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ARTICLE

Change to the recognition and revision of target problems and target problem procedures during eight-session cognitive analytic therapy for self-harm

Chris Gaskell¹ | Peter Taylor² | Zerena Airnes³ | Stephen Kellett^{4,5,6} 

¹North Staffordshire Combined NHS Foundation Trust, Stoke-on-Trent, Staffordshire, UK

²University of Manchester, Manchester, UK

³Greater Manchester Mental Health Foundation Trust, Manchester, UK

⁴Rotherham Doncaster and South Humber NHS Foundation Trust, Doncaster, UK

⁵Clinical and Applied Psychology Unit, University of Sheffield, Sheffield, UK

⁶University of Exeter, Exeter, UK

Correspondence

Stephen Kellett, Swallownest Court, Rotherham Doncaster and South Humber NHS Foundation Trust, Doncaster, UK.

Email: stephen.kellett@nhs.net

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Abstract

Objectives: Defining target problems (TPs) and associated target problem procedures (TPPs) is a key competency of cognitive analytic therapy (CAT). This study sought to categorize types of TPPs identified, assess the acceptability of TP/TPP sessional tracking, assess whether changes in TP/TPP recognition and revision occurred and also whether change in TP/TPPs predicted severity of self-injury urges and psychological distress.

Methods: As part of the RELATE clinical trial, $N=31$ participants were allocated to eight-session CAT. TPs/TPPs were rated for recognition and revision at every session in a nested ABC plus follow-up single case design. The competency of therapists was assessed. TPPs were coded as to whether they were a snag, trap of a dilemma. Linear mixed-effects models tested whether TP/TPPs changed over time and according to phase of CAT. Change in TPs/TPPs were used to predict self-injury urges and psychological distress (i.e., research follow-up measures taken by blinded researchers).

Results: There was strong interrater agreement on whether the TPP was a snag, trap or dilemma. The sessional rating of TPs/TPPs appeared acceptable, as during 97.68% of treatment sessions and 82.60% of follow-up sessions, tracking occurred. Compared to the reformulation phase, awareness and then therapeutic change of TPs/TPPs significantly increased during the recognition and revision phases. Recognition and revision of TPs/TPPs during CAT in the revision phase did not predict self-injury urges and psychological distress at research follow-up.

Conclusion: Early definition and sessional tracking of TPs/TPPs appear acceptable and changes to awareness and

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ability to change TPs/TPPs appears linear. CAT therapists should routinely integrate sessional tracking of TP/TPPs into their work.

KEYWORDS

cognitive analytic therapy, self-harm, target problems

Practitioner points

- The definition of target problems (TPs) and target problem procedures (TPPs) is a form of idiographic assessment.
- Tracking of TPs/TPPs is a means of evaluating the effectiveness of CAT.
- Tracking TPs/TPPs over sessional time provides opportunities for reviews and also problem solving when change is not occurring.

Cognitive analytic therapy (CAT) was initially developed to try to create a common language across the psychotherapies (Ryle, 1979) and is an integrative, brief, collaborative, structured, focused, transdiagnostic, relational and time-limited psychotherapy (Brummer et al., 2024). CAT is delivered in 8, 16 or 24 sessions. Follow-up is part of the CAT model with a single follow-up session for 8 and 16 session CAT and four follow-up sessions for 24-session CAT (Ryle & Kerr, 2020). While research continues to progress, there is recent meta-analytic evidence of the effectiveness and acceptability of CAT (Hallam et al., 2021; Simmonds-Buckley et al., 2022). CAT has been considered as a potential intervention for people that self-harm, because of the importance of relational processes in maintaining self-harm (Peel-Wainwright et al., 2021).

The RELATE trial (relational approaches to treating self-harm) was a feasibility randomized controlled trial (RCT) evaluation of eight-session CAT for adults that self-harm in the community (Taylor et al., 2024, 2026). While the focus of such clinical trials is typically on change in valid, reliable and standardized (i.e., the nomothetic¹) psychometrically validated clinical outcome measures, the effectiveness of CAT in changing the personal and idiographic concerns brought to therapy is an equally important consideration (Kellett et al., 2025). Idiographic outcome measurement has the following characteristics: it contributes towards case formulation, enables therapy to be individually tailored, guides clinical decision-making and is a means of evaluating change (and particularly so in response to specific actions; Haynes et al., 2009). Compared to nomothetic outcome measurement, service users and clinicians alike report that idiographic measures are (a) patient-centred, (b) capable of capturing complex personal concerns and (c) are able to index when therapeutic change has occurred (Haynes et al., 2009). In routine practice, there is often more progress on ideographic measures than there is on nomothetic measures (Edbrooke-Childs et al., 2015).

