HIPAA guidelines about electronic data storage, communication, and security are so explicit and, along with specifying what information can and cannot be exchanged, include measures such as passwords and encryption to protect against hackers and other intrusions.

PROTECTING YOURSELF

Just as it is important to protect clients from the possibility that records may be viewed by others, it is also important to protect yourself. No clear-cut rules exist in this area, but interns and clinicians would do well to ask themselves how what they put in records might later sound in a court proceeding. Gutheil (1980) went so far as to suggest that trainees

> deliberately hallucinate upon their right shoulder the image of a hostile prosecuting attorney who might preside at their trial, and that to this visual hallucination they append the auditory impression of the voice most suited to it. (p. 481)

Gutheil (1980) continued, saying:

> Having achieved this goal-directed transient psychotic state, the trainee should then mentally test out in that context the sound of what he or she is about to write. (p. 481)

This does not mean that you should be frightened about everything you write or that you should expect a lawsuit around every corner. At the same time, however, being aware that your records and notes can be exposed and analyzed in litigation serves as a helpful reminder and incentive to keep the quality of your treatment and documentation at the highest levels possible.

Keep in mind, too, that under HIPAA guidelines, clients have access to their own records. Again, psychotherapy notes are protected if kept separately, but in the portion of the record that is accessible to clients upon request, it is advisable to avoid recording your own emotional reactions or opinions about clients if such reactions could be clinically harmful or litigiously consequential when read by a client.

From a liability risk-management perspective, two things to avoid in records are "raising ghosts" and taking blame. By raising ghosts, I mean recording unfounded or unnecessary speculation in your notes. For example, if a client seems a bit down during a session but there is no reason from the client's history, statements, or actions to suspect suicide potential, it would be unwise for a clinician to record "Client was down today but I do not think suicide potential is high." If you mention suicide, you must also assess the potential carefully and document that you did so. If suicide risk is not elevated above normal, do not mention it at all. The same would apply to issues relating to dangerousness to others. Do not simply speculate about something so serious in your notes unless you followed up on that speculation during your session.

A second thing to avoid in records is taking blame. Do not write in your notes that you made a mistake in treatment. This might feel honest and cathartic, but it could get you into trouble later. If you are tempted to make such an entry, ask yourself what good it serves to write in your own notes that you made an error. You know it yourself, and that is sufficient. Remember the advice your auto insurance company gives you if you are in an accident. If something unfortunate happens and you have to defend an action in court, allow your attorney to advise you but do not put confessions in your records beforehand.

Finally, never falsify records. If your records are demanded for a legal proceeding, you will be asked under oath if your records represent a true and accurate description of your treatment or have been altered in any way since they were originally written. If you alter records and do not so indicate, you may be guilty of perjury. It is far better to be careful in your treatment and in your records to begin with and then to be scrupulously honest if you are ever called to court. If at some point in your work with a client you realize that a previous record was deficient in some way, at the time you notice the deficiency you can make a note that you discovered something that needed to be added or changed in an earlier note. This does not mean you go back and actually change the note. It means you make a separate and later note that indicates the need to adjust, clarify, or correct the earlier note.

For example, suppose that two days after you wrote an entry you are reviewing the notes and reflecting on the earlier session. As you think about the session, you realize that something should be added. At that moment, write the present date and time, then indicate the change or correction. This process demonstrates the value of periodic note review because you must catch such omissions before any trouble develops and legal implications arise. Corrections made after legal action or after an unfortunate event are not likely to carry as much weight in court because they tend to be seen as self-serving.

PROGRESS NOTES AND PSYCHOTHERAPY NOTES

EXERCISE

If you are working in a clinical setting, find out if you can obtain permission to review some of the patient records. Then read the progress notes kept in the records and ask yourself the following questions: Can I detect differences in style or content for different staff members? What notes stand out as useful? What notes are not useful? What matters of style and information account for this difference?

