Practice Bulletin 2
Charting Psychoanalysis

This practice guideline recommends that psychoanalysts refrain from documenting psychoanalytic treatment session by session. We believe that documenting the content of a psychoanalysis seriously alters that treatment process and conflicts with fundamental clinical psychoanalytic skills. In addition, since a dynamic recollection of the psychoanalytic interaction reliably exists in the minds of psychoanalysts and patients and can be retrieved as needed, health care charts are not needed for good psychoanalytic care. We will in this document set forth the practical and theoretical bases of this position. Our suggestions may appear to delineate a departure from the approach that some members and components of this Association follow in keeping records of clinical work. It should be noted that our recommendations pertain only to psychoanalysis and modified psychoanalytic treatment. Other aspects of clinical record keeping are not directly affected by these recommendations. We suggest that clinicians maintain customary methods of documenting the initial professional assessment and prescription of psychoanalysis and events in the clinician- patient encounter that fall outside the scope of the psychoanalysis itself. Psychoanalysts' practice in these areas may be informed by the guidelines of their particular health profession--medicine, psychology, clinical social work, etc.

A. Overview of issues

1. Purpose of documentation. Health care providers maintain charts for two separate but interrelated purposes. The most important reason that a clinician documents a case (keeps a chart with progress notes) is to ensure that another clinician can be apprised of the status of the case and continue the treatment in the event of the absence or death of the treating clinician. Progress notes are also used to chronicle specific findings and events in the clinical encounter. These become important in certain medical-legal situations.

The American Medical Peer Review Association's Guidelines for Documentation of Ambulatory Encounters, which are widely used within the medical community, state that a patient's health record should include sufficient information to assess the previous treatment, to ensure continuity of care, and to ensure necessary and appropriate testing and/or therapy (AMPRA, May 11, 1991). This approach to health care records ordinarily dictates that the clinician document each encounter in considerable detail. The chart must also include certain sorts of information that substantiate the cost of care. "The documentation should support that the intensity of the patient evaluation and treatment reflected the reason for the encounter, the intensity of the problem, and the findings of the examination. The documentation in the record should support the CPT/ICD codes billed" (AMPRA, 1991). This approach is reflected in CHAMPUS regulation 199.2, which

states: "Progress notes are an essential component of the medical record wherein health care personnel provide written evidence of ordered and supervised diagnostic tests, treatments, medical procedures, therapeutic behavior and outcomes. In the case of mental health care, progress notes must include: the date of the therapy session; length of the therapy session; a notation of the patient's signs and symptoms; the issues, pathology and specific behaviors addressed in the therapy sessions; a statement summarizing the therapeutic interventions attempted during the therapy session; descriptions of the response to treatment, the outcome of the treatment and the response to significant others; and a statement summarizing the patient's degree of progress toward the treatment goals. Progress notes do not need to repeat all that was said during a therapy session but must document a patient contact and be sufficiently detailed to allow for both peer review and audits to substantiate the quality and quantity of care rendered" (Federal Register, November 26, 1991).

These general guidelines have been incorporated into the Mental Health Review Guidelines (Anonymous, 1993) that Health Management Strategies International, Inc. uses to review mental health care provided under CHAMPUS and other federal programs. In these systems, the clinician must submit a detailed progress note of each session for which payment is requested. If psychoanalysis is the treatment modality, one must additionally complete the Peer Review Form for Psychoanalysis as outlined in the Manual of Psychiatric Peer Review (Committee on Peer Review, 1981). The clinical experience of our members suggested, however, that the use of this form outside the circle of confidence of this Association tended to degrade the therapeutic alliance (Gray, 1992). The Executive Council of the American Psychoanalytic Association therefore implicitly superseded the use of this form in its resolution of December 19, 1991: "The most recent version of Reporting Information for Claims Review of Psychoanalysis is the official source of protocols for all professional review of psychoanalysis that takes place outside this Association."

