9 Auditing CAT

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This chapter discusses the experience of setting up an audit of activity and outcome in two units which specialised in treating patients with Cognitive Analytic Therapy (CAT). The chapter focuses on the practical difficulties of auditing CAT and tries to draw out general implications for audit in psychotherapy.

General considerations

Increasingly audit is recognised as a vital part of medical practice. Its aim is to improve or maintain high standards of practice and to improve the targeting of limited resources. This is as true for psychotherapy services as for any others; Parry's (1992) path-breaking review of audit in psychotherapy ends with the trenchant remark that unaudited practice of psychotherapy is now indefensible. Indeed a number of features of psychotherapy make the use of audit especially vital. Psychotherapy is different from drug treatment in that the active elements are not prepackaged and quality-assured by a drug company before supply. Rather, the active elements are delivered as a skill by health professionals as they also are in surgery.

Maintaining the quality of the 'active ingredient' provided is therefore an important function of audit. In both surgery and psychotherapy new techniques are pioneered in specialist centres and then are spread more generally throughout the community of practitioners. In differently experienced

Cognitive Analytic Therapy: Developments in Theory and Practice, Edited by A. Ryle
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hands these new techniques may be expected to have differing outcomes. Quality audit is therefore vital to maintain uniformly high standards.

But psychotherapy differs from surgery in the nature of the kind of contact involved with the patient. In psychotherapy the involvement of the therapist in the therapeutic process (countertransference) is both important to therapy and problematic for it. The therapist's therapeutically relevant and emotionally laden involvements do not end with the patient; they may also extend to an organisational level (as it were 'organisational' countertransference) and investments in the organisation may bias or affect therapy. The starkest example of this process is seen in the tensions which develop in departments that are conducting research into different modalities of therapy. Audit in psychotherapy has a function in such situations because it can unearth unconscious countertransferences and challenge received or entrenched ways of doing things. One example of an audit which surprisingly went some way towards achieving this aim is given in Denman (1993). I recounted the experience of doing an audit (in that case of audiotapes) which fortunately turned out to be detached from the emotional embroilments of individual cases but stayed close to the in-session concerns of the therapists. This feature allowed the audit to identify and address certain difficulties that therapists were having in a way which was immediate but which did not seem persecutory and which had not been picked up by supervision. As a result the organisation responded with considerable changes despite a number of glaring structural inadequacies in the audit process.

Psychotherapy also differs from surgery in another way. In psychotherapy a wide variety of conditions are treated with what seems superficially a similar technique. Worse still, the superficial similarity of the treatments offered gives way on closer inspection to considerable individualisation of formulations and therapeutic techniques. Personal factors in the patient and in the therapist take on an importance considerably greater than they have in other treatments. Because of this a further function of audit in psychotherapy lies in the hope that techniques derived from audit will assist the community of psychotherapists to improve practice and to 'prescribe therapy' more rationally. More abstract research than audit, and most particularly the use of randomised controlled trials to probe issues of differential efficacy, has resulted in a confusing and disappointing lack of clear results. Furthermore, and politically more significantly, research has had rather little effect on the actual practice of therapists. Several authors have discussed the inadequacy of the randomised controlled trial paradigm for research in psychotherapy (e.g. Fonagy and Higgitt, 1989) and particularly for research in psychotherapy which is intended to have clear practical application to the practice of psychotherapy in the real world. Audit, with its circular process of examination, organisational change/adjustment and re-examination might work to raise standards and

outcomes where the more linear model of the randomised controlled trial had failed. This hopeful view of audit is taken by Parry (1992), but it may also hold dangers. Audit is not cheap science and good audit is more, not less, organisationally exacting to carry out than good science.

Auditing CAT

Despite the value of audit and the general esteem in which it is held, very considerable difficulties face the auditor in relation to documenting and evaluating the functioning of a department of psychotherapy. In order to illustrate the practical problems, I now turn to the description of aspects of the audit of two departments offering CAT at two central London teaching hospitals—Guy's and St Thomas's.

