Opening a Dialogue: Using Cognitive Analytic Therapy with Depressed Men

Roger Kingerlee, Jane Cawdron and Conrad Barnard

Introduction

Depression is a major contributor to the overall burden of disease, both in the UK and globally (World Health Organization 2016). Surprisingly, however, while research into various aspects of depression continues, until relatively recently, little has been known about *male* experiences and treatment of psychological distress (Wexler 2009). Consequently, depression has in all probability often been under-diagnosed in men (e.g. Cochran and Rabinowitz 2000). Such under-diagnosis may have grave consequences for men. For one thing, depression and heart disease can be linked (Carney and Freedland 2016). For another, there is a significant association between depression and suicide—and in the UK and beyond, the rate of male-to-female suicides is 3:1 in most age groups (ONS 2017). In short, there are excellent reasons to explore new psychological interventions for men's depression.

R. Kingerlee (✉) · J. Cawdron · C. Barnard
Norfolk and Suffolk NHS Foundation Trust, Norwich, UK
e-mail: Roger.Kingerlee@nsft.nhs.uk

J. Cawdron
e-mail: Jane.Cawdron@nsft.nhs.uk

C. Barnard
e-mail: Conrad.Barnard@nsft.nhs.uk

J. A. Barry et al. (eds.), *The Palgrave Handbook of Male Psychology and Mental Health*,
https://doi.org/10.1007/978-3-030-04384-1_25

This chapter examines how the theory and practice of cognitive analytic therapy (CAT) can be applied to working with depressed adult males.

Conceptualising Men's Ill-Being: Depression

Conceptualising male distress and depression is problematic because, as an emerging literature attests (Kingerlee 2012), men often do not exhibit 'classical' symptoms of depression, making identification and treatment complex. In men, an insidious depressive syndrome may be hard to identify—but nevertheless damage health. This has, historically, been termed 'masked depression' (Pichot and Hassan 1973), which may incorporate such behaviours as alcohol abuse, delinquency, reckless behaviour, anger and somatic concerns. It may be that, as Clare (2000, p. 3) says,

> men renowned for their ability and inclination to be stoned, drunk, or sexually daring, appear terrified by the prospect of revealing that they can be – and often are – depressed, dependent, in need of help.

Instead of expressing the emotional impact of losses, men may outwardly diminish difficulties to retain a sense of control. Studies show that men are more likely to rely on externalisation-based defences and coping styles detaching them from their emotions (Levit 1991). This accords with traditional (Western) male cultural training that stresses stoicism, control, denial of weakness and 'logical' thinking (Brannon 1976). But while such strategies may initially be effective, they may become counterproductive, so that men's distress often goes unidentified (Farrell and Gray 2018); and the losses of life that accumulate for many men may result in apparently inexplicable depression, and bouts of anxiety around mid-life. And for older men who rely solely on a significant other to buffer them against life's tragedies, loss of such a person multiplies men's psychological and physical health risks (Fitzpatrick 1998). Given all of which, a better understanding of men's depression may therefore be required in the clinical setting.

Brief Overview of CAT Theory and Practice

CAT is a brief, focused, time-limited therapy that stresses the continual impact of social interactions during human development and life (e.g. Ryle et al. 2014; Marriott and Kellett 2009). CAT theory draws on,

Table 1 The stages of a procedure in CAT

- **External factors**
  Events, cues, context
- **Psychological processes**
  (a) appraising the situation and consider action; (b) relating these to aims, beliefs and values; and (c) selection of response based on prediction of outcome
- **Action**
  Completion of action
- **Evaluation or revision**
  (a) evaluating consequences of the action; and (b) confirming/revising the aim and/or means used to achieve aim

and develops, notions derived from such fields as personal construct theory (Kelly 1955); evolutionary psychology (Price and Stevens 2000); developmental neurobiology (Schore 1994); and attachment theory (Bowlby 1988). All the above, like CAT itself, stress the lifelong importance of the nature and quality of human interactions. Consequently, CAT may be viewed as a 'dialogic' therapy, in which the principal model of the self is based on interactions or dialogues of various kinds, with others.

Within CAT, all interpersonal behavioural sequences—or 'procedures'—'involve predicting or seeking to achieve certain outcomes' (Ryle and Kerr 2002, p. 9). In interpersonal procedures, individuals play a role based on their expectation, wish for or actual attempt to elicit a particular result: the acknowledgement and reciprocation of a given role. Each procedure consists of four connected stages (Table 1).

Developing the theory further, the notion of 'reciprocal roles' is a central concept in CAT and describes, as Denman (2004, p. 56) argues,

> the socially-imparted knowledge of paired social roles which together encode social knowledge about the relationships between people, between self and others, and between the different parts of the self. […] Reciprocal roles describe the parts agents play in enacting certain kinds of relationships and are learned by observation and enactment throughout life.

This, as we shall see, has potential resonance for many men, and the boys they once were. And as Denman (2004) points out—and as often witnessed in clinical practice—the adoption of one part of a reciprocal role in respect of another person may, via a particular sequence of procedures, pressure the other to enact the corresponding role.

In CAT practice, the repertoire of a client's reciprocal roles, and the negative consequences that may result from them, may be systematically mapped as reciprocal role procedures (RRPs) on a diagram, the sequential diagrammatic reformulation (SDR)—which is used to guide, and ground, moment-to-moment interactions in therapy, and outside it. They are also likely to be described, by the end of the first four sessions of therapy, in a jointly constructed narrative, the reformulation letter (e.g. Ryle and Kerr 2002).

