Cognitive-behavioral therapy and mindfulness: A case from a gender perspective[1][2][3][4]

Terapia cognitiva-conductual y de atención plena: Un caso desde la perspectiva de género

Leonell Torres-Pagán[5]
City University of New York

Miguel Vilaro-Colón[6]
NYC Health and Hospitals

Yomarie Rodríguez- Loyola[7]
NYC Health and Hospitals

Abstract:

The following study examined a single case of a young Hispanic man suffering from distorted body image and dysfunctional schemas about himself as a man, exacerbated by hair loss. He reported anxiety and depression related symptoms affecting his daily life functioning. Treatment considered for this case was centered on Cognitive Behavioral Therapy (CBT) with some guidelines suggested by a review of literature on gender role theory. During the course of treatment, other techniques based on mindfulness were included to target anxiety related symptoms, including: breathing exercises, yoga, and guided meditation. In addition, an imaginary exposure technique was conducted to further address patient symptomatology. To guide treatment, measures related to masculinity were used like the Male Role Norms Inventory (MRNI-SF), and the Health Behavior Inventory-20 (HBI-20) to assess preventive and health risk behaviors. A genogram was also used to explore family history and family dynamics. Beck Depression Inventory (BDI) and Beck Anxiety Inventory (BAI) were used as clinical measures for baseline, post and follow up treatment. Masculinity issues, family dynamics and clinical outcomes are discussed.

Keywords: CBT, mindfulness, masculinity, gender role, seeking help

Resumen:

El siguiente estudio examina el caso de un hombre joven hispano que presentaba distorsiones en su imagen corporal y esquemas disfuncionales como hombre, acentuado por la pérdida de cabello. El paciente mostró síntomas relacionados a ansiedad y depresión que afectaban su funcionamiento y rutina diaria. El tratamiento considerado para el caso estuvo centrado en la Terapia Cognitivo Conductual (TCC) con algunas sugerencias provistas por la literatura en teoría de roles de género. Durante el tratamiento, otras técnicas basadas en la atención plena *(mindfulness*) fueron incluidas para la atención de síntomas relacionados a la ansiedad tales como ejercicios de respiración, yoga y meditación guiada. Además, se utilizó la técnica de exposición encubierta para atender la sintomatología presentada por el paciente. Para guiar el tratamiento, se utilizaron medidas relacionadas a la masculinidad como el *Male Role Norms Inventory* (MRNI-SF), y el *Health Behavior Inventory-20* (HBI-20) para el avalúo de conductas preventivas y de riesgo hacia la salud. El genograma fue un recurso clínico utilizado para explorar la historia y dinámica familiar. Las escalas *Beck Depression Inventory* (BDI) y *Beck Anxiety Inventory* (BAI) fueron utilizadas como medidas clínicas para el tratamiento desde su base inicial hasta el seguimiento del mismo. Temas inherentes a la masculinidad, dinámica familiar y resultados clínicos son discutidos.

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[5] Leonell Torres-Pagán, Ph.D. Center for Puerto Rican Studies Hunter College, City University of New York. For more information, write to following email: leonell.torres@upr.edu

[6] Miguel Vilaro-Colón, MD. Roberto Clemente Family Guidance Center and Gouvernour Health, NYC Health and Hospitals.

[7] Yomarie Rodríguez- Loyola, Ph.D. Roberto Clemente Family Guidance Center and Gouvernour Health, NYC Health and Hospitals.

Palabras Claves: TCC, atención plena, masculinidad, roles de género, búsqueda de ayuda

Theoretical and Research Basis for Treatment

Men, in general, find it difficult to seek help which constitutes a barrier for their health care. According to research, men engage less frequently in preventive behaviors such as screening visits, seeking mental health services, and tend to have poor social support and adherence to treatment, among others (Courtenay, McCreary, & Merighi, 2002; Courtenay, 2011). Behaviors such as these can put them at risk. For example, when certain emotions related to anger such as outrage or aggressiveness are released by men, the consequences for their health can be devastating (Dorr, Brosschot, Sollers, & Thayer, 2007; Lupis, Lerman, & Wolf, 2014). Mortality rates for men continue to be on the rise across the top leading causes of death including accidents (Centers for Disease Control and Prevention, 2011). For the Latino, Hispanic and Black men there is an alarming health discrepancy compared to other groups in terms of health outcomes and risk behaviors (Centers for Disease Control and Prevention, 2011; Kochanek, Arias, & Anderson, 2013; Suicide Prevention Resource Center, 2013). In addition, mental health and healthcare utilization is lowered and they shared a staggering disparity in chronic mental health disorders (Centers for Disease Control and Prevention, 2013; Keyes, Martins, Hatzenbuehler, Blanco, Bates, & Hasin, 2011).

The portrayal of risk behaviors and their efforts to silence or disguise their pain towards family, friends and healthcare providers can decrease their life expectancy. A common barrier found within this population for treatment in mental health and healthcare services is likely linked to different constructions of masculinity (Carpenter & Addis, 2000; Courtenay, 2011). The pursuit of masculinity is sustained by traditional attitudes and the behaviors that are expected of men and reproduced by them. Men, society and cultures throughout history have regulated this phenomenon extensively. According to research, a common ground in this discourse is power, which transcends other modalities of masculinities (Connell, 2005; Olabarría, 2009; Toro-Alfonso, 2009). This notion of power could be threatened in the context of therapy. Psychotherapy was traditionally conceived with a structure where emotional expression, introspection and acknowledgment of vulnerability, which are behaviors traditionally assigned to women, were welcome, as opposed to traits frequently linked to masculinity like feeling in control and being independent (Brooks, 1998; Englar-Carlson & Stevens, 2006; Toro-Alfonso, 2012). The therapy room is mainly structured within an intimate environment, where men are expected to disclose their inner difficulties in a setting traditionally associated with weakness. Nevertheless, what happens to men who have the opportunity to reframe their experiences in therapy and reclaim these spaces? How courageous men move beyond these challenges and face their inner fears? How can a therapist engage with men during this process? The following study aims to examine these questions and suggest some alternatives for therapists interested in working with men. The study was approved by the outpatient mental health clinic director and the affiliated institution by meeting the proper ethical guidelines for a case study as an anecdotal single case report.

