# The challenge of psychotherapy across cultures:

## issues arising in cognitive analytic therapy (CAT) for an older male presenting with depression and sexuality-related problems with a younger female therapist in a south Indian context

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**Abstract:**
Although people around the world in very different socio-cultural settings may experience what in Western cultures might be understood as individual psychological distress and disorder, serious problems exist cross-culturally for Western models of mental disorder and psychotherapy in adequately addressing these both conceptually and clinically. In many settings such experiences may, properly, not be attributed to or 'framed' as individual psychological distress or mental disorder either by the person concerned or those around them and might rather be understood and addressed from a more sociocentric view-point and possibly recourse to traditional healing practices.

Addressing 'psychological' distress and disorder cross-culturally also raises serious questions with regard to the ontological validity and 'universality' of Western models of mental disorder and treatment, notwithstanding possible common underlying genetic vulnerabilities, particularly given evolving understandings of the actively intersubjective and relational character of human development and the critical role of these and broader sociopolitical factors in mental health and disorder.

Arguably a model such as CAT, predicated as it is on a construct of a largely socially-constituted Self and with a therapeutic style that is overtly collaborative and jointly exploratory, might offer greater sensitivity and flexibility in approaching such problems cross-culturally. However there remains a need for further development

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of both theory and clinical practice cross-culturally. This includes notably development of a valid and helpful meta-conceptual framework within which to explore respectfully, and integrate into a holistic therapeutic approach, possibly quite diverse cultural and religious beliefs, practices and their meanings. Nonetheless anecdotal reports so far of the use of CAT cross-culturally are encouraging despite these evident challenges.

We report here a successful attempt to offer CAT to an older Indian male by a younger female therapist in a very different context from the one in which the model was developed. We consider some particularly challenging issues arising, including in relation to age, and to sexuality and use of pornography. The CAT relational framework was evidently important in addressing and productively managing the challenging dynamics that occurred within this therapeutic relationship, understood in CAT as reciprocal role enactments. Along with supervision and personal therapy this also enabled the therapist to work with a personally challenging case in a more genuinely compassionate manner. Experience of using CAT in such a context justifies, and confirms the need for, further and more extended studies of their validity and effectiveness cross-culturally.

**Key words:** Psychotherapy, cognitive analytic therapy, cross-cultural, relationality, sexuality, pornography, alcohol, India.

## Introduction

Psychological distress, suffering and disorder in some form has undoubtedly occurred, although evidently to varying extents, in all human societies across the ages, with a multiplicity of causes. However the ways in which this is experienced, manifest, and understood varies enormously, as have the ways in which help may been sought and offered, if at all. In many settings worldwide very few people seek or are given help from Western style mental health services but may rather do so from, for example, members of an extended family or community, from religious practitioners, or from traditional healers. Significantly, people who experience distress or disorder may not seek help, seeing this as inappropriate or shameful, or may be fearful of the negative consequences of stigma (Thornicroft, 2006). This would include many in contemporary Western cultures despite a considerable increase in recent decades in the availability and popularity of psychological treatments in many countries. Many critics would see this 'psychologising' or 'medicalising' trend as, in part at least, an inappropriate professionalisation of human

distress and suffering, including for groups such as refugees, based on inappropriate, crude and limited models (see e.g. Ingleby, 1980; Bracken, 2002; Thomas et al., 2005; Summerfield, 2008; Middleton, 2015; Bracken, Giller and Summerfield, 2016; Melville and O'Brien, 2017; Kopua, Kopua and Bracken, 2019). Many would likewise criticise, without necessarily offering an adequate alternative conceptualisation, an increasing extension of Western psychiatric approaches into non-Western countries, as propounded notably for example by the Movement for Global Mental Health (see Patel et al., 2011), well-intentioned as that may be. It is noteworthy that these developments are inevitably having an effect on local approaches to treatment or indigenous healing practices, including in India (Sood, 2016).