The use of such tools points up another key feature of CAT: the stress, derived from such theorists as Vygotsky (1978) and Bahktin (1986), on the use of 'signs'. In brief, signs (whether verbal or non-verbal communication) are one medium through which an individual's internal and external psychological structures of communication, control and self-regulation are developed and altered (Denman 2004; Ryle and Kerr 2002). Or, as Leiman (1995, p. 118) puts it, 'CAT is based on the joint creation of symbolic tools that begin to mediate the patient's maladaptive action patterns'.

During the time-limited therapy, increased awareness of problematic procedures is likely to precede change in maladaptive behavioural and cognitive sequences that are reciprocal-role-derived—and which are largely or wholly self-destructive. By the end of therapy, clients are provided with a powerful psychological framework for the analysis of their difficulties—and will already often have been helped to begin to remove some of the 'roadblocks' to change (Denman 2004, p. 309).

Finally, there is a good reason to think that the male participants will benefit from the use of CAT. As well as empirical work suggesting that CAT is indeed an effective psychotherapy for various psychological issues, including depression (Marriott and Kellett 2009; Calvert and Kellett 2014), there is, above all, a high level of anecdotal evidence nationally and internationally—strongly reflected in the writers' clinical practice, supervision and research, that CAT can be an effective intervention for men with depression. That is, drawing men's attention to their hitherto unrecognised problematic psychological and behavioural procedures involving their thoughts, feelings and behaviours, in the light of a detailed and empathic understanding of their own psychological history.

We feel that the theory and practice of CAT is especially well-suited to working with men, not least since, as Ryle and Kerr (2002, p. 38) argue, that the process of collaborative reformulation of the salient psychological problems aims to reflect and understand what each [client] brings to therapy, including their cultural assumptions and formation.

This is particularly apt in the current context, since a large and ever-growing body of work, that has emerged over the last century and the last twenty years in particular, has begun to shed light on the cultural context of Western masculinity. While scholars readily acknowledge that there are many partially-distinct, but also overlapping types of masculinity (Beynon 2002; Connell 2005; Elliott 2016), and that these types in all probability have part-evolutionary, part-cultural roots (Price and Stevens 2000), certain commonalities between these 'masculinities' have been identified. Collectively, scholars have suggested that Western men may tend to experience less empathic, emotion-focused care when young—vitiating their ability to effectively emotionally self-regulate (Clare 2000); be treated generally more harshly, and generally less empathically, than women—at cost to their health (hence—possibly—Western men's lower life expectancy than women) (Farrell 1994); and, in keeping with widespread notions of toughness and its importance to masculinity, treat themselves, and other men harshly. One key component here is the minimisation of—or, in some cases, almost complete disavowal of—emotional needs (e.g. Frosh et al. 2002). Here, psychodynamic perspectives can be helpful.

Psychodynamic Perspectives

Psychodynamic perspectives provide insights that can be used to inform a CAT approach to men's depression. A key feature of CAT is that the human mind is formed *socially*. In other words, it is via physical and psychological contact with others, the meaning of which is often mediated via signs (e.g. in the form of language), and internalised by the child in a process that recalls Vygotsky's (1978) notion of the zone of proximal development (ZPD) that the child and his or her reciprocal roles develop. During this process, early caregivers can provide a 'scaffold' for the child's learning and development and, as Ryle and Kerr (2002, p. 42) argue,

> The child's sense of self and emergent repertoire of reciprocal roles will largely reflect the style in which the scaffolding for early learning is supplied.

It is against this developmental background that later psychological development occurs, including the elaboration, from the CAT perspective, of reciprocal role procedures.

A principal exponent of psychodynamic approaches with men is the American clinical psychologist Pollack (1998, 2005), who in effect translates

the cultural notions around masculinity discussed above into psychological terms. Pollack (1998) suggests that men may be prone to:

- separate intellect from feeling;
- express anger, but repress other emotions;
- shut off the more vulnerable, emotional parts of themselves;
- experience feelings of shame—but feel forced to deny the actual experience;
- act less empathically towards others;
- criticise the self harshly (or in Freudian terms, have an over-active super-ego), both consciously and unconsciously;
- tend towards perfectionist behaviour, with self and other; and
- find it difficult—when faced by such actual losses as bereavements—to fully acknowledge loss, and so risk remaining trapped in depression (Pollack 1998).

So, Pollack (1998) argues, Western men would be prone to developing what he terms a false sense of self-sufficiency, often searching for an emotional connection with others, but finding it extremely difficult to achieve this. From this point of view, men are all too prone to pull away from any intimate, and possibly helpful, psychological intervention that is offered.

Put another way, owing to the various pressures on them, men in distress can often find it very difficult to be honest about how they feel—either to themselves or others (cf. Trivers 2011). This leaves key human communication channels blocked, and distress no avenue of escape. Men can find themselves, then, in a state of forced inauthenticity. Sometimes, after years or even decades spent at emotional sea like this, men become in effect marooned, far from sure who they really are.

In sum, psychodynamic perspectives on men's experiences of depression are relatively well-developed including, as they do, salient developmental and cultural material. This, as we shall see, can directly inform the use of CAT with depressed men.

Common Reciprocal Role Procedures and Reciprocal Roles in Men with Depression

Given the integrative nature of CAT, and its manner of incorporating notions from developmental psychology as well as cultural studies, this form of therapy lends itself well to psychological interventions with depressed males.

Above all, the process of identifying depressed men's reciprocal role procedures (RRPs) in CAT arguably offers a unique opportunity for intervention with men. According to Ryle and Kerr (2002, p. 220), RRPs can be defined as

> a stable pattern of interaction originating in relationships with caretakers in early life, [which determines] current patterns of relationships and self-management. Playing a role always implies another [person], or internalised 'voice' of another, whose reciprocation is sought or experienced.