STANDARD FORMATS

In an effort to standardize treatment notes, many agencies have developed or adopted specific guidelines for what should go where in notes. This is very important in medical settings or

group-care facilities where many different treatment professionals interact with many different patients and need to have ready access to key information quickly. Without a standard format, it is nearly impossible for different members of a treatment team to find information in a record. Standardized notes also ensure that each member of the team is working consistently on an identified problem or goal for the given patient and that each treatment team member follows a structured procedure in observing the patient's status, recording information about that status, assessing the patient's condition, and basing treatment on the assessment.

It is very likely that your internship placement will have guidelines for keeping records and recording progress notes. If your agency has such guidelines, you must learn them, practice using them, and get feedback to be sure you are writing your notes correctly. As noted earlier, most agencies conduct periodic audits to ensure that record keeping meets agency guidelines. By making sure your records and progress notes are up to standards, you can save yourself and your supervisor problems later. As a check, interns should initiate their own record and progress note review with their supervisors. Supervisors tend to get busy and overlook such details, so it is a sign of responsibility if interns take the initiative to be sure they are keeping acceptable notes.

In your clinical work you are likely to encounter two types of ongoing notes regarding treatment. For convenience, and consistency with laws such as HIPAA, we will refer to these as progress notes and psychotherapy notes. The former describe records that are part of the documentation of patient treatment available to other staff. By comparison, psychotherapy notes are your personal records of the events of specific therapy sessions or related interactions. Understanding the differences between these note types, and learning how to use each effectively, will help you become more efficient and effective in both your treatment and your record keeping.

PROGRESS NOTES

Progress notes are the core of most clinical records. They provide a record of events, are a means of communication among professionals, encourage us to review and assess treatment issues, allow other professionals to review the process of treatment, and are a legal record. Progress notes have also seen increasing use by insurance providers seeking to determine whether a treatment is within the realm of services for which they provide compensation (Kagle, 1993). In writing progress notes, you must keep all these functions in mind.

When I write progress notes, I find it helpful to ask myself several questions. First, as I write, I review the events in order to again assess and better understand what happened. This helps me process and check my treatment. Next, I ask myself: If I read the notes several months or years from now, will they help me remember what happened, what was done, and why?

Because I may not be the only one to read my notes, I consider what would take place if something happened to me and another clinician picked up my clients. Would my notes enable him or her to understand the client and treatment? If I am in a setting where other professionals refer to the same record, I ask whether the notes I write will adequately and accurately communicate to them. I include legibility in this consideration. If my handwriting is so poor that others cannot read it, the notes will not do them or the client much good. Finally, and very importantly, I ask, What would be the implications and impact if these notes were used as a legal document in a court of law?

TYPES OF PROGRESS NOTES

The two most common types of progress notes are problem-oriented and goal-oriented notes. As the names suggest, problem-oriented notes refer to one or more specific problem areas being addressed in treatment (Cameron & Turtle-song, 2001; Weed, 1971), whereas goal-oriented notes focus on specified treatment goals, with each entry relating in some way to a goal. In systems that use problem- or goal-oriented notes, each therapist, or the treatment team as a group, identifies several key areas of focus in the client's treatment. For example, problems might be identified as:

1. Initiates fights with other residents
2. Does not participate in social interactions

Expressed as goals these might be stated:

1. Reduce incidence of instigating fights
2. Increase socialization

Once a list of the problems or goals is established, progress notes then refer to them by number or name.

The theory behind this approach is that it helps staff target their intervention to meet specific treatment needs or goals. Such notes may also help demonstrate to insurers that the treatment provided is systematic and is related to specific problems or goals for which compensation is being provided.

STYLE OF PROGRESS NOTES

In most progress notes, writing style is not important; clarity, precision, and brevity are. Your goal is to record all the essential information in as little space and time as possible. Because you may be writing and reading notes on many patients each day, you will want to save time by including only the essential details. By keeping your notes succinct, you will also save the time of others who may read them. This is especially important in settings where notes are shared among many professionals, each of whom has contact with many patients. When a clinician must read many notes, every minute saved in reading and writing adds up. As long as the notes are kept accurately and all essential information is provided, the time saved

in charting can be better spent in direct clinical contact or other activities.