Three parameters define a comprehensive audit (Donabedian, 1988): *input*, which refers to the delineation of the resources available and their organisation; *activity*, which describes the activities of the organisation in delivering care; and *output*, which denotes the effects of the care on the patients' well-being and satisfaction.

Input data

The input data of the two organisations, which differed slightly, were described easily in terms of their salient features without formal survey. St Thomas's and Guy's both had departments of Cognitive Analytic Therapy under the direction of the same consultant psychotherapist who, along with other senior Cognitive Analytic Therapists, provided supervision to trainee therapists from a range of backgrounds. Most of these therapists each took on a few patients at a time without pay, in return for tuition; they performed the greatest proportion of the work of the departments. Some attempt was made to send more difficult patients to more experienced therapists. At that time one department (Guy's) took referrals directly (that is, without intervening psychotherapeutic assessment) from a general psychiatric clinic. A closer description of this service and its philosophy can be found in Watson and Ryle (1992), but in essence any patient referred as a psychiatric outpatient who was not judged in need of a specific disposal (admission, pills or systematic desensitisation for example) was offered CAT. St Thomas's took patients referred specifically for psychotherapy more generally from general practitioners and psychiatrists and screened those referrals at intake with an interview by a consultant psychotherapist. However, this interview did not constitute a barrier preventing access to treatment as the consultant involved rarely turned down patients for therapy and mainly offered CAT as a first intervention.

Activity data

Activity data, which included diagnostic, demographic and disposal data, were already being collected routinely at St Thomas's. At Guy's such data were collected using a computer system (CATsys) which had been developed by a member of the auditing team (C.D.).

In addition, a review was carried out of the quality of therapy. This was attempted by conducting a semi-formal assessment of the quality of the therapist's notes in a run of consecutive patients at each centre. CAT, unlike other therapies, lays great stress on the joint production by therapist and patients of documents (usually language-based) which constitute tools for new learning. These documents (the reformulation and the SDR) are meant to encapsulate a procedural understanding of the patients' difficulties. Therapy is focused on the procedures which have been jointly delineated and is reviewed at termination in a further document, the goodbye letter. As a result of the stress on these documents, their formal adequacy was thought to give some guide to the competence of the therapist in doing CAT and so, it was hoped, indicate the quality of therapy achieved.

The documents were inspected by five senior CAT therapists and were rated for a number of different features, including emotional impact, communicative appropriateness, cognitive clarity, and procedural adequacy. (See Ryle (1990) for a further discussion of these features in relation to reformulation.) Without knowledge of a case it is difficult to assess the accuracy of a reformulation in terms of its fit with the patient's story, so we looked for fit with the theoretical requirements of CAT and for internal consistency with other materials in the documents. Clearly, even if a reformulation possessed these features it might still be inadequate for the individual patient, so our criteria represented necessary but *not* necessarily sufficient standards for adequacy.

Output data

Data on outcomes were routinely collected at one centre (Guy's) in the form of a standard battery of tests which were administered at initial interview and at the three-month follow-up visit which is built into the format of CAT. The measures collected were: the Beck Depression Inventory (BDI) (Beck et al., 1961); the Symptom Check List 94 (SCL-94) (Derogatis, Lipman and Covi, 1973); the Inventory of Interpersonal Problems (IIP) (Horowitz et al., 1988); and a social circumstances questionnaire (SAS) (Weissman and Bothwell, 1976). In addition a record was kept of those patients who dropped out of therapy, including the number of the last session which they attended.

Results of the audit

Demographic data

Demographic data were gathered on 153 patients, which allowed some delineation of the demographic characteristics of the patients attending at the two departments. The centres operated different filtering systems before taking on a patient for CAT, and it was of interest to see whether the resulting case mixes would differ. In the event the centres did not differ with regard to the average ages, sex ratio and proportion of single people attending. Both centres had an equally high proportion of white British patients (75%), which contrasted unfavourably with the high proportions of other ethnic groups in the local areas and featuring as users of other parts of the mental health services. However, there were differences between the centres in relation both to the educational attainments of referred patients and to their socioeconomic status. The centre which took referrals direct from a psychiatric clinic (Guy's) had more patients with low socioeconomic class, and the centre which took referrals more generally (St Thomas's) had strikingly more patients with graduate status.

