Delivering brief 8-session cognitive analytic therapy (CAT): the therapist experience

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Abstract:
Whilst cognitive analytic therapy (CAT) can be offered in a brief 8-session format, the therapist experience of this type of focal clinical work has not previously been explored. This study therefore investigates experiences and perspectives of five therapists who delivered brief CAT during the 'Relational Approach to Treating Self-Harm' (*RelATe*) randomised control trial. Semi-structured interviews lasting 45-60 minutes were conducted online and a thematic analysis then identified themes. The five key themes were: *Positive Experience; Pressure and Responsibility; Focused but Flexible; Accessible and Engaging; and Future Utility.* The fast pace and focussed-approach helped create momentum for patients to stay engaged, whilst the brevity and the option to choose the mode of delivery (i.e., online or face-to-face) helped to make brief CAT accessible. Results suggest that therapists had a positive overall experience and could see the future utility of the 8-session approach in routine services, although they did feel pressure of the brief time limit in the context of the increased risk and complexity of the patients. Brief CAT emerges as an acceptable approach to be considered alongside the medium (16-session) and long (24-session) versions of CAT. Recommendations to support the delivery of the briefest version of the CAT model are made.

Keywords:
Self-harm; cognitive analytic therapy; brief therapy; qualitative

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Introduction

Self-harm can be defined as any deliberate act of self-injury or self-poisoning as a means of expressing emotional distress, regardless of the intended outcome (National Institute for Health and Care Excellence [NICE], 2024). Whilst prevalence is difficult to determine as many people do not seek help, it is estimated that around 7.3% of adults and 22.1% of young people in the UK engage in self-harm, with trends suggesting that these numbers are increasing (Lim et al., 2019; NHS, 2016). Self-harm is considered an externalising symptom of often widely differing mental health difficulties and has an adverse ongoing negative impact on wellbeing (Bryson et al., 2021). As well as the physical implications, such as the risk of infections and scarring, self-harm is also a strong predictor of eventual suicide (Duarte et al., 2020). Treatment is therefore important, but a recent meta-analysis demonstrated that, at present, interventions for self-harm have limited treatment effects (Fox et al., 2020). This has led to calls for rapid access to brief and evidenced-based interventions (Saini et al., 2020).

Cognitive analytic therapy (CAT) is a transdiagnostic and relational psychotherapy delivered in 8, 16 or 24 session contacts (Ryle et al., 1990) and the model has a growing evidence base. Recent meta-analyses have demonstrated that CAT generates large treatment effects across a range of symptoms (Hallam et al., 2021) and is differentially acceptable (Simmonds-Buckley et al., 2022). Both meta-analyses noted that the 16 and 24-session versions of the model had been more thoroughly researched in comparison to the 8-session version. Two versions of the brief 8-session forms of CAT have recently been defined and termed the Somerset and the Sheffield models (Kellett et al., 2024). The key difference between these models is that the Sheffield approach reformulates at session 3 and places more emphasis on earlier identification and tracking of target problems/procedures and the Somerset model has a combined reformulation and goodbye letter. The Somerset model has been demonstrated to have equivalent effectiveness to cognitive behavioural therapy (CBT; Beck, 2011), but with lower dropout rates (Wakefield et al., 2021). A service evaluation has demonstrated the feasibility of a brief CAT-based intervention for self-harm, again highlighting the high engagement rates within a relatively complex population (Taylor et al., 2021).

Based on such evidence, a feasibility randomised control trial has since been funded and conducted examining 8-session CAT for self-harm: *Relational Approach to Treating Self-Harm* (RelATe; Taylor et al., 2024). Whilst the results of the RelATe trial are yet to be published, the trial has been being conducted with a view to conducting a future fully powered randomised controlled trial, should the results be positive. As part of the development of an evidence-base, however, it is important to understand the acceptability of any intervention with therapists delivering the intervention and this needs to be considered in equipoise with issues of efficacy/effectiveness. In short, if therapists do not find the brief CAT approach acceptable, then they will not deliver it. Whilst patients' experiences of CAT have been explored (Rayner et al., 2011), therapist experiences have been somewhat overlooked. The aim of the study is therefore to explore therapist perspectives of delivering 8-session CAT (Sheffield model) and additionally experiences of delivering CAT during RelATe trial. This study sought therefore to understand what it felt like to deliver 8-session CAT, what made this work or got in the way, to explore the focus of the approach, and to name the themes within the therapists' experiences. Gaining this insight will help to identify strengths and weaknesses of the 8-session model and the way it is delivered, to help refine relevant aspects of the approach. This will enable a set of recommendations to be made to ensure 8-session CAT is fit for routine service delivery.

