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Cognitive Behavioral Therapy (CBT): A Queer Analysis

By

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Intro and Relevance

My thesis seeks to understand how Cognitive Behavioral Therapy (CBT) impacts individuals, particularly those who are not included in normative culture. Normative culture describes what is considered normal, rational, or acceptable, while also thinking about what is deviant, immoral, or unacceptable. I aim to make space for critical analysis of CBT not to dismiss the value of tools and techniques, but to further see how they can be reshaped by queer perspectives in order to accommodate more individuals and different therapeutic results. Furthermore, I will explain the relevance in incorporating a queer analysis into understanding the therapeutic process. This is done with the goal of making CBT the most relevant and accessible it could be, as it is a commonly used therapy within clinical psychology and has influenced the way newer therapies have been theorized and implemented. Therefore, I seek to understand how the development of CBT has maintained institutional Western norms and ideals, and why it might be critical to understand how the application of queer theoretical concepts such as Donna Haraway's situated knowledges, Jasbir Puar's assemblage theory, and Sara Ahmed's affect theory make the therapeutic process more accessible for queer and trans people of color.

The historical influence of clinical psychology and CBT impacts what kind of healthcare is offered and insured today, which impacts what an individual is able to access and experience. The legitimization of some results over others also influences what tools and techniques are taught to graduate clinical psychology students, which determines the trajectory of future implementation of psychological resources (Haarmans, 2012). This is important to note because while providing a "seemingly neutral and apolitical approach," the institution of psychology has consistently reinforced the social control of dominant institutions by not acknowledging the broader sociopolitical context of normative patterns of upholding power (Yakusho, 2018). Moreover, disguising Western rhetoric as neutral and normative reduces the efficacy and

autonomy of individuals who exist outside of Western norms, like queer and trans people of color. Queer and trans people of color live outside of norms because institutions have consistently not made a comfortable or applicable space for them. Specifically, it is imperative to shift the way in which therapeutic interventions are offered to people who do not exist within the ideals or expectations of a heteronormative, white supremacist, and ableist culture. Broader social conditions influence one's experiences, interpersonal interactions, identity, embodiment, and perceptions, which all contribute to mental health. The relationship between an individual and their environment shapes their experiences and is necessary to consider and include in therapeutic approaches like CBT because what is logical and rational is also dependent on how one experiences the world. In addition, feeling, embodiment, relationships to norms, and other nuanced contributors to mental health are not necessarily captured in dominant forms of data that are heavily numbers-based. Quantitative data is valued in institutions because of the heavily generalizable and efficient results they yield. Generalizable and homogenized data are systematically used to promote hegemonic forms of culture and maintain normative forms of power within psychological therapeutic situations. For people who are consistently not included in normative data, like queer people of color, there may not be a uniform, monolithic definition of what is logical and rational in a therapy session. In addition, what is logical or rational is dependent on one's culture, identities, and experiences. By referencing queer concepts such as situated knowledges, assemblages, and affect theory, I hope to reframe CBT so individuals such as women of color and queer and trans people can be better served. A queered CBT would imagine and validate new ways of experiencing, coping, and healing with the world and the sociopolitical conditions occurring within it.

It is imperative to shift the way in which therapeutic interventions are offered to people who do not exist within the ideals or expectations of a normative, Westernized culture. I seek to examine the history and influences of CBT by understanding how someone can “acquire legitimacy without recourse to binaries or being co-opted by dominant standards”, which are often inaccurate and oppressive for those who “embody difference”(Luka and Milette, 2018). Institutions create and are influenced by cultural norms, which play a role in maintaining hegemony. Moreover, the apparatuses of surveilling and maintaining power, such as the reinforcement and furthering of normative ideas, are interwoven, as institutions interact with each other. Psychology has historically played a role in reinforcing rhetoric in a way that ethnocentrically values Western beliefs and values. Throughout this review, I will examine how queer analytics can open up new ways of doing and accessing therapy. While offering criticism, I see aspects of CBT as helpful in managing thoughts, and useful given its status as a highly legitimized and effective form of therapy. I seek to understand how the experiences, emotions, and ideas of a queer body moving through the world are influenced by the support, or lack thereof, from a highly cognitive therapeutic process. How does a queer way of feeling and acting forge new ways of intervention for healing, and how is this influenced by lack of space within research and a clinical setting?

Section I: Historical Context of CBT; Modern Empiricism within Psychology

Cognitive Behavioral Therapy (CBT) is a type of short-term therapy developed in the 1960s by Aaron Beck and Albert Ellis. CBT was developed to seek more understanding of the interconnectedness of thoughts and behavior while also stressing that individuals could overcome difficulties and meet goals by identifying unhelpful or inaccurate thoughts (Jane