Waiting times

An attempt was made to collect data on waiting times for assessment and for treatment at the two centres, as an important parameter of quality of activity. However, we could not gather this information because a considerable proportion of the notes (or entries on the computer system) lacked accurate dates.

Quality of therapy

An audit of notes was carried out to look at the quality of therapy offered at the centres. Comparisons between the two centres were not possible because we could not complete interrater reliability studies to prove the uniformity of ratings. Raters noted a number of typical failings which were common to both sites. The most frequent failing identified in the notes was of a reformulation letter which embodied an empathic and seemingly accurate account of the patient's life and current target problems but which then failed to give an accurate procedural formulation either in the form of a set of target problem procedures or of an adequate SDR. In such cases the goodbye letter often had a sugary tone and failed to mention ambivalent or negative feelings about termination.

Outcome data on the patients at one centre (Guy's) existed for those

patients who completed therapy ($n = 32$) and there was good evidence for improvement in this group. Follow-up measures were taken at three months post-therapy (at which time the patient also saw the therapist again for a further interview).

Pre- and post-therapy scores for the 32 patients completing therapy were analysed. The mean 'pre' (mean 1.61; SD 0.62) and 'post' (mean 1.31; SD 0.78) scores on the IIP were significantly different ($t = 2.27$; sig 0.025) as were the mean 'pre' (mean 1.40; SD 0.72) and 'post' (mean 1.04; SD 0.78) scores on the SCL-94 ($t = 2.67$; sig 0.008). The scores on the BDI were also significantly reduced (pre-therapy mean 19, SD 10; post-therapy mean 14, SD 10; $t = 2.77$; sig 0.006). However, the scores on the SAS were not significantly changed (pre-therapy mean 19, SD 9; post-therapy mean 18; SD 10; $t = 0.82$; sig 0.415).

In the absence of a control group, the falls in scores which signal immediate psychological distress (the BDI and the SCL-90) are perhaps less impressive than the fall in the scores on the IIP. This is because one might expect general distress to decline with time in any case but the IIP seems to measure long-term interpersonal difficulties. The social adjustment scale measured things like housing circumstances which would be unlikely to have changed in the timescale of the study.

There was some evidence that there was a link between outcome and quality of treatment offered. Drops in the SCL-90 and BDI scores were correlated significantly with the rated emotional impactfulness of the reformulation (0.46, $p < 0.05$ for the SCL-90; 0.41, $p < 0.01$ for the BDI). Procedural adequacy of the reformulation was correlated with drop in the SCL-90 (0.47, $p < 0.05$) and procedural adequacy of the goodbye letter was correlated with the drop in the IIP score (0.37, $p < 0.05$). Finally there was a correlation between a global rating given by the auditor to the overall quality of the notes and drops in the SCL-90 (0.51, $p < 0.01$) and the BDI (0.38, $p < 0.05$).

These five correlations between outcome and quality are encouraging but they need to be interpreted with considerable caution, given that a total of 21 correlations were calculated. Also it is always possible, especially with psychological variables, that, even if valid, the correlations do not represent cause and effect but instead are the result of a common relationship between the variables and a third unmeasured variable.

No demographic features predicted the outcomes of those patients who completed therapy.

Study of those who completed therapy did not exhaust the audit. One-fifth of patients who were booked in for therapy failed to attend their first session with the therapist and a further third attended the first session but dropped out later on. No audited feature predicted who would drop out from therapy.