Treatment Options/Recommendations

Researchers and mental health practitioners in the field of masculinity have argued that the therapeutic model should be attuned or more sensible to male values by being an active process, solving a specific problem in a brief period of time, and having concrete or tangible goals (Brooks, 1998; Englar-Carlson & Stevens, 2006; Mansfield, Addis, & Mahalik, 2003; Toro-Alfonso, 2012). Cognitive behavioral therapy (CBT) as a therapeutic model seems to fit these qualities and also allow the patient to perform therapeutic tasks as an active entity in the process. Nowadays, CBT and other evidence-based modalities have continued to achieve high effectiveness and efficacy for a majority of clinical disorders such as depression, anxiety, and eating disorders, within different populations, and including health conditions (Coull & Morris, 2011; DiMauro, Domingues, Fernandez, & Tolin, 2013; Hays & Iwamasa, 2006; Lincoln et al., 2012; Wagley, Rybarczyk, Nay, Danish, & Lund, 2012). CBT mainly addresses core rigid and dysfunctional schemas about men like the traditional views of masculinity, which can play an important role in the process of therapy, engagement and clinical outcomes by increasing cognitive flexibility (Primack, Addis, Syzdek, & Miller, 2010). An examination of the patient's history, as part of this approach, can provide a clinical compass for both the mental health practitioner and the patient in his pursuit of masculinity. A pursuit surrounded by significant events that may lead to either a healthy self or an unprecedented chain of dysfunctional and rigid schemas about being men.

Despite the CBT rationale, its empirical support and suitability for men, there is a need to examine the sensibility towards this population. Following these premises, it is important to tailor treatments by including a gender role framework. According to a literature review conducted by Spendelow (2015), gender theories such as gender role schemas theory (Bem, 1981) and the gender role conflict (O'Neil, Good, & Holmes, 1995; Pleck, 1995) are both helpful in the context of CBT due to their gender-specific cognitive and behavioral indicators of the maintenance of dysfunctional schemas. Spendelow, also encourages the following when applying gender theory for men in therapy within a CBT framework: (a) including the concept of multiple masculinities, and (b) emphasis on biopsychosocial factors. A discussion of multiple masculinities in therapy can illustrate other views about men besides the hegemonic and traditional ones. An approach on masculinities can be a useful tool to challenge unhealthy hegemonic schemas (eg. men don't speak about their concerns) and encourage coherent views about men (eg. even the strongest men need to speak about their concerns). Once CBT with the described adaptations is placed in motion, it can normalize and promote an active role in men.

On the other hand, the biopsychosocial factors are also a practical tool because this approach conceives masculinity in terms of the mutual interaction with the presenting problem. According to literature on mindfulness, this modality gives special attention to the biopsychosocial factors in order to understand and address symptoms presented by patients (Didonna, 2009; Kabat-Zinn, 2013). In addition, mindfulness does not necessarily distance itself from the main premises of CBT. In fact, it also focuses on the awareness of the rigid schemas patterns and how these can affect the body as well. This is particularly important due to the difficult relationship men have with their body (Burlew & Shurts, 2013). Men frequently experience their bodies in terms of power and performance; however, they don't necessarily feel and live by it (Toro-Alfonso, 2009). Being a man involves ceremonies and worship towards the body that are immersed in silence. For most men, pain is measured by gain, not by weakness. Research has evidenced this silence on disorders associated with the body such as eating disorders and muscle dysmorphia (O'Dea & Abraham, 2002; Ousley, Cordero, & White, 2008; Mussap, 2008). The embodiment of these attributes may place them at extremes.

Nevertheless, a healthy body can be reached by being an active listener to the cues presented by the body itself. The awareness and the attunement provided by modalities like mindfulness, can offer an active role for men in activities such as breathing, yoga, and grounding exercises, among others. According to Jon Kabat-Zinn (2013), one of the main leading authorities in this field, mindfulness and derived modalities are imbedded within a Buddhist tradition which mainly focus on particular ways of paying attention and the awareness that comes through the body. Mindfulness allows patients to increase their self-awareness to reduce levels of stress in response to internal and external aversive experiences. This requires an active role from the therapist, as well as from the patient. Kabat-Zinn stated that mindfulness involves a series of integrative key principles such as (a) non-judging (embracing a nonstop judging attitude towards inner and outer experiences), (b) patience (thoughts are overwhelming and being patient will keep the mind grounded), (c) beginner's mind (should have a willing mind to be able to see or experience everything as the first time), (d) trust (relies in believing in yourself even if there is a mistake), (e) non-directive (a goal can be an obstacle and awareness is encourage), and (f) acceptance (being able to feel and see things as they are in the present time). Mindfulness has gained notoriety across different fields such as education, medicine, psychiatry, psychology, and social work, as a moment-to-moment experience framework (Didonna, 2009; Kabat-Zinn, 2013). There is also a clinical handbook for mindfulness based on studies of the effectiveness of this treatment modality as well as its use within a broad range of clinical disorders such as substance abuse, anxiety, post-traumatic stress disorder, attention deficit disorder, depression and suicidal behavior, eating disorders, borderline personality disorders, obsessive compulsive disorder, and psychosis, among others (Didonna, 2009).

