

SECOND COMMENTARY ON "ARISTOTLE'S FUNCTION ARGUMENT"

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ABSTRACT: Cells, tissues, organs, and human beings *qua* biological organisms have natural functions, but human beings *qua* moral agents do not. Persons-in-society, unlike organs-in-bodies, are the products of culture as well as nature. Bodily diseases, conventionally defined, are undesirable deviations from objectively identifiable *biological norms*. Mental diseases, similarly defined, are undesirable deviations from culturally identifiable *social norms*. AIDS and melanoma are literal diseases; attention deficit disorder and homosexuality are metaphorical diseases. Nevertheless, Megone defends the view that bodily and mental diseases are members of the same logical class. I present a brief exposition of the evidence and reasoning that lead me to the opposite conclusion.

KEYWORDS: action, classification, coercion, disease, excuse, guilt, imprisonment, innocence, insanity defense, involuntary mental hospitalization, justification, lesion, liberty, moral agency, responsibility, values

ARISTOTLE'S FUNCTION ARGUMENT

CHRISTOPHER MEGONE regards his contribution as an explication of the concept of mental illness. I regard it as an evasion of the moral problems and political agendas that the idea of mental illness and its actual uses obscure and negate.

Attributing, as well as refusing to attribute, disease status to *behaviors* has far-reaching implications for medicine, law, politics, and everyday life. Because of the importance of this subject, I am pleased to have this opportunity to try, once again (Szasz 1998a), to clarify what I believe are the crucial issues concerning the controversy about mental illness.

ILLNESS: LITERAL AND METAPHYSICAL

Megone writes, "In 1960 Szasz argued that the concept of mental illness lacked literal meaning," (187). [Szasz] "holds that the concept of physical illness is the paradigm concept of illness" (188). If Megone agrees, he must agree that mental illness is a metaphor. If he disagrees, his thesis is not a refutation of my argument but rather a defense of the view that the class of phenomena we call "disease" ought to be expanded to include both bodily and nonbodily illnesses.¹ Indeed, he asserts that "[i]t remains a possibility therefore that the concept of illness *need not connote any physical disorder*" (189, emphasis added). This claim lies at the heart of Mental Illness as the master metaphor of psychiatry as a religion.

Everyone is free to choose what he regards as the literal meaning of any particular word.² I choose to abide by convention in this matter. For example, under the entry for *honey*, *Webster's International Dictionary* states "(1 A sweet viscid material that is elaborated out of the nectar of flowers in the honey sac of various kinds of bees and stored in the nest for use during the winter as for larvae. (2) Sweetheart, dear—often used as a term of endearment." By common agreement we regard 1 as the literal meaning of honey and (2) as its metaphorical meaning.

The *Oxford English Dictionary* (OED) defines disease as "[a] condition of the body, or of some part or organ of the *body*, in which its functions are disturbed or deranged; a morbid *physical* condition" (emphasis added). It defines diagnosis as "[d]etermination of the nature of a diseased condition also, the *opinion* (formally stated) resulting from such investigation" (emphasis added).

Nosology—the classification of diseases—depends on the identity and interests of the nosologist. Patients, physicians, and third parties (relatives, insurance companies, the state) have different interests in, and agendas about, what *ought to count* as disease-and-treatment. Patients want relief from illness and suffering. Pathologists want to identify the disease responsible for the patient's bodily malfunctioning. Practicing physicians want to treat patients rationally, relieve their complaints, and collect a satisfactory fee for their services. Third parties—relatives, insurance companies, the state—want many different outcomes, such as saving the patient's life, letting him die, providing a maximum of expensive treatment, refusing to reimburse the cost of treatment of non-disease, and so forth. The differences that divide these parties are matters of self-interest, not matters of fact or reasoning; hence, these differences cannot be resolved by evidence or logic. We can acknowledge them as differences and arbitrate the conflicts among the contestants; or we can deny them and pretend that decisions sanctioned by a politically irresistible combination of Medicine and the State are, and ought to be, "valid" for all "rational" participants.