CAT has a three-phase approach regardless of the duration of the intervention and these phases are called *reformulation*, *recognition and revision* (Ryle & Kerr, 2020). Target problems (TPs) and target problem procedures (TPPs; the patterns underpinning the TP) are defined and named during the reformulation phase. These are therefore the idiographic outcome measures of CAT. The naming of TPs and TPPs moves beyond diagnostic labels (but maybe informed by the diagnosis) and collaborative refinement

¹ A nomothetic outcome measure is defined as being psychometrically validated and so suited to measuring baseline 'severity', being able to define caseness cut-off points and being sensitive to measuring change via reliable and clinical change analyses. An idiographic outcome measure provides therapists with a means of monitoring outcomes in a way that is tailored to the individual patient and the difficulties they bring to therapy. Idiographic measures are often suited to intensive measurement.

enables the therapist and patient to then be 'on the same page' in terms of the focus and goals of the intervention (Tanner, 2002). The TP may be about how the patient relates to themselves (i.e., the self-to-self relationship) or how they relate to others (i.e., the self-to-other and other-to-self relationship; Ryle & Kerr, 2020). 'Symptoms' can therefore be reformulated and renamed as a TP, with the TPP clarifying the underlying pattern or procedure (Tanner, 2002). TPPs concerning how a patient relates to others also helps to normalize that the TPP will likely crop up during sessions, and therefore therapist and patient can collaboratively notice when the TPP is active within the therapeutic relationship and so better manage the enactment (Bennett et al., 2024).

CAT's analytic component is represented by 'reciprocal roles' while the cognitive component is represented by 'procedural sequences' (Ryle & Kerr, 2020). The narrative and sequential diagrammatic reformulations (SDRs) used during CAT therefore emphasize reciprocal roles and associated procedural sequences. A reciprocal role is an analytic synopsis of key developmental experiences, whereby both ends of the role are internalized and then acted out. Reciprocal roles therefore influence self-to-self, self-to-other and other-to-self interactions and CAT therapists are expected to notice and manage reciprocal role activation within the therapeutic relationship (Parry et al., 2021). Reciprocal roles determine and drive associated procedural sequences (i.e., the here and now patterns of thoughts, feelings and actions), with these procedures serving to maintain individual reciprocal roles and also providing the links between different reciprocal roles (Ryle & Kerr, 2020).

Tps and TPPs are therefore named in the narrative reformulation letter and are also present in the SDR. The SDR pictorially depicts TPP 'chains' and how they connect with and maintain reciprocal roles (Jenaway, 2024). During the recognition phase of CAT, there is a strong focus on helping patients to better recognize TPs and TPPs as they occur in day-to-day life and also in the therapeutic relationship (Parry et al., 2021). The 'observing eye/listening ear' is introduced which helps patients to helpfully notice (without criticism) when they are enacting TPs and TPPs (Yorke, 2024). During the revision phase, there is then a greater focus on changing TPs and TPPs, but the work of the observing self continues (Toye, 2009). Without the specific naming of TPs and TPPs during reformulation and tracking during recognition and revision phases, then the focus of CAT remains uncertain, and so change is harder to define and identify. Over the course of a CAT, progress would be indexed by improvements in the ability to recognize and then revise TPs and TPPs (Ryle & Kerr, 2020).

There are three types of TPPs and these were initially categorized (Ryle, 1979) as snags, traps and dilemmas. Ryle et al. (2014) provided the following definitions: a trap occurs when underlying negative assumptions and beliefs are being reinforced by outcomes via the action of a vicious circle, a dilemma was evident when psychological flexibility is restricted by access to only polarized alternatives of thinking, feeling or acting, and a snag occurs when an outcome that is actually desired, is then avoided or sabotaged. Snags, traps and dilemmas are stated in the first person in the narrative reformulation letter to help with subsequent awareness and so recognition. The CAT competency model states that therapists should identify, name, reformulate and then track over sessional time the recognition and revision of TPs and TPPs (Parry et al., 2021). When CAT is described as a 'focussed therapy' (Brummer et al., 2024), then this focus partly comes from identifying and then tracking TPs and TPPs. There are several clinical tools that are available to CAT therapists that enable tracking of the recognition and revision of TPs/TPPs but with no established version, no evidence of how widely used these tools are used and whether TP/TPP tracking is acceptable to patients.

Therefore, whilst TPs/TPPs are clearly a central part of the CAT model (Parry et al., 2021; Ryle & Kerr, 2020) research on TPs and TPPs has unfortunately been absent. In this study, sessional TP/TPP outcomes were drawn from the RELATE trial (relational approach to self-harm trial; Taylor et al., 2024; Taylor et al., 2026). Whilst CAT theory suggests that recognition should accelerate during the recognition phase and revision should accelerate during the revision phase (Ryle & Kerr, 2020), these assumptions have not been previously tested. Specifically, this project therefore aimed to (a) assess whether tracking of TPs and TPPs was acceptable and well tolerated, (b) assess whether significant change in TPs and TPPs occurred over time and according to phase of CAT and (c) whether recognition and

revision ratings predicted nomothetic outcome measure scores at the end of CAT (i.e., psychological distress, self-injury urges). It was hypothesized that higher TP and TPP recognition and revision ratings towards the end of therapy would be associated with lower levels of psychological distress and self-injury urges in the post-therapy nomothetic research assessments, adjusting for baseline differences. The importance of this contribution concerns the lack of previous evidence concerning the usage of TP/TPPs during CAT, whether change to TPs/TPPs occurs during CAT, what the shape of change is and whether change is synchronized with the phases of CAT. The anticipated impact is empirical encouragement for CAT therapists to routinely monitor responsivity of TP/TPPs, regardless as to whether the contact agreed is 8-, 16- or 24-session CAT.