These broad challenges also apply to the still evolving CAT model. Indeed given its use within established health services in the West, where many CAT practitioners work and where the model originated, some writers (see Foozoni, 2010; Lloyd and Pollard, 2019), whilst acknowledging the strengths of the CAT model, have criticised an arguable collusion with individually-focused, reductionist, biomedical 'illness' type approaches. This will, properly, continue to be an area for ongoing debate. However CAT theorists historically have trenchantly criticised the damaging limitations of such approaches and have predicated the model on a largely, although not entirely, socio-culturally formed and located Self and consequently on a whole-person, transdiagnostic therapeutic approach (Ryle and Kerr 2002; 2019; Kerr et al., 2015). Nonetheless, serious mental health problems resulting from pervasive, longstanding damage to the structures and processes of the Self, as for example described in the multiple self states model (MSSM) of personality type disorders (Ryle, 1997; Ryle and Fawkes, 2007) have been conceptualised therefore as 'disorder'. This may be frequently, but not always, characterised by disability and/or overt distress to Self or others. From this viewpoint, the frequently long-standing severity and structural complexity of such health problems is seen to merit description as 'disorder' in order to conceptualise and treat them, and it would be seen as a serious disservice therapeutically to these persons ('clients' or 'patients') to do otherwise, or describe them simply as 'distress'. However from this viewpoint descriptions of 'disorder' based simply on check lists of symptoms and behaviours, as occurs in e.g. the DSM (American Psychiatric Association, 2013) and ICD (World Health Organisation, 1990; 2019) systems, although originally well-intentioned efforts at improved validity, would be seen as seriously inadequate and often positively unhelpful (Ryle and Kerr, 2019; and see discussion by Frances, 2013).

CAT theorists would stress that such 'disorder' is multidimensional in character (including for example possibly the genetic through to the socio-political) but is also manifest in and experienced by an individual. Problematically, both the 'individual' Self and its disorders will be, both subjectively and 'objectively', highly variable culturally (see below). Historically, CAT theorists (Ryle and Kerr 2002; 2019) have therefore stressed the importance of culturally-sensitive, developmental biopsychosocial formulation and reformulation. Ryle and Kerr (2002; 2019) note that diagnosis and formulation play separate and complementary roles which need to be recognised. However clear and valid description of groups of 'disorders' are important for communication, treatment and research (see e.g. Chanen et al., 2008), whilst needing also to be individually-focused and culturally-sensitive. Some CAT authorities however (e.g. Mikael Leiman, *personal communication*) would consider such approaches to be inappropriate to the complex field of mental health and psychotherapy. These complex issues, partly semantic in nature, but with their serious implications, will properly continue to be an area of highly charged debate (see Margison, 2019).

Addressing psychological distress and disorder is complicated by the fact that the incidence and prevalence of problems varies enormously (see e.g. Wilkinson and Pickett, 2009), broadly speaking depending on personal and sociopolitical circumstances, and also on the collective well-being and function of a given society and its cultural character. This would include the extent to which it is individually-minded and focused, or more communal and collective. A very considerable literature now attests to the effects of factor such as inequality, poverty, or unemployment (Stieglitz, 2012; James, 2018; Krugman, 2020; Weich and Lewis, 1998; Wilkinson and Pickett, 2009). Strikingly these factors do not stand in a direct simple relationship, in that the experience of these factors depends also on the quality of collective life which may evidently be a mitigating factor. The latter may be adversely affected by collective loss of purpose and pride or a sense of belonging, as may occur in oppressed or demoralised classes or groups within any society, or within indigenous communities and cultures as a result of colonisation and its traumatic effects both economic and psychocultural (Fanon, 1961/1963; Kirmayer et al., 2003, 2017; Mills, 2014; NiaNia, Bush and White, 2016; Kopua, Kopua and Bracken, 2019). A history of economic colonialism and cultural hegemony e.g. as with the British in India (see case example below), along with recent forces of globalisation, will leave significant conscious and unconscious 'traces' in so-called developing, although possibly sophisticated and very old, cultures.