Addams Collective, 2019). Cognitive behavior theorists posit that “internal perceptions, attributions, [and] beliefs...as well as the individual’s adaptation to the world through their behavior” are integral to adaptive functioning (Dobson and Khatri, 2000). CBT asks the client to engage in an intrapsychic process while labeling internalized thoughts as self-attributions, self-statements, and self-efficacy (Dobson & Khatri, 2000). An example of this would be not feeling like maintaining daily aspects of life as feasible, whether they are due to internal or external forces. However, it is important to note that while training in psychoanalytic models of therapy, Beck and Ellis were more attracted to models of therapy that included a more direct emphasis on behavior change, like classic and operant conditioning (Dobson & Khatri, 2000). Therapy that could be replicable and generalizable was a response to the economic and political influence that called for a need to “legitimize” psychology. Predominantly, Beck and Ellis were dissatisfied with long-term forms of psychoanalysis that were common in the field of psychology. At the same time, practitioners within the field of psychology were calling for an integration of science and practice into the therapeutic process. As a result of this push for empirically-based evidence, there was “increased competency of the practitioner” in the form of required licensing during the 1950s (Dobson & Khatri, 2000). Additionally, it is important to note while case studies and anecdotal evidence are helpful in legitimizing treatments, “policymakers and normative science require the use of standardized assessment methods and the use of randomized clinical trials” (Dobson & Khatri, 2000). However, the influences and roots in CBT show how many of these changes to generating thoughts and beliefs are evident in the way that an individual is treated.

The emphasis on empirical research within CBT not only legitimized the field of clinical psychology, but also offered practitioners a standardized and replicable approach. Dobson and

Khatri describe cognitive therapy as consistently perpetuating an emphasis on these traits in the therapeutic process “with a strong tradition of manuals that describe these underlying principles and procedures of the treatment” (Dobson and Khatri, 2000). During the acceptance and integration of CBT, there was also a rise in public demand for lack of damage in the medical and psychological fields. In other words, the variance in practitioners and potential malpractice was considered to be rectified by heavily valuing objectivity. Therefore, the relationship between legitimizing treatment by making steps more standardized and generalizable was strengthened.

The replication and standardization of CBT in its roots allowed it to be offered in the context of managed care. Managed care includes any method that regulates the price, utilization, or site of health services. Introduced by the Nixon administration in the Health Maintenance Organization Act (HMO Act) of 1973, managed care was developed as a means to contain and reduce healthcare costs (Dobson & Khatri, 2000). While creating a more widespread way of accessing therapy, managed care is “associated with powerful financial pressures to keep treatment as short term as possible” (Dobson & Khatri, 2000). In addition, since HMOs fund services, they control the nature, funding, and number of clinical sessions available to patients. This shapes the criteria for what services are available: those that value treatment efficacy, the significance of illness, and cost-effectiveness (Dobson & Khatri, 2000). The managed care system has criteria to ensure that individuals are not “needlessly” in prepaid therapy or abusing the system in some way (Dobson & Khatri, 2000). Surviving “the ‘marketplace’ environment” or not receiving funding is continued through the Health and Social Care Act (Pownall, 2013). Health professions, including therapeutic services, have used normative, quantitative science to uphold methods and models in order to meet the criteria for what services are available under managed care. For example, CBT is highly operationalized, meaning that there are approaches to

define and measure something that is not particularly consistently measurable, like thoughts, moods, and emotions. One of the major themes of CBT has been to look at the measurement of outcomes, like giving self-report questionnaires to the client after the session. These self-report questionnaires can be used by managed care organizations to make sure that the participant is improving and utilizing care while also legitimizing CBT as a therapeutic process.

However, it is important to notice how focusing too much on one method of collecting data can impact the perceived validity of other forms of data. Specifically, an overemphasis on empirical data can create a “monoculture of ideas about the nature of psychotherapeutic change”, particularly when training future therapists in doctoral training programs (Heatherington et al., 2012). This emphasizes the importance of clinical psychology as a legitimate form of accessing therapy (Heatherington et al., 2012). This is supported by the American Psychological Association (APA), which also supports empirically supported treatments and assessment” (Heatherington et al., 2012). Training mental health professionals to understand and treat people’s thoughts and behaviors in a predominantly empirical and standardized manner risk excluding the thoughts and behaviors outside of a normative and quantitative way of thinking about and practicing therapy. Moreover, broader social conditions are not necessarily quantifiable in the form that managed care demands. These conditions, therefore, shape how CBT practitioners assess their clients and their conditions.

Section 2: Neoliberalism

Since CBT is heavily practiced in the United States and other Western countries and through managed care and its connections to federal funding and policy oversight, neoliberalism has impacted the process of CBT as well. Clinical psychology “has been under increasing pressure to conform to the neoliberal system” in order to maintain funding and gain

professionalism (Dudley, 2017). Neoliberalism, while initially connected to political economic practices, suggests principles of individualism and self-reliance (Dudley, 2017). An individual is suggested to gain more resilience in order to overcome a personal struggle, but is also expected to gain access to the “correct form of intervention” (Thompson, 2016). This often takes place in the form of a narrow, linear path of healing. While promoted as a healthy way to cope with adversity, encouraging resilience in a general sense related to an institution “can be understood as a command or technique of regulation” (Ahmed, 2017). Moreover, lack of control over one’s life circumstances and oneself is presented as the cause of struggles while racism and other forms of oppression are reduced to individual choices (Yakusho, 2018). Not only does this normalize the damage inflicted by white supremacist patriarchal influences through what is considered common sense, but it also credits and celebrates individuals for overcoming hardship and blames them if they fail to do so. Common sense is often defined through heteronormative, white supremacist, and ableist ideals. A push for individual resilience ignores the experiences of people in marginalized groups, like queer and trans people of color whose life experiences and conditions can make the experience of therapy different than those who hold more cultural privilege. In addition, the neoliberal idea of resilience is incorporated into therapeutic ideas of healing. By creating and reinforcing a linear and time-limited therapy like CBT, a client is put in a position to become self-reliant and gain resilience. While therapy offers a chance for an individual to learn tools for coping and healing, an overemphasis on individualism fragments and isolates clients from community healing.

