions.

Now understanding the primary WWE cognitive distortion and its operationalization, let us transition to an empowering, practical modification to traditional CBT that aims to "filter" these distortions from clinical work, protecting patients from harm. I call this modified version of CBT "Liberated Cognitive Behavioral Therapy" or "CBT-L." CBT-L is a blend of traditional CBT and Liberation Psychology (Martín-Baró, 1994), with a focus on aligning CBT with its intentions to be collaborative, client-centered, and empowering. The following section will outline several modifications to help clinicians integrate CBT-L into their practice.

## Liberated Cognitive Behavioral Therapy: Decolonizing CBT Application

CBT-L aims to decolonize CBT by filtering cultural bias with the addition of simple tools, both assisting clinicians in their practice, and researchers seeking to retain measurability.

### *Working with Cultural Countertransference: Seeing "Subjectivity" Clearly*

WWE cultureblindness and cultural gaslighting combine to distort certain cognitions or behaviors as either "normal" or "disordered." CBT-L includes the practice of observing what I define as our "cultural countertransference." While "countertransference" is related to our personal feelings and automatic thoughts about our clients (Prasko et al., 2023), "cultural countertransference" takes this a step further, by including our biases related to our WWE cultural lifestyle and framing. I define cultural countertransference as:

> *Clinician assumptions of normality, pathology, and mental illness, located in systemically and culturally specific lifestyle contexts. These assumptions are projected onto clients not as a matter of health, but to align clients with culturally normative lifestyles which may or may not be helpful for client wellbeing or overall mental health.*

In Appendix A, I have included a "Cultural Countertransference Tracker" (CCT) sheet, intended to assist CBT-L practitioners in identifying WWE cognitive distortions in their work with clients. By honoring and reflecting on cultural countertransference, we develop a more self-reflective cognitive style that honors client and clinician perspectives. Not only is the CCT intended to "filter" our biases to move closer to objectivity as providers, but also to highlight our unique strengths, reactions, and perspectives of health as clinicians.

Rather than embody a generalized approach to CBT application, the CCT seeks to reveal what makes clinicians different in their cognitive styles; just as we want to remove our WWE bias from our approach with clients, we also want to address this bias in how we see ourselves as professionals. Learning more about our unique lens via CCT reflection can help us identify which client populations we work best with, what research inspires our curiosity most, and importantly, how we conceptualize mental illness. Considering the unique tapestry of thinkers, clinicians, and researchers in our field, embodying our creativity and personal flavor helps us to humanize and connect with our clinical work, ask innovative research questions, and propose creative frameworks for mental health and healing.

## Mirroring Cognitive Style, Rather than "Challenging" Cognition

"Challenging" thoughts has been a staple of CBT interventions for decades as a part of the cognitive restructuring process (Beck, 1970; Ellis, 1962); however, when utilizing CBT-L, we are *more explicitly*

careful to acknowledge that our WWE-situated cognitions are *not objective*. Therefore, combined with our practice of reflecting on cultural countertransference, modifying thought "challenging" to what I call "*cognitive mirroring*" gives our clients the chance to hear themselves out loud, and importantly, allows clients to personally gauge the behavioral and goal-oriented impact of their own cognition. Here is a small example:

**Traditional CBT Thought Challenge:**

BLACK-IDENTIFIED CLIENT: I can't go the mall, or I'm going to have a panic attack because all white people follow me around in stores. I love shopping, but I'll never be safe from racism.

WHITE-IDENTIFIED THERAPIST: I'm going to challenge that thought— all white people will follow you around in stores, and you'll never be safe from racism?

**CBT-L Cognitive Mirroring:**

BLACK-IDENTIFIED CLIENT: I can't go the mall, or I'm going to have a panic attack because all white people follow me around in stores. I love shopping, but I'll never be safe from racism.

WHITE-IDENTIFIED THERAPIST: You love shopping, you want to shop, and you fear that encounters with racism won't allow you to feel safe enough to enjoy yourself. What can we do to help you feel a little safer to do what you love?

This slight shift is intended to empower clients to (a) recognize their own reasoning connected to a valued behavior, and (b) collaboratively choose strategies to overcome limiting behavior in service of lifestyle, but being more explicitly careful to not challenge assumptions of reality. As outlined above, the primary WWE cognitive distortion is cultureblindness, and when mirroring thoughts instead of challenging them, we allow clients to not become imprinted by WWE distortions, while still encouraging reflection on how cognitions are limiting client behavior. We will now explore two additional worksheet-based modifications.