Given, however, the above material—and in particular Ryle and Kerr's (2002, p. 157) contention above that some procedural patterns remain tied to gender stereotypes that are maintained by cultural, economic and perhaps even evolutionary pressures, it is arguable that men show specific types of procedure.

First, it might be predicted that, given their (hypothesised) lack of early empathic care, as well as the premature truncation of this by caregivers (Pollack 1998, 2005), men would tend to show restricted relationships with others as part of their procedural sequences. In CAT terms, this might mean that men generally, and depressed men in particular, tend to show reduced, restricted and possibly less fulfilling interactions with others. This accords with our clinical experience.

Second—and given especially the psychodynamic material above regarding the lack of empathic early care for men—it could be predicted from the point of view of CAT that depressed men would tend to *treat themselves more harshly*, or at least in different ways, compared to depressed woman. In view of the fact that men are, on average, less likely to seek help for an existing spell of depression than women, and day-to-day clinical practice, this is very probably the case. Under stress, many men find it challenging to 'look after themselves'.

In terms of specific reciprocal roles, in our experience, men experiencing depression are often subject to the following (Fig. 1).

Overall here, the CAT framework offers a concise means for pinpointing—and then changing—the intrapersonal and interpersonal difficulties confronted by depressed men, and so allow the gradual identification, development and mobilisation of what Ryle (1975, p. 13) terms the psychologically healthy, 'central self'.

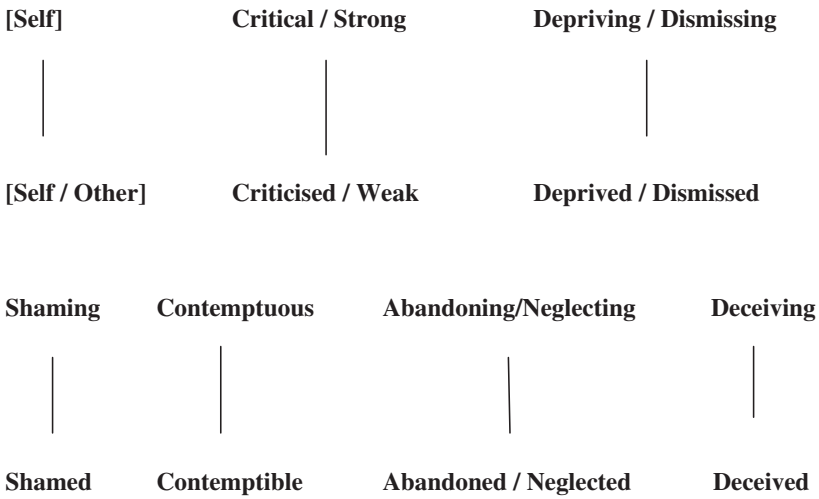

Fig. 1 Reciprocal roles frequently evinced by men

Beginnings: Establishing and Developing the Therapeutic Relationship Up to Reformulation

The material above can be used to inform the establishment and development of the therapeutic relationship with men.

Pollack (1998) argues that men, having been subjected to relatively unempathic early care may—if they get so far as to begin therapy—do so either very reluctantly, begin very hesitantly and are prone to try to pull away from the process. This is observed in CAT with men, where their initial presentation in the service or clinic can be very tentative.

At these times, potentially unhelpful reciprocal roles may be operating. If unidentified and unaddressed, these can lead to the premature truncation of the work—and a state of psychological stasis for the man in question. Reciprocal roles here may include Deceiving/Deceived (where the man is less than honest with himself or others about his feelings), and Abandoning/Abandoned (where the man leaves the opportunity to engage with the clinician).

As another example, some men re-enact a strong and/or controlling role from the outset, as a defence mechanism. One of us experienced an older male making critical comments about the office in which we were meeting, as a way of initially trying to exert control over the (anxiety-provoking) clinical encounter.

In short, rather than colluding in the notion that the clinical issues—perhaps the man's feelings above all—do not need to be addressed, they can be gently and compassionately explored. Here, it can in our experience help to keep in mind such roles as Listening/Listened to; and Engaging/Engaged.

At this early stage of the work, the stress on transparency within CAT—notably around the time of the development of the SDR and the Reformulation letter—usually but not always presented to the person in Session 4—offers certain opportunities. At the very least, these processes offer clear opportunities for specific 'taboo' issues—for example the (potentially shaming) notion or feeling of being a man 'in therapy' to be discussed. Such conversations can also have the effect of both naming, and often, in effect, *reducing* the sense of shame felt by the man—and so promote readiness for psychological change. Furthermore, explicit discussions focusing on the matters of male gender and psychological therapy at an early stage in the work can also make it straightforward to return to such themes as gender-based feelings of shame, if necessary, during the later stages of the work. In particular, there can be discussion of *what masculinity means* to the man in the way that he has led, and leads, his life—including how this might be affecting his well-being and specifically, how this might impact on his depressive symptoms.

As well as linking the man's story of their earlier life with their current (problematic) ways of relating to self and others, a CAT reformulation also considers how those same problematic procedures may be enacted *in relation to the therapist.* One of the main specific therapeutic factors in CAT is the recognition, naming and (respectful) non-reciprocation of those procedures. For many men who present for CAT—particularly who have had experience of emotional neglect and/or abuse to some degree, the reformulation process can be revelatory. This may be the first time in their life that another person has taken the time to get to know their inner life intimately; the first time that a systematic attempt has been made to make sense of it; and the first time that the key issues—and potential solutions—have been spelled out. Openly stating what has happened can also be a huge emotional and even somatic relief for men. Recent evidence suggests that men highly prize such characteristics as being 'honest', 'reliable' and 'dependable' (Men and Boys Coalition 2018). CAT offers an excellent environment for men to rediscover these traits. We now turn to look at how this can work in practice, in a therapy with which one of us was involved.