Using shorthand is one way to shorten progress notes. If you are taking notes primarily for your own use, any system of shorthand will do as long as you can decipher it later. However, if you are writing notes in a record that others share, it is essential that any shorthand be understood by everyone and accepted by your institution. If there is a possibility of misinterpretation, you are better off writing things out in full. You should also be aware that different settings may have different standards for using shorthand or abbreviations, and some may not allow any shorthand at all. If you take notes as part of your internship responsibilities, check to be sure before you write.

STRUCTURED NOTE FORMATS

DART Notes

Some of the most widely used formats for treatment notes have significant problems, especially when applied to psychological, as opposed to medical, settings. One example is the SOAP format, which is part of the Problem Oriented Medical Records (POMR) system (Cameron & Turtle-song, 2002; Weed, 1971). The SOAP format will be discussed shortly, but first let me offer an alternative that most interns find very helpful as they learn to keep treatment notes.

This system actually evolved out of some joking around about my frustration with the SOAP format, which was at the time required of all notes for my internship placement. The acronym for my alternative system is DART, but it began as DIRT, which shows the humor behind its origin and explains why it would probably never be adopted in hospitals. Humor aside, the letters represent useful concepts that will help guide most progress notes. If your agency does not require adherence to some other standard, the DART format is a good method to follow.

The DART system is most useful when you are writing notes about a specific client or event. The *D* in DART stands for a description of the client and situation. *A* is for assessment of the situation. (This *A* was originally *I,* which stood for the clinician's impression and produced the initial acronym.) *R* is for the response of the clinician and client, and *T* is for treatment implications and plan. One way to think of this system is that when you write progress notes you must tell what happened, what you made of it, how you responded, and what you plan to do, or think should be done, in the future. This sequence of events is not only a useful way to conceptualize progress notes, it is also a useful way to approach a treatment interaction.

Description

The first part of any progress note should describe the basic *W* questions of journalism: when, where, who, and what. In practice, these words are not actually used in the progress notes, but the notes must contain the information the words subsume. Usually, the information of when, where, and who can be conveyed in a single sentence. "When" refers to the date and time the event occurred. Some people prefer to put date and time at the end of a note, but I suggest you start the note with this information for ease of reference later. "Where" indicates the location of the event. If the location is always the same, such as a clinic office, this can be omitted. However, if many locations are possible, as in a school, hospital, or other large setting, it helps to note the exact location. Next you should indicate "who" played a significant role in or observed the event you are noting. Noting who was present can come in handy later if there is a need to get additional information about a specific event or client.

Once you have provided the basic information, you should describe "what" is prompting you to write the note. This may be something routine, such as "Mrs. Smith has shown little change during the past week. She continues to pace the hall and talk to herself." The information may be a significant change in a client's appearance or behavior: "During individual therapy today, Joseph informed me that he has been very depressed and is thinking of killing himself." The more significant the event, the more space will be dedicated to the corresponding progress note. One would certainly want to expand on the second notation.

Assessment

Having described what you observed, the next step is to record your assessment of what it means. This is the "why" of the event. You do not always have to offer profound insights or explanations, nor do you always have to know what something means. Sometimes the most important notes are about behaviors that stand out precisely because their meaning is not exactly clear. For example, if a client who is normally rather quiet becomes very talkative and energetic, the meaning of the change might not be clear, but one could note it, suggest some possible considerations, or ask others to offer their insights.

To help guide your assessment, think about how the present event or behavior relates to other knowledge you have about the client and treatment. How does the present situation relate to previous behaviors, to recent events, to the treatment plan, to other factors? Remember that most events reflect a combination of both lasting and temporary factors within the individual and within the environment. Thus, you might observe a change in a client's behavior and note that it seems to reflect stresses over recent family conflicts and may also be a reaction to the overall level of tension in the treatment facility. The most important task is to give some thought to what you observed and try to relate it to your overall knowledge and treatment of the client. Again, this is not just good note taking, it is sound clinical practice.

Response

In good clinical work you must first take in what is happening and what the client is doing and saying. Then you must assess what this means. Your next task is to respond in some way. Your

progress notes should reflect this sequence. After describing and assessing a situation, record what you did in response. The description of your response need not be lengthy, but it must accurately note any important details.