Methods

Design, Approval and Consent

A qualitative design was employed, using structured interviews conducted with therapists who had delivered 8-session CAT for self-harm as part of the RelATe trial (Taylor et al., 2024). Purposive sampling was used, whereby all therapists from the trial were approached via email and asked if they wished to participate. The RelATe trial was ethically approved (Greater Manchester West REC; ID: 318068) and this nested qualitative study was approved as a service evaluation (RDaSH Ref: SE15). To be a patient participant in the RelATe trial, then a person had to have three or more active episodes of self-harm in the previous past year (Taylor et al., 2024). When approaching prospective therapist participants, it was made clear that taking part was optional. Information about the purpose and nature of the service evaluation was given, as well as the opportunity to ask questions. Written consent was sought prior to interviews taking place.

Participants

Demographic characteristics are outlined in Table 1. Two of the therapists were undertaking the CAT practitioner training at the time of the trial, two were qualified as CAT practitioners, and one was qualified as a CAT psychotherapist.

Table 1: Demographic Characteristics of Therapists (N=5)

Characteristic	Mean	SD
Age (years)	45.4	7.27
Years qualified	6.5	11.70
Patients prior to trial	55.8	65.61
Patients in trial	5.4	4.16

Note. Four of the participants were female and one male. 'Years qualified' refers to years since completing CAT practitioner training. 'Patients prior to trial' refers to the approximate numbers of clients the therapist had worked with using CAT prior to taking part in the RELATE trial. 'Patients in trial' refers to the number of clients the therapist worked with as part of the RELATE trial.

Data collection

Interviews were conducted, recorded, and transcribed using Microsoft Teams and were approximately 45-60 minutes long. A semi-structured interview schedule was used to ensure consistency between interviews. The aim of the interviews was to gather information on experiences and perspectives of delivering eight-session CAT for self-harm, including expectations, challenges, barriers, what worked well, and what could be improved.

Interview questions

1. What were your thoughts and feelings about the 8-session approach before you started on the trial?

- Prompts: What were your thoughts on how effective it would be?
- Did you have any concerns, and if so, what were they?
- How did it compare with your expectations?

2. Could you tell me about your experience of delivering 8 session CAT in the trial?

- Prompts: How did it feel?
- How comfortable and confident were you in delivering it?

3. What were the similarities and differences with the 16 and 24 session approach?

- Prompts: What were your thoughts on the shorter timeframe?
- Which techniques, if any, might you have like to use from longer forms of CAT which were missing from this approach?

4. What is the most difficult aspect of delivering 8 session CAT?

5. What is the best aspect of this approach?

6. What did you learn over time about delivering 8 session CAT?

- Prompts: Could you tell me about anything that might have surprised you?
- Is there anything you learnt from this approach that you will carry into your everyday practice, and if so, why?

7. What do you think helped clients to engage and do well with this approach, or to not do well and drop out?

- Prompts: What sorts of things did clients report to be helpful/ unhelpful?

8. Is there anything about 8 session CAT you would change or add?

9. What factors most helped you to deliver the 8-session approach competently?

- Prompts: Were there any particular resources you found useful, and if so, why?

- How did you use supervision in the trial compared to how you would usually?