Case Example: Philip[1]

Philip, a 50-year-old professional gentleman who had been diagnosed with depression, arrived for the therapy assessment on time. At the time of seeking treatment, he was on long-term sick leave from his employment. This had affected his mood but also his level of self-esteem, sense of purpose, role and status as a man.

In hearing Philip's story, it was apparent that there were a number of relational difficulties evident, affecting self and other. We also identified triggering patterns that had lowered his mood. Interestingly they had mirrored problematic patterns from his early years, leaving Philip feeling bullied, criticised, hurt and let down. This led to Philip feeling depressed and lacking in motivation or energy. He shared sadly how he felt he had 'no passion anymore'. It was hard for him to connect with any rage or anger that could have related to how he had been treated by others who had authority over him.

We explored embarking on a longer 24-session Cognitive Analytic Therapy (CAT) and information was given about the intervention, explaining that CAT was a time-limited, relational therapy which focuses upon the problematic procedures that fuel the symptoms affecting the mental distress.

The therapy plan was explained in a way to ensure informed consent and we discussed incorporating mindfulness meditation around session eleven. There is strong research to indicate the value of mindfulness helping not only with observing and developing the ability to radically accept mind states and emotions but to also expand the capacity to recognise the problematic patterns and work towards creating some change (Wilde McCormick 2004; Williams et al. 2007; Hick and Bien 2010).

Sessions 1–4

During the early sessions, we constructed a genogram together and a timeline to gather an understanding of the significant events in understanding Philip's history and story.

After Session 1, Philip took the CAT Psychotherapy File away to complete at home, in his own time and at his own pace. It is designed to help

[1]For the purposes of this chapter, name and details have been anonymised.

identify the traps, dilemmas and snags that form the problematic procedures. In these first few sessions, we also quickly identified the significant reciprocal role and reciprocal role procedures that had been internalised from his early life experiences and relationships with caregivers.

The problematic reciprocal roles for Philip were: 'Conditionally Controlling to Withdrawn and Alone or Passively Rebellious', 'Contemptuous, Violent Bully to Contemptible Victim', 'Neglecting Dismissive to Neglected and Dismissed'. Also it was important to note that Philip held a 'wished for belief' that his 'Utopia' existed where he would experience others as: 'All knowing & providing Ideal Care to Ideally Cared For and Special'. From reflections about the role he had taken on at work and those in his care, he would try to provide this for others. However it would often be at the cost of meeting some of his own needs, usually leaving him feeling let down or used.

The first stage of CAT is, as noted, to collaboratively make sense of the client's problematic procedures and establish the aims or focus for the therapy by reformulation. This is done both in a letter and mapping it visually in a SDR. At the fourth session, the Reformulation letter was read out. Philip has kindly chosen to allow parts of his letter to be shared in the extracts below. Comments relating to CAT theory are in parentheses.

Reformulation Letter

Dear Philip,
[…] When we first met you were able to tell me about all of the previous therapy interventions you have had in these recent months following being off sick from your job […]. In talking about what you felt the problem was you said how you felt "like a little boy, expecting to be punished and still waiting for mummy to love me".

(Here, I was naming how we had noticed very early in the relationship the problematic reciprocal roles that the therapist was being invited into—either "Kindly rescuing or Critically telling off".)

We have begun to talk about your early years and what life was like growing up in your family in […]. We spoke of how you grew up feeling you were a mistake and laughing told me that it was a family joke that you and your brother […] should have been born girls, as Mum wanted the "perfect family". Your laughter seemed to cover the immense pain of not being able to change or be different from how you are born. I do wonder what has happened to the anger and disappointment you feel from not feeling accepted for who and how you are?

(Naming a pattern that we can begin to observe in starting to recognise from Philip's target problem procedures. This was one of his attempts to distance himself from his emotional pain and the anger that he feared. The fear for him was that if he showed anger, he would be like his father, out of control, a violent bully, so his response to this dilemma was to bottle up and suppress his distress and rage.)

You talked of your Mum as someone who was very critical, controlling and blaming. It always felt as if you could never do anything right. Often your feelings and needs were not valued or listened to. It is not surprising that you learned your feelings and needs are not as important as others', and that you were unworthy. That must have left you feeling very despairing and alone.

(This summarised what had been spoken about and naming his core pain and deep sadness of not feeling good enough and acceptable.)

It made you feel you could never "man up" and you felt that at such a young age you were written off. The lack of support and nurture certainly taught you to and left you with the dilemma of either be the "strong man who does not need others" or the overwhelmed "little boy lost". Sadly no-one was able to teach you how to stay with difficult emotions, have a sense of your own power and allow yourself to have support.

(The shame Philip had felt had prevented him from previously addressing his unresolved emotions as it was so painful to acknowledge and accept. The feelings linked to his shame that he found so unbearable were terror, hurt and humiliation. Therefore to connect to his emotions meant, he could no longer distance himself from his distress and inner suffering [Wilde McCormick 2011; Gilbert 2010]. It was important to validate his courage and the strength it took to begin to face these feelings within the therapy.)

Trusting people has always been difficult and felt risky. Either you put on the front of the big smiling […] strong man or you retreat to isolation, withdrawing from people becoming the little boy lost. As we have begun to explore your feelings a little more closely you have begun to notice how angry, despairing and empty you feel. It leaves you feeling embarrassed for the extent that you often feel the victim, unable to stand up for yourself and as if you are trampled on like dirt on people's shoes.