Like your clinical response, your record should reflect a well-founded and rational treatment approach. Here it is sometimes helpful to consider how other clinicians might judge your response. It may also be useful to think about the legal implications. As a legal standard, if something is not recorded, it is difficult to prove it was done. Learn to record scrupulously anything you do or do not do that might later be considered important. Be conscientious about noting such things as referring a client to someone else, administering formal tests or other measures, if giving homework assignments or developing contracts, and scheduling future contacts. Also keep notes if you consult with someone about a case. Include both the fact that you consulted and a summary of the consultation and results (Harris, 1995).

To the extent that the severity of a client's concerns or the riskiness of a clinical decision increases, records should be more detailed. Bennett et al. (1990) suggest that records should describe the goal of the chosen intervention, risks and benefits, and the reason for choosing a specific treatment. It is also advisable to indicate any known risks, available alternatives and why they were not chosen, and the steps that were taken to maximize the effectiveness of chosen treatments. In some instances, documenting what you did not do and why you decided not to do it can be just as important as documenting what you did do. As further information, it is often useful to note any information provided to, or discussed with, the client, and the client's response.

In essence, this process is tantamount to "thinking out loud" in the record. Gutheil advised: "As a general rule, the more uncertainty the more one should think out loud in the record" (1980, p. 482). In this process, the clinician is recording not only the action taken but the reasons for taking or not taking an action. If questions arise later, the explanation is already documented. In a legal context, Gutheil stressed that for liability reasons this process is important because it reduces the possibility of a ruling of clinical negligence.

TREATMENT PLAN

Following the description of your immediate response, the final element of a well-written progress note is your plan for future treatment. This may be as simple as a note saying "Schedule for next Monday" or "Continue to monitor condition daily," or it might be more complex, as in "Next session we will explore family issues. Client will bring written description of each family member, and we will complete family diagrams." Notes of this sort allow you to refer back to refresh your memory of what was planned. This might seem unnecessary to you now, but if you have large and complex caseloads, such records will help you keep track of your clients and their treatment.

If you are working in an agency where a daily log is maintained, it is often possible to leave notes there for other staff. For example, you might conclude a note by suggesting that the evening staff keep close watch on a patient. If something is really important, be sure to highlight it in some way in your notes. Use stars, bold writing, or other methods to make the note stand out. If the matter is urgent or life-threatening, do not leave the matter to progress notes alone; speak directly to someone responsible and document the conversation.

DART IN PRACTICE

To demonstrate how the DART notation approach might work in practice, suppose you were working in a school setting and a child came in with severe straplike bruises and welts across his back. You suspect the child may have been abused, so you discuss it with him. He seems to avoid answering but finally says he fell and hurt himself.

The following sample notes illustrate how you might record this using the DART format. In this example, the DART initials are used to help organize the note and for ease of later location of information. As you read the example, identify how and what information is included in each of the main areas. You may find some information following one initial that might also go with a different initial. In contrast to other systems, the DART model is not so concerned with what goes where in the notes. What matters most is that all the important information gets recorded accurately and in a useful manner.

D: 10/18/2004 Monday: After recess at 10 A.M. today, Timothy North was taking his jacket off and in the process his shirt pulled up revealing straplike red welts across his back. At noon break I spoke with him while the other children were out. I said I noticed he had some red marks on his back. He looked away and shrugged without answering. I asked where he got them, and he said he did not know. Then he said he had fallen down over the weekend. I asked if his parents knew, and he said yes. That afternoon I met with the school nurse, Karen Jones, and Tim. The nurse looked at the marks and asked Tim similar questions; he again said he had fallen.

A: The marks do not look like they came from a fall. Karen Jones, school nurse, agrees. We are concerned about possible abuse. This child has come in with questionable bruises before, but none were this severe, and he has always offered plausible explanations. Given the nature of the present marks, we believe the situation warrants notification of Child Protective Services.