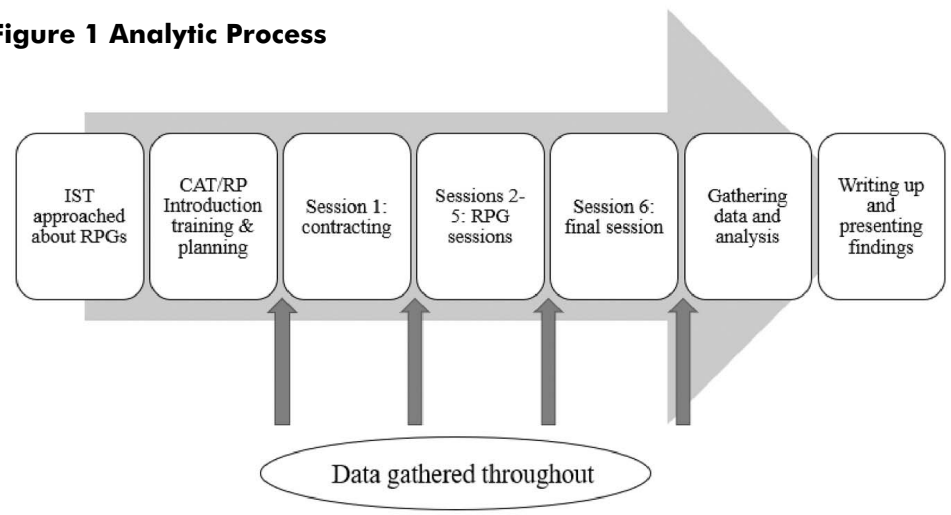
10. Were there any challenges or barriers to delivering the intervention?

- Prompts: For you as the therapist? For the client?

Data analysis

Inductive thematic analysis was used to analyse interview transcripts using Braun and Clark's (2006) guidelines, the steps of which are displayed in Figure 1. A realist, data-driven approach to analysis was taken, identifying semantic themes to explore broad views and experiences, and to give a rich descriptive account of the dataset. Key themes were identified where there appeared to be high prevalence of discussion about a topic and the topic was of relevance to the research aims. There was no specific number of codes needed to form a theme, however, the topic must have been coded a number of times across the dataset as a whole and mentioned by multiple participants in order to be considered a theme.

Figure 1 Analytic Process

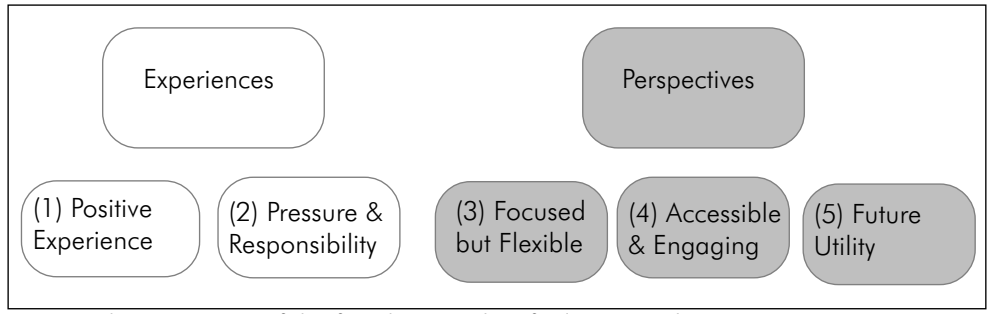


Note. The six phases of thematic analysis, as defined by Braun & Clarke (2006).

Results

Five key themes were identified: (1) Positive Experience, (2) Pressure and Responsibility, (3) Focused but Flexible, (4) Accessible and Engaging, and (5) Future Utility. These were grouped into therapists' own experiences of delivering the approach (1 & 2) and therapists' perspectives of the model (3, 4 & 5) for ease of interpretation. These are presented in a thematic map in Figure 2 and examined in detail beneath.

Figure 2: Thematic Map



Note. A thematic map of the five themes identified, grouped into 'experiences' and 'perspectives' to aide interpretation.

(1) Positive Experience

All therapists spoke positively of their experience of delivering the approach. This related to positive feelings about helping people who really needed it, seeing what clients achieved, and hearing positive client feedback:

> 'It felt like a good thing to be spending my time doing.'

> 'I think it was overall. . . a good experience of actually doing the work. I enjoyed doing the work with people.'

> 'I think service users kind of found it helpful and gave some really positive feedback.'

Therapists also spoke of surprise at how quickly clients progressed and how much change could be made and maintained in the brief timeframe:

> '. . . how easily people were able to change and to kind of embrace the kind of exits to the patterns, I think that surprised me how quickly people did that really.'

'. . . people I think were quite surprised at the gains they managed to make in the sessions.'

'. . . taking a lot of pleasure in hearing that people were still doing well.'

This theme was evident across all five interviews, demonstrating acceptability of the intervention from a therapist perspective.

(2) Pressure and Responsibility

Although overall experiences were positive, the shorter timeframe in this form of CAT was a key topic of discussion. This brought pressure to add value in every session and to work quickly in pinning down target problems and writing reformulation letters. Therapists spoke of this in the below examples:

'I found it quite packed, quite pressured.'