Moreover, clinical psychology is burdened by the neoliberal expectations of productivity. Dudley explains how “the adoption of neoliberal economics...[forces] professions to provide quantifiable evidence to prove their value and legitimacy” through encouraging competition

between and within services (Dudley, 2017). In addition, suggesting heavy manual-based and time-limited forms of treatment as the main path to psychological healing can become technical, stripping the nuance from understanding a client's lived experiences (Milton and Corrie, 2002). Milton & Corrie assert that this is also responsible for "tipping the balance toward technical knowledge over intuition" (Dudley, 2017). While intuition is not easily quantifiable or generalizable, intuition is a key element in the healing contract between a CBT practitioner and patient. However, this aspect of the CBT interaction is erased when a neoliberal empirical foundation grounds the therapy.

Neoliberal rhetoric and its principles of individualism also influence the interaction of positive psychology and clinical psychology. By emphasizing individual goals of positivity and self-control while discrediting institutionalized sociopolitical and cultural forms of oppression, psychology can be implicated in Western society's maintenance of institutional control (Yakusho, 2018). These forms of sociopolitical and cultural oppression shape people's inner and outer lives, which are important in understanding and processing thoughts and emotions. While positive psychology is not a treatment, it is a set of ideas that grew from neoliberal and clinical influences because there is an emphasis on maintaining a sense of individualistic growth while also growing in the suggested way. Specifically, heteropatriarchy and heteronormativity work in concert with capitalism, thus producing and promoting a "correct" way to address the trauma and challenges that CBT is designed to address. By promoting a supposed linear way of healing, there is an upholding and maintaining of norms. American psychology has been dominated by efforts to control negativity through eugenic and essentialist notions and ensure productivity. Ideas of productivity and negativity are often regulated through capitalist notions, which are not necessarily reflective of the individual's identity and experiences (Yakusho, 2018). Moreover,

one's ability to grow from trauma resulting in mental illness is based on an individual's overcoming circumstances based on "character and heredity", rather than acknowledging the broader social conditions a person experiences (Yakusho, 2018). By viewing people who are outside of the norm due to disability, as well as race, gender, or class as a personal problem best solved "through the strength of character and resolve", practitioners assist in a singular way of healing and shun individuals if they do not respond to the therapeutic process. Neoliberal ideology incorporated into the therapeutic process of CBT shames individuals if they do not experience healing in the supposed method or experience more than an appropriate amount of negativity. In addition, the experiences of those who face institutional inequality promote the positivity experienced by those less affected by forms of oppression. A therapy that approaches healing with a heavily manualized and thought-oriented method does not necessarily include the space for the nuances in the non-linear, yet very human, thought processes. By promoting healing in a supposed method, individuals are not given multiple options that are not heavily individualized.

Interlude: Criticism and Gaps in CBT

When CBT is only ever theorized and practiced from a neoliberal and empirically-driven standpoint, the entirety of perspectives towards healing are not included. This is done because CBT overvalues the empirical basis upon which it was built. When healing and mental health is only considered from a science-driven perspective, the nuances in identity and how they impact the healing process is only captured in a narrow form of conceptualization. By creating a limited frame of healing based on objective, highly quantifiable, and repeatable methods, CBT perpetuates neoliberal ideologies.

An important question to take into consideration about CBT is if past adequate treatment parallels or equals clinical significance. In other words, what may be considered valuable and generalizable research may not be applicable or resonant to the nuances of how an individual thinks, feels, acts, or experiences an event. Combined with the burgeoning urgency to legitimize itself as a scientific discipline, psychology facilitated the turn towards empirical and heavily quantifiable evidence, a master narrative. While referring to the meaning of objectivity, feminist scholar Donna Haraway describes master narratives like this as “the God trick”, which was created and is sustained in institutions (Haraway, 1988). While seemingly harmless, psychology’s reliance on quantifiable evidence imposes logics that invalidates the experiences of those who identify outside of the norm. For those who embody difference, using dominant narratives, referencing binaries, or being “co-opted by dominant standards” seems like the only way a subject in a therapeutic setting can gain legitimacy (Luka and Milette, 2018). Since therapy does not exist in a vacuum, seeking to understand the ways in which individuals gain or lose autonomy and agency in a therapeutic setting is integral to queering CBT. In addition, is the absence of particular diagnostic symptoms the same thing as the presence of wellness? Since CBT is occurring in an isolated clinical setting, how is it possible to consider forms of healing through one’s community when only considering a manualized empirical version? Considering the lack of community influence in the therapeutic process of CBT is necessary to reshape the practice, especially when thinking about the way that institutions and neoliberal thought isolate the healing process of an individual and to an individual’s own self-productivity.