## Tracking: Gathering Direct Perceptual Data and Empowering Client Lifestyles

CBT-L engages clients in gathering broader, direct perceptual data within their lived experience with the use of two additional worksheets, intended for use both during treatment and long after treatment to prevent relapse. These modifications, like thought records, are designed to engage client reflection, but also motivate longer-term lifestyle changes. The first worksheet is called the "Energy Audit" (EA; Appendix B) and is intended for use (assuming weekly sessions) after Session 1, after Month 1 (after Session 4), and after Month 2 (after Session 8).

The EA assists clients in gathering data related to broader lifestyle habits, relationships, and behavioral patterns, helping them to connect their mental health status to everyday lifestyle decisions. As outlined in Appendix B, clients will broadly reflect on what behaviors they are choosing to engage in, the direct cognitive-emotional consequences of those behaviors, and encourage clients to self-identify changes to make based on an ongoing reflective process.

Considering assumed WWE "objectivity" of health practices and research institutions, the EA empowers clients to observe their own "feel good" perceptions, rather than being told what they "need to do" based on WWE research. Importantly, this is not designed to limit our clinical capacity to share helpful research findings. On the contrary, the EA is designed to help clients reflect on all behavior and its effects—including the behaviors we may suggest, client strengths, spiritual practices, musical tastes, food consumption, and much more. The EA is an expansion of tracking, both designed to reveal larger lifestyle patterns outside of the client's awareness, and to expand the clinician's ability to gather lifestyle data that transcends our need to ask all possible assessment (or research) questions.

The second worksheet is called the "Behavior Change Notebook Prompt" (BCNP; Appendix C), designed to help clients "tally" how many behaviors they engage in on a daily basis. While the EA is reflective and used across several time points, identifying which behaviors have a nourishing or depleting impact, the BCNP is intended to help clients begin and sustain the practice of increasing the behavioral repetition (or increasing "reps") that improve overall well-being in expansive, daily, nonspecific fashion. Specifically, the BCNP is designed to engage clients in a direct analysis of the numerical relationship between their completed behaviors and mental health status. Also important is the assistance that the BCNP provides to clinicians and researchers in gathering numerical data, analyzing client strengths, and in future research projects, broadly identifying behavior patterns that increase well-being. Outlined in Appendix C in further detail, the BCNP provides numerical data across 4 behavioral categories: Resisting behaviors they wish to extinguish, exposure-based behaviors they wish to increase, coping behaviors to practice regulation skills, and nourishing behaviors-intended to enhance joy, playfulness, and self-compassion.

The BCNP is intended to enhance the client perceptions of control over mental health status, increase empowerment, and increase chosen lifestyle habits that transcend diagnostic categories or preliminary treatment goals. While WWE culture has a habit of defining what is "normal" or "distorted," the BCNP engages both client and clinician in a process of individualized self-discovery, encouraging the collection of behavioral data that not only tailors treatment to the individual, but also tailors individual practices for well-being to be utilized long after termination. The below case vignette highlights CBT-L application and utility:

*"Shuri" is a 32-year-old, Black-queer-identified woman, second-year graduate student experiencing anxiety, perfectionism, and hopelessness, seeing "Marsha" a white-queer-identified woman psychologist.*

*Shuri presented with symptoms of restlessness, racing thoughts, and panic that began following her first year of her psychology doctoral program. Shuri presented to Marsha, a therapist practicing CBT-L, hoping to decrease her symptoms while also being able to complete her doctoral degree.*

*After Session 1, Shuri completed an initial Energy Audit, recognizing that spending too much time around her white classmates left her feeling depleted, while spending time with Black-identified family, in addition to seeking queer community, nourished her. Prior to Session 2, Marsha recognized racial differences between herself and Shuri, and completed a Cultural Countertransference Tracker. In tracking, Marsha discovered that she felt uncomfortable when Shuri discussed racial microaggressions in her graduate program during Session 1, and felt that as a result of that discomfort, Marsha shifted the conversation quickly and didn't give Shuri a chance to process racial harm. Recognizing her cultural countertransference, Marsha planned to use a deep breathing technique to calm discomfort whenever discussing race—to ensure plenty of open processing space.*

