Cognitive Therapy: Basics and Beyond

By Judith S. Beck

Reviewed by Jesse H. Wright, M.D., Ph.D.

Judith Beck has provided a great service to the field of psychotherapy by writing a step-by-step guidebook for learning and practicing cognitive therapy.

Cognitive Therapy: Basics and Beyond is packed with useful information that should help both novice and experienced therapists become better clinicians. In the tradition of Anna Freud, the author has distilled and extended the groundbreaking work of a famous father. She has been remarkably successful in explaining the methods of cognitive therapy originated by Aaron T. Beck and has added her own astute observations on how to become an accomplished cognitive therapist.

Simply put, this is the best book available for learning how to do cognitive therapy. Basic principles are clearly presented and illustrated with dialogue from typical therapy sessions. These illustrations should be especially useful to clinicians because they give a richly detailed picture of how to present cognitive therapy concepts and move successfully through the stages of treatment. Unlike other books on cognitive therapy, this volume is specifically directed at teaching therapy techniques. The historical background, theoretical issues, and research effort of this treatment approach are not covered in depth. Instead, the author gets directly to the point: how to perform cognitive therapy.

All of the basic procedures of cognitive therapy are included. The book begins with a cognitive conceptualization for treatment and then proceeds to instruct the reader on methods of structuring therapy, working with automatic thoughts, modifying underlying beliefs, implementing homework assignments, using advanced cognitive and behavioral techniques, and reducing the risk of relapse. In each chapter, the most important points are highlighted by placing them in a gray tinted box. This format makes it very easy to capture the essence of the author’s message. For example, in chapter 3, “Structure of the First Therapy Session,” 10 specific methods are identified for structuring cognitive therapy. Each of these techniques is then described in detail.

Behaviorally oriented therapists should be forewarned that this book is focused primarily on cognitive conceptualizations and techniques. Although the author demonstrates how behavioral procedures such as activity scheduling, graded task assignments, and relaxation can be incorporated into cognitive therapy, cognitive intentions are described in considerably more detail throughout the volume. Even those therapists who prefer a behavioral approach to treatment could benefit from reading Dr. Beck’s observations on the structure and process of cognitive therapy. Her description of methods for increasing homework compliance, solving difficult therapy problems, and teaching patients to be their own therapists should be of interest to all clinicians.

The majority of Cognitive Therapy: Basics and Beyond is devoted to the fundamentals of this form of treatment. Thus, it should be most useful for students and therapists who do not have an extensive background in cognitive therapy. For these individuals, the book will be an invaluable resource for assimilating the wisdom of a master cognitive therapist. Experienced clinicians may wish to focus on the more challenging discussions of procedures for modifying core beliefs and handling the problematic aspects of therapy. The author’s insights on these later therapy topics are both pragmatic and highly creative. Her suggestions for use of a Core Belief Worksheet and restructuring early memories offer innovative solutions for changing deeply held maladaptive beliefs.

Cognitive Therapy: Basics and Beyond is so full of valuable material that it may overload the reader who tries to digest the information.
too rapidly. This book will probably be of most help to those who are involved in learning cognitive therapy and can apply the lessons in a stepwise fashion. It is highly recommended to any clinician who wants to learn more about how to be an effective cognitive therapist.

Judith Beck has written a classic volume that will be widely used as a standard text of teaching cognitive therapy.

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Ego Defenses: Theory and Measurement (Einstein Psychiatry Publications Series No. 10)

Edited by Hope R. Conte and Robert Plutchik

Reviewed by Scott C. Bunce, Ph.D., and Philip Margolis, M.D.

As the editors submit, the idea that the mind employs mechanisms that can distort or vanquish painful thoughts or feelings is one of the most widely accepted facets of psychoanalytic theory. There remains, however, considerable debate over the precise meaning and function of these defenses. Conte and Plutchik have outlined several important questions in the literature: How many defenses are there? How shall we define them? Can they be arranged hierarchically by virtue of their level of adjustment? Are defenses adaptive or maladaptive, rigid or flexible? Can they be reliably and validly measured, and if so, how? Ego Defenses, organized in two sections of seven chapters each, presents the work of a number of authors who have suggested answers to these questions: Part I addresses theory, and Part II presents methods for the measurement of defenses.

