Practice Bulletin 6
Interacting with Third Parties

This practice guideline considers a variety of conditions and situations that arise from third party involvement in the conduct of Psychoanalysis and Modified Psychoanalytic Treatment (CPT 90845).1 It considers the kinds of interactions with third parties that may adversely affect treatment and considers the dilemmas faced by clinicians when their patients seek third party reimbursement of treatment. The “third parties” referred to herein include the various types of private and government insurance, entitlement systems, and entities involved in reimbursing/financing, maintaining, regulating, and/or subsidizing health care treatment processes and delivery systems. The guideline is not intended to consider issues or inform in matters pertaining to other types of third party involvement in psychoanalytic treatment, such as those of family members or in-laws of the patient. These issues and matters will be the subject of future study.

A. Overview and Guidance Regarding Problems Arising from Third Party Interaction in Psychoanalysis

In the context of their consideration to authorize and subsidize treatment, third parties often impose conditions on both the psychoanalyst and the patient. These conditions can serve a variety of reasonable purposes, such as efforts to contain costs through increased efficiency of care, efforts to discourage inappropriate utilization of benefits, and efforts to minimize opportunities for fraud. Third parties strive to keep these conditions consistent for all mental health treatments. The conditions may become legally binding when subsidy for the treatment is accepted by the psychoanalyst and/or the patient. (Ault, 1995) However, in some circumstances and for some patients these conditions can degrade the psychoanalytic treatment process by limiting the potential effectiveness of the treatment and by compromising the sense of safety required for the patient to fully participate in the treatment. (Gray and Cummings, 1997)

Inherent in the trust that forms the basis of the therapeutic alliance is the patient’s reliance on his or her psychoanalyst to establish a safe environment in which psychoanalysis may take place. This safe environment facilitates the patient’s capacity to participate fully in the treatment process. Without safety, the patient cannot maintain sufficient motivation to explore the unconscious roots of suffering, actively work through insights, and resolve intrapsychic conflicts, deficits and developmental arrests. (Spruiell, 1983; Etchegoyen, 1991)

It is usual and customary for a psychoanalyst to establish a psychoanalytic treatment plan that includes the following elements pertaining to the emotional safety of the patient within the treatment setting and process. Psychoanalysis is established as a unitary therapeutic procedure that continues from start to finish and is composed of

many psychoanalytic sessions, much as one views a surgical operation as a single intervention. (Gray and Cummings, 1997) It is established in a manner to best assure continuity and extension through an appropriate finishing phase to allow for therapeutic closure. It is conducted by the analyst and the patient in a private setting, free from distraction or intrusion by other people. Everything said within the frame of psychoanalysis is to be held strictly confidential by the psychoanalyst and protected to the greatest legal extent. (Etchegoyen, 1991; Langs, 1975; Dewald, 1965; Stone, 1961)

Consistent with these clinical standards, the Supreme Court of the United States (1996) ruled that therapist-patient confidentiality is of such paramount importance that in normal circumstances it cannot be overridden by a trial judge in Federal Court cases. The Supreme Court maintained that “effective psychotherapy…depends upon an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of facts, emotions, memories, and fears.” The Court upheld the principle that “the mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment.” Furthermore, the Court rejected a “balancing component of the privilege” because “making the promise of confidentiality contingent upon a trial judge’s later evaluation of the relative importance of the patient’s interest in privacy and the evidentiary need for disclosure would eviscerate the effectiveness of the privilege.” In other words, “if the purpose of the privilege is to be served, the participants in the confidential conversation must be able to predict with some degree of certainty whether particular discussions will be protected. An uncertain privilege, or one which purports to be certain but results in widely varying applications by the courts, is little better than no privilege at all.” The privilege of confidentiality loses its validity if there is danger that the confidential communications might be divulged at a subsequent time.