METHOD

Trial design

RELATE was an assessor-blind feasibility RCT that took place across two NHS Trust sites; participants were randomly allocated to either CAT plus treatment as usual (TAU) or TAU alone. Outcomes were assessed by researchers that were always blind to allocation. Recruitment took place over 12-months. Because this current project concerns TP/TPP change, then only participants randomised to the CAT arm were included, as participants in TAU did not receive CAT. The trial was pre-registered (ISRCTN code: ISRCTN75661422), the protocol published (Taylor et al., 2024) and ethical approval achieved (Greater Manchester West REC; ID: 318068). The analysis plan was registered on the Open Science Framework (OSF code <http://osf.io/an2z6>). Analysis plan registration occurred after researchers had seen the data, but before any analysis, results were reviewed or interpreted.

Nested single case design

The distinct three-phase approach of eight-session CAT therefore created a nested ABC plus follow-up (FU) single case experiment design (SCED) for each CAT participant (Ferron et al., 2023). The phases and number of associated sessions for each CAT participant were as follows: A=reformulation baseline phase (i.e., sessions 1–2), B=recognition phase (i.e., sessions 3, 4 and 5), C=revision phase (i.e., sessions 6, 7 and 8) and FU (1-session). Follow-up occurred 4-weeks after the eighth and final session. The TPs/TPPs were the intensively measured idiographic measures of the nested SCED design (Ferron et al., 2023). This design therefore enabled initial levels of recognition and revision of TPs/TPPs during the reformulation/baseline (A) phase to then be compared against subsequent progress or not during the recognition (B) and revision (C) phases.

Participants

Participants were adult outpatients recruited from three sources: (a) primary care NHS 'Talking Therapies' services, (b) psychology services based in the community (e.g., NHS student mental health services) and (c) secondary care NHS services. Inclusion criteria: (a) aged ≥ 18 years, (b) have engaged in self-harm ≥ 3 times in the past year (confirmed via the Self-Injurious Thoughts and Behaviours Interview; Nock et al., 2007) and (c) judged by their clinical team as sufficiently contained and safe to be able to be seen for outpatient therapy. The rationale for the three episodes of self-harm in the past year criteria was that the self-harm being treated by CAT needed to be an active and current problem, and therefore not a previous historical problem that was no longer an issue. Exclusion criteria were: (a) the presence of a moderate-to-severe intellectual disability (i.e., IQ: <70) or organic cerebral disease/injury affecting

receptive and expressive language comprehension, as judged by their clinical team, (b) being a psychiatric inpatient, (c) experiencing a current, active episode of mania or psychosis, as assessed via the Mini International Neuropsychiatric Interview (MINI; Sheehan et al., 1998), (d) inadequate English language ability preventing comprehension of study information, (e) receiving another ‘high intensity’ one-to-one psychological therapy (e.g., CBT, DBT; low intensity interventions such as support, psychoeducational or skills groups were not reasons for exclusion), (f) judged to be an imminent risk to themselves, defined as the presence of active suicidal intent or planning to self-harm in the immediate future (e.g., in next week). Individuals with such current risk could however participate in the trial once their level of risk had been assessed as sufficiently reduced.

Brief CAT for self-harm

CAT was started 2-weeks after randomisation and written psychoeducation about CAT was provided to encourage initial attendance. Eight 50–60 min (in person or online) weekly individual CAT sessions were offered. CAT was delivered according to the Sheffield eight-session clinical protocol (Kellett et al., 2025). This provides a detailed session-by-session structure for therapists to follow. The protocol mirrors the three-phase structure of CAT (see Kershaw et al., 2026 for a coproduced example of the protocol with a RELATE participant). There are five psychoeducational materials that support each of the phases which encourage high levels of patient involvement and engagement. At session 1, therapists define and name the key TPs and TPPs with the patient (i.e., using ‘I’ and not ‘you’ language). TPs/TPPs were stated as either snags, traps or dilemmas. These TPs/TPPs were then rated for recognition and revision at each subsequent session and at the follow-up session.

Therapists

CAT was delivered by five therapists at NHS band 8, all with appropriate core professional training (i.e., one CBT therapist, three clinical psychologists and a psychiatrist). Three of the therapists had completed the first-year of their CAT training, and two of the therapists had fully completed the 2-year CAT training. Therapists received fortnightly (60-min) supervision from a CAT accredited psychotherapist, trainer and supervisor (SK). Adherence to the treatment protocol was monitored during clinical supervision and all narrative reformulations, SDRs and goodbye letters were checked and discussed. Where participants consented, sessions were also audio-recorded for supervision and competency rating purposes.

Competency

To assesses therapist competency, a subset ($N=20$) of CAT sessions in the RELATE trial were randomly selected. These sessions were then assessed using a valid and reliable measure of CAT competency (CCAT; Bennett & Parry, 2004). The CCAT has been used in service evaluation and clinical training to identify ‘satisfactory CAT’ and the CCAT is also used in research (see France et al., 2026 for a research example). The CCAT rater makes global judgements across 10 domains of competence across whole sessions, using a scoring manual that contains detailed descriptions of observable therapist performance. In this study, the whole sessions were independently rated by a qualified CAT psychotherapist and supervisor. The CCAT is scored 0–40 and where a score of 20+ is the cut-off score for competent CAT during that session (Bennett & Parry, 2004). The CCAT has acceptable levels of interrater reliability, high internal consistency and is significantly associated with the quality of therapeutic alliance. The average CCAT score was 33.40 ($SD=8.26$, range: 16–40) and all sessions (bar one: CCAT score=16) met the competency criterion.