R: I notified the school counselor, Alice Black, and we contacted Child Protective Services. The contact person at CPS is William Randolph, MSW. He asked if we thought there was imminent danger of severe harm to the child. We replied that we did not have enough information to know that. He suggested we schedule a meeting for Wednesday,

October 20, at 4 P.M. If further concerns arise before then, we will call and inform him.

T: We will keep watch on Tim and check for further signs of injury. Future action will be determined at Wednesday meeting.

Signed, Joyce Jefferson, MSW, Date, 10/18/2004
cc: Karen Jones, Alice Black, William Randolph

SOAP NOTES

As noted earlier, one of the more common standardized note-taking methods is the SOAP format. So-called SOAP notes are actually part of a broader system known as Problem Oriented Medical Records. Comparable to the structure recommended by Piazza and Baruth (1990), which was discussed earlier in this chapter, the POMR system includes four components, commonly referred to as the clinical assessment, problem list, treatment plan, and progress notes (Shaw, 1997). SOAP notes fall in the progress note portion of this system.

The letters in SOAP stand for subjective, objective, assessment, and plan. "Subjective" refers to information about the client's present situation from the client's subjective position. One way to think of this is as the client's presenting complaint or description of how he or she is doing and what he or she needs or desires. "Objective" information is meant to be the external data that are being observed. In a medical setting, this might be blood pressure, temperature, and the like. Such objective data are often much less clear in psychotherapy interactions than in medical practice, though it is possible to offer descriptions of, for example, the client's affect, appearance, and mannerisms. The "assessment" portion of a note reflects how the therapist integrates and evaluates the meaning of the client's subjective report and the objective externally observable data in light of all the other information known about the client. From this assessment, the plan of treatment action is then recorded.

Although the concepts behind Problem-Oriented Medical Records, from which SOAP developed, are quite valuable, my experience with the SOAP format suggests that the terminology is rather ambiguous for use outside medical settings, and enforcement of the terminology can be paradoxically rigid. This situation can readily lead to needless debate about whether an entry should have been placed in the *S, O,* or *A* section (Cameron & Turtle-song, 2002). I have also found that efforts to conform to rigid SOAP guidelines tend to produce contorted writing that may obscure rather than clarify what happened and what was done about it. Nevertheless, many institutions use the POMR and SOAP system, so you should be familiar with them and develop strategies for following these formats. Cameron and Turtle-song (2002) offered some very useful suggestions for how the SOAP format can be used in mental health settings. If this system is used in your placement, your supervisor will no doubt be very familiar with it and can give you useful suggestions for putting your progress notes in the proper format for that institution. If you are interested in knowing more about SOAP, see the original work by Weed (1971) or the more general review of medical records by Avery and Imdieke (1984). Most settings that use SOAP or any of the other standard note formats will have training material or workshops that can teach you more about writing these notes.

EXERCISE

If you are not already writing clinical notes, you may want to develop your skills by choosing a recent interaction with a friend or client and document it as if you were writing a progress note in a clinical record. If possible, review the note with your supervisor and request feedback about how you could improve the note.

TIME-SEQUENCED NOTES

As noted earlier in this chapter and in the discussion of HIPAA and ethics in Chapter 3, psychotherapy notes are different than progress notes and should not be kept in the patient's general record. In contrast to the DART and SOAP approaches, which are used primarily to record specific events or interactions and are kept in the general record, a therapist's personal case notes from individual sessions typically follow a different format and serve a different purpose. Time-sequenced notes are the most common form of notation for therapy sessions. In time-sequenced notes, the therapy session is described as it progressed, with individual elements described sequentially in the order in which they occurred in the session. Some therapists make these notes during the therapy session. Others wait until the end of a session to record what happened.