THE CONCEPT OF DISEASE IN MEDICINE: (SOMATIC) PATHOLOGY

The following excerpts illustrate the meaning pathologists assign to the word *disease* and the way the word is customarily used in medicine.

Traditionally, the study of pathology is divided into general pathology and special or systematic pathology. The former is concerned with the basic *reactions of cells and tissues to abnormal stimuli that underlie all diseases*. The latter examines the specific responses of specialized *organs and tissues* to more or less well-defined stimuli (Robbins 1994, 1).

Rudolf Virchow, often referred to as the father of modern pathology propos[ed] that the basis of all disease is injury to the smallest living unit of the body, namely, the cell. More than a century later, both clinical and experimental pathology remain rooted in Virchow's cellular pathology (Rubin and Farber 1994, 2).

In short, the *medical* concept of disease and, by implication, the concept of diagnosis, denotes a *bodily abnormality or somatic pathology*, that is, a physico-chemical—*anatomical or physiological, structural or functional—alteration of the body deemed to be undesirable*. Not a single textbook of pathology available in the well-stocked library of the medical school to which I am attached classifies clinical depression or schizophrenia—the so-called major mental illnesses that psychiatrists now categorize as brain diseases—as diseases.

Literally, the term *disease* denotes a demonstrable *lesion* of cells, tissues, or organs; metaphorically, it may be used to denote any kind of malfunctioning, of individuals, groups, economies, etc. (drug addiction, youth violence, economic depression, etc.). Extending the criterion of disease from malfunctions of the human body to malfunctions of the human mind introduces a fatal infection into the materialist-medical definition of disease. The mind is not a material object; hence, it can be diseased only in a metaphorical sense (Szasz 1974). However, once a person accepts the fiction that mental illness is a "real disease," he will be compelled to accept the diagnoses of mental illnesses as the names of real

diseases, despite the fact that the criterion for what counts as a mental disease has nothing to do with the criterion for what counts as a bodily disease.³

THE CONCEPT OF DISEASE IN PSYCHIATRY: PSYCHOPATHOLOGY

From the beginning of modern psychiatry, psychiatrists have rejected the narrow, Virchowian-pathological definition of disease. In his classic, *Lectures on Clinical Psychiatry*, Emil Kraepelin (1856–1927)—the founder of modern psychiatry and the creator of the first modern psychiatric nosology—wrote: “The subject of the following course of lectures will be the Science of Psychiatry, which, as its name [*Seelenheilkunde*] implies, is that of the treatment of mental disease. It is true that, in the strictest terms, we cannot speak of the mind as becoming diseased [*Allerdings kann man, streng genommen, nicht von Erkrankungen der Seele sprechen*]” (1).

More than fifty years earlier, the Viennese psychiatrist Ernst von Feuchtersleben (1806–1848) expressed the same view. In his book, *Lehrbuch der ärztlichen Seelenkunde*, published in 1845, he wrote:

The maladies of the spirit (*die Leiden des Geistes*) alone, *in abstracto*, that is, error and sin, can be called diseases of the mind only *per analogiam*. They come not within the jurisdiction of the physician, but that of the teacher or clergyman, who again are called *physicians of the mind* (*Seelenärzte*) only *per analogiam*. (Qtd. in Macalpine and Hunter 1965, 412).

Seele means soul or spirit. *Geist* means spirit, soul, imagination, and mind. Perhaps because it is obvious that the German words *Seele* and *Geist* have nothing to do with the brain, pioneer German psychiatrists had to acknowledge the ambiguity inherent in the term *Seelenkrankheit* and related terms. It is ironic that Megone and biological psychiatrists eager to “medicalize” psychiatry criticize me for taking seriously the strict, medical-Kraepelinian stricture that the mind cannot, literally, be diseased.

Historians of psychiatry have overlooked that these pioneer psychiatrists acknowledged that

the term *mental disease* is a metaphor and that psychiatry is not literally a medical specialty. To be sure, although they used the term *mental disease* to refer to behavioral abnormalities, they believed that most such deviations—epitomized by dementia praecox / schizophrenia—will prove to be attributable to somatic causes, much as the behavioral abnormalities consequent to syphilis could be attributed to such a cause. It remained for the great nineteenth-century charlatan, Sigmund Freud—who was not a psychiatrist!—to persuade the medical profession and the public that mental illnesses were real diseases (Szasz 1990).