Mindfulness has certainly been an unprecedented tool for clinical practice. Despite this, little is known about the process in terms of how it works and whether there is a difference in the reception from a gender perspective. One study aiming to answer this question, found that women benefit more from this intervention than men (Katz & Toner, 2013). Nonetheless, mindfulness provides men with a potential alternative to become fully aware of their body and emotions. The awareness resulted from mindfulness may lead them to be active participants. Therefore, this case study seeks to explore the therapeutic process experienced by a Hispanic man and his initial journey to healing. It also includes an analysis of CBT clinical interventions supported by the gender theory literature, techniques related to mindfulness, and imaginary exposure

used to address patient symptomatology. For the purpose of this study, names or potential identifiers of the patient were changed to protect his identity.

Case Introduction

Rodrigo is a Hispanic man in his late 20's born and raised within a cultural-mixed home environment in the U.S. Northeast Coast. He seeks services without a referral to continue treatment for symptoms related to depression and anxiety exacerbated by recent unemployment. He had received treatment for mental health prior to these services at other facilities. He was initially diagnosed with Obsessive Compulsive Disorder (OCD) by his first mental health therapist and Major Depression by a subsequent clinician. Since he started to show signs of hair loss, he presented high levels of distress related to intrusive and dysfunctional thoughts involving ritualistic behaviors, which escalated in his late twenties, affecting his daily functioning.

Presenting Complaints

At the time of the intake assessment, Rodrigo had resigned to his job and had some doubts concerning the future of his five-year relationship. According to him, he often abandoned jobs due to depressive symptoms and severe anxiety such as panic attacks. He reported a similar pattern with his current girlfriend. According to Rodrigo, it is not the first time they have problems. They have a prior history of breakups because of minor issues (eg. not joining her for family or other social gatherings, among others) related to trust. Rodrigo often considered himself as an impairment due to his inability to provide and help his girlfriend with the rent or other expenses. He also experienced a decrease in his sexual performance towards his girlfriend. Rodrigo associated the presenting problem with the way he perceived himself as a men and his body image. As evidenced during the intake assessment, Rodrigo was wearing a hat and cautiously measured his tone of voice and his movements, seeking reassurance from the surroundings in the room. Rodrigo exhibited poor self-esteem, dysfunctional thought, and distorted body image based in prior experiences and hair loss since he was a young adolescent. He has experienced problems with sleep and concentration. He stated using marijuana to help him relax. Rodrigo also reported severe anxiety, depression and mood swings. Presenting problems also included isolating himself from others when it comes to social activities like family gatherings, friends meetings, sports or recreation events, and job duties.

History

Rodrigo comes from a culturally mixed Hispanic heritage and was raised within a diverse culture environment. Even though he considers himself as Caucasian, his family heritage from the mother comes from a country in South America, and his father from a European country. Rodrigo's parents divorced when he was young and he grew up with his mother. His father later remarried. He is the youngest of four children in his family. He describes his childhood as "*difficult*" once his parents divorced and the relationship with his mother deteriorated. Despite this, Rodrigo continued to have a good relationship with his father and he even considered him as his hero. He also has a good relationship with his brother and considers him as a genuine friend. In school, he suffered verbal bullying and as an adult he has been experiencing interpersonal problems at work and with his family. During college years, he obtained a degree on acting, but later felt unsatisfied and disappointed with the career and decided to work as a computer technician and to have side jobs as a waiter.

Assessment

The following section briefly highlights measures and prescribed medication during the course of treatment.

Self-Report Measures

Male Role Norms Inventory (MRNI-SF). The MRNI-SF is a 21 item self-report measure that examines the examinee's level of endorsement towards traditional masculinity norms (Levant, Hall, & Rankin, 2012). The MRNI-SF includes the following subscales: avoidance of femininity, negativity towards sexual minority, self-reliance through mechanical skills, toughness, dominance, importance of sex, and restrictive emotionality. A high score suggests a greater adherence or endorsement to traditional masculinity norms. The MRNI-SF has shown good reliability and validity with different populations. Rodrigo obtained a total score of 2.6 of 5 during baseline, suggesting some endorsement towards a traditional hegemonic masculinity.

Health Behavior Inventory-20 (HBI-20). The HBI-20 is a 20 item self-report scale that assesses attitudes, behaviors and beliefs towards health (Levant, Wimer, & Williams, 2011). Greatest scores indicate high degree of health promotion behaviors. Items highlight the following: (1) risk behaviors, which includes anger and stress; (2) substance abuse, and (3) health promoting behaviors: diet, preventive self-care and proper use of health care resources. This measure has

reported good internal reliability and validity among different populations. During baseline, Rodrigo reported a score of 3.3 of 5 suggesting the presence of health promoting behaviors.

Beck Depression Inventory (BDI-II). The BDI-II is a 21 item, self-report measure, which examines depression related symptoms, including weight loss, body image and somatic concerns (Beck, Steer, & Brown, 1996). This measure has been widely used in different formats and adapted for diverse populations. It has shown good internal consistency and concurrent validity for clinical and non-clinical populations. The BDI-II is also widely used for screening purposes and research. Depression symptoms ranges are the following: 0 to 13 indicates minimal depression; 14 to 19 mild depression; 20 to 28 moderate depression; and 29 to 63 severe depression. Baseline scores reported by Rodrigo during intake screening was 21, suggesting moderate depression. No suicidal behavior was reported by Rodrigo.

