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The Evaluation and Treatment Service
The Columbia University Center for Psychoanalytic Training and Research

Overview

The Evaluation and Treatment Service is responsible for overseeing all of the evaluations and analyses done by candidates in training. There are two routes by which training cases enter treatment – through the Clinic and through a candidate’s private practice. In both cases, the Evaluation Service serves as an overseeing administrative base of the application process and ongoing treatment.

First year candidates receive supervisors beginning in the fall of their first year. These supervisors work with candidates on analytic engagement, generally with a psychotherapy patient in the candidate’s clinical practice. When the candidate is ready and approved by progression to start a first case, they work with this same supervisor to consider patients from their practice to transition to analysis and/or take an evaluation from the Evaluation and Treatment Service. All other candidates work with their progression advisors to determine readiness for a second or third case and are then assigned an additional supervisor. Each supervisor/candidate pair works together to consider analytic cases from their private practice and from the clinic.

Candidates may choose whether to ask the Evaluation Service for a case or to find the case in their own practice. In the first instance, prospective patients apply to the Center for low-cost analysis. Patients who apply for treatment at the clinic submit an application. The Evaluation Service calls each patient to explain our program and to screen out applications that are obviously unsuitable for psychoanalytic treatment. Despite this initial triage, there is an acceptance rate of about 33% for the cases evaluated by candidates. Therefore, candidates should expect to evaluate 2-3 cases before finding one that is suitable for analysis. With private patients, the candidate should review the case with their supervisor to determine suitability. In both instances, the process of finding a case to begin analysis may take several months.

We believe that the evaluation of patients to assess analyzability is an important part of the candidate’s education, therefore all candidates are required to complete at least three clinic patient evaluations during the course of their training, regardless of whether they choose to treat a clinic patient. Periodically, all candidates will be asked to conduct the assessment of these patients to evaluate whether analysis is the treatment of choice. The Evaluation Service will contact you regarding these evaluations – keeping in mind when you are looking for a training case. Then, if the patient is suitable you may continue to begin their analysis after the evaluation is complete. If they are not suitable, or you are not available to start a case we will help you make a referral to another candidate or to another treatment.
Flow sheets for patient evaluations and required documentation are in this manual and available on our web site. In general, we consider patients who are referred to us via the Clinic as “clinic cases” and patients referred to you through your private practice as “private cases.” Once a case is accepted for analysis, there is not much difference between the two designations, because all of the fees collected go directly to your private practice. Your responsibility to the Center, is to pay a monthly Clinical Training Fee, which is calculated based on what the patient pays you each month.

We cover the basic administrative procedures in this manual, as a guide and supplement to the many others – teachers, supervisors, and colleagues – who will inform your experience getting analytic cases started. Please don’t hesitate to ask us questions along the way. Good luck with this exciting journey!

Sabrina Cherry, MD
Director, Evaluation and Treatment Service

Sarah Hartman, MD
Associate Director, Evaluation and Treatment Service
CHECKLIST: EVALUATION OF A CLINIC CASE

1. When a case is assigned to you for an evaluation the patient will be mailed your office contact information. You will receive the:

   ____ Patient application to the center

2. The patient should call you for an appointment. If you do not hear from the patient within 10 days please notify the Evaluation Service. Once you have set up an initial meeting with the patient you should download the following materials from the Center website:

   ____ Blank Evaluation Face Sheet*
   ____ Blank Evaluation Supervisor Report*

3. You should meet with the patient for an evaluation/consultation (generally multiple visits). Please collect fees of $35 for the first consultation and $15 for each subsequent interview. These should be collected as checks made payable to the candidate. When the evaluation is complete you should submit a check to the Center for the total amount collected from the patient as their “Clinical Training Fee.”

4. You should be meeting with your case supervisor to discuss the case while the evaluation is in process (i.e. don't wait until you are done seeing the patient). If you are unable to start with your next case supervisor in time, you may also ask the Evaluation and Treatment Service to assign an Evaluation supervisor instead.