(At this point we name the one of the dilemmas that we could work on recognising during the therapy.)

Noticing how you feel and having a voice for those emotions is in some ways a new step for you. Finding your voice and letting people know how you truly feel seems to be a big challenge in helping you move forward with your life.

(Identifying the second target problem we would focus on during the therapy.)

I look forward to working with you in our remaining sessions over the next few months. Together we will work trying to gain a better understanding of how these patterns become enacted in your life and how you find ways to become more true to yourself, and meet the "Real Philip".

With very best wishes,
(Therapist)

In the next session, Philip shared a response that he had written. Extracts and commentary follow.

Dear (Therapist),
Thank you. Thank you for listening and putting into words some of the feelings and thoughts that have been broiling away in my mind for years. I have never found it easy to personally express my feelings verbally and so hearing your do that for me was a revelation. Half way through the letter that you read to me, I found that I was nodding along in agreement. It was extraordinary experience […].

(This demonstrates the start of Philip developing a sense of his "voice" feeling heard and the dialogic relationship between client and therapist forming. In CAT—which draws heavily on Vygotsky and Bakhtin— dialogue is crucial in forming the collaboration and trust within the relationship [Ryle and Kerr 2002; Leiman 1992]).

[…..] Some of the insights that you have made concerning my upbringing were unknown, or more accurately, unrealized by me previously and quite literally opened my eyes to what has been happening inside my head, insidiously undermining me all my life […]

(Philip communicates that I had heard his story and in the reconstructive narrative and collaboratively we had made the links between his past experiences and the current procedures gaining a clearer understanding of how this impacted on him.)

We went on to map the reciprocal role procedures on a sheet of paper and begin to name some of the overwhelming emotions that Philip had shared, such as: anxiety, fear, emptiness, despair, hurt, shame and self-hatred. The importance of getting into dialogue with the gritty, disavowed reciprocal roles of his core pain began to bring a richness of understanding into our therapeutic relationship (Hepple 2011).

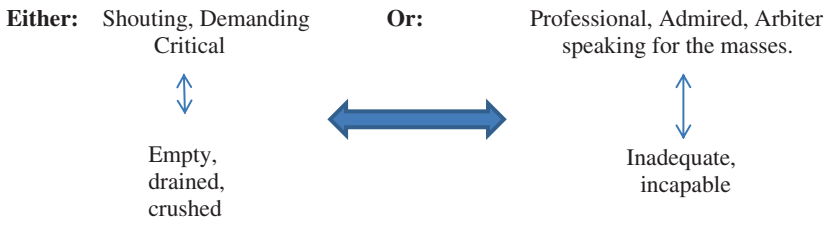

Fig. 2 Extract from Philip's sequential diagrammatic reformulation

Also alongside the SDR (extract in Fig. 2), we had mapped the dilemma that Philip frequently found himself in.

Middle: Exploring and Deepening the Therapeutic Relationship with Men

At best, the therapeutic relationship in CAT for depressed men can offer a precise and transparent means of operationalising key notions. Above all, working with the reformulation letter, SDR and the therapeutic relationship, a detailed picture can be developed of the male client's own sense of relating to the therapist (male or female)—as well as of the therapist's sense of relating to the client. On this basis, the male client's earlier experiences, including those interpersonal experiences which seemed to impact on his sense of having male identity, can be gradually explored, and put in the context of the therapeutic relationship as a way of initiating and enabling change, mid-therapy.

To take another example from our clinical practice, a male client recalled distinctly from his early relationship with his father that to talk 'sensitively', about 'feelings', was to 'talk stupid'. Careful exploration of these memories midway through a CAT therapy, and comparison with the male client's current experiences with the male therapist, went at least some way to begin to undermine and change certain of the client's key reciprocal role procedures (RRPs). The therapeutic relationship within CAT for depressed men can offer a key forum for addressing and normalising the male client's feelings of gender-based shame, notably by helping to pinpoint his place in, and feelings about, the therapeutic relationship.

Frequently, too, in the middle phase of a CAT therapy with men, the clinician and client may find themselves passing through alternating emotional states, a jocular or jovial (and slightly defended) state on the one hand; and a deepening emotional connection on the other. As the man feels more

confident in the clinical setting, and trust grows, very valuable therapeutic work can be done. As layers of defence fall, new, unprocessed material can emerge, and be safely contained, in the therapeutic relationship.

Case Example: Philip—The Middle of the Work

Sessions 5–18

During this phase of the therapy, we continued to work on recognising the identified target problem procedures and gaining more details of Philip's story. He bought a notebook and started to keep a journal reflecting upon his thoughts and feelings during the week, writing down what he was noticing. Frequently throughout the course of his therapy, he would bring his journal and use it as an aide memoir. He actually found it very difficult to connect to his feelings as he either became overwhelmed and distressed or worked hard in trying to distance himself by intellectual efforts such as focusing on wider issues of society or the world. It remained a careful balance to bring back the focus of our sessions and yet respect his limitations. I found myself gently pushing him to the edge of his zone of proximal development, helping Philip to step just a little outside of his avoidant level of comfort and explore his emotions (Ryle and Kerr 2002; Vygotsky 1978).

There were times that it felt as if I moved too quickly to enable him to recognise, only to notice this and then take a few steps back to stay with the feelings related to past trauma. Supervision was essential in helping me to identify this and work effectively with staying within Philip's window of tolerance. This took time and it was very important to pay attention and highlight how he was able to regulate his emotions following connecting to some very difficult feelings. It was helpful that we had contracted a longer period of CAT therapy. As the relationship developed at this phase, Philip talked in more depth of a number of painful and traumatic situations. It became clearer how these more recent events had connected him to the unresolved distress of his core pain.