*During Session 2, Shuri brought her Energy Audit into session to process her findings. Marsha used her deep breathing throughout the conversation to manage discomfort, and successfully mirrored Shuri's cognitions to highlight the cause and effect of her need to connect with Black individuals specifically*:

> SHURI: In the audit I was surprised how little I spend time with Black people, and how much it feeds my soul to talk to my father and sister (tearful)… spending so much time with white classmates makes me feel more nervous, making it harder to perform at school. I think white people really make me restless.
>
> MARSHA [*while breathing deeply, in soft, compassionate voice tones*]: Not feeding your soul by talking to Black people more makes you restless in an already anxiety-producing, all-white environment (graduate school)… using what you found on your Energy Audit, what would it look like to increase the amount of time you spend with Black people, and decrease time spent with white people?

This question led to an empowering exchange, with Shuri reflecting on Black culture, connection, and ways she feels connected to her Black identity, in addition to merely speaking with Black people. Marsha and Shuri ended Session 2 by processing the Behavioral Change Notebook Prompt, and identified a few ways Shuri could begin to take control of her environment. Through continued use of her notebook, by Session 4 Shuri had reduced her symptoms, increased self-compassion, and:

- Increased her resistance to spending time with white classmates, choosing to set boundaries instead of attending all-white events from a place of guilt.
- Increased her exposure to exercise at the university gym, even though she was feeling guilty about going to the gym and not getting work done. Shuri also increased her time seeking queer community, even though feeling "out" sometimes caused her anxiety (as she came out as queer only 4 years ago, with no queer family members to help her make sense of the queer experience).
- Increased her use of spiritual coping skills, engaging more with her Tarot cards, astrology, and calling on the spiritual support of Black ancestors whenever stressed.
- Increased nourishment practices by watching more Black and queer aligned TV shows, reading empowering quotes from Black queer women freedom fighters, and spending much more time speaking and visiting with Black family. Additionally, after first challenging the anxiety of spending time in queer-centered spaces, Shuri began to spend time with a fellow Black-queer-identified woman she met.

Marsha and Shuri ended treatment after 8 total sessions, with Shuri expressing confidence that she would continue to reflect on ways to "feed her soul."

## Conclusion

With great enthusiasm I hope that CBT-L assists clinicians in uncovering their own WWE cognitive distortions, with the understanding that we are all being carried by generationally driven cultural momentum, rather than willfully choosing to embody harmful cognitive styles. Further, with the addition of the outlined modifications and clinical tools, CBT-L seeks to encourage clinicians and researchers to continue to enhance their sense of collaboration with clients and participants, leading to individualized and sustainable interventions that reflect the very best of us as CBT-practitioners, helpers, and human beings.

While certainly outside of the scope of this paper, it may also be helpful to consider the tools outlined by CBT-L not only for psychotherapeutic intervention but as a framework of empowered, self-determining public health practice (e.g., education systems, businesses, etc.). As we aim to increase accessibility to CBT interventions, CBT-L, specifically the EA and BCNP, were designed with those in mind who may not have access to empirically supported interventions delivered by mental health professionals in clinical settings. By engaging in a process of self-discovery, and receiving access to the tools to track those discoveries, CBT-L intends to *liberate* mental health from the shackles of treatment delivery systems, inaccessible clinical settings, and culturally biased WWE mental health perspectives that pervade our health and training institutions.

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## **Appendix A.** Cultural Countertransference Tracking

Cultural Countertransference Tracking (CCT) Directions: After sessions 1, 4, 8, 12, and 16, clinicians fill out this sheet (use another page if necessary) to reflect on the qualitative nature of clinical interaction. Clinicians may want to use the CCT more frequently for clients who feel especially challenging, or for clients who embody a different culture or lifestyle than the clinician (e.g., racial background, sexual orientation, non-monogamous relationship preferences, etc.). *Prompts*:

1. What do I think about this client's primary concern, and what is its root environmental (as opposed to individual) cause? Write as much as possible.

2. What makes me most uncomfortable about this client? What specific in-session client behaviors brings up this discomfort? Write as much as possible.