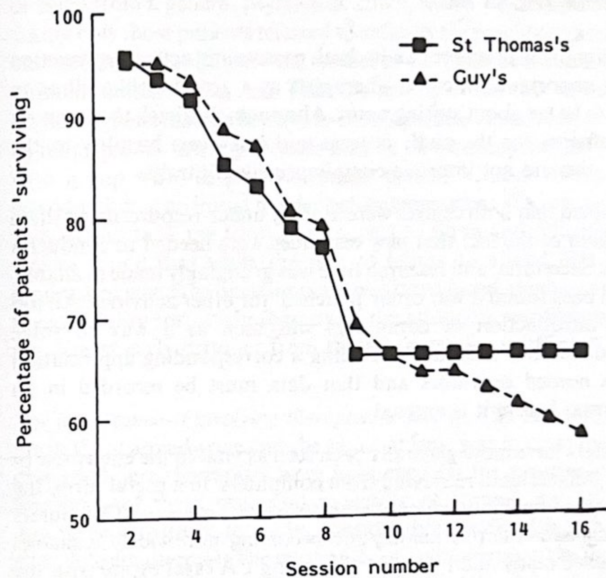

Figure 9.1: Survival curves showing attrition of CAT patients at Guy's and St Thomas's Hospitals

There were trends in relation to low socioeconomic class and severity of the initial condition, but these did not reach statistical significance. There were differences in the dropout rate between the two centres. At St Thomas's the rate of 'no-shows' to session 1 was 16% and of subsequent dropout 29%. At Guy's the rate of 'no-shows' to session 1 was quite a bit higher at 23% and the rate of subsequent dropout was marginally greater at 33%.

Although the data are marginal it is instructive to ponder the survival curves of patients at the two centres, shown in Figure 9.1. The graphs show percentage survival for those patients at Guy's and St Thomas's who started therapy (i.e. attended the first session). The increased attrition at Guy's can be seen to have resulted from continuing attrition after session nine.

The data on dropouts lent slight support to an impression which was prevalent at the two centres, that therapy was in some ways better conducted at St Thomas's and that there were fewer dropouts there. Certainly, in general, the therapists at St Thomas's were more experienced CAT therapists. However, the better results in relation to dropouts may relate only to differences in the sociodemography between the two centres.

Difficulties in conducting the audit

Therapist hostility to the process of audit, both passive and active, represented the single most important difficulty. Therapists as a group dislike filling in forms and tend to be lax about storing notes. Although, feedback to therapists generated enthusiasm for the audit process and less overt hostility to the auditors; sadly, this did not improve compliance significantly.

It should be noted that both centres were already under-resourced and there was no recognition of the fact that new resources were needed to conduct a successful audit. Secretarial and research time was grudgingly made available, and when it had been found it was often 'poached' for other activities. All too frequently the introduction of computers was seen as a way to solve administrative difficulties without there being a corresponding appreciation that computers needed operators and that data must be recorded in an appropriate format before it is entered.

While computers have more generally been seen as vital to the enterprise of audit, there are difficulties in retrieving from computers, in a useful form, the kind of unstructured text data which therapists feel is necessary. Computers also require specialised skills (fortunately now becoming more widely available) and in consequence many audit systems (including CATsys) expire with the departure of their enthusiastic but secretive creators. Furthermore computers rarely make the gathering of data easier than it had been by hand; rather they make the gathering of more data easier than it would be by two hands. So, while installing computers increases the potential level of output of a department, it does not make existing tasks easier to perform.

Audit is primarily a political and social enterprise rather than a scientific one. Its principal aim is to change practice for the better. In the pursuit of this aim it may be necessary to do things which would not be the best policy during a scientific research project—for example feeding back initial results to workers early in the process. The kind of data which needs to be gathered is local and not necessarily of general interest to the scientific community. These unglamorous features of audit are often minimised in departments of psychotherapy where the production of scientific papers is a chief aim but one which can turn out to be at variance with the needs of the audit process.

Lessons learned from the audit

The value of comparing services The two-site model allowed audit to be conducted in the form of a natural experiment. The similarities of approach and leadership at the two centres allowed comparisons to be made between differences in organisation of the sort which had major service implications. Taking all patients not thought suitable for other treatments (e.g. admission or pills) from a general psychiatric clinic, which was the model at Guy's, and taking only those patients referred specifically for psychotherapy by psychiatrists and general practitioners, the model at St Thomas's, represent appreciably different models of service. That the results of the two services should be so similar suggests that the barriers to entry operated consciously and unconsciously by many psychotherapy services may be unnecessary and may deny treatment to a group who, in practice, could benefit. Chiesa (1992) researched the introduction of an initial barrier before assessment at a psychotherapy service. The barrier took the form of a request to fill in and return a questionnaire. Chiesa found that while the rate of failure to attend first assessment was diminished when the questionnaire was introduced, there was no evidence that the suitability for psychotherapy of the attenders was thereby increased and the rate of early dropout from therapy was also unaffected.