The American Psychiatric Association has not published specific requirements for the contents of a chart. Psychiatrists follow a variety of guidelines that may have been developed for their specific practice setting, e.g., those of the Joint Commission on Accreditation of Health Organizations, or by a third party, e.g., Medicare. The American Psychological Association Guidelines recommend that each patient-psychologist contact be documented in detail. (Board of Professional Affairs, 1987, Sections 2.3.5 through 2.3.7 and 3.4.)

It is the impression of this committee that the practice of keeping progress notes for psychotherapy and psychoanalysis varies considerably from clinician to clinician, and that this variance is not related to the core profession of the clinician. Teaching centers seem to favor punctilious documentation, while busy independent clinicians may rely more on memory than on a written chart. The demands of the health care management industry for detailed explanation of every therapeutic intervention encourage the creation of increasingly voluminous records of diminishing usefulness. This has led clinicians generally to reconsider the function of the health care chart. Berwick's aphorism (1994), "Record only useful information only once," aims to mitigate this tendency.

2. Professional liability. Insurance underwriters are concerned that clinicians whose practices fall well within the standard of care have been vulnerable to adverse

judgments in lawsuits because this good care is inadequately documented. They consider it imperative that record keeping meet the criteria of standard professional practice. As part of their efforts at risk management, underwriters consistently urge psychoanalysts to keep records that demonstrate that appropriate care was provided to the patient. They indicate that the absence of such records may in itself be considered evidence of negligent or inadequate medical or other health care practice. In addition, the absence of records that were kept as part of ordinary clinical practice undermines the evidentiary credibility of the physician's testimony. Records add weight to the credibility of the doctor's testimony. Without records, the word of the opposite party gains in significance in relation to the doctor's testimony based on unsupported recollection. Insurance companies have raised these issues and are concerned about them. This concern is a source of difficulty experienced by the American Psychoanalytic Association's Committee on Professional Insurance in its efforts to mediate between the underwriters and the insured members. Since there is no written charting standard that is specifically pertinent to psychoanalysis as a mental health procedure, insurers, quality assurance reviewers, and courts focus by default on the formal charting standards recommended by other official health care organizations, as noted above in section 1. They tend to apply these standards to psychoanalysts with the expectation that the reasoning and conditions of practice that motivated creation of those standards are identical for psychoanalysis.

Psychoanalysts, both military and civilian, find that these formal regulations and the associated informal expectations pose several discrete and major threats to the technique of psychoanalysis. Both the Committee on Peer Review and the Committee on Professional Insurance receive complaints and requests for support from American Psychoanalytic Association members who feel that they cannot comply with these standards for external reporting while maintaining minimal standards of psychoanalytic technical competence. One of the better existing protocols for external reporting (Anonymous, 1993) seems to be founded on a fundamental misconception of the psychoanalytic process. Members have condemned our publication, Reporting Information for Claims Review of Psychoanalysis, on the same grounds (Marill, 1993).

There is no way to avoid the conflict between the interests of psychoanalytic patients and the psychoanalytic treatment process on the one hand, and the interests of psychoanalysts as potential defendants and their liability insurers on the other. We recommend a solution that goes far in the direction of protecting psychoanalysts who may become involved in lawsuits, but we believe that we have defined the point beyond which further defensive charting practices is likely fatally to degrade the psychoanalytic treatment process. The near-perfect documentation of every detail of a psychoanalysis that our legal advisers may advocate will by its very nature destroy a psychoanalysis, because that activity negates the clinician's efforts to establish a trusting therapeutic relationship with the patient. Since our priority must be to establish and maintain the environment that best allows the psychoanalytic process to develop, we must accept some legal risk. We hope that our recommendations will help limit that risk. It cannot be eliminated.