3. When I become uncomfortable in session when these client behaviors arise, how do I respond (or not)? Write as much as possible.

4. What behaviors does my client exhibit in response to my behavior when I become uncomfortable? Write as much as possible.

## **Appendix B.** Energy Audit

Energy Audit instructions: At the beginning of treatment, and again each month, reflect on all energy you consume on a daily basis. Here we are defining "energy" broadly, such as: The people you interact with, TV you watch, social media you engage in, physical activity, etc.

*Reflect*:

1. What energy is nourishing me, energizing me, bringing me joy, excitement, and inspired mood states? List as much as possible; use extra paper if needed.

2. What energy is depleting me, bringing me low energy, restlessness, agitation, low self-esteem, and low mood states? List as much as possible, use extra paper if needed.

**Appendix C: Behavior Change Notebook Prompt**
**How to Start Your Daily Behavior Change Notebook**

Urges travel through your brain like cars travel roads. Your brain is like a highway, and the smoothest roads are the ones MOST travelled. This means that the behaviors we want to stop are also the ones that are the EASIEST to give into.

But there is good news: You CAN change your brain, for GOOD!

Changing the brain is like creating new roads: You start walking into the wilderness, and if you keep walking the same path over and over, a road will begin to form. Even better, if you stop walking down certain roads, they disappear for good, making it harder to go back down the roads you don't want to travel. What does this metaphor have to do with your notebook?

Simple: The more you resist behaviors you want to stop, and the more you practice behaviors you want to continue = the more new "roads" you build in your brain, and the more old "roads" you stop using. Even better, new roads (behaviors) get easier to use the more you travel them!

This means that the more repetition or "reps" you practice resisting urges you want to stop, and the more "reps" you practice doing behaviors that you want to, your behavior changes over time.

Changing behavior is challenging, but with the help of this journal it becomes simple to change for good, track progress, and feel good about the hard work you put in! Here are the steps:

Step 1: Resist the urge to act on behaviors that you want to stop.

Step 2: Act on behaviors you want to start and keep doing.

Step 3: Every day, track the number of "reps" you do across four behavioral categories, and reflect on the relationship between the # of reps you did, and how you feel as a result. Here are the categories:

1. Resistance reps: Notice and describe urges, then resist them. Write down your favorite tools when resisting, and master the strongest tools! Count your reps.

2. Exposure reps: Face your fears, but on purpose. What fears are getting in the way of your life? Challenge fear, do it anyway, take back your LIFE! Count your reps.

3. Coping reps: Master your go-to emotion regulation and coping skills. Resistance and exposure will bring up discomfort. Which coping skills will you use? Count your reps.

4. Nourishment reps: Building self-compassion skills increases the joy and inspiration you feel. What will you do to create joy in your life? Count your reps.

# Harm in Psychological Interventions for People With Psychosis: The Twin Arms of Disempowerment and Discrimination

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THE INSTITUTIONS underpinning mental health research, clinical practice, and policy often structurally devalue people with psychosis, in some cases causing lasting harm. While examples of this harm are often relegated to the past (e.g., lobotomies; long-term institutionalization; George et al., 2023), negative impacts persist today, including socioeconomic marginalization undergirded by punitive social welfare and healthcare policies. For example, a recent meta-analysis of studies from 1957–2021 suggests that the 15- to 20-year "mortality gap" (i.e., 15- to 20-year shorter average lifespan) among people with schizophrenia is worse now than it was in the 1950s (Correll et al., 2022). The mortality gap among people with bipolar disorder is also growing (Staudt Hansen et al., 2019). While these shocking disparities are sometimes blamed on people with psychosis themselves (e.g., due to higher rates of smoking, poor eating habits, or sedentary behavior), strong evidence suggests that inequities in healthcare access and quality are a major contributor (see Roberts et al., 2022; Solmi et al., 2020, 2021). In spite of multiple major studies pointing to schizophrenia as one of the single largest predictors of COVID-related death and illness severity (e.g., Barcella et al., 2021; Lee et al., 2020; Hassan et al., 2022), few U.S. states prioritized access to COVID vaccinations for individuals with serious mental illness (Kumar et al., 2021). These inequities are generally even greater among people with psychosis with additional marginalized identities and experiences (Das-Munshi et al., 2017, 2021; Livingston, 2020).