The importance of involving therapists in audit The auditors and the audited must, if not already one and the same, at least stay in close touch. In the audit described here, therapists were heartened by the positive outcome results. Feedback of these results at a variety of formal and informal meetings diminished hostility to audit considerably. Sadly this did not in general stimulate an interest in the mechanics of audit amongst the therapists. Rather an 'expert syndrome' developed, with one member of the team (C.D.) becoming identified as the resident audit expert to whom all questions could be referred and then (all to often) forgotten. This meant that audit took some while to take off again after C.D.'s departure.

Conclusions

A 'warts and all' audit of Cognitive Analytic Therapy has been described. Many of the problems and limitations of the audit exercise will be similar for other departments of psychotherapy not practising CAT. However, some of the features of CAT should make it especially easy to audit. The use of measurement and monitoring is built into the structure and philosophy of the therapy, making compliance with auditing by both patient and therapist more likely. In CAT, specific documents are generated whose formats are to some extent defined by the requirements of an explicit theory, and this allows quality assurance monitoring to be attempted on the documents.

These audit-friendly features of CAT are perhaps not present entirely by accident. There are obvious links between the concept of procedural change in CAT and the idea of the audit cycle; if therapy is to some extent 'psychic audit', then audit can be seen (albeit fancifully) as therapy for therapy. Therapies need to be able to self-monitor and improve themselves and the audit-friendliness of CAT should be a positive advantage to both auditors and therapists.

The audit described here also shows how a relatively simple exercise of defining quality standards for the documents of CAT and the use of a simple and fairly standard battery of outcome measures can constitute the core of an achievable rolling audit for CAT. It would be valuable now for the community of CAT therapists as a group to define a basic audit package which should ideally be incorporated into the practice of CAT as a general rule. This might include the use of quality standards applied to audiotapes of therapy (which would clearly have advantages over audit of notes), but equally such an endeavour might be too time-consuming for routine audit. Naturally it will be vital to introduce regular reviews of the results of such auditing and to make sure that practice does change as a result. CAT therapists ought to be good at this; it is, after all, what they are meant to be doing in therapy.

Editor's note

A computerised audit system was established after Dr Denman's departure from Guy's, and therapist cooperation has been achieved. Therapist training and supervision have improved. Audit of the 1993 cohort of patients shows that the attrition rate of patients who attended their first session was only 17%, and that despite markedly higher psychometric scores at intake the scores on discharge were only marginally higher than before.

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10 Research relating to CAT

Anthony Ryle

The relation of psychotherapy research to theory and practice is a complex one. We are a very long way from being able to enunciate a theory of human nature and change which could generate hypotheses capable of elegant disproof through experimental designs. The attempt to emulate such designs has generated some distressingly simple models, but the pressure to demonstrate and measure what psychotherapy can achieve has nonetheless been a healthy one, providing some safeguards against the bias generated by enthusiasm for particular models (which is not to deny that such enthusiasm is probably a potent therapeutic factor).

The first presentation of a new therapy is usually in the form of individual case histories. When well observed, these can be as valuable as were the contributions of natural history to biology, providing the starting point for more critically designed studies of a number of cases through which some idea of the general effects of, and specific indications for, the approach may be gained. Traditionally the next step is a controlled trial comparing the approach with an alternative. While the placebo effect which confounds drug trials should not be a problem—for maximising the effect is a legitimate aim of psychotherapy—the standardisation of input (the same dose of the same substance) cannot be reproduced, each patient–therapist pair being necessarily unique. The matching or homogeneity of populations on the basis of psychometric and clinical data, already somewhat dubious in drug trials, is a real problem when one considers, to take one example, how many different human experiences and personalities may contribute to the development of

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