The sequential approach is often used for records of therapy sessions because there are simply too many elements to address each separately following a more structured format. Sequential notes also enable the clinician to observe the order of events as they occur within a session. This can provide extremely useful clinical information. For example, it is probably not mere coincidence if a client begins by describing family conflicts, then shifts the topic to problems at work. Sequential notes follow this shift and enable the clinician to notice it in the record even though it might have gone unnoticed during the session. An example of an abbreviated sequentially ordered progress note from a therapy session follows. Note the use of an informal shorthand to save time:

2/9/2004 2–3 P.M. JA began session by revu of 1st wks sesn. Said he had thought about it & did not understnd why he had cried about father. We explored this more. JA cried again, rembrd fishing trip and fathr takng his fish away. Felt humiliated. Realized this was typical pattern. Gave recent example of visit during Xmas. His father was critical of JA's job, an argument developed and JA returned home early. We explored pattern of seeking approval and

fearing rejection. JA realized that anger is also there. This comes out in marriage as well. JA is often angry w wife if she disapproves of anything he does. He described two examples, when he cooks and in child care. He is not comfortable with own behavior but is having hard time chnging. Agreed to explore this more nxt sessn.

In a one-hour session, there would obviously be more that could be recorded, but in this example the therapist has chosen to note the events and topics she considered most important. This will vary from therapist to therapist and is also closely tied to theoretical orientation. Analytically trained therapists, for example, would be likely to make much different notes than those recorded by a behavioral therapist.

PROCESS OR PROGRESS NOTES

Process notes are yet another type of note with which you should be familiar. Process notes refer to notes in which the therapist includes personal reflections on not only the observable interactions in treatment but also the therapist's own thoughts and considerations of such things as the unconscious dynamics of a patient or the transference or countertransference issues in therapy. As contrasted with progress notes, which focus more on the externally observable, empirical events of treatment, process notes delve into the psyche of the therapist and patient. Notes of this type can be especially useful in training because they allow interns and their supervisors to review not only what was going on externally during the interaction but what the intern was thinking (Fox & Gutheil, 2000). Professionals trained from a psychodynamic perspective will be quite familiar with process notes and may consider them essential to training and treatment.

Prior to the establishment of the protections now included in HIPAA, many professionals who valued process notes had legitimate concerns that such notes might be sought by insurance companies. Legally, clients also have access to their general medical records, and a client who reads a therapist's private speculations on the client's libidinal attachments, latent desires, or other potentially sensitive matters might not understand the purpose of such notes or the terminology involved. These concerns have largely been addressed by HIPAA protections, but, again, only if psychotherapy notes are kept separately from other records. HIPAA protections notwithstanding, however, be aware that process notes may also be problematic in legal proceedings and, as discussed in Chapter 3, HIPAA does not protect notes against court orders (Harris, 1995).

Given these concerns, many professionals have chosen to reduce substantially or eliminate the introspective and theoretical contemplation that was once standard in process notes. This is unfortunate, because process notes can be tremendously valuable in clinical practice and especially in clinical training. For an excellent review of this topic and suggestions for effective use of process notes, see Fox and Gutheil (2000). Ultimately, what you choose to put in your notes is up to you and your supervisor, but keep in mind the benefits as well as the risks, and, again, be aware that your notes may be read by other persons.

SIGNING NOTES

The final step in writing progress notes is signing them. As an intern, you should check with your supervisor to be sure you understand exactly how notes or other documents are to be signed and how you are to identify yourself with your signature. Some institutions require interns to sign notes and identify themselves as "Psychology Intern" or "Social Work Student." It may also be necessary for your supervisor to co-sign any work that you write. This might include daily progress notes, or it might apply only to more lengthy reports. Because different agencies or institutions will have different policies, the only sure way to know you are following procedures is to ask from the beginning.

Along with being sure to list your status correctly, you should also consider the legibility of your signature. Mine happens to be almost totally illegible. With experience, secretaries, students, and colleagues all learn more or less how to decipher my scratchings, but those who have less experience and do not know me well are often at a loss. This can present a problem for progress notes, because sometimes there are questions relating to notes, and people need to know who wrote them. If no one knows who you are and they cannot read your signature, it is going to be difficult to find you. My solution is to always print my name above my signature. Because most people will be less familiar with interns than with regular staff, it is especially important for you to be sure people can read your writing and to identify your status clearly.