3. Higher informed consent standard. In the absence of specific published guidelines for charting psychoanalysis, an affirmative decision to omit charting may appear to represent a departure from the general standard of health care that requires explicit documentation of the treatment process. To date, it has been prudent but cumbersome

for psychoanalysts routinely to inform prospective patients at the outset of treatment about the special technical issues of charting psychoanalysis and of the variant of charting standards that they propose to follow. The recommendation to inform patients in this manner represents an expansion of the "higher informed consent standard" that applies when the proposed method of treatment is not one that the "majority" of practitioners would select. This became apparent in the case of Osheroff v Chestnut Lodge (Civil Action No 66024, Circuit Court for Montgomery County, Maryland, 1984), which was settled out of court and thus did not establish a legal precedent. Citing the landmark informed consent decision of Canterbury v Spence (464 F.2d 772, 787, D.C. Circuit, 1972), Klerman stated, "The psychiatrist has a responsibility to provide information as to alternative treatments. The patient has the right to be informed as to the alternative treatments available, their relative efficacy and safety, and the likely outcomes of these treatments. This is a special requirement on the respectable minority of physicians, since they should inform the patient that their treatment is not the one most widely held within the profession" (Malcolm, 1986). This principle applies not only to those psychoanalysts who are psychiatrists, but to the entire range of mental health professionals who make up the membership of the American Psychoanalytic Association. The creation and approval by this Association of specific published guidelines for charting psychoanalysis represent a first step toward authenticating the standard practice of the national psychoanalytic community. In advance of efforts by this committee to develop guidelines for charting psychoanalysis, members of this Association, working within their local professional groups or as individuals, had developed prototype charting methods the aim of which was to integrate psychoanalysis into diverse mental health care delivery systems that offered a spectrum of treatment modalities and required strict accountability documentation. Reporting Information for Claims Review of Psychoanalysis (Altschul et al., 1986) is one such effort to define and limit the information that a psychoanalyst might be expected to give to an external reviewer. We attempted to become familiar with these methods and we gave great weight to the experiences of those who use them as we developed our recommendations.

We are offering practice guidelines for the American Psychoanalytic Association to approve for use by the entire membership. These may not be recognized as constituting a standard of practice unless or until they are widely applied. We will indicate areas where we believe consensus is so great that a standard of care could readily be defined: but there remain areas where the spectrum of practice is too diverse for anyone to be considered a standard. In areas where there is not yet a standard, we hope that members will choose to integrate our suggestions into their individual practices and into the policies of their psychoanalytic clinics, in order to achieve a uniform standard within the profession. While adherence to the consensus or majority positions noted in these guidelines can obviate higher informed consent requirements, we emphasize the voluntary nature of these guidelines and advocate respectful acceptance of the minority of our members who may prefer different standards or who wish to explore alternative solutions.

4. Military Psychiatry. Several members of the American Psychoanalytic Association practice in military settings. The Walter Reed Army Medical Center has a flagship department of psychiatry that may serve as a model for all branches of military service. Psychiatrists in its outpatient clinic maintain extensive charts for all patients, including

those in ongoing individual medical psychotherapy. Resident and staff psychiatrists are encouraged to assess and document for each session the status of symptoms, the significant therapeutic interventions, the patient's response to them, and the progress toward treatment goals. They may develop and record elaborate dynamic formulations of the case prior to the inception of individual medical psychotherapy. Military psychiatrists seem generally to experience little trouble creating such chart notes, and military psychoanalysts are accustomed to doing this for their brief psychotherapy cases. It is the opinion of this committee that these record-keeping conventions may create significant technical problems for long-term dynamic Individual Medical Psychotherapy (CPT 90844) and that they are utterly impractical for Medical Psychoanalysis (CPT 90845).

B. Technical problems in charting psychoanalysis (CPT 90845) and derivative psychotherapies

1. Privacy and confidentiality. It is important in this situation to distinguish secrecy from privacy and from confidentiality. As psychoanalysts, we are mindful that a demand for absolute secrecy may suggest or reflect an effort to conceal substandard care or even criminal conduct, while a countervailing insistence upon total disclosure may suggest or reflect a covert aim to destroy the psychoanalytic treatment process. Protocols exist the aim of which is to ensure privacy when clinicians must communicate with a variety of reviewers (e.g., Beigler, 1979; Borenstein, 1985). They are designed to prevent anyone from making unsanctioned connections between documented clinical information and a specific individual. These protocols were developed to be flexibly applicable for implementation in any setting. Instead of using these protocols, a health care entity may establish its own.