   Note: The Evaluation and Treatment Service has the final authority for the disposition of the patient. The evaluator is responsible for conveying the our recommendations to the applicant in a timely manner. While doing the evaluation, if you and your supervisor feel that the patient is not appropriate for analysis please contact the Evaluation and Treatment Service ASAP. We will discuss with you possible referral options for the patient and help you to find an appropriate disposition. This can be done before your evaluation write-up is complete, we do not want to leave the patient hanging.

   While the Evaluation and Treatment Service shares medical-legal responsibility for patients applying for analysis, you are responsible as the treating clinician to make appropriate assessments and document them during the evaluation as you would any patient that you see in your office. If you have any
concerns about patient safety during the evaluation process please consult with your supervisor and the Evaluation Service.

5. Evaluation write-up: Write up your evaluation and recommendations within four weeks of the case being assigned with the patient. If the evaluation is not completed in this time period, the candidate should update the Evaluation Service about the progress of the evaluation. This may be in the form of a de-identified email to the Clinic Directors stating the dates on which the patient was seen and the number of sessions that have occurred and what the status of eval (ongoing eval, extended eval, doing preparatory psychotherapy with a view towards conversion)

______Evaluation Write-up or progress note: there must be documentation as noted above every 4 weeks during an the time you are seeing the patient until a final disposition is determined re: referring or starting analysis.

______ Evaluation Face Sheet*

______ Evaluation Supervisor Report* -The candidate should make sure that the supervisor submits a note confirming agreement to begin analysis with this patient or concurring with the decision to refer out. The Evaluation and Treatment Service will not be able to review your evaluation until this is received.

6. Case review: The Evaluation and Treatment Service will review the case in a timely manner and the candidate can then discusses the treatment recommendation with the patient. If the case is accepted for analysis and the patient agrees to proceed, the following paperwork is completed:

______ Beginning Analysis Face Sheet*

______ Consent form signed (both pages)*

______ Initial Medication Face Sheet* (if patient already on meds or if they are being initiated.)

Once these forms are received by the Evaluation and Treatment Service, Dr. Margaret Hamilton will give you a date as of which the analysis can start. You may not start until these forms are received.

*all starred forms are found on our website
CHECKLIST: CONVERTING A PRIVATE PATIENT INTO A TRAINING CASE

1. Candidate meets with case supervisor to discuss suitability of a patient in the candidate's private practice for analysis. If candidate and case supervisor decide that the patient is suitable for analysis, the candidate must write up an evaluation of the case (an outline of the Evaluation Summary can be found in your manual or obtained from the Evaluation and Treatment Service). The candidate should also complete an Evaluation Face Sheet. These two items should be handed in to the Evaluation and Treatment Service together.

   ____ Evaluation Write-up

   ____ Evaluation Face Sheet*

2. The candidate should make sure that the supervisor submits a note as well, confirming agreement to begin analysis with this patient. The Evaluation and Treatment Service will not be able to review your evaluation until this is received. (Blank Supervisor Report forms can be found on the web site).

   ____ Evaluation Supervisor Note*

3. The Evaluation and Treatment Service will review these materials and consider whether to approve the patient for analysis and give approval to move ahead to the next step. If the Evaluation and Treatment Service approves the case, the following paperwork must be completed and turned in prior to starting the analysis:

   ____ Beginning Analysis Face Sheet *

   ____ Initial Medication Face Sheet* (if patient already on medication or if they are being initiated.)

   ____ Signed Consent Form* - two pages,

   ____ Director of Evaluations Private File Form*
   this should be completed attached to the signed consent form (see above)

Once these forms are received by the Evaluation and Treatment Service, Dr. Margaret Hamilton will give you a date as of which the analysis can start. You may not start until these forms are received.