'To be able to be able to rate the [target problem] procedure, you've got to have it pinned down enough in session one. I think that. . . is quite challenging.'

'I suppose that reflects some of that pressure I felt in having to write that letter, in having to invest in that relationship quite quickly from a time perspective.'

Risk and complexity being high due to the nature of the client population added to this pressure, as therapists were trying to hold space for risk issues whilst still adhering to the protocol:

'I think there's a time pressure to eight sessions with a complex client group, that doesn't leave you the same space to work with what comes up, while also trying to work with everything you need to get done.'

It did seem, however, that the pressure related to degree of experience of the therapist. This was evident as newly qualified therapists reported more pressure and anxiety, but how their confidence grew over time, whilst more experienced therapists did not emphasise the pressure as much:

'I think probably all those things become easier the more experienced you are, because you have your own style and you know the model and you can use the model and flex it to who you are and how you work.'

'. . . you maybe needed to be a bit more skilled to do an effective eight session cat.'

'I think at the end my confidence grew. . .'

It should be noted that the pressure of delivering the approach was sometimes hard to disentangle from the pressure that came with being part of a research trial. Therapists described feeling a sense of responsibility to get it 'right' and were aware of feeling watched due to recording sessions for adherence ratings.

'I suppose, and maybe this is a trial thing. . . I felt really responsible. So I was a bit like 'I'm not just seeing. . . Joe Blogs. . . I'm seeing Joe Blogs but like, oh my God, I've gotta get this right because. . . there's a lot resting on this'.'

Overall, this theme shows that therapists delivering the approach felt a definite sense of pressure and responsibility to work quickly and work well. This primarily related to time and the added risk and complexity in the target population, but this sense of responsibility was hard to differentiate from the trial conditions. Whilst pressure and responsibility were reported by most therapists, it appeared to reduce as experience increased.

(3) Focused but Flexible

Therapists reported the approach to be highly focused on self-harm as the problem, rather than as a symptom of another problem, which helped to enhance understanding:

'I'd probably sort of superficially worked on [self-harm] with people before and felt like we'd sort of understood it as almost like a symptom linked with another problem. But actually, when people were bringing that as the problem, there was. . . the depth at which we understood it. . .'

'All the participants in the trial have the same dilemma of either 'I'm cut off from my feelings and at risk of self-harming' or 'I'm overwhelmed with my feelings and at risk of self-harming'.'

The focus was guided by the protocol, which appeared to provide structure and help therapists to stay on track. Therapists described the containing nature of the protocol in maintaining the focus:

'And the protocol. . . actually it provided a really containing

framework to think about. It gave you a real sense of how to pace it and how to structure it.'

'. . . what I've discovered really early on was that actually having the protocol was really, really containing and so you weren't having to do a huge amount of the thinking of 'how do we fit this into eight sessions', because the protocol became a guide of how to structure it.'

Despite being highly focused, therapists still described a flexibility within the protocol to deliver it in their own style and to adapt the content to their clients' individual needs:

'It's got what I've called. . . having a 'loose/tight' focus.'

'There's a lot of conversation about holding [the protocol] lightly, so it's about achieving the things that need to be done, but doing it in your own style and doing it flexibly and in response to the client's needs.'

Supervision also appeared to be focused on the approach, helping therapists to bring the protocol to life but with the flexibility to think about what the therapists were bringing and their own confidence too:

'Normally. . . my supervision would be a bit broader and it would be including things about. . . organisational and systemic issues as well, whereas this was purely kind of a therapy focus and thinking about CAT so it was more focused.'

'[Supervision] gave me that reassurance that I was doing it right, but it also helped me to boil it down to eight session size.'

Overall, the focus of the approach, guided by the protocol and by supervision, seemed to help counteract some of the difficulties with the time pressure as there were guidelines of what to cover and when. Whilst the approach was highly focused, it also had enough flexibility to avoid rigidity and to ensure it could be tailored to suit both the clients' needs and the therapists' style.