Therefore, the Supreme Court ruled the psychotherapist-patient privilege serves not only the patient’s privacy interests but also a transcendent public interest for society as a whole. This privilege belongs to the patient, and can be waived by the patient. If the patient does not waive the privilege, the psychotherapist (defined broadly in a manner that includes the psychoanalyst) is considered to be responsible legally to protect the patient’s confidentiality through the exercise of appropriate professional authority and responsibility. Although the effects of this Supreme Court decision might not yet extend to state courts or to situations involving release of clinical information to third parties, the decision tends to boost the broad societal expectation that psychotherapists will be expected to exercise due professional responsibility in protecting the patient’s confidentiality. In addition to the relevant legal standards, the Court’s decision was based in part on the Justices’ awareness of pertinent ethical and technical standards involving the treatment of patients by psychotherapists2, which are consistent with the Court’s decision.

The Committee on Peer Review recognizes that the centrality of a safe environment for treatment is not altered by the choice to conduct psychoanalysis or a modified psychoanalytic treatment under the auspices of third party authorization and/or subsidy. Medical legal standards regard the therapist/analyst as the ‘captain of the ship’ of treatment (the relevant legal principle is respondeat superior), and regularly assign primary responsibility for the conduct and outcome of the treatment to the doctor over all other parties. We recognize that many patients may assume that the psychoanalyst’s decision and willingness to establish the treatment plan in conjunction with a third

party's authorization and subsidy means that the psychoanalyst is reasonably confident that the treatment plan is safe for the patient and can support an effective treatment process. Otherwise, we recognize that some patients may expect that their analyst will decline to establish such a treatment plan. A major state medical board has declared: "Without regard to whether an act or failure to act is entirely determined by a physician, or is the result of a contractual or other relationship with a health care entity, the relationship between a physician and a patient must be based on trust, and must be considered inviolable." (Medical Board of California, 1996)

Therefore, we maintain and recommend the following:

1. Psychoanalysts strive to maintain and exercise sufficient authority to establish psychoanalysis or modified psychoanalytic treatment under conditions of third party involvement that preserve privacy, trust, confidentiality, efficacy, and safety of treatment for the patient. (See also sections B and C below for further recommendations to accomplish these aims.)

2. Psychoanalysts may decline to establish a psychoanalysis under conditions that, in the light of the particular circumstances, render the treatment process unable to meet the basic standards of a private, confidential psychoanalysis deemed warranted by the analyst for the patient's treatment.

B. Conditions that Favor Appropriate Establishment of a Psychoanalytic Treatment Plan When a Third Party is Involved:

The following ten factors are offered for consideration as fostering safety in establishing and conducting psychoanalysis or modified psychoanalytic treatment in the context of third party involvement. Presence of these ten conditions can appropriately balance (1) the risks to confidential treatment resulting from fulfillment of third parties' requests for accountability and (2) the benefits of receiving third party financial support to advance the ability for psychoanalysis to relieve patients' suffering. The presence of each of these conditions is not a guarantee that a safe and confidential course of treatment may be achieved. Similarly, the absence of any one or more of these conditions may not mean that treatment cannot be provided safely or that treatment may not or should not proceed. Depending on the individual situation and the scope of informed patient consent, indication that these ten conditions are not likely to be fulfilled in a given situation of third party involvement may lead the analyst to reconsider plans to embark on psychoanalysis or modified psychoanalytic treatment.

1. To assure continuity of treatment, pre-authorization of psychoanalysis is sought from any third party that would be expected to subsidize the treatment. Psychoanalysis may be pre-authorized on the basis of a clinical evaluation of the patient. (Council, 2000)

2. Review for pre-authorization of psychoanalysis or modified psychoanalytic treatment is conducted by a consultant psychoanalyst. On May 10, 1990, the Executive Council of this organization recommended a procedure by which patients for whom psychoanalysis (CPT 90845) is prescribed "will see a consultant for a second opinion examination similar to that for elective surgery before this treatment is funded." (Council, 1990) This Association's practice

guideline on External Review of Psychoanalysis (Council, 2000) contains a recommendation that patients seeking third party subsidy for their analysis be referred to a consultant for review. It is recommended that the second opinion consultant be an appropriately qualified psychoanalyst peer of the treating analyst, acceptable to both the treating analyst and the third party. Preferably, such a consultant would be an experienced psychoanalyst who is certified by the Board on Professional Standards of the American Psychoanalytic Association or a comparable certifying body that the Board may designate and approve for these purposes. In this type of pre-authorization review, the treating psychoanalyst would not have written or oral communication to the third party. With the patient's informed consent, the consultant reports to the third party ONLY as to whether psychoanalysis is or is not indicated (i.e. no diagnosis, personal details, or other clinical information would be reported).