Since CBT has been heavily influenced by Western ideals, politics, and economics, it is important to maintain a critical eye in understanding who is comfortable in a therapy setting influenced by normative culture. Therefore, conceptualizing and theorizing a queer framing of

CBT would prove beneficial in making the therapeutic process more relevant to the individual and in the uniqueness and nuance of emotion, growth, and healing. While a queer lens of analysis offers a new perspective on the therapeutic process, it is vital to not reify normative patterns or create a monolithic definition of queerness. Drawing upon crip scholar Kafer's insight about the (dis)ability system, we can see how CBT functions to reify dominant patterns that rely on disassociating the individual from the social context. Kafer discusses how theorizing about disability often risks a watered-down and reductive idea of it (Kafer, 2013). This resonates with the idea of how change under a neoliberal blanket is often described as a "mantra of identity" (Puar, 2012). Kafer mentions how political and medical institutions attribute normalcy and deviancy to certain minds and bodies (Kafer, 2013). Kafer provides a new way of understanding the ways institutions reify dominant narratives and maintain power. While mental health/illness is seen as a curable/fixable, short-term, and individualized "problem", this only isolates an individual further away from community help. Instead of viewing the social processes and policies as apart of a person's process of healing, an institutional and medicalized approach "treats" the condition and the person with the condition.

While being careful to understand the way that therapy is replicated and applied, an integral piece of framing CBT through a queer lens is to recognize the autonomy of the individual. Because there is no singular definition of queerness or "queering" something, there is no singular way to understand individuals in therapy without asking. Instead of assuming that the practitioner possesses all of the expert knowledge, theorizing ways to queer CBT centers the individual's autonomy and knowledge at the forefront of importance. Autonomy is important to note as not the same as the individualism that neoliberalism promotes. Rather, it is closer to the increasing agency of an individual. Some of the ways agency is increased is by recognizing the

complexity in the relationships between identities, how one's identities shape one's experiences, and how one's experiences influence, or situate, one's knowledges. To clarify, the complexity of an individual's identities are always intersectional, polyvalent, and shifting. CBT and the clinical context it operates in excuses the expert knowledge of people like queer trans people of color is not as intelligible or legible through a quantifiable format. However, this does not diminish the agency of an individual if the practitioner does not understand the nuances in how they feel or their process of healing. Gaining more nuance in qualitative accounts could be influential in CBT because this increases the agency of queer and trans individuals in how the healing process unfolds. While qualitative data is utilized in research, there are still ways in which the responses of an individual are stripped back or made to be quantifiable. However, this is why new ways of envisioning therapy are integral. Not only does theorizing a queer framing of CBT weaken the hierarchical roles of expert/practitioner and non-expert/client, but it also opens up space for the individual to gain more autonomy in their healing process.

Seeking to reshape CBT through a queer lens is not a rejection of CBT, but rather, as Kafer puts it when discussing bodily instability, opens a path to "pluralize" the ways of understanding (Kafer, 2013). The increased agency depends on reconceptualizing defining characteristics of how individuals might move through or sit with their trauma and mental health situation. Rather, considering how identities that are more than categories, like race, gender, sexuality, and disability, are considered as "events, actions, and encounters between bodies" (Puar, Kafer, 2013).

Section 3: Queer Feelings and Transformational Healing

Since CBT has been heavily influenced by Western ideals, politics, and economics, it is important to maintain a critical eye in understanding who space is made for in normative culture. This necessitates a queer lens, as it would provide new ways of conceptualizing, experiencing, as well as supporting others in the therapy process. Because of the conceptualizations of objective fact, common sense, and deviance, it is important to consider how this affects a deeply personal experience in the context of therapy. The origins of queer were for individuals who were read as “renegade, strange,...or perverted” (Somerville, 2014). In the first two decades of the 20th century, “queer” became linked to sexual practices and identity in the United States, particularly in urban settings. Later, during the 1980s, the use of the word “queer” was reclaimed, mostly because of the lack of institutional help during the AIDS epidemic. As a result, the field of queer theory emerged. Drawing on the ideas of denaturalization from Michel Foucault, theorists like Judith Butler, Donna Haraway, and others, centered the discourse of queer theory around identities, emotions, and actions that are considered non-normative. This is partly because an individual’s queer sexuality and gender, and the way they intersect with other aspects of identities, is transformative, yielding an understanding of subjectivity that is a “set of effects produced in bodies, behavior, and social relations by a certain deployment” (Somerville, 2014). A queer analysis marks a site for challenging normative points of institutions and culture and has the potential to “destabilize the ground upon which any particular claim to identity can be made” (Somerville, 2014). Therefore, a queer analysis is critical for widening the understanding of and responses to CBT. While queer studies are cited as using an intersectional approach (Somerville, 2014), queer theory seeks to understand the relationships, or as Jasbir Puar defines, the *assemblages of identity*. Rather than sinking into “the intersectional mantra of identity”, queer

theory seeks to understand how relations of forces and encounters between bodies shape experience.