(4) Accessible and Engaging

Therapists described the accessible nature of a brief piece of work that clients could commit to, even when they may have a lot going on in their lives (as was common in the target population). Offering sessions online increased this accessibility, and whilst it posed some challenges for therapists (in building rapport, managing risk, and mapping collaboratively) it did not appear to disadvantage clients:

'I suppose committing to a shorter piece of work is less onerous than committing to a longer piece of work. . . I don't think my client would have done a longer piece of work. And also the flexibility that it could be online.'

'[client] said to me it was the only piece of therapy that they had been able to successfully take part in and complete, because we'd been able to work with them quite quickly, but also because eight weeks was a really realistic time frame for them to be able to commit. . .'

It also appeared to help clients to engage in further support post-intervention:

'They felt quite empowered. . . and a lot of them, where they maybe had struggled a little bit to engage with some of the support available and services, afterwards had then been a lot more open to it, and had gone on to do other interventions in the service.'

Therapists reported that the fast pace of the approach, with early feedback in terms of reformulation letters, helped provide momentum. This supported clients to be more engaged and involved in the process:

'I think [the brevity] really helps focus attention and the. . . sense of momentum, that 'this is the time we've got and we're not trying to look at everything, we're just focusing here on what can we do that's more useful than the patterns that we're stuck in already'. That's potentially very useful.'

'I think having a map and having a reformulation letter so quickly means people instantly feel like something is happening. So I think that's really important.'

'. . . at the end of that two sessions you've then got a letter. . . of somebody reflecting your life back at you. I think you're kind of 'in' by then.'

This increased engagement also appeared to come from clients writing their own reformulation letters, which helped to redress the power imbalance:

Actually, clients are really, really good at being able to reflect and to do that. And I think it's a really important way to set up how you share power in the sessions. . .'

It was clear to see that the approach was accessible and engaging. This appeared to be due to the brevity and pace creating momentum, as well as the option to work online. The collaborative nature of the approach also helped with engagement by sharing the power.

(5) Future Utility

A number of the therapists talked about how the approach could be utilised in services moving forward. This included bridging the gap between primary and secondary care and supporting clients who may not fit the criteria of one service or another:

> '. . . at the moment people have to wait to go to another team for therapy. But it doesn't have to be like that and I could easily be working, doing eight session work with some of the people that we see in our team.'

> 'It just felt like I was working constantly with that group of people that fell through the cracks and it felt really good.'

There were suggestions for future development. These included extending the time frame of the intervention (without adding more sessions) and the follow-up period, to give time for letter writing and to allow clients more time to implement changes:

> 'I think maybe if. . . the window had been a bit longer. So we could have missed a week [to write] either letter. I think that might have been helpful.'

> '. . . one of the things I've wondered about is doing eight sessions but not in eight weeks and what difference that would make. You know, so that you were only offering eight hours, but building within that more time for people to be practising exits'

> '. . . that slightly extended time frame to consolidate, to practise the recognition and revision, had been really useful.'

It was evident that the therapists were able to see where the approach could fit in a real-world context, and how this could help to improve the offer that services can provide to ensure wrap-around care for vulnerable clients. This also helped therapists to feel like their work was worthwhile. Therapists did feel, however, that increasing the treatment and follow-up windows may be beneficial to reduce time pressure on both clients and therapists.

Discussion

When self-harm is an aspect of a patient's problems, then CAT therapists would normally consider the 24-session approach. The RelATe trial (Taylor et al., 2024) is testing the feasibility and acceptability of offering 8-session CAT. This nested project was concerned with the experience of delivering the briefest version of CAT to patient group that self-harm, because acceptability is important in terms of both patient and therapist perspectives. In summary, five key themes arose from the interviews conducted with therapists involved in the RelATe trial: Positive Experience; Pressure and Responsibility; Focused but Flexible; Accessible and Engaging; and Future Utility. These themes aligned with the aims of the project, naming themes of the experience of delivering eight-session CAT in the trial, to understand what it felt like to deliver this version of CAT, what made the 8-sessions work, and what got in the way, and to explore the focus of the approach. The findings suggest that therapists had a positive overall experience, though they did have feelings of pressure and responsibility, mainly due to time pressure. Therapists could see where the 8-session model could be utilised in routine service delivery and felt it was highly accessible and engaging, even for patients that may have struggled to engage previously. Whilst the approach places demand on therapists to work quickly, the focus, protocol and support from clinical supervision help to mitigate some of this. The approach differed from therapists' previous experiences by placing self-harm as the core focus, rather than as an expression of another difficulty. However, therapists described the approach as flexible enough to be tailored to the needs of individual patients, meaning the focus did not create rigidity. The 8-session CAT therefore needs to not get caught up in a dilemma of being either overly focussed or overly loose.