These various dimensions of mental health present a considerable challenge to any, including current Western, models whether more biomedical or socio-psychological, which implicitly aspire to be universal. Given the recognised social and cultural major determinants of mental health and disorder and its treatment, Ryle and Kerr (2019), argue that any meta-conceptualisation or adequate model must incorporate both psychologically and neurobiologically-based understandings of human intersubjectivity and relationality, both immediate and communal, in order to understand the aetiology and occurrence of mental disorder, however conceived. Understanding the ways in which many more sociocentric and traditional societies and cultures offer a form of 'resilience' as they function, and how they understand and address 'mental' distress and disorder more collectively could make an important contribution to improving Western models. It can be argued that these approaches with their implicit emphasis on relational and sociocultural dimensions of mental health and well-being also map onto and confirm what we do already 'know' and accept with regard to common effective treatment factors. These include notably strength of therapeutic alliance (see e.g. Roth and Fonagy, 2004; Castonguay and Beutler, 2006; Norcross, 2011; Lambert, 2013; Wampold and Imel, 2015), and to social 'connections' (see e.g. James 2018; Hari, 2017), and to the importance of social context in both presentation of disorders and in rehabilitation (see Harris, Brown and Robinson, 1999). But it is also evident that social context and the way in which it is internalised, including in more traditional societies, may also be part of the problem. This too requires a valid and more comprehensive model of mental health to address it.

This outline of a challenging situation is notably different from the descriptions of and approaches to cultural variability of mental disorder usually articulated in most Western models (see summaries in e.g. Sadock, Sadock and Ruiz, 2015; Harrison et al., 2018), even the more thoughtful. These typically see mental disorder as a constant, underlying, more or less endogenously-arising entity cross-culturally which may simply vary in its expression and detection rates, rather than being a different entity depending on context. Formally diagnosing someone as 'depressed' (and see case example below) and locating an illness 'within' them, even if there does exist some genetic vulnerability (see discussion by Plomin, 2018), is very different from saying this person is located within and shaped by a particular socio-cultural context, and has been a victim of a stressful, hostile context which may be dysfunctional and possibly 'unsurvivable' (and see discussion in Kirmayer et al., 2017).

Understandings of a largely socio-culturally constructed self as articulated in CAT and also by group analysts and more explicitly relational psychodynamic therapies (Dalal, 1992; Mitchell, 2000; and see Bruner 2005; Brown and Zinkin 1994; Bateman, Brown, and Pedder, 2000) imply furthermore that the very 'felt sense' of the individual self and its sense of relation to others will be very different in different cultures. Any cross-culturally valid model or meta-conceptualisation of mental disorder will need to be adequately sensitive and flexible to accommodate differing concepts of self, its subjectivity, and its disorders, and to address the socio-cultural context in which any disorder may occur (see discussion by Krause, 1998; and Bhui and Morgan, 2007). This is a major challenge, implicitly addressing as it does multiple epistemological domains.

The cognitive analytic therapy model (see Ryle 1990; Ryle and Kerr 2002; 2019; Ryle et al., 2014; Kerr, Hepple and Blunden, 2016) arguably offers a deeper understanding of, and respect for, cultural diversity based on a concept or 'organising construct' of a largely relationally, dialogically (see Leiman, 2004) and socially-formed Self, underpinned developmentally by our human capacity and need for intersubjectivity and relationality. This is understood to underlie the transformative psycho-developmental process of 'internalisation' of socio-relational experience as proposed by Vygotsky (see summaries in the context of CAT in Ryle and Kerr 2002; 2019; Kerr, Hepple and Blunden, 2016; and see Wertsch, 1985; Bruner 2005). As such CAT can be seen to offer an attempt at a more comprehensive meta-cultural model of psychological development and disorder. In addition to understanding and working with the largely relational and social origins of the Self and its internalised reciprocal roles, CAT also offers an approach that helps people identify and modify unhelpful coping patterns (reciprocal role procedures) arising subsequently. These may manifest as both Self-other and Self-Self procedures which may be clinically 'symptomatic' (see case example below). Importantly all of these enactments of RRs and RRPs are likely to occur within the therapy relationship and challenge it. Identifying and working with these is a key aspect of CAT (see case example below) and contributes powerfully to the creation of a strong therapeutic alliance.