The history and neoliberal influence of CBT firstly create a one-size fits all and bootstrap theory of healing. To legitimize the field of psychology, practitioners felt the need to make theory and practice more evidence-based, quantitative, and repeatable. While these aspects of empiricism might be necessary for research, they don't allow for much variability in the individual to be expressed. In addition, there is the reification of what is considered a normal way of healing. Neoliberal conceptualizations of healing promote a short-term therapy that integrates an individual back into normative society. Remembering that, normative culture promotes neoliberal ideals of health that are tied to productivity, clients feel pressure to be individually accountable after the short-term therapy commonly offered under managed care known as CBT. Queer and trans individuals, however, complicate this idea by bringing in different timelines of experiencing grief, trauma, and healing. Oftentimes the process of growth and healing for these individuals arises out of not identifying or resonating with what is considered common sense or normal for who they were socialized to be or exist as. Each queer and trans individual has a different concept of identifying with gender, transcending gender, or rejecting gender altogether. This involves a critical consideration of what is regarded as "the way it has always been" in pursuit of it being healthy and true to them. Individual accountability isolates individuals in their healing process and yields them responsible if they do not follow an expedited and rational form of healing.

Queer analytics uncovers the importance of affective knowledge, a form discredited by the dominant values of empiricism. Affective knowledge is the experiential knowledge that Comfort, which is "the promise of a 'sinking' feeling", is often a critical aspect of how

individuals replicate heteronormative ideals and actions. Ahmed clarifies how heteronormativity assuages individuals because there is warmth from “being faced in a world one has already taken in” and been shaped by (Ahmed, 2004.) As a result, “life as we know it” is reified by what is comfortable and normatively known (Ahmed, 2004). Queer clients seeking CBT do not “sink” into the form of comfort being offered in traditional CBT settings. Part of this comfort is not reacting to the healing process in acceptable or expected ways. Not finding comfort in the CBT methodology can open up a queer space for CBT healing to take place through listening to where queer and trans individuals feel or do not feel a “sinking” feeling in a therapeutic process. Oftentimes the persistence in finding a new way to experience emotions is because of the lack of space and acceptance that normative culture perpetuates. Finding new responses and space is particularly helpful in understanding how different cultural experiences a person has can make CBT more or less effective for the client. However, Ahmed questions how defining queer ideals can “rely on the existence of others who fail the ideal” and puts into consideration how this can quickly turn into regulating “who can and cannot embody the queer ideal” (Ahmed, 2004). A critical aspect of recognizing a queer ideal or lens is to “avoid positing assimilation or transgression as choices” (Ahmed, 2004). The existence of queer experiences and lives does not stop the attachments that aid in the reproduction of heteronormativity and queer individuals remain shaped by which they fail to reproduce, but this just increases the intensity in which queerness can act. Integrating theoretical concepts like affect theory into the therapeutic process is essential because there are patterns of feeling, thinking, and healing that are unique to an individual, thus shaping the therapeutic process and healing. While specific to the individual, not seeking to understand how feeling the achievement of norms and feeling uncomfortable when norms are disrupted can limit the meaning and healing in a therapy session. Instead of trying to

cling to the opposite, leaning into the value of affect could make CBT more effective for queer and trans people of color because of how seemingly stable norms are revealed as constructions to be challenged. Through affective and situated knowledges, individuals create a unique accumulation of individual knowledge. While not clinically checked off, an individual has autonomy and wisdom about their experience instead of trying to filter it through a lens of manual and rational thinking.

Currently, CBT does not make space for affective knowledge in its implementation because of its overvaluing of empirical knowledge. Since empirical and scientific data is heavily relied on in the implementation and legitimacy of CBT, queer perspectives could prove helpful to show new forms of intervention in therapy while still valuing the replicability and efficacy of therapy. Instead of continuing to value quantifiable evidence within CBT, integrating a queer lens allows an individual's complexity to be expressed in fuller depth. A queering of the practice changes the emphasis away from an objective view of CBT. The emphasis on collecting the most generalizable data for the most effective therapies strips individuals of autonomy. The ways that multiple cultural identities interact are not able to be conveyed in the discussion because quantifiable data, while generalizable, necessitates analytical uniformity. In the context of scientific evidence, intuition or a "gut feeling" can never defend itself, but addressing an individual's mental health requires "an extraordinary level of empathy, intuition, and imagination to comprehend" (Dudley, 2017). However, quantifiable and efficient data is labeled as objective, yet still contains "collective historical subjectivity...and embodied accounts of the truth" (Haraway, 1988). Haraway incorporates a queer sense of identity and experience in her challenge to scientific objectivity. In critiquing objectivity, Haraway argues that situated knowledges, or knowledge based on one's experiences in the world, are necessary for the practice and

development of data. Since there is truly no objective way of perceiving or understanding the world, Haraway encourages situating individuals in a partial, not universal way.