Measures

Research trial: Clinical outcomes

Nomothetic outcome measures were completed as part of the RELATE trial at baseline, 12-weeks and 18-weeks after randomisation. The 12-and 18-week assessments were the research follow-ups. The researchers conducting assessments at the three time-points were always blind to allocation (see Taylor et al., 2024 for the trial methodology). The Alexian Brothers Urges to Self-Injury scale (ABUSI; Washburn et al., 2010) assessed the severity of urges over the preceding week. Emotional distress over the preceding 30-days was assessed using the Kessler Distress Scale (KDS; Kessler et al., 2002).

In session: Target problems and target problem procedures

The TPs/TPPs named and agreed in the first session and were also repeated in the narrative reformulation letter. Goodbye letters from therapists also contained sections on how the TP/TPP had changed and what would keep that changing going. The Kershaw et al. (2026) coproduction provides examples of snags, traps and dilemmas. The 'trust radar' TP had a trap TPP of *'feeling I'll be hurt or abandoned, I am always on high alert. I pick up on body language and behaviours and if these are not to my high standards, I leave but then feel hurt and abandoned.'* The 'my selfish snag' had the TPP of *'I like to look after myself, but if I do that, I label it as just being selfish and so don't do it.'* The 'my self-harm dilemma' TP had the TPP of *'I'm either lost in and overwhelmed by emotions (and self-harming) or I am numb and cut-off.'* The protocol dictated that a maximum of three TPs/TPPs being identified, but there could be a single TP/TPP. Recognition was rated at each session from 0 *'cannot see the pattern'* to 100 *'spotting it really well'* and revision was rated at each session as 0 *'have not been able to change it'* to 100 *'changing it very effectively.'* The protocol dictated that therapists should review patterns in the progress of recognition and revision of TPs and TPPs at each session with the participant and therefore feedback the results. Because the revision phase of CAT is where change work is emphasized, lack of revision during reformulation and recognition phases would not seen as cause for concern. When patients were not progressing in terms of recognition during the recognition phase and revision and during the revision stage, then this was discussed, problem-solved and considered as a potential enactment.

For the 31 participants randomized to the CAT arm (M age=28.58; SD=10.25; 27 female, 2 male, 2 non-binary), 30 started CAT and in the first session 59 TP/TPPs were named and rated. On average, each participant had two TP/TPPs (actual mean=1.90 TP/TPPs). Twenty-eight participants attended four or more sessions (i.e., meeting the study criteria for full attendance) and 23 then attended for the clinical follow-up. At least one recognition or revision score was recorded for at least one TP/TPP on at least one occasion for all 30 participants. For the 30 participants who entered treatment, all had at least one TP/TPP rated at the first session and at the final CAT session. Sessional TP/TPP ratings were available from 23 participants. There was moderate agreement between independent raters on classification of TPPs as either traps, snags or dilemmas ($\kappa=.64$). Following discussion and then independent re-rating of TP/TPPs, the degree of agreement improved ($\kappa=.89$). The discussion concerned the theoretical differences between snags, traps and dilemmas.

Definitions and statistical analysis plan

Full treatment was defined as attending for four or more sessions (Taylor et al., 2024). TPPs were coded by two CAT therapists independently and the level of agreement calculated using Cohen's kappa (Cohen, 1960). The McHugh (2012) guidelines were used to assess the degree of agreement: 0–0.2 ('none'), .21–.39 ('minimal'), .40–.59 ('weak'), .60–.79 ('moderate'), .80–.90 ('strong') and >.90 ('almost perfect'). Clinical follow-up was conducted by the therapist that delivered the CAT and research

follow-up was conducted by the blinded researchers. Acceptability of rating of sessional ratings of TPs/TPPs was estimated by calculating the density of measurements achieved in the total possible number of (a) treatment sessions and (b) clinical follow-up sessions. Each participant therefore generated a time-series of sessional TP/TPP recognition and revision scores. In a few cases, a participant's score was initially recorded as a range (e.g., 10–15) rather than a specific value because the participant could not decide on a discrete value. Here, the lower value was used as the dependent variable. Imputation methods were not applied, with missing data not contributing to analyses.

To analyse changes in recognition and revision ratings, linear mixed-effects models were used using the *lme4* (Bates et al., 2015) package in R (R Core Team, version 4.3.3). The data structure for the mixed-effect models had 3-levels (i.e., sessions nested within TP/TPPs nested within participants). An intercept-only model was first fitted to estimate baseline variability and calculate the intraclass correlation coefficient (ICC). This quantified the proportion of variance attributable to between-participant and between-phase differences. Fixed effects for phase and session number (tested in separate models given inter-relatedness) were then added to assess change in recognition and revision of TPs/TPPs. Session number was centred at zero to improve interpretability. Finally, models were extended to include random slopes and so whether this improved model fit was assessed. Clinical follow-up session ratings were not included in the mixed-effects model. This was because of the time interval between the final CAT session, and the clinical follow-up (i.e., 4-weeks) was not consistent with the weekly sessions. Trajectories of predicted revision and recognition TP/TPP scores, based on the linear mixed-effects model, along with 95% confidence intervals, were visualized using the *ggplot2* package (Wickham et al., 2019). There was no indication of non-linear effects from plots and so only linear effects were tested.

