GUIDELINES FOR THE INITIAL WRITE-UP

Writing an initial account of your thoughts regarding a new analysand can be quite valuable at the beginning of treatment, even for the most experienced analyst. To begin the process of writing a case report, we ask you to pause shortly after the analysis begins and organize your thoughts about the patient and the treatment. Writing the initial report should help you answer a few key questions with confidence:

- What is the nature of the problems that will be the focus of treatment?
- How do you imagine these problems may have developed?
- How might psychoanalysis help the patient?

The initial report should be 2-3 pages in length - no longer. It should be organized as follows:

- Identifying information (approx. one paragraph), including how your patient came to you, and, if relevant, details about the setting and any collateral contact.
- Chief complaint (approx. one paragraph)
- A short developmental/social history of the patient (1-2 paragraphs).
- Your initial assessment of the patient (what's the nature of the patient's problems) including DSM-V and structural diagnoses.
- Your initial working psychodynamic formulation (How did the patient come by these problems? What maintains them? What are the obstacles to addressing them?)
- Your understanding of the indications for psychoanalysis (why psychoanalysis and how might it help?).
- Your speculation about what the treatment might hold in store for the two of you.
- Your sense of what it's like to work with this patient; your initial countertransference.
- How you and your patient discussed the beginning of analysis.

GUIDELINES FOR THE 6 MONTH WRITE-UPS

The six-month reports build upon your initial report, and each successive 6-month report builds on those that come before. Taken as a whole, your write-ups tell the story of the analysis. These write-ups are one of the key indicators of your development as an analyst. The 6-month write-ups are an opportunity to fill in key pieces of history that you have learned, refine your assessment and formulation, and most importantly, describe the course of the analytic treatment. Please do not repeat historical information found in the earlier reports in the body of the 6-month write-ups.

The 6-month write-ups should be 2-3 pages in length — no longer. They should be organized as follows:

- Chief complaint, if it has changed since initial report, and/or significant history that has become apparent since the initial report. (approx. one paragraph)
- The treatment: This section should be the bulk of the write-up and should tell the story of the treatment to date. Focus on synthesizing the significant aspects of the work that has transpired, rather than trying to provide every detail of the treatment.

A successful write-up includes the following:

- **A trajectory**. We want to hear how things have changed between and within your patient and you over the course of the treatment. Has the transference changed? If so, how? How has the countertransference changed? What about the way in which you two relate to each another?
- **Verbatim examples of dialogue**. This might include dreams, fantasies, interpretations, reactions, etc. — the moment-to moment exchanges that we sometimes call micro-process.
- **Your own process**. Describe not only what you heard and said, but what you understood about it (or not); how you felt and what you thought; how you made your choices about your interventions; and how you understood what happened next.
- **Experience-near descriptions** that take your reader into the room with you and your patient. Countertransference descriptions tend to be especially effective.

SUBMITTING YOUR WRITE-UPS

Please submit all write-ups as emailed Word, Pages, or pdf documents to your File Reviewer and your consultant, and please cc Zan Christensen, who will make sure they are filed in your Progression record.

For every write-up, please make sure the following information is clearly indicated at the top of the first page:

1. Your name
2. Date of the write-up
3. Control case number and identifying initials or pseudonym
4. Date the treatment began, and, if different, date of the start of the control case
5. Write-up number or period covered by the write-up. Example: “6-month write-up no. 4” or “Months 24-30”
6. Name of your consultant
7. Hours of consultation to date