The relative advantages of this method include the fact that it takes place outside the psychoanalytic treatment frame, setting and therapeutic relationship. This method aims to insulate the processes of pre-authorization evaluation and communication of the result from the psychoanalytic treatment process. Such insulation may allow the experience of the review to be analyzed like any other extra-analytic matter affecting the patient's life. The feature of limiting the consultant's interaction with the patient to a single episode at the beginning of treatment reduces the risk of complicating the analysis with split transference.

We acknowledge several potential disadvantages of this method and urge further study of ways to mitigate against their emergence and adverse effects. First, there is the disadvantage that, in practice, such methods may create pressure and opportunity for the development of prejudice and systems of patronage among consultants and treating psychoanalysts. Second, the method gives limited time and opportunity for the consultant to know and understand the patient and the quality of the developing therapeutic alliance with the treating psychoanalyst. Finally, this method requires additional resource expenditure for the evaluation process by the consultant that tends to duplicate the evaluation process previously performed by the treating psychoanalyst.

3. Patients, and their guardians in cases of child psychoanalysis, are offered the opportunity to give informed consent that a review by a third party may take place. (Council, 1990) The informed consent process includes an explanation by the consultant to the patient of the implications of the patient's waiver of confidentiality protection for any report which is to be released, as well as and an opportunity for the patient to see and approve any report to be sent by the consultant to the third party. (Gray, Beigler, and Goldstein, 1995) For example, the fact of the existence of the treatment is private and confidential knowledge that is revealed externally when a request for review and subsidy of treatment is made. 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 maintain full privacy and avoid external review of their treatment. (Gray and Cummings, 1997)

4. Treatment oversight by the third party is limited and contained to the process involved in pre-authorizing psychoanalysis. Beyond pre-authorization, there is no ongoing review of treatment by the third party.

5. Awareness of the risk that third party review intended to limit the duration of an individual patient's treatment can in some instances disrupt or defeat the treatment, guides efforts to accommodate third party concerns when a psychoanalysis extends well beyond usual duration.3 (Dewald, 1965; Stern, 1993) The effort to provide open-ended duration is generally viewed as a key technical feature of a psychoanalytic treatment plan. It aims to provide sufficient assurance of continuity of treatment to allow the patient the ongoing opportunity and freedom to express unconscious thoughts and feelings. This opportunity and freedom is essential if the patient is to participate fully and meaningfully in the psychoanalytic treatment process and finish the treatment in a manner that is consistent with appropriate therapeutic closure. The fact that a psychoanalysis extends beyond a certain duration should be understood in the context of the nature and severity of the clinical problem being addressed. Duration is a function of the clinical objectives (aims and goals), the nature and scope of which emerge during a psychoanalytic process that expands through resolutions of internal conflicts, deficits, arrests, and character pathology to allow and promote resumption of emotional growth along multiple developmental lines. Greater than average duration is not necessarily an indicator of impasse or poor outcome. (Echygoyen, 1991; Langs, 1975; Stone 1961). If a pre-authorized treatment extends beyond the usual and customary length for such treatment as established by available statistics4, the third party may request a review for claims consideration. The patient is referred to a psychoanalyst consultant for this review, as recommended by this Association's practice guideline, "External Review of Psychoanalysis" (Council, 2000). If treatment is authorized for continued subsidy by the third party, the length of the extension period should be significant enough to avoid the above mentioned danger of premature ending and to assure that future review requirements for extension do not constitute an ongoing review of psychoanalytic treatment. In some instances, continued subsidy for treatment is not contractually available, in which case the psychoanalyst and patient should recognize that circumstance.