Linear regression was used to regress the 12-week self-injury urges or distress score (measure taken by the blinded researcher) onto the average revision or recognition ratings over the last three CAT sessions (i.e., the revision phase of eight-session CAT) but adjusting for urges or distress as baseline. Any sessions that occurred outside of the therapy window (i.e., outside of 12-weeks from randomization) were excluded. This was because these sessions occurred after the 12-week assessment occurred, and so could not be used as a predictor. The regression analysis enabled an assessment to be made of whether revision and recognition ratings during the change-focused revision phase of CAT were associated with residualized change in outcome (distress or self-injury urges; Castro-Schilo & Grimm, 2018). This approach was preferable to using change scores, because there was no expectation that baseline outcomes would be substantially correlated with revision or recognition ratings at the end of CAT. All analyses were undertaken using R (R Core Team, 2025). Distributional assumptions for the linear regression were examined using the *check_normality()* function from the *performance* package (Lüdtke et al., 2021). Linear mixed models were fitted using the *lme4* package (Bates et al., 2015). Data cleaning and visualization were undertaken using the *tidyverse* package collection (Wickham et al., 2019).

RESULTS

At session 1, 26 traps, 11 snags and 22 dilemmas were identified and then rated for recognition and revision. Of the 216 attended sessions (excluding follow-up), TPs/TPPs were rated in 211 sessions (i.e., 97.68% adherence) and there were 6.81 TP/TPP ratings per participant over sessional time. At follow-up, there were 19 TPs/TPPs rated against 23 sessions (i.e., 82.60% adherence).

Mixed effects models: Recognition of TPs/TPPs

First, the intercept-only model showed that the average intercept for recognition of TPs/TPPs was 61.33 (SE = 3.70, $t(28.83) = 16.6$, $p < .001$). The ICC was 63.47%, with 34.71% being between participants, and 28.75% being TPs within participants. Session number was significantly associated with recognition

TABLE 1 Model outputs and fit statistics for each iteration of the mixed-effects regression model predicting recognition outcomes.

Parameter	Random intercepts	Time	Time + random slopes	Phase	Phase + random slopes
Fixed effects – Mean [95% CI] (SE)					
Intercept	61.33 [54.06, 68.59] (3.70)	48.18 [41.04, 55.31] (3.63)	47.6 [37.66, 57.57] (5.06)	50.09 [42.81, 57.38] (3.70)	50.10 [40.93, 59.26] (4.66)
Session (Time)	–	4.16 [3.58, 4.74] (0.30)	4.38 [3.03, 5.72] (0.68)	–	–
Recognition phase	–	–	–	10.28 [6.86, 13.70] (1.74)	10.40 [6.62, 14.17] (1.92)
Revision phase	–	–	–	23.02 [19.51, 26.53] (1.79)	23.56 [15.85, 31.27] (3.92)

ratings, increasing by 4.16 points per CAT session (see Table 1). When allowing slopes to vary, the model then had significantly improved fit ($\chi^2(4)=175.72, p<.001$), with TP/TPP recognition ratings increasing 4.38 points per session. In a separate model, with dummy variables representing recognition (B) and revision (C) phases (i.e., rather than using session number as the predictor), ratings significantly increased during the recognition phase (+10.28) and then again during the revision phase (+23.02) when compared with the ratings during the reformulation (baseline A) phase. Allowing random slopes significantly improved model fit ($\chi^2(5)=102.73, p<.001$), with higher recognition ratings during the recognition phase (+10.40) and the revision phase (+23.56) compared to the reformulation phase. Figure 1 contains the mixed-effects regression model predicting recognition outcomes.

Association of recognition of TPs/TPPs with nomothetic outcomes

The linear regression model was significant ($F(3, 56)=6.96, p=.002$) which tested whether average recognition ratings across the last three sessions of CAT predicted self-injury urges at 12-weeks (i.e., controlling for baseline self-injury urges). This accounted for 17.04% of the variance in outcome. However, recognition ratings were not significantly associated with self-injury urge severity ($\beta=-0.001$ ($CI=-0.07-0.07$), $p=0.99$). In the linear regression model examining whether average recognition ratings across the last three sessions of CAT predicted psychological distress (while adjusting for baseline distress), the model was significant ($F(2, 54)=17.96, p<.001$) and accounted for 37.72% of the variance. However, again recognition ratings did not significantly predict lower psychological distress scores at follow-up ($\beta=0.03$, ($CI=-0.02-0.08$), $p=.274$). As a post-hoc sensitivity analysis, analyses were repeated but just with the recognition ratings from the final CAT session. The final recognition rating was not associated with self-injury urges ($\beta=-0.02$, ($CI=-0.09-0.06$), $p=.671$), but the relationship with psychological distress was significant ($\beta=0.06$, ($CI=0.01-0.11$), $p=0.027$).