Following this point, we had incorporated the use of mindfulness into our sessions to develop the skill of this practice to help to become more self-aware and notice what he was feeling (Segal et al. 2002; Williams et al. 2007; Hick and Bien 2010). The aim was that this could provide a platform for Philip to begin to non-judgementally validate his emotional experiences and work towards developing some self-compassion. Philip made a commitment to regularly practicing. By using mindfulness Philip was able to develop a way of helping to name, accept and regulate his difficult emotions. It also proved valuable

in assisting him to access a deeper level of connection to his feelings than we had previously managed. Philip created a "safe place" for himself where he would meditate mindfully, internally constructing an image of Mount Kailash in Tibet. With this in mind, he described being able to stay with and accept the emotions, along with the bodily sensations that he experienced, thus leading him to develop a greater capacity of acceptance and understanding for himself.

Philip regularly shared his dreams within the CAT session, as this deeper connection with his difficult emotions seemed to play out when he slept. Many of his dreams had violent, disturbing content, and we were able to consider how this gave 'voice' to his anger, rage and fear of events that he found so difficult to express, previously, by day.

It was during this working phase of the CAT therapy that we were also able to utilise the benefit of writing "no send" letters which enabled Philip to access, express and process many unresolved feelings, learning to have a voice. Reading these aloud enabled Philip to hear his own words and feel more empowered, while also releasing his feelings of grief, anger and loss related to the traumas he had encountered.

The therapeutic alliance was providing him with a different response to managing his emotions and began to equip him with scaffolding he needed. Philip was starting to find alternative ways of responding to his target problem procedures and feelings as they were evoked.

Philip identified these "Exits" as: Recognising the feeling/Finding a voice and open up to others/Being kinder to myself/Use mindfulness/Connect with others (through hobby)/Recognise I have choices/Allow self to do things that are enjoyable and develop new hobbies.

First Step Towards Change

The emphasis in CAT on the 'creation of a non-collusive, collaborative relationship' (Ryle and Kerr 2002, p. 33) also offers a clearly-defined testing ground for change in the midst of therapy. This inevitably means different things to different men; but where—perhaps for the first time—particular feelings start to be noticed, say, they can be carefully and gently explored in the previously unfamiliar setting of individual therapy, enabling men's awareness of and confidence in their emotional lives to begin to develop.

This can mean, too, men 'trying out' new reciprocal roles which previously would have seemed strange to them, or would have been shunned. In our experience, through the vehicle of CAT, men are often able to begin to become more caring and empathic towards themselves, often for the first time.

It is helpful, if this issue emerges, for it to be explicitly identified, discussed and normalised within the therapy.

In this way, the middle phase of a CAT therapy with men can be a critical one, where the historical defences can be reduced; and authentic contact is established both between the clinician and the man concerned and between the man and his own interior, emotional life. Where such trust and honesty emerges, significant therapeutic progress can occur.

End: Working Towards Endings in CAT with Depressed Men

CAT requires the therapist—and the client—to keep the end in mind from the beginning (Ryle and Kerr 2002). A CAT reformulation letter will often name enactments of problem procedures which are likely to occur around termination. For some men, in an echo of the early phase of CAT noted above, this includes the possibility that they would abandon therapy before it abandoned them—either dropping out or withdrawing emotionally prior to the ending. In order to avoid this, the therapist can note the passing of sessions in each session counting down the remaining number—and openly discussing the implications.

The other main technique to facilitate a good ending is the writing and exchange of therapy 'Goodbye letters'. These perform a number of functions—they require both parties to really focus on the end. They are meant to allow each party separately to make a realistic evaluation of what has been achieved. The therapist explicitly invites the patient to name the (inevitable) disappointments of therapy as well as what has been valuable, to avoid as far as possible unhelpful idealisation, placation or avoidance. The therapist's Goodbye letter also may serve as a transitional object—a sign that can carry something of the relationship in the absence of the therapist, as well as of the exits from problem procedures that are to be practised in future. They are read aloud, given the power of hearing the spoken word. For the client, this entails acknowledging their experience of the alliance now the therapy is at the end, to express both progress made and give voice for any disappointments and sadness, thus validating the end—and often in a different way to previous endings experienced (Ryle and Kerr 2002; Corbridge et al 2018).

Sometimes, clinical experience shows that men—perhaps unexpectedly—cherish both their Reformulation and Goodbye letters, keeping them for years, referring back to them at times of emotional need.

Case Example: Philip—Moving Towards the End of Therapy

Sessions 19–24

We had previously spoken and named our ending, counting the sessions down each week on our sheet of session dates. The ending of our work naturally brought up some difficult emotions for Philip as it triggered strong feelings from the past and he was reminded of his core pain and previous endings encountered. This connected him with feelings about significant losses in his life, especially as he had made a decision to end his career and not return to a job he had loved. This was a painful choice. But he was able to recognise that he "deserved better" and it was not a healthy environment. Philip understandably had fears about ending the therapy as he felt he lacked confidence. Helpfully, he was able to voice these fears and we validated his feelings. We talked about the usefulness of having follow-up sessions to be able to come back and reflect together how he was learning to 'stand on his own feet'.

We negotiated to share goodbye letters in the penultimate session which enabled greater time to process the letters together and reflect on the ending. Philip read his letter to me aloud first. Exchanging letters in this way often enables clients to feel less anxious as they are able to voice their own letter first and are not comparing what they have written to what is delivered by the therapist and anxious that they may not have 'got it right'.