Beck Anxiety Inventory (BAI). The BAI is also a 21 item, multiple choice, self-report measure for mental health screenings of anxiety related symptoms, including subjective, somatic or panic-related (Beck & Steer, 1993). BAI has been adapted for multiple populations and has evidenced high internal consistency. It has also been used for clinical screenings in different formats and research. Scores can range from 0 to 7, meaning minimal level of anxiety; 8 to 15 as mild anxiety; 16 to 25 as moderate anxiety, and 26 to 63 as severe anxiety. Rodrigo reported a BAI baseline score of 16, which indicated moderate anxiety.

Genogram. The genogram is a clinical assessment tool that allows mapping out or tracing multigenerational patterns transmitted within the family dynamics. Monica McGoldrick and Randy Gerson first developed genograms in 1985 and it has been widely used in mental health, specifically in family therapy as well as medicine and education, among others (McGoldrick, Gerson, & Shellenberger, 1999). The genogram obtained from Rodrigo supported a dysfunctional relational pattern between him and his mother. There were alliances towards his father and brother (see Figure 1).

Medication. The medication prescribed by the psychiatrist during baseline was Fluoxetine 20 mg. an SSRI to decrease depression and anxiety related symptoms. After two months, his medication was increased to 40 mg. due to a severe episode of anxiety. His medication dose was kept to 40 mg. until the end of treatment.

Case Conceptualization

The first encounter with Rodrigo was highlighted by a firm handshake. He seemed to struggle to keep his body posture. He appeared profoundly sad and filled with unmet expectations about his life. Nevertheless, Rodrigo wanted to reach out to connect not only with the outside world, but with himself. Stevens (2006), based on his clinical work with men stated the following: (a) men seek intimate and deeper connections, however, they lack knowledge or are even too afraid to start one; (b) they experience a broad range of feelings and have an idea of their collateral effect on their interpersonal relationships, which sometimes require coaching and reassurance; and (c) there is an urge to being in pain like the usual expression "no pain, no gain", but without showing vulnerability. Rodrigo's gestures, tones and movements were cautious during the interaction. He started the conversation with these words: "*my whole world is upside down*". This is the first moment during this process, that Rodrigo courageously asked for help.

As an initial step, the therapist acknowledged Rodrigo's efforts in session and encouraged him to continue. Rodrigo, suddenly but carefully opened up, "*I cannot stand the way I look…"* His statement revealed incongruence about his notion of self and as a man. He removed his hat and attributed his doubts to his hair loss. He further continued to express how his hair loss had been affecting his daily life ever since he was a young adolescent. According to Rodrigo, during his adolescent years before the first signs of hair loss, he was confident in himself, even daring in circumstances in front of the public, meeting girls and making friends. He was also an active student in theater and sports. It seems that there were no rivals and he always prevailed in these arenas. Everything started to change once he realized there was something different. At first, Rodrigo thought, he was not seen and treated like before by his male peers, friends, and even by some family members. His experience was more noteworthy during his college years where he enrolled in acting. Not only he was experiencing hair loss, he was also physically injured and some movements required for doing sports or recreation exercise were limited. He also stated that his libido and desire for his current girlfriend had decreased dramatically. At his young age, he had been feeling and living like an older man.

The struggle to look healthy and show virility is almost a mandatory statement for men; however, that does not necessarily correspond to how they feel. Men, actively and silently suffer from this struggle often through ceremonies or rituals. For Rodrigo, his ritual involved not letting anyone be aware of his vulnerability. According to research, hair constitute an identity for men which reflects power, dominance and virility, typically linked to masculinity (Korhonen, 2010; Mannes, 2012; Ricciardelly, 2011). He pointed out that, he spent some time struggling with going to a barbershop and demanding a haircut that did not expose him. Only a few people have seen his "*secret*" and the barber is one of them. In the past, there was a barbershop suburban culture linked to masculinity, but now there is a mainstream trend suggesting differences in social status and race among men (Barber, 2008). There was no doubt that Rodrigo was questioning his role among his male counterparts and his contribution to society. As part of his rituals, facing a barbershop surrounded by many men from different backgrounds was a defining moment for him, his vulnerable identity and his status. Nevertheless, his most difficult challenge was when he was the one behind the wheel when it came to fixing his hair. Sometimes these rituals would take him hours and if he did not succeed a certain look, he would miss his job, a date or an important event. He described that if the rituals did not meet his standards, his expectations ended in painful experiences, which included screaming or hitting himself. Rodrigo attempted several medical and non-medical treatments for his hair loss, but these were only temporary and ineffective solutions.

A clinical diagnosis and a framework to guide therapy was discussed to properly address Rodrigo's symptomatology taking into consideration the limited time for treatment due to the therapist's postdoctoral fellowship status at the facility. A diagnosis of Obsessive Compulsive Disorder (OCD) fitted the criteria for the presenting problem. However, there was a deeper structure of the problem linked to the way he relates to others and especially towards himself. There was an opportunity to address his presenting problem within a CBT approach, integrating a gender theory framework with some adaptations as suggested by Spendelow (2015). Rodrigo's anxiety related symptoms were grounded in the way he felt about himself as a hopeless man, which exacerbated his depression. It was also important to understand that his hair loss could be a distraction to the therapeutic process. His hair loss can be seen as a symptom corresponding to an underlying problem with the way he saw himself and the distorted schemas he had about being a man (eg. men should not cry, men don't have doubts, men should be able to provide for the home and relationship, among others). Seeking alternatives and healthy cognitive schemas about masculinity was needed as part of the therapy process. This included conceptualizing his diagnosis into one that is consistent with persistent depressive disorder and meets the following: low energy, low self-esteem, poor concentration and feelings of hopelessness. The diagnosis allowed the clinician to have a wider view about the nature of the presenting problem.