Mixed effects models: Revision of TPs/TPPs

The intercept-only model showed that the average intercept for revision of TPs/TPPs was 27.34 ($SE=3.14$, $t(27.57)=16.60, p<.001$). The ICC was 43.04%, with 42.18% being between participants, and 0.86% being TPs within participants. Session number was associated with revision ratings and increasing by 6.16 points per session (see Table 2). Allowing slopes to vary improved model fit ($\chi^2(4)=70.88, p<.001$), with revision ratings increasing 6.08 points per session. When compared to the reformulation (baseline A) phase, revision ratings significantly increased during the recognition phase ($B=+16.22$) and then again during the revision phase ($C=+34.04$). Allowing random slopes

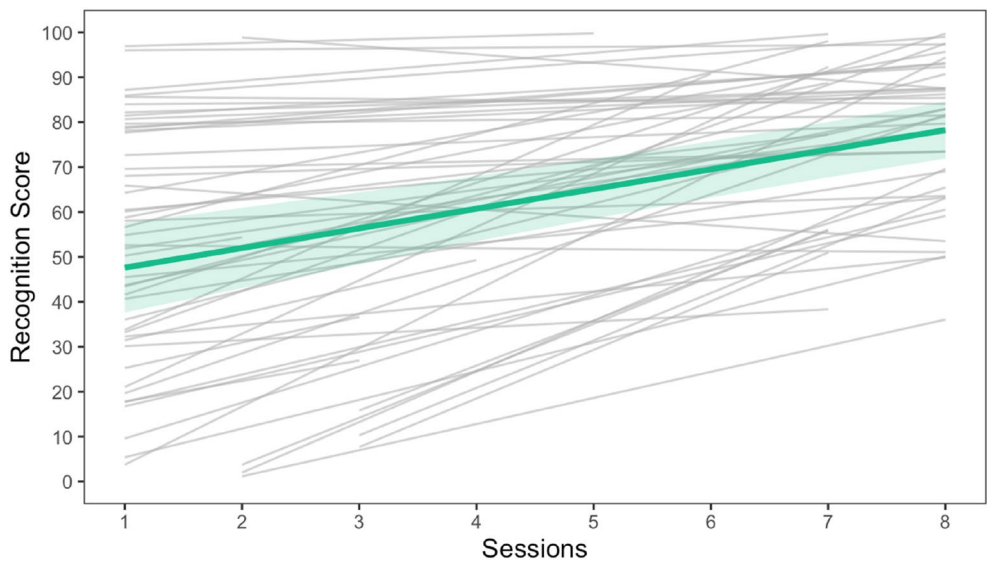


FIGURE 1 Overall slope and intercept from the mixed-effects regression model predicting recognition outcomes, with individual participant slopes overlaid in the background.

TABLE 2 Model outputs and fit statistics for each iteration of the mixed-effects regression model predicting revision outcomes.

Parameter	Random intercepts	Time	Time + random slopes	Phase	Phase + random slopes
Fixed effects – Mean [95% CI] (SE)					
Intercept	27.34 [21.16, 33.51] (3.14)	7.47 [1.76, 13.17] (2.90)	7.68 [2.64, 12.72] (2.56)	9.91 [4.11, 15.71] (2.95)	10.01 [5.66, 14.36] (2.21)
Session (Time)	–	6.16 [5.66, 6.67] (0.26)	6.08 [3.03, 5.72] (0.54)	–	–
Recognition phase	–	–	–	16.22 [13.08, 19.37] (1.60)	15.86 [11.71, 20.02] (2.11)
Revision phase	–	–	–	34.04 [30.82, 37.26] (1.64)	33.57 [27.63, 39.51] (3.02)

significantly improved model fit ($\chi^2(5)=47.53, p<.001$), with higher revision ratings during the recognition B phase (+15.86) and the revision C phase (+33.57) compared to the reformulation (baseline A) phase. [Figure 2](#) contains the mixed-effects regression model predicting recognition outcomes.

Association of revision of TPs/TPPs with outcomes

The linear regression examining whether average revision scores over the last three sessions predicted self-injury urges at 12-weeks (while controlling for baseline urges) was significant ($F(2, 56)=7.20, p=.002$). This accounted for 17.62% of the variance in 12-week self-injury urges. Revision scores did not significantly predict self-injury urges ($\beta=0.02, CI=-0.05 - 0.10, p=.532$). In the linear regression model examining whether average revision scores over the last three sessions of CAT predicted psychological distress (while adjusting for baseline distress), the model was significant ($F(2, 54)=17.09, p<.001$) and accounted for 36.49% of the variance. Revision scores did not significantly predict distress scores ($\beta=-0.01, CI=-0.06 - 0.04, p=0.696$). A post-hoc sensitivity analysis just used revision