Confidentiality is the matrix for the evolution of a psychoanalytic treatment process. Psychoanalysis is designed specifically to help patients gain access to aspects of their minds that they ordinarily do not allow themselves to know, and to gain understanding of their motives and the methods they use to keep these matters out of awareness. Material that one has kept from oneself is extremely difficult to share with another person. This becomes possible only when the patient comes to believe on the basis of actual experience that the analyst will safeguard those confidences (Tower, 1960). A major impediment to many analyses is a patient's belief that the analyst will behave in a manner that creates an actual contemporaneous repetition of childhood trauma or reenacts pathological relationships (Weiss, 1971). Often considerable time and analytic work are needed before the patient recognizes that this is a transference resistance that protects one from the anxiety associated with the freedom of an analytic setting in which anything may be imagined and spoken (A. Freud, 1950). To accomplish this therapeutic task, it is essential that the analyst constantly maintain strict neutrality. We know from experience with training psychoanalyses that if the analysand verifies that the analyst makes judgments and that these are communicated to or discoverable by external sources, the resistance to disclosure is fortified through its correspondence with external reality in a way that greatly reduces its analyzability. This always burdens and sometimes may fatally compromise the psychoanalytic work. As A. Freud (1950) noted, "What is endangered by this 'judging capacity' of the . . . analyst . . . is the idea of complete and inviolate confidentiality of the material, which is a prerequisite for free association. No analysand succeeds in divesting himself of all defenses or controls unless he can be certain that the derivatives of his id will not become known beyond the

confines of the analytic situation." We believe these observations are applicable not only to training analyses but equally to cases of clinical psychoanalysis. Many situations of external review raise concerns when they fall short of meeting the standards of peer review and confidentiality (Lipton, 1991). Medical-legal informed consent standards seem to indicate that mental health professionals must explain to patients the extent to which they aare waiving their right to confidentiality and the possible consequences of this waiver in instances of external review. In order to guarantee fully informed consent, psychotherapists and psychoanalysts often need to share the full content of the documents with the patient for consent prior to release for external review. A patient may suggest language to be included or revisions to be made to the documents; this may facilitate the process and allow for fully informed consent to release the documents. This committee is aware of cases in which, after this fully informed consent procedure is performed, patients elect to deny permission to release the requested documents. Instead, they make alternative arrangements to avoid this type of external review of their treatment.

2. Therapeutic alliance. We believe a serious dilemma is created for the maintenance of the patient's ability to work in the psychoanalysis when chart records (including progress notes), which are susceptible to external scrutiny, must ultimately be available for review by the patient. This is true even in an ideal case when an external reviewing party can faithfully guarantee that the privacy of patients' records will be strictly protected. Ideally, such records would be written in a manner to allow the patient to read them without experiencing them as traumatic or as premature interpretations. This ongoing task of preparing accurate records serves competing purposes--to provide accountability to outside parties and also to provide a harmoniously therapeutic reading by the patient. This task represents a challenge to reach an ideal form, which can never actually be achieved in a technically pure sense. Therefore, harm will inevitably come to the treatment alliance, to the efficacy of the treatment, and thus to the patient, whenever and however frequently the patient reads the records.

There is a significant difference between a narrowly acceptable subspecialty practice of working with a patient to create periodic reports for third party review and the practice of creating a daily progress note for external review, with or without the patient's cooperation. Both practices are reasonably experienced by patients as a violation of boundaries both between the patient and the psychoanalyst and also between the psychoanalytic dyad and the outside world. However, the practice of creating a daily progress note produces a violation so severe as to disrupt the therapeutic alliance irreparably. The damage done to the efficacy of psychoanalytic treatment by the requirement to create daily progress notes for external review may be seen as relatively comparable to the contamination risks and potential damage introduced into a surgical situation if the surgeon were to break aseptic technique by writing chart notes with one hand while performing surgery within the patient's chest cavity with the other.