In many ways this paper represents the outcome of a dialogue its authors began following a presentation of this challenging case made by one of us (ATR), which seemed to merit publication, about how to attempt to locate and interpret this use of CAT within a broader consideration of the implications of socio-cultural context and the challenges this raises for models of mental disorder in general and also CAT. These are variously

major interests of both authors despite their differing backgrounds. We will now offer a description of a broadly successful therapy undertaken in south India and illustrate some of the very particular challenges arising in this context. This will highlight the considerable personal and therapeutic challenges faced by a young female therapist in this context working with a much older male with problems around intimacy and sexuality, abuse of alcohol and an associated 'depression'. This work occurs in the context of a presentation that would not be described as 'psychologically minded' in a Western therapeutic sense. We will also aim to reflect on and consider how and why this therapy was challenging and how it helped and enabled change. We will then also aim to reflect on the use of a model such as CAT in differing sociocultural contexts and to consider some of the possibly irresolvable challenges this may raise and their implications.

## Case Example

(de-identified and with permission) (Therapist ATR)

**(Cognitive Analytic Therapy for the wise old 'Dadaji' (grandfather) in India)**

CAT was introduced in India in 2011 and the Indian Association for CAT (IACAT) was launched in 2012. This is supported also by the International Cognitive Analytic Therapy Association (ICATA). The IACAT is still in its early stages and is being established in Bangalore. As noted above, CAT provides a therapy model that views the Self as largely socially constructed and also a part of the social environment. A relational model such as CAT enables the therapist to work creatively, integrating both cultural and religious values into one's work whereby the client is viewed from a holistic perspective.

The current case presented in a culture where elders are considered the wisest and the head of the family (Jeste and Vahia, 2008). Advice is sought from them on issues that include intra-family conflict and their decision is the final one. In this case the client, an elderly gentleman aged 75, was seeking therapy from a female counsellor who was much younger which would be considered rather unusual in this culture. He presented furthermore with intimate issues around excess watching of pornography. This presentation will also highlight the changing client-therapist relationship over the course of therapy. Therapy raised culturally based struggles around the use of pornography by an elder and overcoming personal challenges and prejudices as a therapist, and also

learning to position oneself in a more compassionate role in relation to both therapist and client.

Bhaumik was a 75 year old client who presented to a fee-paying out-patient clinic where he paid a minimal amount through a sliding scale scheme. He stated that he was 'getting addicted to pornography and feeling depressed'. He had met with an automobile accident and since then avoided going out, so as to not be hit and be crippled. He lived by himself in the city and being alone, indoors, he was lonely, feeling depressed and the time he spent on pornographic material on the internet was increasing each day. He was worried that it would all 'go out of hand'.

Bhaumik's father served in the army until independence and was a disciplinarian. His mother was a home-maker and he was extremely close to her. Some of his siblings took an active role in disciplining him and he remembered being beaten by them. Bhaumik got married (this was arranged) at the age of 29. He had three children with his wife. All of them stayed in different cities while his wife stayed with the son. Bhaumik and his wife had conflicts from the early days of marriage owing to differences in background and expectations from the marriage. According to him she was not like his mother who took care of her husband. His wife was also in conflict with his mother who stayed with them until she passed away. A few years into their marriage, his wife accused him of infidelity and chose to live separately as he was sexually involved with other women. Bhaumik belonged to a voluntary fellowship, the membership of which was part of his identity. He was also an active member in the senior citizen's forum in his locality. He had stopped being involved in these since the accident and had barely any social interactions. He sought therapy when he was unable to stop watching pornography and thought he was getting depressed. The therapist and the client agreed to a contract of 16 sessions.

As the therapist and the client started work, there were evidently many challenges to overcome, including multiple cultural factors that influenced the therapeutic alliance. Three of them are explored below.

**Age**

Both the client and the therapist were of Indian origin – a culture where old age is associated with wisdom, respect and potential for spiritual growth. Human life is believed to comprise four stages (*ashramas*): 'Brahmacharya' or the Student Stage, 'Grihastha' or the Householder Stage, 'Vanaprastha' or the Hermit Stage, 'Sannyasa' or the Wandering

Ascetic Stage. At the Sannyasa stage, a person is supposed to be totally devoted to God. He is a *sannyasi*, has no home, no other attachment; he has renounced all desires, fears, hopes, duties, and responsibilities. All his worldly ties are broken, and his sole concern becomes attaining moksha or release from the circle of birth and death (Mondal, n.d.).