To remain a viable science of the mind, psychoanalytic theory must continue attempts to validate its assumptions and to integrate these findings with knowledge gleaned from other disciplines. For readers less versed in the literature, Buckley provides a well-written historical overview of the taxonomy and description of defenses. The remainder of the theoretical portion of this volume presents numerous efforts to integrate psychoanalytic thought with other perspectives.

Most of the authors have adhered to similar definitions of defense, as theoretical abstractions that describe a particular way in which the mind works, a process by which painful thoughts, feelings, or motives are rendered less potent. Finding the appropriate level of analysis, however, was perhaps the most vexing task facing the various authors at both theoretical and assessment levels. As each level of description has its costs and benefits, it is vital to choose a level of analysis appropriate for the phenomenon of interest. Safer and Hauser suggest that the lack of crisp, empirical definitions of defenses and disagreement over a taxonomy have made research on ego defenses difficult, in part owing to difficulties in measurement. Agreement on an operational definition of defenses would increase our ability to focus empirical work, but this does not necessarily mean we should settle on a canon. Continued work on taxonomic issues has resulted in important theoretical developments. Safer and Hauser, for example, explore the question of whether defenses can be organized into a developmental continuum according to their level of maturity or their degree of pathology. Their own work suggests the predominant type of defense used by individuals may be affected by age, gender, ego development, or cognitive level.

Plutchik examines ego defenses within a psychoevolutionary theory of emotion. He argues that there are eight basic emotions, and that a number of conceptual domains—personality traits, ego defenses, and diagnoses—are derivatives of these eight emotions. One ego defense is thought to operate in response to one basic emotion plus anxiety. The
scope of Plutchik's attempt to integrate various levels of description is laudable. However, the specificity and precision of dynamic description may be lost in his effort to gain systemic clarity. It is probably too simplistic to describe eight basic defenses as linked to eight basic emotions. Defenses are dynamic processes, usually defined by the process with which they neutralize the offensive material. The same mechanism could operate on any number of emotions, cognitions, or desires.

The Horowitz and Stinson chapter implicitly acknowledges the complexity inherent in research on unconscious mental processes. By taking a microanalytic approach to case material, their techniques exemplify important methodological considerations for defense analysis. They have shown how Freud's description of the interaction between conscious and unconscious processes might be explained in light of recent cognitive science models of the mind. Within a parallel distributed processing account of the mind, control processes are thought to determine which of many levels of unconscious processes will be allowed to become conscious, thereby allowing image distortions in the individual's person schemas. They do not, however, articulate the motivational aspects of their theory well. Control processes are proposed to modify thoughts and communication to avoid unwanted states of emotion, but the role of defenses vis-à-vis motivation is not examined. This is troublesome because there has been some conflation of emotion and motivation, particularly in the literature on emotion. The role of a defense is often either to keep a given desire or motive unconscious or to prevent acting on that desire when the consequences are too dire. This is underscored in Dahl's chapter, where he integrates defenses with an information feedback theory of emotion. Dahl sees emotions as one of the primary systems we have for surviving in a dangerous world, facilitating communication and the recognition of the intentions of other members of our own species. Defenses are thought to serve two primary functions in this theory: 1) to restrict awareness of emotional experiences and wishes and 2) to inhibit the acts related to the wishes.

Benjamin begins her chapter by suggesting that defenses need not offer protection from forbidden impulses, yet she reintroduces motivation as the realization of wishes or the avoidance of fears; hence, motivation plays a central role in her theory. Benjamin extends defensive theory by operationalizing psychoanalytic hypotheses within an interpersonal context, asserting that defenses can at times be adaptive, primarily when they preserve interpersonal relationships. This is not inconsistent with Freud; defenses allow us to operate in a social world with interpersonal constraints.