6. The third party authorization and subsidy of treatment do not impose practices and procedure involving record keeping and charting of psychoanalytic treatment that violate this Association's practice guidelines (Gray and Cummings, 1997; Cummings and Gray, 2000; Cummings, 2000).

7. The psychoanalyst and patient are confident in the third party's understanding and consideration to preserve the treatment alliance and the fundamental standards of quality treatment, including the patient's right to maintain treatment with his or her psychoanalyst in a manner that is free from intrusion or pressure from the third party to change to a different psychoanalyst or transfer to a different treatment modality during the course of an ongoing psychoanalysis or modified psychoanalytic treatment.

8. Urges on the part of some patients to have their analyst or psychoanalytic consultant champion efforts to obtain subsidy for treatment that is known to be

outside the third party's contract limitations should be the subject of analysis and not the impetus for collusion in action by the treating or consulting psychoanalyst.

9. If the psychoanalyst has a contract with the third party, the contract does not restrict the professional from free and open dialogue with the patient. It is important that the psychoanalyst be free to offer patients the opportunity to give their informed consent in regard to any reservations or conflict of interest involving financial incentives or constraints that are built into a contract with the third party. Examples might include capitation or case-rate agreements governing services to patients, or any other contractual factor that might compromise or give the appearance of compromising the professional's advocacy for the patient. Such discussion is appropriate before the treatment plan for psychoanalysis or modified psychoanalytic treatment is established and has begun, or whenever such reservations or conflicts of interest arise subsequently. (Gray, Beigler, and Goldstein, 1995) Otherwise, it is ethical for a psychoanalyst under contract to a third party to decline to establish and conduct psychoanalysis or modified psychoanalytic treatment (CPT 90845) under such adverse contractual circumstances. (See section C.1.b.)

10. The patient is willing and able to interact administratively with the third party to arrange authorization and reimbursement of the treatment in accord with this practice guideline. As part of the process to achieve informed consent for third party involvement in the treatment, the clinician may choose to supply the patient with copies of this and other relevant practice guidelines for psychoanalysis. (See also section C.3.a.)

C. Management of Adverse Conditions Encountered in Interactions with Third Parties Which May Tend to Jeopardize Psychoanalysis

1. Insufficient Freedom to Provide Informed Consent

   In the process of establishing and conducting a psychoanalysis, a vital component in the formation and maintenance of a trusting therapeutic alliance is the ability of patient and analyst to establish the frame of the treatment through frank discussion of the nature of the treatment and the conditions under which the treatment is to be conducted. (Etchegoyen, 1991; Langs, 1975; Dewald, 1965; Stone, 1961). In certain situations involving third party authorization and subsidy of treatment, the third party imposes conditions that expressly or implicitly restrict the freedom of analyst and patient to discuss these matters. The psychoanalyst is advised to establish treatment only under conditions where open and honest communication and informed consent is permitted between the psychoanalyst and the patient; otherwise the effort to establish of a safe and effective psychoanalytic treatment plan can be unacceptably compromised. (Medical Board of California, 1996)

   a. Response to legal conditions restricting informed consent and/or the viability of confidentiality for psychoanalysis:
   Some health care systems (e.g. Medicare) establish regulations for authorization and subsidy of treatment which carry the weight of law as they

attempt to execute the directives, spirit, and intent of legislation. (Ault, 1995) Regulations that apply to psychoanalysis are likely to have been created to cover the broad range of medical practice, including all mental health treatments, in a fair and balanced manner. Therefore, conditions to protect the viability of psychoanalysis in particular may not be considered when policy is established, and psychoanalysts may find themselves in an apparent legal conflict when regulations are created that could tend to violate the trusting relationship between the analyst and the patient or violate other technical aspects of psychoanalytic treatment. Such binds may exist for some time until a remedy is achieved, necessitating temporary responses to protect against harmful influence on patient care.