Course of Treatment and Assessment of Progress

The following steps conducted by the therapist after the clinical assessment included gathering information about his developmental history. According to Rodrigo, he met all the developmental milestones. His history was also recovered by incorporating experiences and family relational patterns with a genogram. Examining his views of the role he occupied in his family and the expectations he may have as a man in a family shaped by divorced was an important aspect during this process. The evaluation took three sessions which allowed Rodrigo to assess feelings of guilt and responsibility due to his mother's actions towards him and his brother after the divorce of his parents. According to Rodrigo, there was an abusive pattern towards him specifically, because he resembled his father in "*personality and appearance*". There was also an opportunity to address the anger he had towards his mother with role play and cognitive restructuring. Rodrigo had an additional challenge by examining the role of his father during his childhood. Possible feelings of abandonment or resentment were explored. The role of his father and the notion of masculinity derived from his experience had an influence in his identity as a man.

The establishment of a common language sensitive to masculinity allowed him to engage in the therapeutic process and build rapport. The goal set for the following four sessions mainly concentrated in normalizing his seeking help behavior towards healthy schemas of masculinity. MRNI-SF scores on avoidance of femininity, toughness and self-reliance through mechanical skills supported his difficulties on this domain. Nevertheless, even though Rodrigo exhibited a high adherence to traditional roles, his scores on HBI-20 suggested health promoting behaviors. As evidence of his health promoting behaviors, he had sought mental health services in the past; however, the incongruence found on his scores provided a clue about the way he engaged in seeking help. Seeking help

related events were discussed to further review maladaptive patterns that prevented him to speak out about his problems, which include sudden outburst and avoidance behaviors. His inability to perceive these events as opportunities to address problems within his notion of manhood was important. His cognitive schemas suggested a rigid structure. However, there were other masculinity schemas that challenged his model, such as the one that expressed his father. A general discussion about attributes he ascribed to men allowed him to explore traditional roles as well as alternative versions, including qualities he ascribed to his father such as being caring, understanding, brave, a hero, and a gentleman.

During the discussion, there was an inner struggle reported by Rodrigo related to the fear of losing his father without making him proud. An expected legacy seems to be unmet by Rodrigo and sustained by his cognitive schemas suggesting that he has failed as a man. An incomplete sentences activity also supported his cognitive schemas. The importance of his statement was a key aspect to properly introduce the CBT model. Five psychoeducational sessions with special emphasis on how cognitive schemas sustained his symptoms related to depression were delivered. It was important to understand that failure as a core belief was reinforced and maintained by his avoidant behavioral mechanisms. Automatic thoughts related to other scenarios including his girlfriend and work related events were also discussed His acting background was used as a metaphor to identify, restructure automatic thoughts and cognitive schemas.

The opportunity allowed him to actively participate as an editor of a script for his own movie. Rodrigo chose a background story and scenes to deliver a message to an audience. He reexamined the scenes and the possible reactions from the audience based on his cognitive schemas. An outer experience provided him a chance to experience his emotions. The struggle to hold his emotions was inevitable; however, Rodrigo found a courageous way to channel his doubts and his pain. The encouragement of these emotions was therapeutic for him and also normalized them within a gender perspective. Rodrigo slowly began to relate to his girlfriend more intimately in terms of closeness and trust. He also started to gain confidence on himself and started to look for job offers. He also made additional efforts to spend some time with his mother.

The acknowledgment of the emotional realm was a core feature for this process. Treatment later focused on increasing awareness of his distorted thought and body image by integrating an exploration of gender roles presented by Rodrigo. This included exploring the connection between his body image and the emotional realm. Mindfulness techniques such as the breathing exercises were initially used to introduce the role of the emotions over the body within a period of three sessions. He was able to engage in the activity. He also has some activities at his disposal due to his acting background. At the beginning of the process, he experienced some struggle, but later he was able to achieve goals established during this stage. Some exercises related to yoga were also included. The room used for the sessions included a mirror which provided him an additional way to study his movements and regulate his breathing. Sometimes, while doing the activity, he was not wearing a hat. The ability to control his breathing served as a basic grounding exercise before proceeding to the guided imaginary technique known as the body scan, which took approximately four sessions. According to Kabat-Zinn (2013), the body scan technique is an effective tool to develop concentration and increase attention at the same time. For clinical purposes we included the use of subjective units of distress (SUD) as a tangible measure to illustrate Rodrigo's performance and areas of opportunities at the end of the exercise. SUD reported by Rodrigo were written in paper by the therapist and later placed in the wall to discuss areas of opportunities. This adaptation seems to be sensible to men in therapy by allowing them to be active participants and have tangible goals. His areas of opportunities mainly concentrated closer to the upper body and towards his head. Sometimes while doing the activity, he started crying or was unable to concentrate. According to the Window of Tolerance Model (WTM), there is a range or window of optimal arousal between the sympathetic hyper arousal and the parasympathetic hypo arousal where emotions can be tolerated and experiences can be integrated (Siegel, 1999). The WTM has been applied when working with patients who have problems regulating their emotions due to developmental trauma (Ogden, Minton, & Pain, 2006). The therapist gradually discontinued the activity when Rodrigo struggled or surpassed his tolerable window. The therapist, also followed up with a discussion of the events that transpired during the activity. In the course of the activity, Rodrigo points out certain automatic thoughts and events once near the upper body. The process and re-processing of his emotions can have a profound impact on his cognitive schemas. By discussing these challenges with

the therapist, he was able to reorganize some of his experiences and implemented them to the activity. Rodrigo described the body scan as exhausting, but he expressed how much he learned from the process and embraced his fear.

