of knowledge and \textit{Ideology and Utopia} so popular. This is a book rich with sociological insights that no scholar interested in Mannheim, the sociology of knowledge or the development of social thought should ignore. Kettler, Meja and Stehr provide an excellent introduction, note on the translation describing the difficulties of translating German into English, and index, which greatly facilitate full comprehension of Mannheim's "notes." This book is worth your time and probably your money.

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John B. Harms

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This collection of eleven essays by anthropologists, psychologists, psychiatrists, sociologists, social workers, and legal practitioners is truly an interdisciplinary effort of ambitious scope. The essays cover most of the topics one would expect from such a volume: the controversies surrounding involuntary treatment, the stigma attached to accepting the role of mental patient, the adjustment problems of former patients, the confidentiality of the client/therapist relationship, and the efficacy of community-based treatments. But the real strength of the volume is not the scope of the topics covered, but the novel and creative ways in which the topics are approached.

In one of the more thought-provoking essays, sociologist Henry Steadman reminds us of the tendency on the part of mental health professionals to greatly overestimate the potential for violence of persons receiving psychiatric care. From this admittedly well-tread ground Steadman emerges with a novel construction of the problem—should there not be, he argues, an affirmative right to "not be a false positive"?1

Richard and Mark Pasewark (clinician and attorney, respectively) deal with the disproportionate amount of societal concern surrounding the insanity defense, a defense rarely invoked and more often than not unsuccessful when invoked. The Pasewarks' unique contribution is in the form of a challenge. After reviewing the various tests that have been used over the years to define legal insanity (e.g., the Durham rule, the American Lawyers Index guidelines, as well as the older NcNaughton test), the authors ask us to ponder why we demand linguistic precision in an area that rarely impinges upon the criminal justice system, yet feel oddly complacent with such vague constructions as "beyond a reasonable doubt" that are of relevance to virtually all criminal actions?

The Barrow and Gutwirth piece on the efficacy of community treatment also poses a question worth pondering. After lamenting the contaminating influence of the "attention placebo effect" upon empirical data in this field, they suggest that perhaps we should see the effect as a blessing and not a curse. If our data indicate that switching from treatment X to treatment Y produces positive results, why waste much time and energy trying to discover whether the true
difference is between the two treatment modes, or merely in the
patients' reactions to the attention afforded them by making any
change? Why not instead seek creative ways to prolong the placebo
effect?

There is a cloud to the silver lining, however. Part of the frustra-
tion readers feel in consuming this kind of collection is that, precisely
because so many areas are touched upon, those that we would like to
see developed more fully are not. In their introductory chapter, the
editors present an elegantly simple taxonomy for discussing the scope
of patients' rights. The four categories are; explicitly granted consti-
tutional rights, rights granted by the courts through common law,
rights granted in specific state and federal statutes, and rights im-
plied in the professional codes of conduct adopted by the various
associations of mental health practitioners. These categories are pre-
sented, but not mentioned again. Yet, volumes could be written about
the historic and doctrinal interrelationships among these different
kinds of rights. Criminal neglect of those involuntarily committed
after having been judged "Not Guilty by Reason of Insanity," for
example, might be deemed unconstitutionally "cruel and unusual
punishment," but courts will invariably look to the standards set by
the various professional associations in making that determination.

Another appealing yet underdeveloped concept is presented by
law professor John Monahan in his concluding chapter—the difference
between "positive" and "negative" rights. Positive rights define the
scope of what the state must do for mental patients, while negative
rights refer to things the state is strictly forbidden from doing to
them. The crucial difference between the two, as Monahan points out,
is money:

It costs virtually nothing to give a patient the right to send uncensored
mail, make phone calls, receive visitors, or refuse treatments. These are
all essentially rights to be let alone, and leaving someone alone is,
among other things, free. . .

Positive rights, on the other hand, are expensive by their very nature.
If one has a right to have an individual treatment plan drawn up, some-
body has to pay a mental health professional to do it. If one has a right
to a high staff-to-patient ratio, the checks of the additional staff have to
be signed (264-265).

Monahan is surely right when he argues that positive rights cost
money while negative rights generally do not. But it does not neces-
sarily follow that negative rights will be respected. Administrators can
and do often fail to respect either set of rights. On May 13, 1983, an
interim consent decree was issued by the United States District Court
in Northern California in Jamison v. Farabee, which grants to involun-
tary patients the negative right to refuse certain antipsychotic drugs.
One of the litigants had this to say about the case: "The underlying
political reality of the treatment of mentally ill patients is that cost
considerations sometimes severely constrict the alternative offered to
patients. Thorazine, Prolixin, and Haldol are quite inexpensive com-
pared with adequate staffing levels." The absence of positive rights,
then, does not imply the presence of negative rights—the latter may
still have to be won through prolonged litigation.