Contemporary psychiatrists do not even attempt to assimilate the idea of mental illness to the idea of bodily illness. In *Psychiatric Diagnosis*, Donald Goodwin and Samuel B. Guze, two of the most respected psychiatrists in the United States, state: “Classification in medicine is called ‘diagnosis’” (xi). This is wrong. The medical classification of diseases is called *nosology*, not *diagnosis*. The authors also misuse the word *disease*. They write, “When the term ‘disease’ is used, this is what is meant: A disease is a cluster of symptoms and/or signs with a more or less predictable course. Symptoms are what patients tell you; signs are what you see. The cluster may be associated with physical abnormality or may not. The essential point is that it results in consultation with a physician” (xi). In other words, *disease*, according to these authorities, is *not an observable phenomenon* but a social relationship. This quaint notion, based on an elementary failure to distinguish between the concept of disease and the concept of patient role—implies that, if there were no doctors, there would be no diseases. What makes Goodwin’s and Guze’s concept of disease—“the essential point [of which] is that it results in consultation with a physician”—especially remarkable is that it is asserted by physicians many of whose “patients” suffer from “diseases” characterized by the patients’ *not* wanting a consultation with a physician.

Goodwin’s and Guze’s assertion that mental illness need not be associated with physical abnormality is contradicted by other psychiatric

experts who claim that *all* psychiatric diagnoses name somato-pathological conditions. For example, Allen Frances (1993), the chief architect of the American Psychiatric Association's internationally influential *Diagnostic and Statistical Manual (DSM-IV)*, states, "The special features of *DSM-IV* are elimination of the term 'organic mental disorder' because it incorrectly implied that other psychiatric disorders did not have a biological contribution" (3). In other words, the scores of mental diseases manufactured by adding the suffixes *phobia* and *philia* to Greek or Latin terms—such as agoraphobia and zoophilia—are all real (bodily) diseases (Szasz 1993).

Donald F. Klein, professor of psychiatry at the Columbia University College of Physicians and Surgeons, and Paul H. Wender, Distinguished Professor of Psychiatry at the University of Utah School of Medicine, write, "Biological depression is common—in fact, depression and manic-depression are among the most common *physical disorders* seen in psychiatry" (4).

The National Alliance for the Mentally Ill (NAMI), the most influential mental health lobby in the nation, proclaims: "Mental diseases are brain disorders" (1997).

Indeed, many psychiatrists now assert that all mental diseases are *brain diseases* and that advances in our understanding of the functioning of the brain will provide irrefutable proof for this assertion. However, if these claims were true, they would establish not that mental diseases exist or are literal disease, but rather that the term *mental disease* is used synonymously with brain diseases. I do not question that brain diseases—such as epilepsy and paresis (neurosyphilis)—are literal diseases. Indeed, they are our models of literal diseases that affect behavior and were, not long ago, confused with so-called mental diseases. My point is that the claim that mental diseases are brain diseases is inconsistent with the legal and social differences that continue to be attached—by psychiatrists, lawyers, journalists, and lay persons alike—to persons with brain diseases and to persons with mental diseases, respectively (Szasz 1998c).

CHRISTOPHER MEGONE'S CONCEPT OF DISEASE

Megone states, " while it is broadly correct to locate mental illness as related to failure in intentional action, such a failure can itself be understood as a failure of function" 188). There are two problems with this statement. First, the term *intentional action* is a misleading pleonasm: it implies that some actions are *unintentional*; *actions are, by definition, intentional*. Unintended "actions" are properly called movements or reflexes. Second, Megone's interpretation of mental illness is tantamount to changing the definition of *disease* from a disorder of cells (that exhibit evidence of injury) to a disorder of moral agents (who exhibit failures of intentional action). Actions are the properties of persons as actors in society. According to Megone, it is irrelevant whether or not the "patient's" body exhibits a demonstrable somatic-pathological alteration. This definition removes the concept of disease from the realm of pathology and places it in the realms of ethics, law, and politics (the realms of *intentional actions*). The "conditions" thus constructed—epitomized by Masturbatory Insanity in the past and Attention Deficit Disorder today—are made to appear as diseases by categorizing them as instances of psychopathology.