At that moment of the treatment, he was ready to continue with the following stage based on imaginal exposure. The stage included four sessions to target anxiety related symptoms in a gradual and repeated fashion. Before proceeding to the imaginal exposure, it was necessary to delineate a plan to manage negative affect. This included brief breathing and body scan exercises as grounding techniques. It was also necessary to mentally rehearse the procedure frequently at home and during sessions. In sessions, the therapist asked Rodrigo to vividly imagine worst-case scenarios in hierarchy steps before going to a social related event, for instance his work, until the association between the anxiety and the stimulus weakened (Neudeck & Wittchen, 2012). The task required more effort from Rodrigo in the beginning. The therapist used SUD to monitor the level of distress. If the reported distress was more than six or seven, the therapist gradually stopped the activity and discussed areas of opportunities with Rodrigo. Once again, these discussions allowed him to reprocess his emotions. In addition, he had the time to reorganize and introduce new elements to alter the outcome for the following attempt. By the end of the sessions programed for the exercise, he was able to decrease his SUD from three to one. In addition, he stated that this strategy was helpful before and after job interviews. In fact, two weeks later, he started working. Even though, he still had some doubts about himself while working in a new environment, he thought it could be an opportunity to help his girlfriend and face his anxiety. He even had a second job offer and was working as a freelancer repairing computers.

The outcomes reported by Rodrigo during this period were temporary, yet relevant to treatment. After a few months, he left his job because he was struggling with his anxiety and dysfunctional thoughts. His window of tolerance continued to be limited, but manageable. According to Rodrigo, he had received good feedback about his performance from the managers, but for him it was simply not enough because he felt that others were judging him. The judgement included his perception as a man in areas related to his physical appearance and his interactions. Nevertheless, instead of working on his dysfunctional thoughts, he chose to escape from the “threatening” environment. His usual reaction was accompanied by anger outburst towards others and himself.

In order to decrease his anxiety, the imaginal exposure technique was periodically practiced in therapy to decrease symptomatology. The process allowed him to attune to his emotions and challenge some ideas about the view he had of himself as a man. Rodrigo continued to show interest and compliance with the process. He also managed to find another part-time job. He reported improvements on his maladaptive patterns and regulating his outbursts. One of the sessions was highlighted by Rodrigo’s new appearance after he had shaved his head. Rodrigo stated feeling better with the outcome; however, before executing the action, he struggled with the decision. According to him, he was able to talk about the plan to shave his head with his girlfriend. His action of shaving his head can be interpreted as another outburst or a common reaction towards his anxiety; however, there was another side of Rodrigo. He described this experience as reaching another level of intimacy in which he trusted the process within the context of help seeking and support from his girlfriend. Furthermore, gaining trust was another step closer to self-acceptance and a healthier man. The following stage required an in-vivo exposure, however, it was not possible due to the therapist’s limited time at the facility to continue treatment. The last sessions with the therapist were focused on decreasing SUD with learned techniques and monitoring cognitive schemas to avoid symptoms relapse. These sessions mainly focused on reviewing outcomes and areas of opportunities. In addition, Rodrigo had a chance to talk about his view on men and his position suggesting healthier schemas. At that time, Rodrigo decided to continue treatment at the facility with another therapist.

In summary, the treatment lasted twenty-six sessions. The approach applied for treatment was an opportunity to integrate CBT sensible to men following suggestions by the literature on gender role theory. Challenging dysfunctional and traditional masculinity schemas gave Rodrigo a room to embrace healthier ways to relate to others and himself as a man. In addition, weekly rehearsal mindfulness techniques and imaginary exposure allowed him to address symptoms related to anxiety that were affecting his daily life functioning. Finally, the acknowledgment of a connection between his emotions and his body as a man was important to address presenting problems.

Complicating Factors

In this case, Rodrigo presented few complicating factors. However, his hair loss as a main concern could have been an obstacle in the process. The attention brought by Rodrigo's hair loss was redirected to encourage a periodical examination of core beliefs supported by his family dynamics and his perception of himself as a man. The process was overcome by promoting an awareness of his inner struggles within a gender role framework and encouraging a reorganization of his experience within his body and his emotions that led to acceptance. Another complicating factor was the difficulty to include his family and his current girlfriend due to the therapist's schedule. The family oriented approach could have been an effective way to increase openness to share thoughts and feelings among family members, the girlfriend, and to openly discuss their roles and expectations.

Access to Barriers to Care

Time employed for Rodrigo's treatment was limited due to the therapist's post-doctoral fellowship position at the facility. The limitation did not allow the therapist to conduct a further discussion and implementation of a treatment focused in-vivo exposure and relapse prevention strategies in managing possible future anxiety and depression related symptoms.