Slavin and Grief invoke evolutionary theory to help decide the argument between classic psychoanalytic views and object relational views of what gets repressed and why. As products of evolution through inclusive fitness, parents necessarily have self-interests that compete with the interests of their offspring, and children must negotiate the parental world to survive. Because reproductive success relies on continuation of the genome, it is in the children's best interest to repress competitive parts of the self necessary for future reproduction. Reproductive success requires investment in both selfish interests and the social interests characteristic of object relational views.

Methods of measurement should necessarily derive from theoretical hypotheses concerning the variable of interest. The over-determined nature of psychoanalytic conceptualizations of intra- and interpersonal processes makes the assessment of defensive processes difficult, labor-intensive at best. Three approaches to the measurement of defense mechanisms are presented in this volume: self-report inventories, projective methods, and scales for rating clinical material. The development, reliabilities, and validities are described for three self-report instruments, the Life Style Index (Conte and Apter), the Defense Style Questionnaire (Bond), and the Defense Mechanism Inventory (Ihilevich and Gleser). Although self-report
inventories are convenient, and can offer predictive validity, they have serious limitations for use in assessing dynamic defenses. Bond is appropriately cautious about the conclusions that can be drawn from self-report measures of defenses. Self-report is subject to the motivations and openness of the subjects at the time of their response, and at best, taps conscious derivations of unconscious intrapsychic processes. Thus, high test-retest reliabilities probably reflect trait-like defensive styles, or the propensity to use particular defenses, rather than defenses per se. This limits their use to a particular range of psychodynamic hypotheses: those concerning character styles. These instruments can be useful as long as their limitations are acknowledged.

Two chapters address the assessment of defenses with projective measures, which purportedly allow the direct assessment of defenses because the ambiguous stimuli are thought to evoke actual defensive responses. The Defense Mechanism Profile (Johnson and Gold), a projective sentence completion instrument, avoids a forced-choice format that might elicit responses that are neither accurate nor representative. The projective task helps establish ecological validity, but it is still vulnerable to self-report biases—that is: Do the subject's reports reflect actual situational responses? Ritzler nicely summarizes and cogently critiques several methods for assessing defenses by use of the Rorschach. His discussion exemplifies the complexity of defense measurement that contributes to the low validity and reliability plaguing projective research. He appropriately emphasizes the need to validate existing schooling systems with behavioral or clinical observations of defenses.

The last two chapters exemplify the methodological rigors necessary to capture a relatively unconscious intrapsychic process. Perry and Kardos review the Defense Mechanism Rating Scales (DMSR), one of two rating systems in this volume that rely on extensive analysis of case material. The DMSR allows for good ecological validity and internal reliability, but falls prey to observer bias: it can be difficult for a rater, having identified a particular defense, to avoid "observing" clusters of related defenses. Bauer and Rockland have attempted to cope with this observer bias in their Inventory of Defense-Related Behaviors by rating specified behaviors, rather than abstract "processes," as present or absent in clinical material. However, defense mechanisms are abstractions, reflected in numerous behaviors, whereas any behavioral assessment instrument is limited by its taxonomy. This difference may result in the low interrater reliabilities found for several defense mechanisms.

Ego defenses represent complex, dynamic intrapsychic phenomena that must be understood within a larger dynamic system of personality. This complexity contributes to a feeling that many of the authors could not do justice to the intricacies of their theories within the spatial limits of these chapters. Most of the chapters describe published work, however, and are well-referenced, so the motivated reader can follow up on interesting concepts. Overall, it is encouraging to see both theoretical and empirical work on psychoanalytic concepts. To remain a viable science of the mind and of clinical services, psychoanalysis must continue its dialectic within the field while integrating the best that other disciplines have to offer. This book is a step in the right direction.

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**Psychotherapy in the Age of Accountability**

By Lynn D. Johnson

Reviewed by Marcia Kraft Goin, M.D.