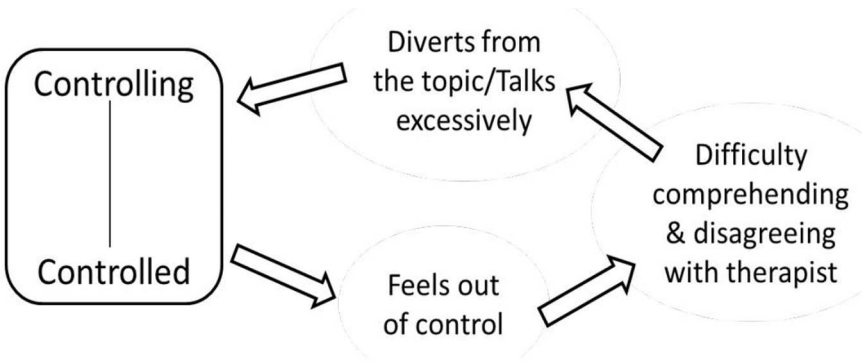
Bhar and Dhruvarajan (2001) and Jamuna (2000) as quoted in Jeste and Vahia (2008) have stated how Indian literature on philosophy and religion indicates that older people are generally considered wiser than their younger counterparts. Some more recent intergenerational considerations on ageing in India are offered by Bhat and Dhruvarajan (2001).

> *Ageing in India:* Often members in the family look up to the elders for advice and guidance in their lives. Ancient Indian philosophy also talks about how parents are nearly equal to God – *mathru devo bhava, pithru devo bhava* (Mother is god, Father is god). Taking care of parents is a sacred duty and failing that would have dire consequences in after life. They are treated with utmost respect by their children or anyone younger.

Hence for both the client and the therapist, it was a challenge to recognize and acknowledge the roles they played in the cultural context- to move from *wise elder–novice youngster* to work 'collaboratively'.

In the initial sessions Bhaumik seemed controlling of the sessions by diverting the discussions away from his difficulties. He would constantly direct the flow of the conversation.

Figure 1: The client in the sessions




The therapist often felt confused and helpless and struggled to explore his issues with him and to challenge him. She would in turn criticise the model as possibly not suitable for clients in their old-age.

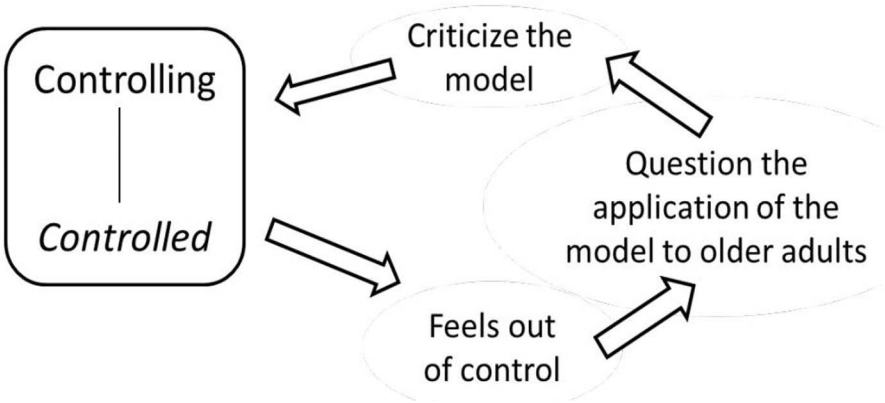



Figure 2: The therapist in the sessions

> 'I have noticed how each time we come around to talk about you, it is as if you push me away by talking about worldly affairs . . . it could be scary or even shameful to see what might come up if we were talking about you. It could be embarrassing. . .'

**Sexuality in India**

Another aspect of culture that influenced the therapeutic alliance was the issue of sexuality. Some of the ancient India texts like the Vedas and other texts on Hinduism and Buddism mention attitudes towards sex and how it is a central theme and natural component of the Indian psyche (Chakraborty and Thakurata, 2013). However these views on sex changed with the British rule in the 1800s and the 1900s. Victorian values stigmatized Indian sexual liberalism as 'barbaric'. A number of movements were set up like the Brahmo Samaj that worked towards 'reforming' Indian private and public life which led to a more puritanical attitude to sex even within marriage and the home (Chakraborty and Thakurata, 2013). In the current context, sexuality is considered as something to be discussed in hushed voices and discovered behind closed doors. Talking about sex, including sex education in schools, is still a contentious matter.