DICTATION

Whether you write or dictate your progress notes, their content and structure should follow the guidelines offered thus far. This may sound easy, but for most people, dictation takes some getting used to. The typical approach of beginners is to write their notes first, then read them onto the recorder. That is not exactly a model of efficiency. If you work in a setting where dictated notes are an option or requirement, the following suggestions may help.

Dictation is like writing; both take practice to develop. When people begin dictating, it may help to work from a brief written outline. This is not as lengthy or redundant as writing the entire entry beforehand, but it does provide some structure and a reference point. It is also possible to use a general outline, such as the DART format, and then make notes about the specific details for each client or event.

When you are dictating, keep in mind that the people who will transcribe your record have only what they hear on tape as a basis for what they will write. Remember to speak clearly, spell out unfamiliar names or terms, and verbally indicate where punctuation, paragraph breaks, or symbols go. With the

advent of digital recording systems, one can now speak quite rapidly, because the person transcribing the note can easily stop or move back or forward to keep up. If a slower, tape-based system is in use, you may need to speak more slowly so the typist can keep up. Whatever system you use, you can save the typist time by using the pause button on the recorder when you stop to think. Also, do not be afraid to make corrections if you realize that you made a mistake or left out a detail earlier in your report. Rather than rewinding and starting over, if you realize you made an error or omission, you can say something like, "I just realized I left out a sentence. Could you go back to just after . . . and insert. . . ." When you have dictated the correction, you can continue from where you left off.

In most large institutions, you may never meet the staff who transcribe your dictated notes. Because I find this structure unfriendly, I make it a point to get to know the people who will be typing my notes. Building relationships with records, secretarial, and other staff is not only rewarding interpersonally, it can also help prevent and more easily resolve a host of problems. Good secretarial work can be extremely valuable, so it is important to respect and support the people you work with. One way to show your respect and build a relationship is to visit with folks when you begin your internship and stop by from time to time later to say hello. It also helps to conclude your records by thanking the person who is doing the typing and acknowledging that person's work.

Future directions for dictation involve voice recognition systems, in which one speaks directly to a computer that then prints the text of what is said. These systems are growing in sophistication and can already manage complex clinical terminology and editing functions. However, such systems require the user to speak clearly and relatively consistently. This may take some getting used to, but with practice one can learn to interact effectively with such systems.

EXERCISE

To gain practice in dictation, think of an interaction that occurred in class or with your peers. Use a tape-recorder and dictate your notes as if they were to be given to a secretary for typing. Then, either type the notes yourself from the tape, or ask a willing friend to try to type from your notes. Your friend can offer feedback about how fast you spoke, whether you misspelled a technical term, whether you were clear about punctuation, and so on. Remember, dictation is a skill that takes time to learn. Do not be embarrassed about hearing your own voice or about how your notes read on the first try. With practice, you will find that dictated notes go much faster and can be just as informative as written notes.

PROGRESS NOTES AND SUPERVISION

I have described the importance of progress notes for meeting agency standards, ethical guidelines, and legal documentation. In addition, progress notes can also provide useful material for clinical supervision. The general subject of supervision was discussed in Chapter 4, but a few additional comments are warranted in the context of notes.

It is a good practice for interns and supervisors to make reviews of progress notes a regular part of the supervision process. This review serves several functions. As noted earlier, reviewing notes with supervisors helps to ensure that the intern's records are up to agency standards. Because record keeping is an important but often overlooked part of clinical training, supervisors may wish to offer advice about the content or the style of an intern's notes. Reviewing notes also allows interns the opportunity to ask about any issues pertaining to record keeping and note taking. Beyond the clerical aspects of note taking, reviewing notes and records helps supervisors observe what interns consider to be significant about a case or therapy session. Supervisors can monitor the intern's records of the content and process of therapy sessions, and the notes can be referred to as needed to supplement or guide case discussions.

USING YOUR NOTES

Having devoted this chapter primarily to how to keep records and progress notes, it should not be forgotten that the primary purpose of notes is to assist the treatment of your clients. It is surprising how often therapists take notes at the end of sessions but then do not refer to them again before the next session with their clients. This can easily happen as therapists with busy schedules shift from seeing one client to the next with little time in between. Understandable though this may be, the quality of treatment may be lessened as a result.