Lynn D. Johnson writes with the authority of a long-time case management reviewer for one of the largest employee assistance
programs. He knows the needs and attitudes of the managed care administrators and has myriad opinions about the accountability of therapists across the country. His book informs the reader about a model of treatment that he believes achieves therapeutic success while working within the confines of a managed care system.

The first of the book's three sections, "An Integrative Approach," describes Johnson's therapeutic technique, which makes use of aspects of behavioral, psychoanalytic, Gestalt, T-group, and other models of brief psychotherapy. Johnson believes that his technique achieves focused quality care in the shortest possible time. The second section, "Supportive Concepts," deals with the matter of time in psychotherapy (how much time is really necessary, time-limited and time-sensitive psychotherapy, and other issues) and with motivation and compliance. The final section, "Specific Applications," discusses the application of time-sensitive, accountable, and effective treatment in working with traumatized patients, adolescents, and those with alcohol and drug abuse problems.

It is implied throughout the book that the restrictions placed on therapists by managed care will in fact benefit patients. The author envisions that the demands of managed care will provide an impetus for therapists to work faster to enable patients to get better within the delineated time limits. This view conveys the idea that for the most part therapists are self-serving miscreants who will dawdle along unconcerned about patient care until prodded into action by the almighty dollar. In my years of supervising the training of hundreds of psychiatric residents I have found the opposite to be true. Most therapists are humane and compassionate professionals working to find the most effective way to help their patients.

Clinicians have long searched for speedier resolution of their patients' problems. From the beginning of the development of psychoanalytic therapy, as Freud wrote in *Analysis Terminable and Interminable*, attempts have been made to "hasten the time-consuming process." The setting of time limits, Mann's focal therapy, and Alexander's corrective emotional experience all represent our colleagues' concern with time and their efforts to shorten the process. With the advent of behavioral and cognitive therapy, clinicians hoped that treatment based on learning theory would achieve this goal. We have learned that certain problems do respond more readily to behavioral intervention and that certain patients are able to make productive use of homework assignments and other practical techniques. Some patients can respond to these techniques, but not all patients are alike. Although the author states that his focused technique can be used even with the most severely mentally ill patients, his section on the severely traumatized patient does not bear this out. In this section he states that the therapist is not the patient's protector and "If the patient cannot remain safe, she must reach out to crisis agencies or emergency rooms." A therapist cannot say this to a patient without completely abdicating professional responsibility. Besides abandoning responsibility, Johnson is relying on a system of care (crisis agencies and emergency rooms) that is rapidly disappearing.

It has become all too common for treatment planning to be dictated by faceless reviewers rendering clinical judgments through checklists on computer screens. Despite the limits set on treatment duration by managed care, it is the professionals who still bear the heavy burden of ultimate responsibility for their patients' well-being—morally, ethically, and legally. This cardinal principle is not taken into account in this book.

Despite my misgivings, I believe this is a book worth reading. The treatment examples are instructive and thought provoking, and they include treatment techniques that may be helpful for certain patients. Primarily, it is a useful handbook for understanding the attitudes of managed care employees. Although neither fun nor conceptually provocative, the book will help you grasp reviewers' perspectives and will educate you as to what they want to know and how you are accountable to them.
Achievement and Addiction: 
A Guide to the Treatment of Professionals

By Edgar P. Nace

Reviewed by Philip J. Flores, Ph.D.

Edgar Nace has written an important book about a subgroup of addicted patients that can sometimes be overlooked and neglected. He begins his book by confronting the stereotypes that are occasionally held about alcoholics, addicts, and substance abusers. He then explores ways in which many of these assumptions and typical images do not fit when attempts are made to understand or explain why highly successful, intelligent, motivated, and achievement-oriented professionals succumb to a disorder that remains baffling to a large portion of the general population. Even though the general public’s attitude about addictions is changing as the problem grows and more accurate information is made available, it is still a confusing disorder to many professionals in the treatment community. Nace’s explanations of the phenomena of addiction take on added significance because he does not permit himself to escape into stereotypes about its causes. For instance, although he pays homage to the disease concept of addiction, he avoids the pat answer that addiction is just a disease. He recognizes that a number of variables influence the addiction process. Genetics, personality, social influences, peer pressure, availability of the drug or substance, interpersonal psychodynamics, subtle interactions of grandiose defenses with shameful affect, and neurological/biochemical influences all combine to produce a predictable but complicated process that is called addiction.