In Bhaumik's case, his wife and children had abandoned him because they had disapproved of his interactions with other women. They assumed that he was sexually involved with many women and were embarrassed. According to them it was unacceptable for someone in their old-age to have any desires including sexual. For the therapist to have a client in his old age to talk about his sexuality was not a familiar or common experience.

> 'I am a woman, almost one-third your age, maybe the age of your

grandchildren. I wonder if this makes it even more difficult or any easier for you to talk about sex and your addiction to pornography?'

For the client to seek therapy in such a context was probably a desperate cry for help. Drinking alcohol and sexualising difficult feelings had become ways of coping.

'Watching porn and masturbating probably makes you feel more alive and youthful and helps forget some of the physical and emotional vulnerabilities that one attributes to age?'

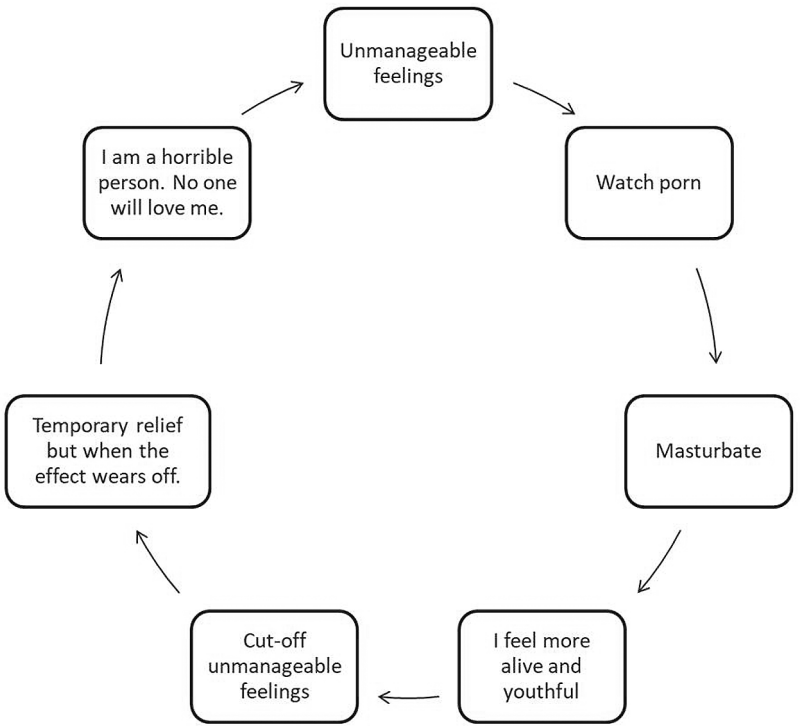



Figure 3: A trap showing a problematic sequence (RRP) of thoughts, emotions and behaviours

**Managing the therapist's anxiety**

The therapist was in the novice professional phase according to the model of therapist development by Ronnestad and Skovholt (in Skovholt, 2003). She was a recent graduate trying to define her professional identity. As described by the model, she was struggling with precision in boundary regulation, including issues of responsibility, setting realistic goals and so forth. Ronnestad and Skovholt state that disappointments with self

and with inadequate client progress can fuel a sense of inadequacy, which was true for her. Recognising areas of deficit, the therapist sought out personal therapy and regular supervision for her cases in order to be effective.

In the sessions when the client and the therapist started engaging with therapy, Bhaumik reported that he constantly imagined all women naked. This included the therapist too. The therapist wondered if he was managing unmanageable feelings arising in therapy by sexualising her.

> 'By sexualising me in your head, then I cannot be your therapist and we wouldn't have to talk about your difficulties. . .'

This recurred in therapy towards the ending. In the last few sessions the client reported a sudden increase in the number of images of naked women he imagined. He also stated that he was sad that the sessions were coming to an end.

> 'It is as if sadness is managed by sexualising it, so then you don't have to feel the sadness. Just like how you managed the home-sickness by sexualising it when you first lived away from home at the age of 19. Engaging in sex at that time had become a way of coping and it looks like now that we are going to end, you are managing the sadness in a similar manner.'