While there is scholarly debate concerning the sources, structure, and meaning of the "therapeutic alliance" (cf. Etchegoyen, 1991) we believe that there is consensus within the American Psychoanalytic Association on the proposition that standard technique mandates that psychoanalysis is a procedure in which two and only two individuals are engaged: the psychoanalyst and the analysand. The conduct of psychoanalytic treatment requires a setting that is free from distraction or intrusion by others (Tower,

1960; Gottschalk and Whitman, 1962; Zetzel, 1970). Recent studies suggest that intrusions which psychoanalysts have previously regarded as benign may pose dangers to the therapeutic alliance. For example, Lipton (1991) offers a thoughtful study of the dynamic conflict that arises in the psychoanalytic situation when a motivation to maintain confidentiality coexists with a motivation to reveal what happens in the analysis. He focuses on two varieties of reporting-- publication of case histories and communication within the committee structure of psychoanalytic training facilities. He directs our attention to the clinical consequences of our scientific and educational disclosures by presenting the latter as points along a continuum that includes gossip, defamation, and invasion of privacy. From this perspective he suggests that, more often than we like to believe, these disclosures are harmful to the patient.

This Association's Task Force on Informed Consent to Review reported similar concerns on December 19, 1991, at which time the Executive Council endorsed in principle the importance of obtaining informed consent from patients if details of their psychoanalytic treatment are to be reported to third parties (Task Force on Informed Consent to Review, 1991).

3. Psychoanalytic listening. Activity by the psychoanalyst to select items from each session to be documented for possible external review will distort the process of evenly hovering attention that characterizes classical psychoanalytic technique. Any written or electronic documentation of the psychoanalytic process will therefore create some distortion in the analyst's memory, which is further compounded if the analytic work progresses in tandem with the need to document the treatment process (Adams-Silvan, 1993). We believe this is an absolute problem apart from that of confidentiality. This topic has only recently begun to receive the intense scrutiny it requires.
In a review of the literature on psychoanalytic listening, Adams-Silvan reminds us of Freud's recommendation (1913) that one maintain "the same evenly suspended attention . . . in the face of all that one hears." Freud's recommendation is designed to help the clinician maximally absorb and remember everything the patient communicates, free from any requirement for specific, immediate understanding of each element. This technique allows the psychoanalyst to develop a vast data base about the patient that is stored in preconscious or unconscious areas of the clinician's mind. The psychoanalyst's unconscious, primary mental processes continuously organize these data during the course of treatment; thereafter these formulations are subjected to timely, rational, secondary process scrutiny (Adams-Silvan, 1993). We believe that it is possible to achieve consensus among members of the American Psychoanalytic Association that this special use of the psychoanalyst's memory is fundamental to good psychoanalytic technique.

From this perspective, we suggest that since a dynamic recollection of the psychoanalytic interaction reliably exists in the minds (mental apparatus) of psychoanalysts and patients and can be retrieved as needed, a written history is not required for good psychoanalytic care, currently or in the future. We suggest that efforts to create accountability documents during the course of a psychoanalytic treatment have been shown definitely to damage the essential skill elements of psychoanalytic listening and memory. We believe that it is possible to achieve consensus among members of the American Psychoanalytic Association that documenting the content of a psychoanalysis is unimportant and seriously alters that treatment process.

C. Recommendations

1. Psychoanalysis is a therapeutic intervention that the clinician prescribes after a professional assessment of the individual. This report takes no position on the specific content of mental health assessments conducted by the diverse clinicians who are members of the American Psychoanalytic Association. Each of their professions has or will develop adequate guidelines for the initial assessment, and our members can follow the guidelines of their respective professions for conducting and documenting this aspect of their work.
The documentation of the initial assessment by a psychoanalyst may take the form outlined in Reporting Information for Claims Review of Psychoanalysis (Committee on Peer Review, 1990) or clinicians may develop an alternative protocol appropriate to their type of practice.