Follow-Up

During treatment, Rodrigo had been asked by the therapist to complete baseline and post measures related to patient symptomatology. Follow-up measures were administered three months after terminating treatment with the initial therapist. In this period, Rodrigo continued treatment with another therapist for three more sessions and then decided to discontinue services including medication. According to Rodrigo, he had met most of the objectives established for this particular time of his life like feeling better, finding a job and being more involved in the intimate relationship. The first therapist contacted Rodrigo to administer follow up measures as agreed in prior meetings before ending treatment. These measures included the BDI-II and BAI. Figure 2 shows the scores obtained for each measure and timeframe. The findings suggest improvements in symptoms related to anxiety and depression from baseline to follow-up. Baseline scores on BDI-II was 21 compared to score of 15 documented during the post treatment stage. The BAI baseline scores reported by Rodrigo was 16 compared to 9 obtained after treatment. Despite these scores, there was an increase on the medication prescribed by the psychiatrist from baseline until the post treatment stage due to a severe episode of anxiety two months after initiating treatment with 20 mg. of Fluoxetine. His dose increased to 40 mg. and kept until the end of the post treatment stage with the first therapist. Nevertheless, his symptoms continued to improve without medication and treatment when he completed the follow up measures for the BDI-II (score: 11) and BAI (score: 7).

The MRNI-SF as a measure related to gender roles and the HBI-20 for health-promoting behaviors were only administered during baseline and follow-up. Table 1 presents the MRNI-SF total and subscales scores during baseline and follow-up, while Table 2 presents the HBI-20 total and subscales scores obtained by Rodrigo. Figure 3 compares both MRNI-SF and HBI-20 total scores during baseline and follow up. These findings show an improvement in his rigid schemas about men. In addition, scores reveal an improvement in his health-promoting behaviors. Both measures supported treatment outcomes and served as a channel to encourage Rodrigo to achieve healthy views about masculinity. Furthermore, even though, he did not pursue further treatment, he expressed feeling better. According to Rodrigo, he has been studying for a certification as a computer technician and currently holds part-time contracts as an IT in a well-known company. He also stated that his relationship with his girlfriend and other members of his family, including his mother, continued to improve significantly. Rodrigo also added that he was able to effectively cope with some of his anxiety and his depression related symptoms with strategies he learned during treatment. In addition, Rodrigo was feeling more comfortable and more accepting with his body image than before. Nevertheless, he recognized that these outcomes are part of an ongoing process and understands that he will eventually restart his treatment in the future, if needed.

Treatment Implications of the Case

This case illustration highlights the importance of evidence based therapy models for men like the CBT and the integration of a gender theory framework suggested by recent literature to support treatment outcomes. A common language sensible to men and the effectiveness of the CBT allowed Rodrigo to engage in the therapeutically process and address presenting problems. Furthermore, the integration of mindfulness techniques as an active ingredient in therapy represented an effective tool to focus

on Rodrigo's symptoms by providing a grounding anchor. The grounding exercises allowed him to increase awareness and closed the gap between his body and his emotions. This part of the treatment was important because it provided him with the opportunity to address his negative affect and reprocess his experience. During this process, he had an active role and had tangible goals with the use of SUD. Even though, one of the main key principles of mindfulness is a no-striving approach, the SUD allowed him to guide his own process and create a map of his experience by attuning to his emotions and his body cues. These techniques were key factors that led him to the following stage, which involved imaginal exposure. This stage was periodically rehearsed in sessions and target symptoms were addressed. Even though the in-vivo exposure stage was not possible due to the therapist's time limitation, certain outcomes were reported. According to research conducted on imaginal exposure, some factors could have explained these outcomes such as emotional activation and processing as well as habituation of the stimulus (Neudeck & Wittchen, 2012). These factors were addressed in this stage.

On the other hand, the clinical assessment treatment for this case was a fundamental aspect because it provided the therapist a clinical compass to map and monitor Rodrigo's presenting problems and treatment outcomes. The use of genograms as an initial step was important not only to assess family dynamics but also to examine Rodrigo's male role models during his development as a man. The genogram allowed him to address his perception about masculinity within the relationship of his parents and work towards alternative and healthier views about himself. Additionally, the use of clinical measures (eg. BDI-II and BAI) included in treatment allowed the therapist to further monitor depression and anxiety related symptoms. Having tangible measures and objectives allowed the therapist to have a preliminary view of Rodrigo and guide his treatment. In order to understand the complexity of the symptoms, traditional endorsements of hegemonic masculinity and promoting health behaviors measures (eg. MRNI-SF and HBI-20) were included as a rational for treatment.

Nevertheless, the study includes a limitation with follow-up. Rodrigo was no longer under the care of his first therapist and initial treatment framework. In addition, the design of the study did not allow a proper examination of the contribution of each approach, including medication prescribed by the psychiatrist. Despite these limitations, the study and its findings suggest the importance of these strategies within the context of help seeking in men and mental health.

Recommendations to Clinicians and Students

The use of evidence-based treatments such as CBT with special considerations on gender has showed potential when examining the outcomes in this case. In addition, taking into account measures related to gender roles and health promoting behaviors can be helpful to understand unhealthy schemas of masculinity presented in men. Due to the complexity of the case, it was important to address the presenting problems from a wider perspective by including these measures and an inclusive framework of reference like the gender theory instead of only relying on patient treatment history. A further discussion of the patient's concerns requires a clinician approximation to the phenomenon that plays in the patient's belief systems supported by the interaction of multiple factors such as culture, history, and family dynamics, among others. Likewise, the use of measures for clinical symptoms to assess clinical outcomes is encouraged to establish and monitor treatment at baseline and follow-up level. This allowed the therapist to meet his goals and assess the treatment.

On the other hand, when working with anxiety related symptoms, mindfulness techniques can be an excellent resource to increase awareness between the body and the emotions. These techniques are necessary to developed grounding skills before proceeding to challenging interventions like the imaginal or in-vivo exposure. These skills also provide the patient the ability to regulate emotions and reorganize his experience. For therapists conducting these techniques, it is even more important to understand and help the patient during this stage to process and re-process his emotions. Therapists who embrace this, will be mindful of the patient and their therapeutic process.