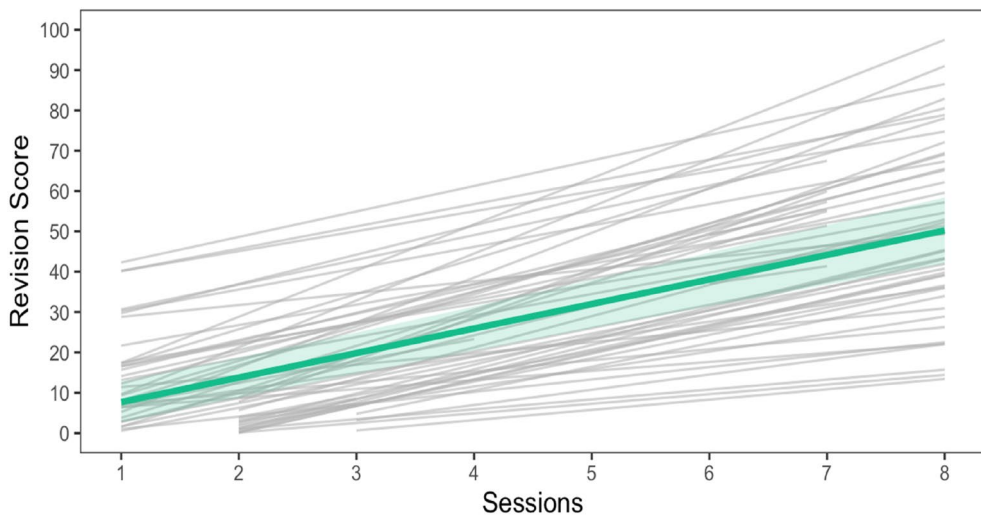


FIGURE 2 Overall slope and intercept from the mixed-effects regression model predicting revision outcomes, with individual participant slopes overlaid in the background.

ratings from the final CAT session, rather than the average across the last three sessions. Final revision rating was not associated with self-injury urges ($\beta=0.02$, $CI=-0.06-0.10$), $p=.616$) or distress ($\beta=-0.0004$, $CI=-0.06-0.56$), $p=.988$).

DISCUSSION

This has been the first study to identify the types of TPs/TPPs that are defined and worked with from first session of eight-session CAT, whether sessional tracking of TPs/TPPs is acceptable, whether change occurs to TPs/TPPs, whether the timing of changes to TPs/TPPs reflects the theoretical phase-structure of CAT and finally whether change in the recognition and revision of TPs/TPPs predicts self-injury urges and psychological distress when CAT is completed. Despite the theoretical importance of TPs/TPPs in the CAT model, research on TP/TPPs has not previously been conducted (Ryle & Kerr, 2020). This project was undertaken by creating a nested ABC-FU SCED design (Ferron et al., 2023) in the CAT arm of a feasibility RCT for self-harm (Taylor et al., 2024, 2026). Such brief psychological interventions for self-harm are a health service priority (Lockwood et al., 2025). The nested design enabled the reformulation phase to act as the baseline 'A' phase, against which changes in recognition and revision of TP/TPs during the recognition ('B') and revision ('C') phases could then be compared. Brief CAT has the same tripartite reformulation, recognition and revision structure as the sister 16 and 24-session formats and benefits also from a well-specified session-by-session treatment protocol (Kellett et al., 2025). Agreement on classification of TPPs as traps, snags and dilemmas was only 'moderate' at first but improved to 'strong' after discussion. This indicates that reliable classification of TPPs into their theoretical subtype is possible but likely requires additional training to synchronize raters.

The current study aggregated and analysed group-level patterns of changes to ratings of TPs/TPPs over sessional time to assess for generalized change patterns (see Horan et al., 2025 for an example of a TP/TPP SCED). The regression approach taken took a multivariate, multilevel and random effects approach, and this has been previously advocated with idiographic measures (Haynes et al., 2009). The significant regression models index linear progression in the recognition and revision of TPs/TPPs. Natesan Batley et al. (2020) emphasize immediacy of change in an idiographic measure when a phase is instigated as being necessary to show strong evidence of treatment effectiveness. This was not the case here as steady progression across the three phases was more in evidence. Focusing on TPs/TPPs is an

item on the '*review and evaluation of process and outcome*' subscale of the CCAT (Bennett & Parry, 2004) and in the current study levels of CAT competency were satisfactory.

Tilden (2020) emphasized the importance of balancing idiographic and nomothetic measurement, as was the case here. The regressions conducted revealed little relationship between changes in the in-session rated recognition and revision of idiographic TPs/TPPs and the nomothetic outcomes of the clinical trial (i.e., the valid and reliable measures of self-injury urges and psychological distress taken by blinded researchers). Recognition and revision of TPs/TPPs in the change-oriented phase of eight-session CAT (i.e., the last three sessions) did not predict distress and urges to self-injure. The presumed mechanism of CAT action is revision of TPs/TPPs (Ryle & Kerr, 2020) and this has recently been formalized in the eight-session CAT protocol through the co-creation of a change map during sessions 6–8. Change maps name healthy reciprocal roles and procedures, and so share the same structure as SDRs and still contain an observing eye (see France et al., 2026 for an example). Qualitative content analysis has previously found a three-stage revision process during CAT: (a) increased awareness, (b) creation of new roles and procedures and (c) learning methods that support the maintenance of change (Sandhu et al., 2017).