Megone's argument supports, and is supported by, the standard psychiatric concept of *mental disease*. For example, M. G. Gelder, professor of psychiatry at Oxford University states, "Psychiatry is a branch of medicine concerned with mental disorders. Mental illnesses are *disturbances of behavior* appearing after a period of normal development" (801, emphasis added). Even more telling is the definition of neurosis offered by Charles Rycroft, a leading British psychiatrist and psychoanalyst:

The neuroses resemble physical illnesses in that they have symptoms of which the patient complains, but they are inexplicable without reference to the patient's personality and motives, i.e., *they are creations of the patient himself* and not simply the effects of causes operating on him. The idea that the neuroses are illnesses is a *useful social fiction* since it enables

neurotic phenomena to be dealt with therapeutically, but it is based on a confusion of thought, viz., the equation of unconscious motives with causes. (102)

Asserting that neuroses, rather than persons, *have* symptoms is not only treating a psychiatric abstraction as if it were a moral agent, it is claiming that a certain kind of behavior is a disease. This claim is inconsistent with Rycroft's recognition that neurotic symptoms are "creations of the patient himself," in which case we ought to view neuroses as *actions* (resembling malingering *qua* fake disease).

Furthermore, Rycroft's assertion that neurotic symptoms are "inexplicable" without reference to the patient's personality and motives is plainly erroneous. Biological psychiatrists have no trouble attributing them to allegedly demonstrable or putative chemical imbalances in the brain or molecular abnormalities in neurons, explanations the media, patients, and the relatives of patients find wonderfully persuasive (see esp. Szasz 1997, 1996). Finally, Rycroft's suggestion that viewing neurosis as illness is a "useful fiction" is tantamount to a declaration of intellectual bankruptcy: Rycroft admits that, in psychiatry, the identification and classification of diseases does not rest on observations, clearly defined conceptual categories, or scientific principles, but serves the causes of professional expediency and psychiatric gnosticism.

ON THE DIFFERENCES BETWEEN SOMATIC PATHOLOGY AND PSYCHOPATHOLOGY

The crucial differences between medical diagnosis and psychiatric diagnosis reflect the crucial differences between the social roles of the regular physician and the psychiatric physician, as well as the crucial differences between the social roles of the voluntary medical patient and the involuntary mental patient. These differences may be schematized as follows:

- The diagnosis of a bodily illness—say, sarcoma—is the operative word that justifies a physician to admit to a hospital a patient who wants to be in a hospital and consents to being admitted to one.

- The diagnosis of a mental illness—say, schizophrenia—is the operative word that justifies a psychiatrist to incarcerate in a mental hospital a person *who does not want to be in a mental hospital and refuses to consent to being admitted to one.*

In 1913, Karl Jaspers (1963)—then a famous psychiatrist, later a famous philosopher—acknowledged the unique importance of the use of force in psychiatric practice and the special social roles of *doctor* and *patient* thus created. He wrote, "Admission to hospital often takes place against the will of the patient and therefore the psychiatrist finds himself in a different relation to his patient than other doctors. He tries to make this difference as negligible as possible by deliberately emphasizing his purely medical approach to the patient, but the latter in many cases is quite convinced that he is well and resists these medical efforts" (839–40). I will return to this point later. Linguistic considerations also help to illuminate the differences between literal-bodily disease and metaphorical-mental disease, as well as between disease and diagnosis. A competent user of English does not attribute motives to (non-psychiatric) diseases and does not call a motivated action a (bodily) *disease*. We do not attribute motives to a person for having leukemia, do not say that a person has reasons for having glaucoma, and would be uttering nonsense if we asserted that diabetes has caused a person to shoot the President. But we can and do say these things about a person with a mental illness. One of the most important philosophical-political features of the concept of mental illness is that, at one fell swoop, it removes motivation from action, adds it to illness, and thus destroys the very possibility of separating disease from non-disease, and hence diagnosis from disease. Medical diseases are *discovered* and then given a name, for example, Acquired Immune Deficiency Syndrome (AIDS). Mental diseases are *invented* and then given a name, for example, Attention Deficit Disorder. The validity of this generalization ought to be obvious to any careful observer of modern medicine.