However Bhaumik did write a brief poignant, good-bye letter This was in English but with some Hindi words which are translated, as shown below:

> Attention Ms Ann,
>
> First of all thanks for the attention given to me for counselling in the past 15 weeks.
>
> I must confess that your counselling has helped me a lot in recovering from my depression which I was undergoing for various reasons.
>
> It also helped me in thinking about various aspects of my life and realising my weak points.
>
> I have confided in you to an extent which I have never done with anyone in my life.
>
> Your diagnosis of my problem was done well and understood by me.
>
> Life cannot be perfect but you made me realise that the best of the given situation is to accept and cherish.

I shall remain thankful to you for giving me enough encouragement to live peacefully.

Thanks. May God bless you and your family.

Bhaumik.

During this therapy it was uncomfortable for the therapist as a woman and she often struggled to be empathic in the sessions. Managing her own anxiety along with engaging with the client was a challenge. She constantly worked towards identifying her prejudices towards sexuality in old age. She questioned her own cultural beliefs about relating to an elder as being in a position above her, of being wiser, well adapted to life and not requiring help from a younger therapist. Constant supervision helped her to challenge some of her beliefs. Some of the anxiety was managed in personal therapy. Working with Bhaumik was a challenge for the therapist because it evoked a lot of her own anxieties. Being in constant supervision helped the therapist to be effective and in tune with herself. The client was committed and engaging in the sessions and was determined to change his life. It was difficult for him to talk about his problems with a woman but ultimately the CAT approach enabled him to engage well with the process. By the end of therapy he had become more aware of his thoughts and emotions. He had become much more accepting of himself and was beginning to get comfortable with the idea of letting go.

The work with Bhaumik clearly also involved recognition of how culture has a major role in the therapy room. The therapist's experience was consistent with the findings of Jim and Pistrang (2007) that a shared cultural background may not always be beneficial. However listening for and trying to make sense of the client's culture clearly helped in understanding his distress and to his feeling understood, and ultimately to a productive therapy outcome.

## Discussion

This case history illustrates the successful use of CAT in engaging and working with a very challenging client in a socio-cultural setting quite different from the one in which the model was initially developed. It remains the case that a huge section of the population in this setting would be unfamiliar with the idea of therapy, or if they are then the idea of a fixed, time-limited contract would be perplexing for many. Resource limitations also restrict the availability of such treatments. However

Bhaumik completed a course of therapy and reported considerable improvements in his well-being overall and with his presenting problems. It also demonstrates, within the limitations of difficult life circumstances, a positive outcome, including by the client's account. Some of the challenging issues in this therapy arose around the status of male-female relations, of older-versus-younger persons, and was compounded by presenting problems around a real sense of 'depression' (whether or not this would be concordant with Western diagnostic categories), and around intimate and potentially shameful sexual practices. The latter are recognised to be especially challenging therapeutically in any setting (see discussions from a CAT perspective in Ryle and Kerr, 2019; Wood, 2006; Kellett, Simmonds-Buckley and Totterdell, 2017). Therapy also took place in the context of a challenging socio-economic context which, like many and probably most around the world, offered little support to disabled and unemployed, especially older persons. The client was furthermore facing further issues in relation to ageing and mortality, although in a culture where 'death' and re-birth are seen in a very different way from current common beliefs in the West.

Interestingly, an earlier version of the CAT psychotherapy file, now amended, commenced by stating that '. . . We have only one life'. Furthermore documents such as this are often reported to be hard to understand or use by clients in this Indian setting.

Nonetheless the account of therapy given above suggests that a model such as CAT, notwithstanding its origins, can be helpful in conceptualising presenting problems in a non-judgmental manner and in addressing difficult and personally challenging dynamics inevitably arising in the therapeutic relationship between a younger female therapist and an older male in this context. These dynamics were evidently challenging for both therapist and client in relation to and challenging personal identity and 'security' in an uncomfortable, fundamental sense. This extended well beyond the simple anticipated enactments of their clinical roles as therapist and client/patient. For the therapist this reminder of the importance of attending to security was salutary. Such dynamics (reciprocal role enactments) both clinically and culturally related are unavoidable in any setting and may often not be identified, but are perhaps more clearly thrown into relief and highlighted here. What does appear to have occurred however is that the CAT approach has enabled a making sense of, and resolving presenting problems, and working productively and non-judgmentally in a collaborative and compassionate way with the client. For the therapist this enabled an empathic response even although the client might have been expressing or enacting

