Is Piers optimistic or pessimistic in the historical sense about filicide? Children still die or are killed, she says, but in some instances the murder of children has been replaced in part by the use of lesser forms of violence against them. Most important, though, we now do something as a community and a world that we have not done in the past—we directly and openly condemn the killing, abuse, and neglect of our children.

In relation to the question of the value of children in today's society, it would have been interesting to have Piers include comments on both abortion and voluntary nonparenthood. However, social workers will find Piers's sensitivity to the dilemma of the siblings of murdered children most useful.

JANE TOTMAN
Department of Social Services
California State Polytechnic University
Pomona

Suicide: Inside and Out. By David K. Reynolds and Norman L. Farberow. Berkeley: University of California Press, 1978. 237 pp. $10.95 cloth, $3.85 paper.

Suicide rates in mental hospitals have been found to be five times higher than in the general population. To answer the question of why suicide occurs at all in a mental hospital—a place that offers treatment and protection—the authors of this book decided to use the method of "experiential research" (not to be confused with the experimental method as misprinted in the foreword of the clothbound version). Not only is the subject matter of this publication extremely important to mental health service providers, but the methodological approach is worthy of serious consideration by social workers in all fields.

In studying the causes of suicide among psychiatric patients, Reynolds, a cultural anthropologist, adopted the identity of a severely depressed young war veteran on the verge of suicide. From his perspective as a participant-observer, he examined the effects that the environment of the psychiatric ward had on depressed, suicidal patients.

This book provides an excellent example of what the experiential strategy can offer researchers. In his role as David Kent, a depressed patient classified as suicidal, Reynolds was able both to substantiate what he and his coauthor found from earlier interviews with suicidal patients and to offer new insights into the effects of the psychiatric environment on suicidal patients. For example, as Kent, Reynolds found that although he was classified as suicidal and was subject to one-to-one observation by ward staff, he had numerous opportunities to kill himself.

In addition, his strategy allowed Reynolds to examine the effects other patients have on the suicidal patient, a factor previously uninvestigated by researchers. The authors state that "when the staff is hostile or indifferent and mutual support among patients collapses, it may indeed look like the end of the world to a depressed patient." (P. 183)

In many respects, this work provides a useful contribution. The chapter of reflections adds significantly to the conceptualization of factors contributing to suicide in psychiatric settings. However, the major portion of this book is a straight presentation of Reynolds's field notes. The notes are insightful, but the observations and interpretations are sometimes blended, making the distinction between data and analysis somewhat unclear.

The major strength of this work, the personal insights gained by Reynolds, is closely related to its weakness, a frequent characteristic of the participant-observer approach. The insights gained from this methodology were quite apparent in Reynolds's account of the personal growth and increased professional understanding he gained by taking on the identity of a person without the power to control events in his own life—a role that led to a feeling of hopelessness. Perhaps social workers in other fields could similarly benefit from an experience such as Reynolds's by taking the identity of the clients they serve.

RONALD E. PARSONS
School of Social Work
Michigan State University
East Lansing

Alcoholism and Treatment. By David J. Armor, J. Michael Polich, and Harriet B. Stambul. New York: John Wiley & Sons, 1978. 349 pp. $16.95.

This book is a reissue of an evaluation of alcoholism treatment that appeared initially in 1976 as a Rand Corporation report.[1] That report, in suggesting that abstinence was not a necessary corollary of successful treatment for alcoholism, raised a furor among those concerned with the treatment of alcoholism. The only material in this book that was not in the Rand report is Appendix B, which provides 180 pages of the criticism and rejoinders engendered by the original report. The appendix is most useful, providing a rather thorough discussion of the methodological shortcomings of the study. Some of the major problems discussed are: the length of time allotted to follow-up after entry to treatment (one cohort was observed for six months and another for eighteen months); high attrition rates in the follow-up of the two cohorts; lack of control groups; and unsatisfactory operationalization of such major variables as treatment, remission, and "normal" drinking.

Rather than attempt to elaborate on all these issues, this review will be directed to the more general problem that perhaps generated the heated response: that of the legitimacy of the authors' policy suggestions given the operational measures actually used in their research. The most debated and general conclusion of the authors was that clients who drank "normally" had remission rates similar to those of clients who practiced abstinence. The question is whether the research measures provide a valid base for that conclusion.

The essential problem in research is how well the empirical model fits the conceptual model (that is, the generalizations that are drawn). This problem is particularly important when the generalizations have policy implications for human services. The issue is espe-

[1] David J. Armor, J. Michael Polich, and Harriet B. Stambul, *Alcoholism and Treatment* (Santa Monica, Calif.: The Rand Corporation, 1976).

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cially complicated because there is no "test" for judging how well research findings fit policy generalizations, and in the end the quality of the fit is a matter of the extent to which the generalizations makes "good sense" to others.

In this case, the "fit" has come under serious question. The authors defined normal drinking (posttreatment entry, six months and eighteen months) in terms of the following criteria: average daily consumption of less than three ounces of ethanol (one to three ounces could be obtained through the consumption of three to six cans of beer, *or* three to five glasses of wine, *or* four to six shots of liquor); consumption on a typical day of drinking of less than five ounces of ethanol; the absense of tremors; and the presence of no more than three of the following five symptoms—blackouts, missed meals, morning drinking, being drunk, and missing work. (Pp. 98-99)

The authors assumed that this operationalization would be accepted as a reasonable definition of normal drinking for individuals who had sufficient trouble in dealing with alcohol to require treatment. Furthermore, they felt justified in suggesting that, based on this measure of normal drinking, more flexible goals in the use of alcohol during treatment could be entertained as a serious policy.

However, the correspondences between the operational measures and the conceptual policy suggestions failed to meet the criterion of making "good sense." And from the standpoint of research, the design was simply inadequate to support speculation on whether alcoholics in treatment should continue to drink.

If the book is evaluated in terms of its methodological and statistical content, it represents a major contribution in alcoholism treatment evaluations and provides an excellent case for studying basic problems in alcohol research. If it is evaluated as a model for linking research and policy generalization, it fails to set a high standard.

NORMAN R. KURTZ
Brandeis University
Waltham, Massachusetts

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