Nace’s effort to identify and explain the interplay between these forces is both the strength and one of the main weaknesses of his book. His dissecting of the variables that influence and contribute to addiction is very helpful in familiarizing the reader with the special set of circumstances that confront the addicted professional. Consequently, his insights provide a useful perspective on the ways that these influences can make diagnosis and treatment more difficult for this population. On the other hand, Nace comes precariously close to furthering the belief that an addicted professional is unique, special, or different from other addicts or alcoholics. Successful treatment of addiction, especially in the beginning, requires that more emphasis be placed on the similarities among those who are addicted than on the differences that may exist. Nace, to his credit, addresses this issue later in his book when he writes about the different strategic approaches to treatment for early-stage and later-stage patients. However, one book cannot be all things to everyone, and Nace’s intent is clearly to identify the ways in which the addicted professional is different. As he cautions, he is using the term “different” conservatively and does not want it to suggest that this is an elite group. He goes on to present convincing evidence that the alcoholic’s and addict’s inclination to believe he or she is unique or special contributes not only to the disorder, but also to recovery.

Throughout, Nace does a commendable job of integrating the theoretical and the practical. In Chapter 4 he presents many useful recommendations and clearly written suggestions on intervention, diagnosis, and evaluation. He provides many nuts-and-bolts suggestions about what to do, how to do it, and when. His theoretical perspective encompasses both the disease concept and the most current positions within psychodynamic theory.

Drawing on the world of Kohut, Khantzian, and Kurtz, he admirably integrates two different theoretical perspectives, showing how the disease concept and psychodynamic theory can complement each other. For example, he
illustrates how Kurtz's writings about addiction and shame complement Kohut's and Khantzian's views on the relation of shame to narcissism. He draws parallels between Kurtz's perspective on addiction as an attempt to combat shame and Khantzian's self-medication hypothesis, which defines addiction as an attempt at self-repair that fails.

The book does have an unacknowledged bias. Although I personally hold to and agree with most of his recommendations on treatment, he fails to speak to the chasm that exists between the majority of the addiction treatment community and the small but powerful community of researchers, educators, and treatment professionals who are strongly opposed to 12-step abstinence-based models and disease-concept-oriented approaches. Although the majority of treatment personnel who work with addiction would find Nace's perspectives and recommendations useful, helpful, and complimentary, there are growing numbers of more academically and behaviorally oriented individuals who would vehemently disagree with Nace's position on addiction. It is not necessary that Nace address this controversy, but it would have been helpful to at least acknowledge it.

Despite a few oversights, the book is an excellent one by an author who obviously understands the addictive process thoroughly. It reflects the insights of someone whose interest is not merely passing or purely academic. Dr. Nace has obviously worked extensively with this population on a personal and intimate level. This is a clearly written and concisely organized book that makes judicious use of clinical examples to help illustrate what could otherwise be dull, abstract, and ponderous reading. His cleverly presented examples help his material come alive on the page. Nace's book will be helpful to the beginning student of addiction, the seasoned practitioner who wishes to expand his or her understanding of this disorder, and the experienced addiction specialist who wishes to know more about this segment of the addicted population.

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Eye Movement Desensitization and Reprocessing: Principles, Processes, and Procedures

By Francine Shapiro, Ph.D.

Reviewed by Thomas D. Geracioli, Jr., M.D.