There are other frustrations to be experienced with interdis-
ciplinary volumes covering a broad subject matter. One problem is
the lack of precision involved when contributors write for an audience
of professionals outside of their own milieu. The most frequently
recurring instance of this phenomenon here is the tendency of non-
lawyers to make vague references to "a court" or "the court" having
decided something in a particular case. Attorneys are accustomed to
being told conveniently which court was involved. One of the con-
tributors is further guilty of referring to a decision by "an Alabama
court," which to the legal practitioner suggests a state court. The case
being alluded to was, in fact, a decision made by the United States
District Court in Alabama.

Attorneys will not be the only ones pulling hairs at certain junc-
tures. Social psychologists may be upset with the writer who uses a
quote from Milton Fishbein in support of his use of attitudes to predict
behaviors. That is all fine, as far as it goes. Fishbein argues that certain
kinds of attitude statements can be used to predict actions. But the
general kinds of attitude statements used by this particular contributor
in his own research hardly fit the Fishbein mold. Indeed, Fishbein
would probably dismiss them as being of very low predictive utility.

Perhaps the persons who will be most disturbed by the Bloom and
Asher collection are those most directly involved in the patients'
rights movement. The trigger of their reaction will be the neutral tone
which clinicians and researchers alike use when reporting data that
laypersons would find upsetting. Several of the contributors to this
volume predict in a matter-of-fact tone that even were we to greatly
restrict the State's authority to involuntarily commit citizens, the 
current victims will be the future victims anyway. In other words, 
why bother to make changes?

Patient's rights activists will be most indignant after reading the 
two reports in this volume on attitudes towards mental patients. In 
one of the two essays, Paul Freddolino accurately reports that “a 
majority” of surveyed clinicians replied affirmatively when asked if 
“patients should be made more aware of their rights.” Given that 
the sample revealed a 65 percent acceptance of the statement, per­
haps a more disturbing assessment is that fully one-third of mental 
health professionals admitted openly that they prefer to keep patients 
ignorant of their own legal rights! It is all a matter of perspective.

The Bloom and Asher volume is destined to provoke controversy. 
Patients’ rights activists will be pleased by much of what appears here, 
but will be angered by the highly readable Epilogue from John Mona­
han, in which he argues for the status quo. Those who embrace a tradi­
tional medical model of treatment will be warmed by Monahan and 
and a few others, but will be put off by what they might see as a radical, 
Szasz-ian tone in a number of the essays. If our best work is accom­
plished when our beliefs are under fire, the heuristic value of this volume 
should be enormous.

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FOOTNOTES

1. This of course refers to the erroneous rejection of the null hypothesis.

2. “Landmark Victory—Involuntary Mental Patients can Refuse Drugs,” 48 
ACLU News, No. 4, p. 1. Published by the ACLU of Northern California 
(May, 1983).

3. Fishbein and Ajzen, Belief, Attitude, Intention, and Behavior (Chapter 8). 
Reading, Mass.: Addison-Wesley, 1975.

Joseph H. Fichter, The Rehabilitation of Clergy Alcoholics: Ardent 
$24.95 (cloth).

This book arose from theological reflection on the problem of 
clergy alcoholism. Survey techniques are used, based on the implicit 
AA-inspired division of drinkers in three pure types: “normal” drinkers, 
“wet” alcoholics (alcoholics who still drink), and “dry” alcoholics 
(alcoholics who have stopped drinking).

Such a rigid typology imposes limitations upon the study. By 
drawing the clerical drinking population from among those who have 
“hit bottom” and then stopped drinking, the author perpetuates 
the same classical mistake that E.M. Jellinek made: that of generalizing 
from AA members towards the whole “alcoholic” population. The 
“disease” notion of alcoholism resulting from such sampling proce­
dures certainly has its merit, yet it tends to favor psychologic and 
biologic explanations of alcoholism over sociologic explanations. The 
procedure also results in a failure to appreciate the role of the “Medi­
terranian” type of drinking in the etiology of alcoholism. Finally, it 
fails to appreciate the role of the “contractual” method in alcoholic 
counseling and of other methods whereby controlled drinking is sought 
instead of permanent abstinence and sobriety.

The author distinguishes between spirituality and religiosity. The 
former is attached to AA affiliation, while the latter involves adherence 
to an organized religion. Spiritual awakening, such as is expected from 
an AA member only rarely appears to be anything sudden or spectac­
ular, but it is still experienced by many as “unlike anything they had 
previously experienced.” The study points out that sobriety among 
the alcoholic clergy can best be maintained when spirituality is re­
inforced with religiosity. Most clergy alcoholics are reluctant to par­
ticipate in the AA fellowship to the extent of becoming full-blown 
members. Even though the ministers and priests had no hesitancy in 
admitting that they were spiritually bankrupt when they were in their 
worst stages of alcoholism, the spiritual renewal obtained by partici­
pation in the AA did not seem to suffice for their recovery. Ability 
to stay away from drinking was not found in proportion to the degree 
of spiritually achieved in the process of rehabilitation. On the contrary, 
there were many recovered alcoholics among the clergy who exhibited 
a relatively low level of spirituality achieved in the rehabilitation