Extracts from Philip's Goodbye Letter follow.

Dear (Therapist),
I really don't know what to write in this. I really think I don't want to write this. […] You know I hate goodbyes […]. Firstly, thank you for listening to me. I certainly have never spoken to anyone at such length about what goes on inside my head.

Thank you for making me feel comfortable enough to open up and […] for helping me to see and understand that feelings are part of the human condition and as such should be embraced and not locked in cupboards marked "not to be opened under any circumstances". I know that you understand that I still find dealing with emotions difficult but I now understand that they need dealing with. That remains an adventure for the future! Not one I'm particularly looking forward to but one I know that I have to undergo […].

(Philip was able to express his thoughts and feelings about this therapy in a balanced way, including, later on in the letter, naming the difficulties of

ending that he feared, as well as the work that he knew he still needed to address).

Extracts from the therapist's Goodbye letter follow.

Dear Philip,

[…] It is sad that for so much of your life you have struggled to be yourself or allow yourself to feel, respond or express your emotions. Instead you lived your life by how you think you "should be" rather than accepting and valuing who and how you are. Trying to control yourself to push feelings away has not helped you tolerate, value or understand your feelings. This pressure has created the distress you feel as it has been virtually impossible to be yourself or feel valued for being or feeling the way you do. […]

Letting me see the part of you that can have difficult feelings, such as when you have been frustrated, disappointed, felt shame or annoyed has been a big step. It is one you still struggle with but nevertheless has meant you have taken huge risks to manage things differently. Allowing the "real Philip" to be seen and heard in turn has enabled you to value yourself and recognise what you have needed. […]

You are now able to give much more thought to yourself and what <u>you</u> may need, not just giving it to others. It has been a pleasure to see how you are [moving] towards developing the self-care and compassion you need. There is a small light of hope and excitement starting to glimmer through as you think of the future with more positive feelings.

The reflections and the ensuing discussion allowed Philip to think about what he had accomplished during the therapy, and what he still needed to focus on after completing the intervention. Philip was able to share his appropriate emotional response to the sadness of ending and saying goodbye, as he had valued the therapeutic relationship.

Philip attended the usual follow-up appointments that are indicated for CAT and demonstrated that although things were not dramatically different for him, he had been able to maintain the changes. Further contact from Philip at a later date where he had written a letter out of the blue also highlighted how he had positively managed to hold on to these changes, and was still using his exits two years after his treatment.

*

Working with many men in CAT in this manner, it can feel, towards the ending, that therapist and client are moving inexorably back to the emotional shallows, having explored the depths. Follow-up meetings with such men, however, indicate in fact that—as within the work with Philip—the

benefits of deeper, authentic emotional contact are not fleeting, but are seen as personally valuable, and sometimes transformative. For many men, having CAT may be a unique experience in their lives, especially if they have developed within, and have learned to re-enact, reciprocal roles associated with traditional, restrictive Western masculinities. Often, these men develop new roles during CAT that can take them forward in new and adaptive ways. Frequently, too, men in CAT proudly discover or rediscover their capacity to be honest, loyal and dependable—prized characteristics for many males—with others, and above all with themselves.

In this sense, for many men, CAT can chart and begin to untangle the early damage done by abuse, neglect and trauma to their ability to reciprocally relate. Given the central importance of relationships to human health, this alone can be a major step forward for an individual man.

Conclusion

With its careful, detailed emphasis on a person's developmental beginnings, focus throughout on interpersonal relating, and the use of the therapeutic relationship as a crucible for change, CAT has much to offer men who experience depression as a model of psychotherapy. Extensive clinical experience using CAT in the UK and elsewhere over the last three decades or so indicates that many men—some of whom bring high levels of attachment and/or developmental trauma, and associated interpersonal difficulties to the clinical setting—do very well indeed when they take the opportunity of engaging in this modality, and opening a dialogue about how they really feel.

In our experience, unquestionably helped by the humane transparency that is a hallmark of CAT, many men who encounter depression come to see themselves, and their relationships, more openly, honestly and with less stigma, and understand more clearly how their issues originated, and how they have been re-enacted in their day-to-day relationships. Perhaps, above all, men come to mobilise this new emotional and psychological awareness to reconfigure their self-to-self relationships, or self-care, in ways that, sometimes, they would not have thought possible.

Acknowledgements The authors would like to thank Philip for kindly allowing his material to be used in this chapter; and Dr. Mark Westacott for his insights and support during the writing process.

References

Bahktin, M. M. (1986). *Speech genres and other late essays*. Austin: University of Texas Press.

Beynon, J. (2002). *Masculinities and culture*. Milton Keynes: Open University.

Bowlby, J. (1988). *A secure base: Clinical applications of attachment theory*. London: Routledge.

Brannon, R. (1976). The male sex role: Our culture's blueprint for manhood and what it's done for us lately. In D. David & R. Brannon (Eds.), *The forty-nine percent majority: The male sex role* (pp. 1–48). Reading, MA: Addison-Wesley.

Calvert, R., & Kellett, S. (2014). Cognitive analytic therapy: A review of the outcome evidence base for treatment. *Psychology and Psychotherapy: Theory, Research, and Practice, 87*(3), 253–277. https://doi.org/10.1111/papt.12020.

Carney, R. M., & Freedland, K. E. (2016). Depression and coronary heart disease. *Nature Reviews: Cardiology.* Online advance publication. https://doi.org/10.1038/nrcardio.2016.181.

Clare, A. (2000). *On men: Masculinity in crisis*. London: Arrow.