*all starred forms are found on our website
**Evaluation and Treatment Service Evaluation Write-up: for clinic and private patients***

1) Identification of Patient and Chief Complaint  
   a. Include referral source

2) Description of Patient and Mental Status  
   a. Comment on the presence/absence of poor impulse control, severe anxiety, affective or psychotic symptomatology, suicidal or homicidal ideation

3) Presenting Problems/HPI

4) Previous Treatment/Past Psychiatric History

5) Past Medical History

6) Personal and Family History  
   a. Include substance abuse history with pertinent negatives

7) Evaluation Process  
   a. Include patients’ interactions with you, attention to early character resistances, transferences and countertransference

8) Assessment  
   a. Structural formulation/level of psychological organization – include quality of object relations, degree of identity consolidation, quality of affects, types of defenses and degree of superego integration  
   b. Psychodynamic formulation

9) Diagnosis  
   a. Structural Diagnosis – describe level of organization as predominantly borderline, narcissistic or neurotic  
   b. Phenomenological diagnosis – DSM IV, all five axis

10) Recommendations  
   c. Include treatment recommendations (for or against analysis) with rationale, reservations and prognosis.

* The first year course on evaluating a patient for psychoanalysis and your supervision should be your reference point in determining analyzability and writing this evaluation. Please refer to that course syllabus and to your supervisor for guidance.
Patient Fees and the Clinical Training Fee

After the Evaluation and Treatment Service approves a patient for analysis, the candidate sets a fee with the patient and the patient pays the candidate directly each month. The candidate must keep track of these fees in order to calculate the Clinical Training Fee that they in turn pay to the Center each month. The clinical training fee will be equivalent to the amount the patient pays each month to the candidate up to a cap of $320/month for each month of the year. If the patient pays the candidate more than $320/month the candidate makes a profit. For monthly bills which are less then $320, the clinical training fee is equal to the amount you have collected from the patient. This means that the fee you pay for your control cases may be different each month. It is the candidate’s responsibility to keep track of this and inform Judy of the monthly fees.

All clinical training fees are payable to Columbia University. You must write an individual check for each clinical training fee for each patient for each month (so – if you have three cases, you must write three checks each month for the clinical training fee). Please note the #sessions the patient was seen and the name of your supervisor on the memo line (for tracking purposes)

For Evaluations:
1) Evaluations of patients in the candidate’s private practice- there are no clinical training fees.

2) Evaluations of patients referred by the Evaluation and Treatment Service - the candidate should collect payment of $35 for the first session and $15 for each additional session. These fees should be collected as checks made out to the candidate. The amount the candidate collects should be paid to the Center as a clinical training fee when the evaluation is completed.

3) For extended evaluations/preparatory psychotherapy – the fee structure should be discussed with Dr. Cherry and Dr. Hamilton and individual decisions will be made.
ONGOING PAPERWORK FOR ALL ANALYTIC CASES

_____ Three Month Summary#
   This should be handed in 3 months after the analysis begins.
   An outline of what this write-up should contain is in the Evaluation and Treatment Service Manual.

_____ Yearly Summaries#
   Due September 1 every year that you are a candidate.
   An outline is in the Manual

_____ Yearly Summary Face Sheet*
   Due September 1 with the Yearly Summaries

_____ Initial Medication Face Sheet*
   This is to be filled out whenever a patient on medication is begun in analysis or whenever a patient in analysis is begun on medication. Once this is completed the ongoing information regarding the patient's medication is noted on the Medication Flow Sheet (see below).

_____ Medication Flow Sheet*
   These sheets (one/medication) are filled out every three months. They are to be updated (on the sheet) every time a change in medication is made during the three month interval covered by the sheet. The analyst is responsible for updating this even if the analyst is not the prescribing physician.

_____ Termination Summary#
   To be completed within three months of terminating a case.

_____ Termination Face Sheet*
   To be handed in with the termination summary.

*all starred forms are found on our website

These write-ups should be discussed with your supervisor. For additional assistance, you can also speak with the instructor of your annual writing course.
Treatment Summary Guidelines: For Three Month and Yearly Summaries

Treatment summaries are due for every case after the first three months and then annually on a specified date. The treatment summary is a narrative description of the analytic process over the specified course of time.