Under CBT and other highly mechanistic therapies, the degree of variation in situated knowledges, especially emotional knowledge, is not given the full recognition necessary in the complexity of identity. In addition, by emphasizing a scientific approach within the therapy process, the dominant forms of maintaining power, which are also relative and subjective, are used as a way to make claims of logic and rationality (Haraway, 1988). Instead of conceptualizing patterns of power as fixed, Haraway theorizes how instability and undefinability become fundamental to the production of knowledge of one's subjectivity. While something quantifiably undefinable is considered negative in an empirical context, accepting the complexity and ambivalence, or rather the difference in experiences shaping knowledge, is critical in deploying a queer-informed version of CBT. Integrating situated knowledges into reshaping the therapy process allows data to be understood as "always interpretive, critical, and partial" (Haraway, 1988). Acknowledging the influence and strength of partial perspectives in processing thoughts, feelings, and behaviors weakens the hierarchy between the practitioner who supposedly possesses ultimate knowledge and an individual having therapy performed from a manual on them. While being conscientious of accountability and embodiment, an individual also has more autonomy in accessing therapy when partial perspectives are acknowledged and integrated into the healing assemblage. This is also reflective of the assemblages between identities and experiences that can affect what is considered common sense, logical, or normative in the therapeutic context of CBT. A part of accountability is what Haraway refers to as resonance, which examines where identities are located and the relationship between them

(Haraway, 1988). Particularly, the way that queer and trans individuals think and feel is a useful analytic in reconceptualizing CBT because of where their situated knowledges lie.

In addition to discrediting affective knowledge, CBT strengthens the hierarchy of expert knowledge, along with the practitioner while deflating the experiential knowledge of others. Through affective and situated knowledges, individuals create a unique accumulation of individual knowledge. While not clinically checked off, an individual has autonomy and wisdom about their experience instead of trying to filter it through a lens of manual and rational thinking.

For queer individuals, personal thoughts, emotions, and experiences are often tied to others in the community. Particularly, the level of community engagement in each other's lives shapes how we experience complicated emotions like grief. Ahmed notes how "it is because of the refusal to recognize queer loss that it is important to find ways of sharing queer grief with others" (Ahmed, 2004, p. 161). The sharing of queer grief with others opens up new pockets of understanding and differing sets of knowledges, and how the healing or intervening process for individuals is completely different. Instead of seeing CBT as addressing the negative thoughts one might experience, we might benefit from reconceptualizing the negative into queer grief in need of a non-heteronormative, non-white patriarchal space for expression and reconfiguration of well-being? Thinking about how the ways that queer people experience emotion, including pleasure, allows "bodies to take up more space"(Ahmed, 2004). While queer/trans people of color have not been allowed as much space in the development of CBT and other highly clinical therapies, reshaping, especially through the lens of queer/trans people of color can allow for these to be creative and nuanced, and more effective in the ways of moving through a healing process.

CBT's deployment of neoliberal individualism as a way to heal from trauma literally narrows the space of treatment to the clinician's office. This spatial configuration physically and epistemologically confines how marginalized individuals cope, avoiding any community spaces for healing. There is a disconnect between a political context and the "contours of everyday life", which does not acknowledge the way that queer subjects occupy different places within the social order (Ahmed, 2004). Institutions impact the ways in which individuals move through and experience their lives. Ahmed conveys the role that institutions have in replicating the norms that individuals experience, stating "the personal is structural...you can be hit with a structure; you can be bruised by a structure" (Ahmed, 2017). Moreover, an institution serves as a "structure in order to give evidence to structure" (Ahmed, 2017,). This highlights how therapy as an institution influences the reification of what is considered normative and objective. However, queer and trans individuals, as well as those who queer normative aspects of institutions and culture, are faced with assumptions of heteronormativity and whiteness, and assimilation. There is often an emphasis on dealing with a problem within an institution, or "in-house", which does not offer a chance for community integration and influence. This further shows how a therapeutic relationship that operates in the context of something shielded from the public eye further reinforces the hierarchical relationship in the form of gatekeeping information. Making decisions for queer and trans people of color is often nuanced and complex in these situations as well, and in how others use this to reproduce norms, which is why opening CBT up to more community-based settings outside of a clinical office can prove beneficial. This begins to show how a queer perspective, or queer lens, can benefit CBT in understanding new ways of offering a step towards more relevant, effective, and accessible forms of CBT. While depicting the ways in which the academy as an institution furthers racism and other forms of normative power, looking

at similar patterns of assimilation or rocking the boat within an institution is critical when reshaping CBT practices.

Ahmed notes how public spaces and social norms can dictate how one's body experiences the world. As a result, it is not just institutions that carry influence. We also simultaneously carry 'impressions' from others while making these impressions on our community. This shapes our bodies, our gestures, and our turns of phrase and is a "dynamic process of perpetual resurfacing" (Ahmed, 2004). In addition, since small, everyday social norms contribute to the shaping of bodies and lives, integrating community aspects into therapy can influence the experiences we have and influence a path of healing. Reciprocally shaping others and others shaping us is a dynamic, flexible, and constant process. This only increases the pursuit of queering CBT because recognizing the strength in community relationality is a recognition of "having something", which Ahmed cites as necessary to recognize "oneself as losing something" (Ahmed, 2004). This emphasizes how feeling and processing is a community-oriented and not individualistic process. This is integral in acknowledging how normative ideas and scripts can be internalized from external circumstances. An example of this is "gender fatalism", which describes the assignment of norms and expectations as "what you receive from others that will determine how you are positioned in relation to others" (Ahmed, 2017). Furthermore, feeling uncomfortable is a sign that one is being "affected by that which persists in the shaping of bodies and lives" (Ahmed, 2004, p. 155). This changes the way bodies and affective knowledge contribute to therapy's intervention because sensing what is uncomfortable may be new openings for pathways of change.