Cochran, S. V., & Rabinowitz, F. E. (2000). *Men and depression: Clinical and empirical perspectives*. San Diego: Academic Press.

Connell, R. W. (2005). *Masculinities.* 2nd ed. Cambridge: Polity.

Corbridge, C., Brummer, L., & Coid, P. (2018). *Cognitive analytic therapy: Distinctive features*. Oxon: Routledge.

Denman, C. (2004). *Sexuality: A biopsychosocial approach*. London: Palgrave.

Elliott, K. (2016). Caring masculinities: Theorizing an emerging concept. *Men and Masculinities, 19*(3), 240–259. https://doi.org/10.1977/1097184X15576203.

Farrell, W. (1994). *The myth of male power: Why men are the disposable sex*. New York: 4th Estate.

Farrell, W., & Gay, J. (2018). *The boy crisis: Why our boys are struggling and what we can do about it*. New York: Houghton Mifflin.

Fitzpatrick, T. R. (1998). Bereavement events among elderly men: The effects of stress and health. *The Journal of Applied Gerontology, 17,* 204–228.

Frosh, S., Phoenix, A., & Pattman, R. (2002). *Young masculinities: Understanding boys in contemporary society*. London: Palgrave.

Gilbert, P. (2010). *The compassionate mind*. London: Constable.

Hepple, J. (2011). The chicken and the egg. *Reformulation, 4,* 19.

Hick, S. F., & Bien, T. (Eds.). (2010). *Mindfulness and the therapeutic relationship*. New York: Guilford Press.

Kelly, G. (1955). *The psychology of personal constructs*. New York: W. W. Norton.

Kingerlee, R. (2012). A transdiagnostic model of male distress. *Psychology and Psychotherapy: Theory, Research and Practice, 85*(1), 83–99. https://doi.org/111/j.2044-8341.2011.02017.x.

Leiman, M. (1992). The concept of sign in the work of Vygotsky, Winnicott and Bakhtin: Further integration of object relations theory and activity theory. *The British Journal of Medical Psychology, 65,* 209–221.

Leiman, M. (1995). Early development. In A. Ryle (Ed.), *Cognitive analytic therapy: Developments in theory and practice* (pp. 103–120). Chichester: Wiley.

Levit, D. (1991). Gender differences in ego defences in adolescence: Sex roles as one way to understand the differences. *Journal of Abnormal and Social Psychology, 61,* 992–999.

Marriott, M., & Kellett, S. (2009). Evaluating a cognitive analytic therapy service: Practice-based outcomes and comparison with person-centred and cognitive-behavioural therapies. *Psychology and Psychotherapy: Theory, Research, and Practice, 82*(1), 57–72.

Men and Boys Coalition. (2018). *The Harry's masculinity report.* Retrieved June 15, 2017, from http://www.menandboyscoalition.org.uk/wp-content/uploads/2018/01/The-Harrys-Masculinity-Report-pdf.

Office of National Statistics. (2017). *Suicides in the UK: 2016 registrations*. Retrieved from http://www.ons.gov.uk/ons/rel/subnationalhealth4/suicides-in-the-united-kingdom/index.

Pichot, P., & Hassan, J. (1973). Masked depression and depressive equivalents: Problems of definition and diagnosis. In P. Kielholz (Ed.), *Masked depression* (pp. 61–81). Berne: Hans Huber Publishing.

Pollack, W. S. (1998). Mourning, melancholia, and masculinity: Recognising and treating depression in men. In W. S. Pollack & R. F. Levant (Eds.), *New psychotherapy for men* (pp. 147–166). New York: Wiley.

Pollack, W. S. (2005). Masked men: New psychoanalytically oriented treatment models for adult and young adult men. In G. E. Good & G. R. Brooks (Eds.), *The new handbook of psychotherapy and counselling for men: A comprehensive guide to settings, problems, and treatment approaches* (pp. 203–216). San Francisco: Wiley.

Price, J., & Stevens, A. (2000). *Evolutionary psychiatry: A new beginning*. London: Routledge.

Ryle, A. (1975). Self-to-self, self to other: The world's shortest account of object relations theory. *New Psychiatry*, 12–13.

Ryle, A., Kellett, S., Hepple, J., & Calvert, R. (2014). Cognitive analytic therapy at 30. *Advances in Psychiatric Treatment, 20,* 258–268. https://doi.org/10.1192/apt.bp113011817.

Ryle, A., & Kerr, I. (2002). *Introducing cognitive analytic therapy: Principles and practice*. Chichester: Wiley.

Schore, A. N. (1994). *Affect regulation and the origin of the self: The neurobiology of emotional development*. Hillsdale, NJ: Lawrence Erlbaum.

Segal, Z. V., Williams, J. M. G., & Teasdale, J. D. (2002). *Mindfulness-based cognitive therapy for depression*. New York: Guilford Press.

Trivers, R. (2011). *Deceit and self-deception*. London: Penguin.

Vygotsky, L. S. (1978). *Mind in society: The development of higher psychological processes*. Cambridge, MA: Harvard University Press.
Wexler, D. B. (2009). *Men in therapy: New approaches for effective treatment*. New York: W. W. Norton.
Williams, J. M. G., Teasdale, J., Segal, Z., & Kabat-Zinn, J. (2007). *The mindful way through depression*. New York: Guilford Press.
Wilde McCormick, E. (2004). Mindfulness and CAT. *Reformulation, 3,* 5–10.
Wilde McCormick, E. (2011). Compassion in CAT. *Reformulation, 3,* 32–38.
World Health Organisation. (2016). Retrieved November 18, 2016, from http://www.who.int/mediacentre/Factsheets/fs369/en/.