Sessional tracking of TPs/TPPs means that the focus of the work is retained, progress is evaluated and necessary actions can be taken to enable change. This would therefore be the first CAT example of the use of routine outcome monitoring and associated feedback (McAleavey et al., 2024). The feedback of sessional TPs/TPPs recognition and revision ratings for eight-session CAT has been further developed into a graphical format, so that patient and therapist can easily plot projections and take associated indicated actions (see Kellett et al., 2025 for an example). This would be idiographic identification, assessment and tracking in clinical action (Haynes et al., 2009). Definition of TPs/TPPs as either snags, traps or dilemmas means that idiographic concerns are relationally reframed and also theoretically grounded. There is considerable flexibility in naming TPs/TPPs, because the snags, traps or dilemmas identified can reflect problems in self-to-self, self-to-other and other-to-self relating (Ryle & Kerr, 2020).

Sessional tracking of TPs/TPPs was part of the treatment protocol and the high-density levels of ratings across each course of CAT and at follow-up would index high therapist adherence (Parry et al., 2021; Power et al., 2022) and also the high acceptability of TP/TPP tracking with participants (Frumkin et al., 2021). Acceptability with participants is likely due to the idiographic nature of TPs/TPPs (Haynes et al., 2009). Brief CAT has been described as trying to create and maintain a '*loose-tight focus*' (Kellett et al., 2025); the naming of TPs/TPPs at session 1 creates the focus, and the sessional ratings of recognition and revision maintains the focus. There is no reason why 16 and 24-session CAT are not compatible with the same TP/TPP tracking approach.

In terms of study limitations, then the most obvious is that each TP/TPP was an idiographic measure and therefore there was no traditional psychometric reliability and validity information. Beltz et al. (2016) offered a robust clinical defence of idiographic measures and particularly when used in combination with nomothetic measures, as was the case here. The reformulation phase could be criticized as an unsuitable baseline 'A' phase, because there is contact with a therapist. Where baselines have been compared with and without contact with a CAT therapist, then no significant differences were found (Kellett et al., 2022). The sample size was small and was restricted by what was available from the RELATE trial, which had a recruitment target of $N=30$ CAT cases. The small numbers meant that the analyses of associations of TPs/TPP changes with nomothetic outcomes were underpowered. As noted, the analyses were observational and correlational and the lack of comparator TP/TPP ratings in a TAU arm limits confidence in the results. While the shape of change in the recognition and revision of TPs/TPPs appeared fairly linear, caution is needed in interpreting linear change without any comparator, as improvements may reflect regression to the mean or other artefacts. The sensitivity analyses conducted need to be treated with caution, given their post-hoc nature.

In terms of future research, there needs to be testing and comparison of TP/TPP responding across a wider range of clinical presentations. This will help to define whether there are disorder-specific response patterns, or whether the shape of recognition and revision is generalized and universal. Comparing shapes of change across 8, 16 and 24-session CAT is now warranted. Longer term follow-up would be helpful. Further progress in TP/TPP revision may be possible in lengthier CAT formats (i.e., final session ratings

shown here did not show mastery) and this needs to be tested. There needs to be development and comparisons of differing types of TP/TPP feedback systems. There is a CAT-app that has been developed (Kellett et al., 2020) and digitization of TP/TPP tracking therefore holds promise. Qualitative evaluations of TP/TPP definition and tracking would be welcome, from both therapist and patient perspectives. Where qualitative research has been conducted with therapists concerning the eight-session CAT (Payne et al., 2026), identifying and tracking TPs/TPs did not emerge as a major concern. The relationship between idiographic and nomothetic outcomes is worthy of further investigation (Vittengl et al., 2013).

To conclude, this project has explored the acceptability of tracking TP/TPPs during brief CAT for self-harm, whether change to TP/TPPs occurs and whether this is important in terms of self-injury and psychological distress. The study emphasizes the importance of TP/TPP identification and tracking as a key CAT competency (Parry et al., 2021). TPs/TPPs can be both patient-centred and theoretically grounded and the three-phase CAT approach means that responsivity can be easily evaluated. The relationship with nomothetic outcome is less clear and needs further investigation. The importance of this study is in (a) reemphasizing the centrality of TP/TPPs in the CAT model, (b) that TP/TPPs tracking appears acceptable, (c) TP/TPP tracking forms part of the evaluation of outcome and (d) is a means of signalling when the therapy is not working, so that early remedial actions can be taken. The attitudinal factors that may be inhibiting TP/TPP routine outcome monitoring in CAT therapists need to be explored (Duncan & Murray, 2012). CAT training courses need to emphasise TP/TPP identification and tracking as a key clinical competency. Further TP/TPP research is clearly indicated with the 16 and 24-session formats and with other presenting problems and also in other age groups.

AUTHOR CONTRIBUTIONS

Chris Gaskell: Formal analysis; data curation; writing – original draft; writing – review and editing. **Peter Taylor:** Conceptualization; investigation; funding acquisition; methodology; writing – review and editing; project administration; writing – original draft. **Zerena Airnes:** Formal analysis; writing – review and editing; writing – original draft. **Stephen Kellett:** Conceptualization; investigation; funding acquisition; writing – original draft; methodology; writing – review and editing; formal analysis; supervision.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

The data and the analysis are available from the corresponding author on request.

ORCID

Stephen Kellett  <https://orcid.org/0000-0001-6034-4495>

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