2. Psychoanalysis is a unitary therapeutic procedure. We suggest that psychoanalysis is most appropriately viewed as a single therapeutic intervention composed of a number of repetitive technical entities, much as one views a surgical operation as a single intervention. In psychoanalysis one listens neutrally to all communications of the patient, and makes them part of one's own memory. These communications are continuously inscribed, organized, and reorganized in the memory of the psychoanalyst. At moments when a coherent picture of the patient's problem emerges from this process, the psychoanalyst may perform a psychoanalytic technical intervention. Examples of technical interventions are, but are not limited to, clarification and interpretation (Bibring, 1954).

Psychoanalytic treatment is a continuum of such listening-remembering-intervening microstructures. We believe that it is not appropriate to document microstructure for external review. The macrostructure of psychoanalysis consists of several defined phases from inception through termination. One may be able to document macrostructure if certain precautions are observed.

3. The act of documenting psychoanalysis tends to conflict with the clinician's technical skills. In the present state of psychoanalytic science, documentation of clinical encounters poses serious problems of which the clinician must remain aware. Documentation of microstructure is almost always inappropriate in the ordinary clinical situation. Documentation of macrostructure may be feasible and we believe some members of the American Psychoanalytic Association will identify or develop a methodology for such documentation. Reporting Information for Claims Review of Psychoanalysis (Altschul et al., 1986) and its revision that incorporates material pertinent to work with child and adolescent patients (Committee on Peer Review, 1990) represents the ongoing effort of this Association to solve this problem. In our opinion, each method entails a departure from basic technique and involves risks to the psychoanalytic treatment process. Many members of the American Psycho may rationally elect never to write such reports; others may be willing occasionally or regularly to accept the risk this activity encompasses for the sake of the offsetting economic benefit to the patient. Since there is a range of attitude among members of the American Psychoanalytic Association, we believe consensus cannot be achieved on this point at this time. The Executive Council already has taken the position that

psychoanalysts who prepare such documents are advised to obtain the informed consent of the patient (Task Force on Informed Consent to Review, 1991).

a. Process notes. Process notes that are created for educational purposes (e.g., supervision of psychoanalytic control cases) are fundamentally different from progress notes and other chart documents created for external scrutiny. This committee views the creation of process notes as an attempt to gather samples of raw psychoanalytic data for use within the ambit of confidentiality that exists around patient, analyst, and supervisor, whereas the charting of progress notes for external scrutiny aims to comply with standards and regulations external to the psychoanalysis. If process notes are written solely to be shared with a colleague or mentor in a supportive educational setting, they will not interfere markedly with the psychoanalytic process. Creating chart notes for external review does tend to conflict with psychoanalytic activity because it concentrates the thinking, listening, and memorial activities (Loewald, 1972) of both patient and analyst onto external issues, criteria that must be met, dangers to confidentiality, and so forth. It detracts attention from the free association process that is fundamental to psychoanalytic technique.

It is the opinion of this committee that process notes are not an appropriate component of a psychoanalytic chart. If process notes are to be created or kept, they should be separated physically from files of patient health care records, and they should contain no material that might be used to identify the patient.

b. Working notes. Occasionally or routinely, some psychoanalysts use a sketchy form of process notation in the course of psychoanalytic treatment. We believe these also are fundamentally different from progress notes. The clinical use of working notes is optional; their value in the psychoanalytic work is a very individualized matter, derived from the analyst's education, experience, and preference. The content of working notes is informal and freely determined by the analyst. For example, such notes may contain aspects of processes (e.g., dreams) intermixed with formulations, metapsychological comments, and other speculations and questions that pertain to the analyst's work on the case. Working notes do not reflect the treatment process and are not intended to. They are a reflection of the mental life of an analyst engaged in psychoanalytic clinical work. An analyst may use working notes as an optional method of self-supervision and self-education, or for the purposes of informal research.