There are several elements that should be included in every write-up:

1. Identifying information (approx. one paragraph)
2. Chief complaint (approx. one paragraph)
3. Initial diagnostic impressions, including structural diagnosis and DSM-IV diagnosis(es).
4. A SHORT history (1-2 pages). This should be included in every write-up seminal elements of the history, particularly those which are important to the way in which the treatment unfolds. You may choose to introduce history that emerges later in the treatment in the context of the analytic process in which it was produced. In each successive treatment summary, the points emphasized in the history may change as your understanding of the patient evolves. As the candidate progresses through analytic training, the summary may focus less exclusively on the previous one year and more on the analysis as a whole.
5. History of the treatment to date (depends on length of case, 1-2 pages)
   a. If it’s a conversion – short history of the psychotherapy
   b. Analytic process to date – even if you’ve written up the same patient before – the material from the prior years’ work should be distilled and presented in a way that always allows the reader to have an account of the analysis as a whole.
6. The treatment (5-6 pages) – microprocess and macroprocess
   “he said–she said” alternating with formulation

Here are some guidelines for thinking about what to include in “#6” – the treatment. This should constitute the bulk of the write-up. The **microprocess** gives the reader a sense of what is happening in the room on a moment to moment basis, while the **macroprocess** gives the reader a way to conceptualize the developmental trajectory of the analysis.

- Create an experience near narrative that takes your reader into the room with you and your patient
- Give verbatim examples of “he said/she said”, dreams, fantasies, and interpretations
- Demonstrate your presence in the analysis by telling your reader what you did, what you said, what you thought, what your countertransference was, and how you interacted with your supervisor
Choose **powerful moments** in the analysis and describe them in a way that allows the reader to feel a real sense of what was going on between you and your patient. This might include descriptions of
- analytic process (what you each said, how what you said affected the patient and led to new associations, dreams, affects)
- the experience of the transference
- the experience of the countertransference
- resistance
- emotion/affect
- how you worked with dreams and fantasies

**Connect these moments** in a way that demonstrates the trajectory or movement of the analysis, giving the reader a sense of important transitions. This might include giving the reader a sense of the way in which resistance, transference, defenses, and countertransference are developing and changing in the course of the analysis. When possible, give the reader an idea of what moments or developments in the transference have led to these changes.

Keeping in mind that the experience near quality of the write-up is of prime importance, try to give your reader a sense of your theoretical understanding of what was happening when you **reflect back on the process**.

**Avoid jargon** – write it the way you’d tell it to a colleague

Writing up a case is difficult but can help you to understand the way in which your day to day work with the patient translates into the development of an analysis. Looking at the broad sweep of your work is essential for formulating the macroprocess and will inevitably lead to greater understanding in your work with the patient in the future.

*The Center has a comprehensive Writing Curriculum, directed by Dr. Elena Lister. Dr. Deborah Cabaniss is the Chair of the didactic component of the program. This outline is adapted from classroom material developed in the Writing Curriculum. Please refer to those classes for guidance in approaching the write-ups and for feedback on your work. All write-ups (for candidate years 2-4) are: about 10 pages, double spaced, 12 pt font with usual margins.*
Termination Summaries

The termination summary should describe the process leading up to termination and provide a summary of the clinical process during the final months of analysis.

It should include:

1) A description of who initiated discussion of ending the treatment including the circumstances of the discussion, amount of time between the discussion, setting the termination date and actually ending the treatment
2) Prominent transference and countertransference paradigms activated during the discussion of termination
3) Re-working of central themes and emergence of new material during the termination phase
4) An overview of gains made in the analysis and possible issues/topics left unanalyzed
5) If analysis ended pre-maturely or in a stalemate, describe the dynamics of that process

Timing:

1) If the patient terminated >3 months after the most recent yearly summary was submitted, the termination summary should include everything a yearly summary should include as well as the termination details
2) If the patient terminated <3 months since the last yearly summary, the termination summary can be briefer. The information above should be included and this can be constructed as an addendum to the last yearly summary.
3) If the patient was accepted for analysis but never began treatment, the termination summary can be a brief note detailing that fact as well as the analyst’s thoughts about why the patient fled.
Medical/legal dimensions of Training Cases

1. Consent

Patient’s sign consent forms at three junctures. First, when applying to the clinic for evaluation they sign a form which details the application process and indicates that they are familiar with clinic evaluation procedures and understand that they are applying for psychoanalysis. (see Consultation Information Sheet)

Second, when the complete the enhanced assessment with the research assistant, they are asked if they are willing to participate in ongoing research projects at the Center and if so are asked to sign a consent for them at this time.