After looking at queer perspectives on individuals, institutions, and the relationship between the two, the incorporation of new spaces and methods of Cognitive Behavioral Therapy

is necessitated. While not dismissing the contributions and methods that CBT has provided individuals, imagining and discussing new forms of accessibility, efficacy, and relevance is crucial if therapy is to be accessed by more individuals outside of the norm, like queer/ trans people of color. Understanding the relationships between individual identities and communities, the emotions and affect that are derived from these identities, and how one's identity, experiences, and affect translate into a uniquely situated knowledge offer theoretical pathways to imagine new avenues for healing through CBT. Queering CBT can shift the clinical setting for clients and practitioners since new ways of understanding healing are coming from all parties of the therapeutic alliance, creating an environment where the opinion of the client and their chosen community is valid, not just the practitioner.

MAST: Mutual Aid Self/Social Therapy

A queer lens of understanding, specifically facilitated by situated knowledges, assemblage theory, and affect theory, crafts new ways and locations in which CBT can be used. One way is introducing the integration of mutual aid into CBT. Mutual Aid Self/Social Therapy (MAST) is a free and voluntary intervention for addressing the institutional role in pathologizing emotional health and creating a hierarchical system. Drawing on a myriad of techniques from therapies like CBT, Rational Emotive Therapy, Dialectical Behavioral Therapy (DBT), and existential psychology, MAST aims to allocate more understanding and autonomy to individuals. This is done in order to improve the mental lives for individuals while also collaborating with others in one's community and to demystify the therapy process. Drawing "on the power of small groups" like groups of triads/ teams, MAST seeks to create "a more immersive and experimental understanding" of therapy techniques while also maintaining a desire for radical change in

society (The Jane Addams Collective, 2019). Specifically, individuals participate in forming an intentional community where participate in a group session. In this group session, the roles of practitioner and client are switched. The participants are given equal opportunities to view all parts of the therapy process because they are also given access to view the practitioner's materials, increasing the decision-making and perception of those outside of normative culture like queer and trans individuals.

MAST attributes larger sociopolitical and sociocultural conditions to influence the healing process. Stating how it is “naive to believe that mental health models that directly benefit from ... unjust and oppressive societal structures offer the best advice to bolster a community's mental self-defense and health”, the goal of MAST is not to assimilate the individual to the status quo. Instead, this combined approach encourages individuals to regain autonomy over their emotions and work within their communities to promote a similar process of healing (Jane Addams Collective, 2019). MAST allows clients to manage and process their emotions in a way they find gratifying, which places more autonomy on those accessing MAST and moves away from authoritarian influences, like gatekeeping through client and practitioner barriers in the therapeutic process of CBT. Regaining autonomy in the therapeutic and healing process looks different than a neoliberal form of individualism because autonomy accepts complex and multifaceted ways of knowing and healing without gatekeeping knowledge. Thus, more client autonomy decreases the hierarchical relationship between practitioner and client while moving away from a medicalized diagnosis and treatment. Understanding how what is productive and gratifying is contingent on experiences that derive from an individual's identity. Thus this approach is critical because it moves away from simply administering a manualized/ jargon of therapy.

In addition, MAST emphasizes how transparency is a key process in therapy, and explaining tools informally to friends can help in the healing process for individuals (The Jane Addams Collective, 2019). This is particularly intriguing when understanding new interventions of therapy because outside of the regulations of distributing information, more individuals are accessing knowledge on the therapeutic process. Discussing what confidentiality means to an individual and how what may seem like common sense to another may not be to another is also a part of the initial stages of MAST (The Jane Addams Collective, 2019). By including clients in the definition of confidentiality, participants are actively shaping their therapy process and have an active role instead of simply receiving therapy, breaking down the hierarchical structure of receiving therapy. While not a substitute for psychotherapy or psychiatry, it is an opening to understanding how radical ethics can influence therapy. MAST acts as a foot in the door to integrate community understanding and agency in navigating therapy.

MAST also recognizes that there is not a presupposed, linear path of healing, but rather that individual's experience advances and setbacks, some of which are directly discussed in therapy. Relapse reduction strategies, like pinpointing future situations that could trigger similar feelings and thoughts are encouraged. Additionally, understanding how future situations of setbacks are opportunities for learning shifts how change is seen as partial instead of the whole story of change (The Jane Addams Collective, 2019). MAST opens up a new opportunity for support after the therapy process. Since individuals are switching between the role of counselor and client, an individual does not need to wade through a clinical setting to reach out for help in the future. Since "supporters and narrators collaboratively engage in conversation and inquiry to comb through a specific area" of a narrator's life, other members within the group setting of

MAST possess more experiential knowledge of an individual, further reinforcing the network of support and mutual aid in the future.