behaviours which appeared contrary to her own personal beliefs. In terms of change process, it would appear that for Bhaumik recognising some of the (socio-culturally located) relational origins (RRs) of his beliefs and coping patterns (RRPs) enabled him to discuss and modify these so some extent at least. In so doing he was apparently able to derive a greater satisfaction and fulfilment in life. Therapy apparently also, more simply, undoubtedly enabled and offered an experience of dialogue and 'befriending' (see discussion by Harris et al., 1999) to an older male who was clearly very distressed and struggling. By his account this was helped greatly by the diagrammatic and written reformulations (the 'map' and letter). This work was also greatly assisted by ongoing supervision and self-reflection, in the context of personal therapy, on the part of the therapist, including in relation to some challenging and extremely uncomfortable 'sexualised' enactments by her client.

As such we might attempt to identify common factors operating cross-culturally and highlighted in more recent infant and developmental psychology (see review by Trevarthen, 2018) in terms of human mental health needs. These would include dialogue, meaning making, companionship and relationality, including extended and communal relationality, and a sense of pride and purpose in this (south Indian) context. In this context the approach offered appeared to be respectful, flexible, non-judgmental, collaborative and compassionate (see discussion by Youngson, 2012). It was also, importantly, localised (see Bruner, 2005). From a CAT perspective, it would be argued that such a 'localised', whole person and whole context approach should be routine in treatment approaches of whatever modality anywhere, including in the West. Indeed it has been previously suggested that any diagrammatic reformulation or 'map' is always, in effect, a 'micro-cultural' reformulation (Ryle and Kerr 2002; 2019). Such an approach would be at odds with the increasing, individually-focused, technologisation and commodification of health care in the West and worldwide. It would however be consistent with many more traditional sociocentric values and approaches.

The use of CAT as an individual therapy in such contexts is not without considerable challenges and will require further clinical and theoretical development of the model. This may include notably incorporating a recognition that work across cultures may involve acceptance and recognition of diverse beliefs, values and practices which will inevitably be a considerable, and perhaps insurmountable challenge to the beliefs and values of those from other cultures.

This has certainly been the personal therapeutic experience of both authors (see Ryle and Kerr, 2019; Rafi, 2015). This might include challenging the idea of the 'universality' of such beliefs and values, and of models of mental disorder (see discussion in Kerr, 2009). This recognition also implies the need for respect for the 'voices' of those living and those working therapeutically across different cultures. Cross-cultural and clinical diversity plays out notably also in the tensions between the rights of an individual and that of a sociocentric whole to which an individual may or may not feel part of, and to which they may or may not feel respect and obligations. Questionable Western-type 'aims' such as 'being assertive and individually successful', or seeing it as normal to diminish the importance of older people or to place them in care homes, may not appear desirable or morally appropriate in many more traditional cultures. Such problematic issues are inevitably experienced by many colleagues in therapeutic work in different cultures, and including by immigrant therapists (Akhtar, 2006). Seriously uncomfortable discrepancies, for example around issues of power and dominance and the ways in which they are internalised in health professionals from different cultures, have been poignantly noted by others working and supervising cross-culturally, including in an Indian situation (see Emilion and Brown, 2017).

We would argue that explorations such as those described above can potentially illuminate and contribute to our understandings of human mental disorder and its possible treatments. It is encouraging that in recent years, partly facilitated by the development of the International Cognitive Analytic Therapy Association (see www.internationalcat.org), therapeutic experience with CAT is accruing from cultures other than the British and Western one in which it initially developed, including in India. These include settings as diverse as Africa, Asia, Latin America, Australasia, and with some 'minority' indigenous or immigrant people in colonised, Westernised or Western countries. These developments were certainly enthusiastically welcomed by the late Anthony Ryle the creator of CAT (*personal communication*). Development of adequate models with which to acknowledge and address these issues is in itself an important aim. Further theoretical development and clinical studies are urgently needed, including in the Indian setting outlined above, and description and formal evaluation of this work is keenly anticipated. □

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