In this book, Francine Shapiro details the clinical procedures and theoretical principles of eye movement desensitization and reprocessing (EMDR). Recently, EMDR has been gaining popular acceptance as an effective treatment for posttraumatic stress disorder (PTSD), among other putative indications, although awareness of the technique within academic medical centers remains dim. Preliminary research on the clinical efficacy of EMDR, cited by Shapiro, is highly encouraging, but additional well-designed studies are needed to validate its usefulness and to explore its effects. This book is timely insofar as it provides the uninitiated with a comprehensive introduction to EMDR by its creator.

Shapiro traces the origins of EMDR to her days as a graduate student in 1987, while walking in the park—she noted that her own rhythmic eye movements seemed to be associated with the immediate disappearance of some disturbing thoughts. When later recalled, these thoughts "were not as upsetting or as valid as before." Indeed, the central procedure in EMDR involves using the fingers to lead the client in back-and-forth eye movements while he or she holds "targeted" problematic images in consciousness. Shapiro claims that repeated sets of directed eye movements activate the brain's "information-processing system" and facilitate the
therapeutic working-through of traumatic experience. A typical "set" consists of at least 24 bidirectional eye movements. Other stimuli, such as bilateral, alternating hand taps or stimulation of the acoustic apparatus, are also said to mobilize the information-processing system as well as eye movements. Although no in-depth exploration of the different neuronal afferents evoked by these different stimuli is attempted, consideration is given to the possibilities that either alternating hemispheric activation alone (in the absence of any specific movement) or the rhythmicity of movement itself is of clinical importance.

The EMDR protocol itself consists of eight "essential" phases—"client preparation, history, and assessment," followed by "desensitization, installation, body scan, closure" and, finally, "reevaluation." Shapiro asserts that "dysfunctional material" (images and associated cognitions, typically trauma-related) is "stored in its original state-specific form" and is stimulated if it is held in consciousness. Processing of this material, which had been arrested, then proceeds if the information-processing system is simultaneously activated during sets of repeated eye movements. While traumatically engendered dysfunctional material is said to be held in a "neuro network" that operates autonomously, or is effectively cut off from other networks, similar traumatic events are regarded as being linked associatively to the target memory or image. Once activated in a directed manner, the patient's capacity for "spontaneously generated recovery" reportedly leads to a healthy physiological transformation of both the nodal trauma and associated traumas, so that thoughts of the traumas are no longer associated with pain or pathological reactions. Once this desensitization to the traumatic material and the associated "negative cognition" (such as "I am a permanently damaged") is achieved, the next step is the "installation" of an appropriate replacement "positive cognition" (such as "I am healthy") that was previously agreed upon between clinician and patient. This positive cognition allegedly generalizes to the entire associative memory network that had held the incompletely processed traumatic material. Shapiro believes that use of her method can "accelerate" information processing to such a degree that enduring symptomatic relief can often be obtained with just a few treatment sessions and, sometimes, after only a single session. She hypothesizes that the rapid, "time free" nature of EMDR-invoked accelerated information processing might involve neurophysiologic mechanisms similar to those that permit elaborate sequences to be dreamed in a relatively short time during REM sleep.

Although use of directed eye movements is reminiscent of certain mesmerizing techniques, and the reported association of eye movements with cerebral activation is vaguely reminiscent of neurolinguistic processing theory, the technique of EMDR appears novel. However, the EMDR premise that "most psychopathologies are based on early life experiences" should resonate with psychoanalytically oriented therapists, as should Dr. Shapiro's admonition to "stay out of the way of the client during successful processing." Although Shapiro repeatedly prescribes formal training in EMDR prior to attempting its use, study of this book by experienced, well-trained psychotherapists should permit safe experimentation with many of its methods.

The book is not without flaws. It is loosely constructed and long; elimination of frequent repetitions alone could reduce its 400 pages without any loss of information. The focus is clinical, and properly so, but treatment of associative memory, neurocircuitry, and neural network architectures is simplistic. But in the final analysis, if EMDR does pan out to be generally efficacious in the treatment of PTSD, then it constitutes a major contribution to our clinical armamentarium. This book is highly recommended for anyone interested in learning about or practicing the technique of EMDR.