If psychoanalysis is the treatment of choice for the patient and significantly adverse legal constraints exist, it is appropriate for the psychoanalyst to explain to the patient whatever the psychoanalyst knows about the nature of the legal restrictions and regulatory conditions and what the implications of those restrictions and conditions are for the patient's treatment. If warranted, the psychoanalyst may explain that these regulations do not permit the psychoanalyst to establish a desirably safe, confidential psychoanalysis for the patient. A psychoanalyst should not, of course, make such representations about the import of particular regulations without ensuring that such representations are well grounded. The psychoanalyst may also consider whether or not alternative treatments could provide some relief to the patient. A referral might be offered to the patient, or the patient could be offered a choice to be treated by the psychoanalyst employing treatment modalities other than CPT 90845 (psychoanalysis and modified psychoanalytic treatment) that can be conducted satisfactorily under the conditions imposed by the third party. It is reasonable to explain to the patient and appropriately chart that this alternative treatment plan may represent suboptimal treatment if the indicated psychoanalytic treatment cannot be conducted satisfactorily given the conditions imposed by the third party. In this manner, the psychoanalyst may comply with legal regulations to the fullest possible extent without establishing an unsafe or unsatisfactory psychoanalytic treatment plan for the patient.

b. Response to contract restrictions on informed consent:
   In recent years, with the proliferation of varieties of managed care and/or capitated third party reimbursement systems, many professionals have elected to contract with these systems to provide services to their subscribers. Some contracts have reportedly contained specific clauses, sometimes called "gag clauses", that forbade the professional from discussing with a patient certain features of the professional's contract with the third party. For example, the professional might be restricted from discussing ways in which the professional's role of advocate for the patient could be in conflict with financial incentives offered by the third party and/or constraints imposed by the third party. Such incentives and constraints may be designed to keep the professional in compliance with cost containment philosophies regarding the design and delivery of care. They might be interpreted to bar the professional from answering patients' questions or discussing matters

relevant to any apparent discrepancy between the published benefits offered by the insurance plan and the actual extent and conditions under which benefits are most commonly authorized.

This committee believes that psychoanalysts should carefully scrutinize language in contracts with third parties and seek to clarify and confirm the psychoanalyst' ability to communicate freely with the patient and should consider whether to initiate psychoanalysis or modified psychoanalytic treatment when such incentives and/or constraints exist and open dialogue between doctor and patient is constrained.

2. Telephone Review

Psychoanalysts deciding whether to participate in telephone review of treatment should carefully consider the best interests of the patient, taking into account the specific circumstances. The act of communicating with the third party by telephone about the patient or the patient's treatment can be problematic from many perspectives, including at least the following: (1) it can violate therapeutic confidentiality, (2) it has the potential to circumvent the patient, (3) it can produce unacceptable and avoidable risks of violating fundamental technical features of the psychoanalytic treatment alliance between the analyst and patient (Cummings, 1999), (4) it may not create an adequate record of content for future reference, nor provide adequate safeguards that information divulged will be limited to essentials, (5) clinical data provided by the clinician by phone may be transcribed by the reviewer and could become part of the patient's record with the third party, (6) the patient's consent for communication by phone may be insufficient or vague, and (7) there may be insufficient verification that the call is legitimate, i.e., that it is from a proper and authorized reviewer. These potential adverse conditions pertaining to telephone review apply equally to treating and consulting psychoanalysts.

The Executive Council of the American Psychoanalytic Association adopted the following resolution on the issue of telephone review (Council, 1989):

The therapeutic efficacy of psychoanalysis depends upon a special, confidential dyadic relationship between doctor and patient. The psychoanalytic method is uniquely vulnerable to significant alteration or even destruction by the introduction of observers into the psychoanalytic situation. The American Psychoanalytic Association opposes all methods of quality assurance review, including telephone review, that are based on such interventions which are inconsistent with fundamental principles of psychoanalytic practice.
We believe that accountability of psychoanalytic treatment may be achieved without an additional person actually intruding into the psychoanalytic situation. The American Psychoanalytic Association has developed and endorsed methods of review that tend to protect the treatment process while addressing the needs of third-party payers.