Through its community involvement, elimination of hierarchical structure, and inclusion of experiential knowledge in the therapeutic process, MAST is just one possible manifestation of radical queer therapy. The ideas and practice are related to feminist and queer epistemologies of relationality and healing. For example, MAST includes that it is not traditional psychotherapy or group therapy, but values learning sustainable ways of coping with everyday life and personal growth while also helping others. By integrating principles of mutual aid into the therapy process, MAST echoes Puar's emphasis on assemblages. Assemblage theory highlights the relations of different domains of knowledge, or different ways of knowing, and how they shape bodies. There is a leaning on "doing" rather than "being" in MAST, which highlights the way in which MAST is taking therapy out of a singular theoretical realm. This echoes Puar's association with assemblage theory by not viewing differences as fixed, categorical identities. Instead, situated knowledge is gained through experience and relationships with others. Recognizing the value of integrating aspects of multiple therapies within the sessions while also valuing the responses of individuals to shape the therapy process ultimately creates a manifestation of a queered CBT. This includes others and their set of experiential knowledge, and how they help each other heal. This is also understanding the motion of Haraway and situated knowledges. Instead of participating in an isolated process in a clinical setting, MAST is relying on the sets of situated knowledge of healing and growth.

While still utilizing aspects of Cognitive Behavioral Therapy, MAST seeks to integrate various other parts of similar therapies to create a synthesized form of community therapy. In addition, MAST breaks down the hierarchical structure of therapy that is responsible for

gatekeeping information and controlling the therapy process. However, a highly critical aspect of MAST is affective knowledge from oneself and others in a community having more space to be expressed than in a common therapeutic setting. By taking MAST outside of a clinical setting, there is no attempt to adhere specifically to a manualized process or prescribe to specific therapeutic practices. Rather, MAST seeks ground on the blending and flux of theoretical ideas, as well as respecting the knowledge that arises from one's lived experience. MAST encapsulates a queering of CBT because of the way the therapeutic process is shaped by members in a community, not simply a uniform, replicated short-term process of healing.

Conclusion

CBT has certain benefits and could provide more benefits for queer and trans individuals, but it needs to be reshaped. While proposing newer and modified forms of CBT is helpful in reshaping theoretical approaches, not critically interrogating or synthesizing interdisciplinary and inter-institutional ways of thinking will simply further the reification of normative and ineffectual ways of identity, healing, and experience. A queer envisioning of CBT creates an opportunity for individuals to create a distinct, meaningful narrative in therapy instead of continuing to value a manualized, empirical version of knowing. MAST is just one conceptualization of queering a highly clinical therapy.

The nature of queer is that it is sticky and ambivalent. Shifting in meaning, connotation, and significance over history, the salience of queerness is contingent on the way it has been used. Queer or to queer is important because it has been used to identify and express on individual, intrinsic levels, while also encapsulating larger community and coalition efforts. In the context of CBT, the act of queering therapy opens pathways for divergent and productive relations to

materialize in the healing process. By incorporating queer feelings and their resistance to the presumed comfort of heteronormative models of existence that Ahmed discusses, CBT could offer new pathways of experience in the therapy process. I have brought Puar's assemblage theory to CBT practice to reflect on the ways bodies as forces confront institutionalized forms of healing within CBT. Finally, Haraway's presentation of feminist objectivity as partial and contingent allows recognition of the appropriateness of queering CBT, so as to allow new forms of knowledge to emerge and change when the context shifts. Queering CBT in the sense of MAST and near future Imaginings of healing may mean recognizing how a short-term process of healing and feeling is not necessarily in a clean-cut manualized version. There is no linear way of healing since healing is a unique, intrinsic process to an individual. However, learning about the myriads of healing experiences from individuals in a community context allows more options and agency in deciding how to heal. This offers up more complications and complexity in the healing process, but dismissing this complexity does not promote sustainable healing. Continuing to provide a manualized, objective approach, while less time-consuming and less intensive of critical evaluation, will only further reify and condition normalized forms of thinking, feeling, and healing leaving queer and trans individuals on the outside of CBT.

Somerville reminds us that "the future is not a matter of chronology but one of vantage and privilege" (Somerville, 2014). For future considerations of queering CBT, I find it integral to look at how other forms of community therapy can start to dislodge the clinical, objective, and hierarchical structure of CBT. At the same time, shifting clinical training towards working with and valuing more qualitative research in training practitioners would work towards understanding how queer/trans people of color provide rich perspectives on thought, behavior, and emotion. In noting the white neoliberal foundation of CBT, it is not enough to simply change

the demographics of practitioners or to “diversify the institution ” of psychology. Rather, it is crucial to challenge the heteronormative, patriarchal, and individualistic ideology the therapy relies upon, thus calling for further queer analysis by continuing to question engagement with normative values and expectations. By being critical and reflective of the previous and current marginalization of queer and trans people as clients and practitioners within the institution, factors like vantage and privilege and who it is given to in the space of a therapy like CBT are grounds for reshaping. I call for a therapy that values the complexity of healing for individuals who are often so overlooked, like queer and trans people of color.

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