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Appendix

Table 1. MRNI-SF total and subscales scores reported for baseline and follow-up treatment.

Subscales	Baseline	Follow-up
Avoidance of Femininity	2.3	1.3
Negativity towards Sexual Minority	1	1
Self-Reliance through Mechanical Skills	4.6	4.3
Toughness	5.3	2.3
Dominance	2	1
Importance of Sex	1.3	1.3
Restrictive Emotionality	1.6	2
Total	2.6	1.9

Table 2. HBI-20 total and subscales scores reported for baseline and follow-up treatment.

Subscales	Baseline	Follow-up
Diet	1.8	5
Preventive Self-Care	3.3	4.6
Proper Use of Health Care Resources	4.3	5.8
Risk Behaviors	3.3	2.6
Substance Abuse	3.6	3.6
Total	3.3	4.6

Figure 1. Rodrigo's Genogram

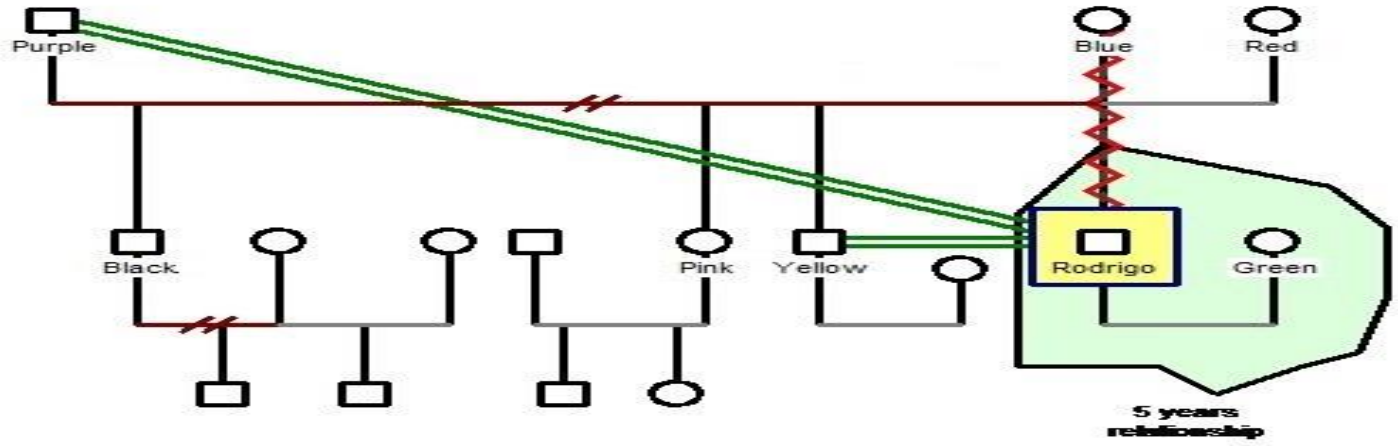

Figure 2. BAI and BDI scores reported for baseline, post and follow-up treatment

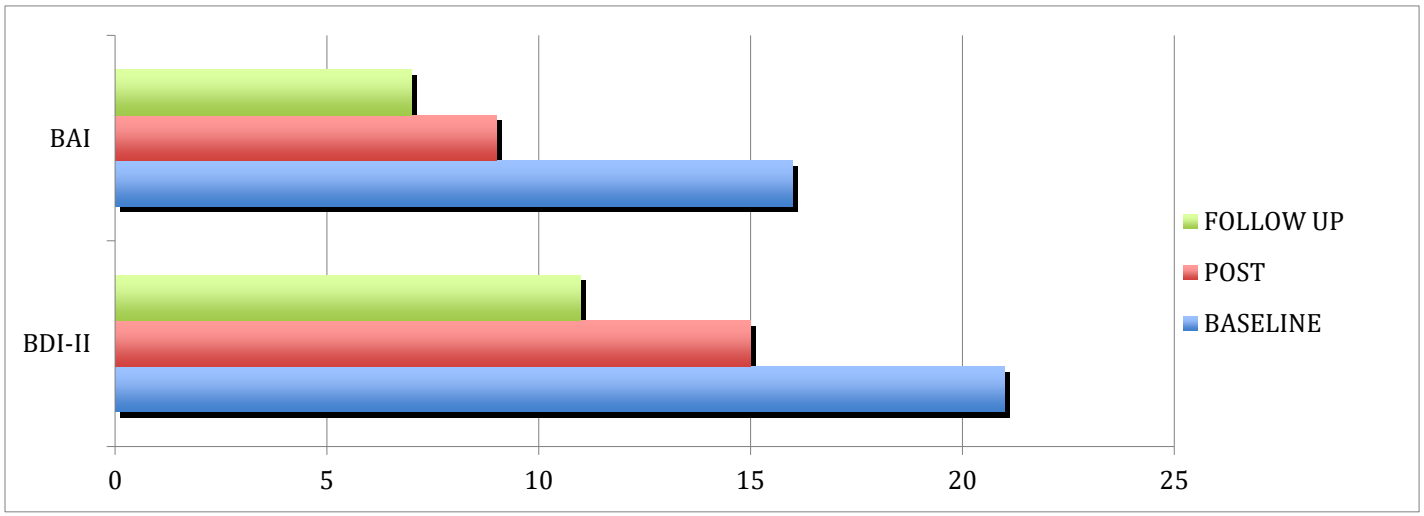

Figure 3. MRNI-SF and HBI-20 scores reported for baseline and follow-up treatment.