We advise our members considering participation in telephone reviews to consider the individual circumstances, including the presence of patient consent, the above risk factors, and any potential benefits to the patient from the analyst's

cooperating in a review that might nonetheless have some potential adverse consequences. Members may seek to pursue methods of review endorsed by this Association.

3. Conflict, Inquiries, and Admnistrative Issues with Third Parties

a. Problems when the patient is not able to interact administratively with the third party: It is appropriate for the patient to interact with the third party to make the necessary inquiries regarding the patient's contracted insurance coverage and to interact with the third party to arrange pre-authorization and other administrative matters. Problems may arise when the patient is unable to accomplish these tasks. This committee has gathered experience and understanding of the complexity of managing these problems through its years of assistance to members of the American Psychoanalytic Association. The committee's experience indicates that direct interaction of the treating analyst with the third party over administrative matters can degrade and limit the psychoanalytic treatment process. Therefore, we advise that alternative approaches be explored, as appropriate depending on the individual circumstances. A consultant psychoanalyst may be able to assist the patient when direct administrative involvement is required. Patients can benefit from assistance with effective written communication to interact successfully with the third party. Such written communication is sometimes more effective if this and other practice guidelines are referenced and appended. If the third party requires billing statements from the treating analyst, these administrative documents can be given to the patient for authorization and transmission to the third party. The ultimate judgment regarding management of these administrative matters will be made by the treating practitioner on the basis of the clinical data presented by the patient and the diagnostic, treatment, and administrative options available in the particular clinical setting.

b. Decisions to decline to work in conjunction with third parties:
The analyst's attitude, frame of mind and emotional disposition toward the patient are significant considerations that bear on the decision to undertake an analysis. These factors might in some instances be impacted significantly and adversely by the prospect of intrusive third party participation in the analysis. Since such adverse impact may be a realistic obstacle to effective treatment at the outset, analysts with such concerns should take these concerns into account before undertaking an analysis under conditions where the analyst anticipates intrusive third party involvement. Analysts who are reluctant to work within a third party system may choose to decline to do so and should inform the patient of this choice before the treatment starts or in the event that an issue of third party involvement emerges during treatment. In such instances, analysts are advised to explain to the patient the potential risks and benefits of reviewed psychoanalysis. (Gray, Beigler and Goldstein, 1997; Gray 1972)

c. Persistent disagreement: There may be elements of a third party's established policy and contract with which a psychoanalyst disagrees and with which the analyst does not believe he or she could comply in a forthright

manner. We do not advise that the psychoanalyst conduct a clinical evaluation or establish a psychoanalytic treatment with an expectation that the analyst will not be honest and truthful in all communications. If the analyst agrees to establish the treatment in conjunction with a third party, the analyst is advised (and is frequently legally bound) to comply with the requirements that the third party establishes, and to which to analyst has agreed.

d. Reform of third party systems: If a psychoanalyst elects to undertake efforts to reform a third party system or a third party contract, the psychoanalyst should consider whether such efforts can be conducted within the process and context of an ongoing clinical case without undue jeopardy to the patient and the patient's treatment process, and means to minimize any such risk.

D. Employment by a Third Party

If a member of this Association is employed by a third party as a utilization reviewer, case manager, administrator, or in any other capacity, it is expected that the member will act in all instances in accord with the ethical standards approved and maintained by the American Psychoanalytic Association.

E. Parental Involvement in Child Psychoanalytic Treatment

Questions may arise concerning the concepts discussed above and how they might be applied to the establishment of child psychoanalytic treatment or modified child psychoanalytic treatment. In some respects, the establishment of the frame of such treatment differs from the establishment of the frame of an adult psychoanalytic treatment. It is rare that parents or guardians are not closely involved in the establishment and maintenance of treatment processes for children, not only from the standpoint of financial support for the treatment, but also often as active partners in the treatment. Child psychoanalysts use varying approaches in this regard. Some advocate minimal active parental involvement in treatment; at the other end of the spectrum, others advocate extensive and active involvement within the frame of the treatment. The relative merits and problems associated with such various approaches currently remain the subject of research.