Third, they sign a two part consent form when they are accepted to begin analysis regardless of whether they are entered treatment via the clinic or your private practice and regardless of whether they will be a clinic pay or private pay patient. The first page is an informed consent for psychoanalytic treatment. The second page is a form on which they consent to be contacted to be invited to participate in future research. All patients must sign this page and check either yes or no.

2. HIPPA

The Evaluation and Treatment Service is a non-HIPPA entity. Therefore, all patient records and information are being maintained in a de-identified manner. Thus, patient names do not appear in their charts and the list which matches patient name to patient file number is kept in a separate place. Patient charts and records do not contain any other identifying information. Here is a list of all information that can not appear in your charts, file sheets, clinical presentations or write-ups:

Patient initials – you may make up a single initial to use to refer to the patient. In addition we ask that you also make up a single initial to use when referring to other members of the patients family and their life (including friends, employers, schools attended, etc.) if you refer to them in write-ups.

Specific dates - we ask that you refrain from using specific calendar dates in write-ups. For example, instead of saying “the patient arrived on October 5” you might say, “the patient arrived for the first session of the week.”

Finally, information about or referring to patients should not be conducted via email. Instead please use paper fax machines (no computer based faxes please). This includes sending reports to the Evaluation and Treatment Service, Progression Committee and to your supervisor or writing preceptors.
3. Charting psychoanalysis

The APsaA continues to maintain on their web site that it is not customary for psychoanalysts to chart treatment progress session by session with regards to the psychoanalytic process. The APsaA, however, does stipulate that clinicians should maintain the “customary methods of documenting events in the clinician-patient encounter that fall outside the scope of psychoanalysis itself.” Thus, factors related to medical, psychiatric, psychological, or social work aspects of the treatment should be charted. Our view, at the treatment clinic is that deciding where psychoanalysis itself ends and psychiatric/psychological factors begin is not always clear. We therefore advise that you maintain accurate, up to date patient records as you would any patient in your private practice. The annual write-ups which you hand in to the Center are not a sufficient clinical record of the patient’s ongoing treatment and do not fulfill this basic professional activity of maintaining treatment records in your office. See also the APsaA Practice Bulletin which discusses this issue

http://www.apsa.org/About_APsaA/Practice_Bulletins/Charting_Psychoanalysis_Clarification.aspx

4. Informed consent to review

Discussing patient material or sharing appointment records with third parties (managed care companies, professional peer review) is a complex process with many factors and should be handled on a case-by-case basis. The APsaA website also discusses some of these topics. In either case, you should discuss these issues with the Evaluation and Treatment Service prior to making any decisions about sharing patient information. See also these APsaA Practice Bulletins which discuss these issues

http://www.apsa.org/About_APsaA/Practice_Bulletins/Interacting_with_Third_Parties.aspx
http://www.apsa.org/About_APsaA/Practice_Bulletins/Informed_Consent_to_Review.aspx

4. Ethics

As in any profession, psychoanalysis shares fundamental standards of ethical practice and the APsaA has outlined them on their website.


Topics such as: professional competence, respect, mutuality in informed consent, confidentiality, truthfulness, avoidance of exploitation, scientific responsibility, protection of the public and the profession, social responsibility, and personal integrity are all discussed. There is also a course led by Dr. Elizabeth Tillinghast in the fifth year curriculum on Psychoanalytic Ethics and practice. If you have any concerns in this area, please feel free to discuss them with the Evaluation and Treatment Service.
APPENDIX

Please note that these are all downloadable from the Center’s web site at:
http://www.psychoanalysis.columbia.edu/inside-center/candidates/forms

Patient Forms:
  Patient Application
  Consultation Information Form

Analyst Forms:
  Evaluation Face Sheet
  Beginning Analysis Face Sheet
  Consent Form and Addendum
  Director of Evaluations Private File Form
  Medication Face Sheet
  Medication Flow Sheet
  Yearly Face Sheet
  Termination Face Sheet