The practice of keeping working notes creates a medical-legal dilemma. These notes are not clinically valid as progress notes; they are not created with the intent that they would ever become publicly revealed, and they may not be intelligible to a reader other than the analyst. In the event of a subpoena, courts seem to consider any notes that are maintained and identifiable as pertaining to the clinical case to be part of a patient's clinical record. This committee recommends that if working notes are created, they should contain no material that might be used to identify the patient. They should be separated physically from files of patient health care records, and they should be kept only so long as they are useful for their limited purposes.

c. Psychoanalytic research. Some members engage in psychoanalytic research and maintain research records (Wallerstein, 1988). Such research records, including research notes and research protocols, should be filed separately from clinical records. Such records are not appropriately considered to be a part of a patient's health care chart. To protect research records from becoming a legal part of the patient's chart, they should contain no marks or information that could identify the patient as an individual.

Systematic clinical research that is performed in this country must comply with established legal and ethical standards for research on human subjects. Informed consent is one such standard. To the extent that a systematic psychoanalytic research method would tend to distort a particular psychoanalytic treatment in the manner described in section B above, informed consent of the patient must include explanation of these distortions prior to the onset of research involving the patient or the patient's treatment. Some research methods may distort very little, whereas methods that serve dual purposes of accountability and systematic research may be expected to result in greater distortion of the treatment process (cf. Gray, 1992).

We believe there is no consensus among members of this Association as to whether retrospective clinical case studies and the use of case vignettes in theoretical papers should be subject to the usual research standards for informed consent. These activities are not generally intended to represent systematic or controlled research in modern times (Wallerstein, 1988). It is the opinion of this committee that the American Psychoanalytic Association should make no attempt to specify a uniform standard to be applied to the development of such clinical study material for publication or use at educational conferences or for other educational purposes. There are too many individual variables in each case. A uniform standard might tend to stifle creativity and potential, while offering a false sense of security in regard to issues of confidentiality, privacy, informed consent, etc. Members who are engaged in these activities may wish to review the careful consideration of these issues given in the literature (Stein, 1988a, 1988b; Lipton, 1991; Klumpner and Frank, 1991).

4. Ordinary health care charts are not needed for good psychoanalytic care. Psychoanalytic patients remember the course and content of their treatment in the manner that is most useful to them. Memories of the psychoanalytic encounter persist well beyond the termination of clinical work. In the course of clinical follow-up studies, Pfeffer (1959) found interviewers readily elicited transference phenomena on the basis of which they could construct a picture of the course of the analysis that proved very similar to the account of the treating psychoanalyst. Pfeffer's later work and that of other independent investigators support the conclusion that organized unconscious memories of the procedure endure (Bachrach et al., 1991). Norman et al. (1976) suggest that the transference neurosis and its resolution become an unconscious structure that remains available for continuing emotional growth after termination.

We believe external documentation of the psychoanalytic process is not required for good clinical care because even in the event that the psychoanalyst becomes disabled or dies, the history of the prior psychoanalytic work will be available in the dynamic memory of the patient, who will communicate it to the successor clinician in the course of free association. Detailed progress notes are not required to guide the second clinician; indirectly they may violate the precept that one should not

communicate with one's successor (Tower, 1960). We believe it is possible to achieve consensus among members of the American Psychoanalytic Association that detailed progress notes of the psychoanalytic process are not useful for continuing care.

We trust that members of the American Psychoanalytic Association will find this solution to the problem of maintaining a psychoanalytic chart supports their daily clinical practice.

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The American Psychoanalytic Association does not intend this Practice Bulletin to state or serve as a standard of practice for mental health care. It is intended as a guideline only. The ultimate judgment regarding a particular clinical decision or method of intervention or overall treatment plan will be made by the practitioner on the basis of the clinical data presented by the patient and the diagnostic and treatment options available in the particular clinical setting.