In instances where a child psychoanalysis or modified child psychoanalytic treatment is being established, and where a governmental or private insurance or health maintenance system is an additional third party, the concepts involving the establishment of safe treatment as discussed above can be appropriately applied by regarding "the patient" as including the child and parent (or guardian). This defines the child and parents (or guardian) as the first party, the analyst as the second party, and the insurance entity as the third party. The guidelines we have outlined regarding interacting with third parties in regard to the psychoanalytic treatment of adults can then be applied, pari passu, to child analytic treatment. Special and additional considerations of this general approach that may occur in cases of non-intact families and other situations where various degrees of estrangement may exist between parents and/or children will be covered in a separate report on review of child psychoanalysis.

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1 - Modified psychoanalytic treatment (MPT) is closely akin to psychoanalysis and is conducted in the context of the basic fundamentals of psychoanalysis, with modification of one or more elements (e.g. frequency of sessions) to meet the clinical needs of the particular case. MPT is supported by all psychoanalytic practice guidelines approved by the American Psychoanalytic Association.

2 - An amici cure brief was submitted to the Supreme Court in this case by the member organizations of the Psychoanalytic Consortium, consisting of the American Psychoanalytic Association, Division of Psychoanalysis (39) of the American Psychological Association, National Membership Committee on Psychoanalysis in Clinical Social Work (affiliated with the National Federation of Societies for Clinical Social Work) and the American Academy of Psychoanalysis.

3 - The context of this discussion does not extend to include pressures from changes in third party coverage (e.g. as a result of contract re-negotiation or legislation) that occur over time and apply generally for policy holders. It is understood that it is not feasible for a third party to guarantee that such changes in coverage would not occur.

4 - Criteria indicating the standard frequency of psychoanalysis and the point at which a psychoanalysis may be considered to extend beyond usual lengths are as follows: Standards of the American Psychoanalytic Association indicate that the minimum frequency of psychoanalysis is 4 sessions per week and that 5 or more sessions per week is often optimum. Modified psychoanalytic treatment (MPT) often is conducted at a frequency less than 4 sessions per week. Based on survey research by the Committee on Psychoanalytic Practice, the mean duration of a properly completed psychoanalytic case is approximately 1000 sessions; therefore a psychoanalysis may be considered to extend beyond usual lengths at plus one standard deviation from the mean, or beyond 1575 sessions. (Brauer, 1997)

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This report was originally prepared by the Subcommittee on Interacting with Third Parties of the Committee on Peer Review of the American Psychoanalytic Association: Robert R. Cummings, M.D., Ph.D. and Sheila Hafter Gray, M.D. (co-chairs), Jerome Blackman, M.D., David Fedders, M.D., Joanne Marie Greer, Ph.D., Leon Hoffman, M.D., Roberta K. Jaeger, M.D., Mark Leffert, M.D., Leon A. Levin, M.D., Frederic J. Levine, Ph.D., and Richard West, L.C.S.W. The subcommittee was assisted in preparing the report by members of the Joint Committee on Confidentiality, including Paul Mosher, M.D. and Barry Landau, M.D. The report was revised and developed further by the Committee on Peer Review of the American Psychoanalytic Association: Robert R. Cummings, M.D., Ph.D., (chair), Paul M. Brinich, Ph.D., Lida M. Jeck, M.D., Leon A. Levin, M.D., Richard West, L.C.S.W., and Sheila Hafter Gray, M.D. (consultant). It was written for the committee by Robert R. Cummings and Sheila Hafter Gray.

The American Psychoanalytic Association does not intend this practice guideline 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 factual circumstances, including the clinical data presented by the patient and the diagnostic and treatment options available in the particular clinical setting. This practice guideline was approved by the Executive Council of the American Psychoanalytic Association on December 20, 2001.

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