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TheraScribe for Windows
By Arthur E. Jongsma, Jr., L. Mark Peterson, and Kenneth Jongsma
New York, John Wiley and Sons, 1996, $345.00

Reviewed by David Bienefeld, M.D.

TheraScribe will help you “spend time on patients, not paperwork,” boasts the box of this “computerized assistant to psychotherapy treatment planning.” The authors have attempted to create a program that allows clinicians to generate legible, organized treatment plans, saving the clinician’s valuable time. It also serves as a “consultant,” providing suggestions for diagnosis, goals, objectives, and interventions.

The program is organized in a sensible fashion that is applicable to most clinical settings. The “Next” button at the bottom of most screens generally takes the user to where he or she is likely to want to be. A flow chart in the User’s Guide maps the logical terrain. The user first identifies himself or herself by name and password and is then taken to the opening screen. When adding a new patient, one is prompted for demographic and insurance data, as well as assessments completed (e.g., Beck Depression Inventory, Luria-Nebraska Battery).

The next section, the largest, details the presenting problems. These problems must be selected from a generous list, to which the user may add his or her own choices. Nested within the Presenting Problems display are further displays regarding behavioral definitions of the problems, long-term goals, short-term objectives, therapeutic interventions, and progress notes. Like the presenting problems, these must be chosen from a library, which the user may edit. He or she is then returned to the main logical stream to select treatment modalities (such as group therapy) and treatment approaches (such as cognitive restructuring).

Then the clinician completes a mental status screen, using libraries and free text. Next, the program provides a differential of DSM-IV diagnoses matching the primary problem; the user may select or edit. Final screens elicit information about prognosis, discharge criteria, and provider credentials.

The libraries of problem definitions, goals and objectives, and interventions are quite large and generally relevant. The choices that ship with the program seem weighted toward behavioral and popular-psychological philosophies. For example, the objectives for depression include numerous items such as “Identify cognitive self-talk that is engaged to support depression.” Therapeutic interventions include writing letters to lost loved ones and reading Hazelden self-help books. Psychodynamic objectives and interventions seem stuck in notions such as “anger directed inward.” These libraries are, however, easily modified by each user. The printed report, as advertised, is quite attractive; it is sensibly arranged and easily tailored. It is easy to assess one’s status in completing the report with just two clicks of the mouse.

There are some annoying aspects to the strategy of the program: inexplicably, the program automatically loads the record of the (alphabetical) first patient. Thus, the record of Anna Abel is always loaded at boot-up. Two providers may access one patient’s record, but only if one is identified to the program as the “supervising provider.” In a setting where a physician is prescribing medications and a counselor is providing therapy under the supervision of a third person, someone is denied access to the record. Nesting progress notes within the Presenting Problems display is counterintuitive and forces the user to descend through several layers to record a progress note. The Progress screen, too, is less helpfully organized than most of the others.

The program itself requires a healthy amount of hardware. Operating with less than a Pentium processor, 12MB of RAM, and Windows 95 yields unacceptably slow performance in supporting the handsome (but
unnecessary) graphics. Installation is simple, and the User’s Guide is clearly written.

The biggest question left in the mind of this reviewer is, “Why bother?” Managed care organizations will insist that treatment plans be completed on their own proprietary forms. Individual clinicians will derive no benefit from this program. The only setting in which TheraScribe might have use is in a multi-provider group, where standardization of records is desirable for internal purposes. (Here, however, the inability of more than one primary provider to access records requires the generation of hard copy.) Since the progress notes are so clumsy, it seems that the one purpose of the program is to generate a hard-copy treatment plan. After some hours spent becoming familiar with the program, this computer-literate user found that it took considerably longer to complete a treatment plan with TheraScribe than it would have taken to fill in a comparable form by hand. Even identifying only one presenting problem, one must navigate through at least 35 displays to complete the assessment. Like many works of software, TheraScribe seems like a clever idea in search of a purpose.

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