I confess to having been guilty of this myself on occasion. I recall an instance in which a client said he had given a great deal of thought to what was said last week, and I found myself internally struggling to recall just what it was we had discussed. It has also happened that I "assigned homework" (i.e., suggested that a client do or write something between sessions), which I then forgot to discuss. Clients have called me on this and in some cases have expressed their displeasure over what appears to be a lack of concern or attention.

Beyond a matter of courtesy or simple forgetfulness, many clients may actually consider such oversights unethical. In a survey of 96 adults, some of whom had experience as clients and others of whom had not, Claiborn, Berberoglu, Nerison, and Somberg (1994) found that in a list of statements about 60 possible hypothetical events that might occur in therapy, the statement "Your therapist does not remember what you talked about in the previous session" was ranked fourth highest among events considered to be ethically inappropriate. The mean ranking for this item on a scale of 1 to 5, with 1 being "completely inappropriate," was 1.32. Clearly, at least in this sample, recipients of clinical services placed a high value on therapists being aware of the content of previous sessions.

Given this finding, it certainly behooves the therapist to take the few minutes before a session to review the notes from the last visit. With heavy caseloads and busy schedules, oversights and lapses of memory are almost sure to occur unless clinicians take good notes and then make use of them. On the other hand, clinicians who make efficient use of progress notes will be more aware of the sequence of events across sessions. This will lead to better therapeutic care and will result in higher levels of satisfaction on the part of clients.

OTHER GUIDELINES

This book has emphasized repeatedly that you must know your limits and be open to learning. This applies to records and notes as much as any other aspect of your internship. If you do not know how to write a note, or if you are unsure of the wording to use, ask for help. If you are describing an interaction with a client, do not write notes designed to impress everyone with your skills. While you are an intern, humility is a virtue, and hubris can get you into trouble. Remember simplicity and objectivity.

Another principle of note taking is to be constructive. This is especially important if you are writing notes in a record that is accessible to others. Although part of your task is to assess and try to understand what you observe, your purpose is not to ascribe blame. Your goal is to facilitate treatment, not to be critical of clients or staff. For example, it would not be constructive to write a note such as "Dennis is up to his old tricks again. Found him masturbating in front of the television. Sometimes I think we should cut the thing off." This may sound shockingly callous, but I read precisely this note in staff records. Interns learn by example, but some examples are best not followed. Imagine the impact of such a note if read by an outside professional, a family member, or in a court of law.

For similar reasons, if you are working in an institution where many staff members record notes in the same book, using the record to question or attack the conduct of other staff is not a good idea. Consider, for example, "The night shift is still not following through with last week's treatment plan. How is he supposed to get better if we are not consistent?" This note may stem from legitimate frustration, but a formal progress note may not be the best place to air those feelings. I have read record books that sounded more like a name-calling war between staff than a mutual discussion of treatment. Such notes cannot really be helpful to the clients or the staff. If you have concerns, address them with your supervisor, but keep the progress notes objective.

Finally, from the outset of your career, develop good note-taking and record-keeping habits. Make yourself write notes immediately or as soon after an interaction as possible. Schedule the time you need for note taking and do not sacrifice this to other distractions. Keep your notes as thorough as they need to be, follow any required format, and establish a process of review to ensure that you keep everything up to date.

Faced with the many demands of clinical work, it is all too easy to become careless, or to let other tasks take precedence over note taking (Kagle, 1993). If you need 10 minutes for note taking between therapy sessions, schedule that in and do not allow it to be taken up instead with phone calls or other distractions. Unless they are urgent, save those other matters until you have finished your notes. You will be surprised how much gets forgotten or lost even by the end of the day. The longer you wait to record your notes, the less accurate and less valuable they will be. When it comes to clinical record keeping, a little compulsivity is not a bad quality to develop. Not only will well-kept notes enhance your clinical treatment, they can also make the difference between whether or not an insurance company pays for services. In our litigious society well-kept progress notes may also save you untold legal problems if you are ever called on to produce them in court.

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