The time-limited nature of the approach largely underpinned most themes. The focus this brings has been suggested to be a factor in clients engaging in brief interventions (Lyons & Low, 2009), perhaps by increasing the motivation and accountability for change (Markussen et al., 2021). The present findings support this hypothesis as therapists described a sense of momentum and 'buy in' due to the fast pace, as well as increased accessibility due to the relatively short-term time commitment and the choice regarding mode of delivery. This could help to explain the low attrition rates found in 8-session CAT previously (Taylor et al., 2021; Wakefield et al., 2021). The protocol used in the trial aided the focus, whilst allowing therapists to practise with authenticity and tailor the approach as needed, aligning with the notion of *'flexibility*

within fidelity', outlined by Kendall and Frank (2018). This is significant, as therapist flexibility has been associated with better outcomes for clients (Owen & Hilsenroth, 2014).

An interesting paradox occurs in that often less experienced or less qualified therapists offer briefer interventions (for example in the stepped care approach seen in NHS Talking Therapies services), and yet, it appears that more experienced therapists are better equipped to cope with the demands of a faster pace. The findings in this project suggest that this is due to efficiency and confidence in using the Sheffield 8-session CAT model of identifying target problems early, early narrative reformulation, active mapping, and goodbye letter writing (Kellett et al., 2024). This aligns with research suggesting number of years' experience is related to reduced anxiety and improved decision making in therapists during brief work (Dawson, 2017). More experienced therapists also showed a clearer understanding of the boundaries and limits of the work, and so were not trying to fit 16- or 24-session CAT into 8-sessions. This highlights the importance of ensuring therapists are trained and confident not just in the theoretical model, but in leveraging time effectively (Reynolds Welfel, 2003). Therapists in brief interventions may need to take more initiative (Fosha; 2004), which requires a sound working knowledge of the CAT model and this needs to not be an enactment in the CAT model. Whilst focus and initiative taking is arguably important in all therapies, it is amplified during brief therapies, where time really is of the essence. Whilst the protocol gave therapists a sense of security in relation to adherence, it is important that supervisors of 8-session CAT are mindful of therapists' confidence with the brief CAT format, as feelings of incompetence can impact the working alliance and, ultimately, treatment outcomes (Bernstein, 2021).

Limitations of the present study should be noted. Only five therapists were interviewed as this was the available sample, and one therapist only worked with one patient in the trial. No cross-coding took place to check reliability. The sample size was small, limited to the trial and a larger sample size may have brought up alternative perspectives. As the model was only delivered under trial conditions and not in routine service delivery, it was challenging to disentangle how much of the pressure was attributable to the trial conditions versus the 8-session model itself. In a routine-service context therefore, the pressure noted in the analysis may become less pertinent (and other pressures possibly emerge). It should be noted that the present study is qualitative and so does not provide evidence of the efficacy of the 8-session approach. Further research in the form of efficacy and effectiveness trials are needed to more clearly define the clinical outcomes of 8-session CAT for self-harm (and other clinical presentations).

Practice Recommendations

The following six practice recommendations are made based on the study findings: (1) ensure that therapists using the model are trained in the focal 8-session approach and have access to the treatment protocol, (2) adapt clinical supervision to the demands of the brief approach, (3) consider offering 8-session CAT to patients who may be struggling to engage in longer forms of CAT, (4) offer patients the choice to have CAT online to improve accessibility, (5) for therapists to consider to leaving an additional weeks' gap between sessions two and three to write narrative reformulations, and (6) to offer an extended follow-up period where indicated (by client preference and clinical judgement).

Conclusions

The 8-session CAT approach in the RelATe trial has emerged as an acceptable therapy to deliver for therapists with the right support. The evidence base for any therapy needs to balance indices of effectiveness, efficacy and acceptability. Further research is needed regarding the 8-session CAT approach as it is underrepresented in the CAT evidence base. As services often want to commission brief interventions, then the 8-session CAT approach is emerging as an important contribution to any service offer as it combines brevity with theoretical adherence, but in a manner that does not sacrifice the individuality of each patient. □

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