To repeat: literal (bodily) diseases are physico-chemical phenomena or processes, for example, the abnormal metabolism of glucose. The disease *qua* somatic pathology is the abnormal metabolism; the diagnosis, *diabetes*, is its name. Somatic pathology is diagnosed by finding physical abnormalities (lesions) in bodies, not behavioral abnormalities (misconducts) in persons. Disease *qua* somatic pathology may be asymptomatic (for example, hypertension). Changing the official classification of bodily diseases cannot transform non-disease into somatic pathology, or somatic pathology into a non-disease. Metaphorical (mental) diseases are the names of personal behaviors, unwanted by the self or others. The disease *qua* psychopathology and its diagnosis/name (Panic Reaction) are one and the same thing. Psychopathology is diagnosed by finding behavioral abnormalities (misconducts) in persons, not physical abnormalities (lesions) in bodies. Disease *qua* psychopathology cannot be asymptomatic. Changing the official classification of mental diseases can transform non-disease into psychopathology, and psychopathology into non-disease—for example, smoking from habit (non-disease) into Nicotine Dependence (disease), and Homosexual Perversion (disease) into a constitutionally protected personal preference (non-disease).

Diagnoses are disease-names, much as Christian (first) names are person-names. Nowadays, we routinely give disease-names not only to instances of somatic pathology (bodily diseases) but also to instances of psychopathology (mental diseases). Indeed, *if we want to treat a particular instance of (mis)behavior—as a matter of law or social policy—as if “it” were a disease*, we are *expected* to call it a *disease*, for example, alcoholism. Not surprisingly, we diagnose mental illnesses by finding abnormalities (unwanted behaviors) *in persons*, not abnormalities (lesions) *in bodies*. That is why forensic psychiatrists—whose clients often do not regard themselves as patients—“interview” criminals called “patients,” whereas forensic pathologists—whose “clients” are typically dead—examine body fluids, whose source is often unknown to them. Again, I offer below a schematic generalization to underscore these differences:

- Anthrax is a disease, regardless of whether anyone recognizes or interprets it as such. It is a “biologically constructed” disease. It can, and does, kill its host.
- Attention Deficit Disorder (a diagnosis) is a disease only if it is authoritatively interpreted as such. It is a “socially constructed” disease. “It” cannot kill the patient.

In the case of bodily illness, the clinical diagnosis—that is, the disease-name attached to the patient—is a hypothesis, typically confirmed or disconfirmed at autopsy (by the pathological diagnosis). The pathological diagnosis *is* the disease. In the case of mental illness, the clinical diagnosis—that is, the disease-name attached to the patient—is the only kind of diagnosis there is. In psychiatry, there is no clinical-pathological conference: it is not possible to die of mental illness or find evidence of such an illness in body fluids or tissues. In the absence of a pathological diagnosis, the clinical diagnosis—the so-called psychopathology—validates its own disease status. The term *alcoholism*, for example, functions as both a phenomenon and its name; diagnosis and disease are one and the same thing. I have long maintained that we ought to restrict the definition of literal disease to demonstrable bodily lesion, with the pathologist as the final arbiter of what counts as a disease. This definition may be regarded as the gold standard of illness. The analogy is apt.

- Gold as monetary standard cannot be manipulated by the authorities who have the power to determine what counts as legal tender.
- Somatic lesion as disease standard cannot be manipulated by the authorities who have the power to determine what counts as disease-diagnosis.

A further similarity between these two “fixed” standards is that both are now *anachronisms*: paper currency unbacked by gold has everywhere replaced gold as legal tender; (mis)behavior unrelated to somatic lesion is everywhere routinely diagnosed as disease. Thoughtless use of the terms *disease* and *diagnosis* to refer to both sick bodies and sick persons renders much of the debate about illness-and-treatment—especially the treatment of so-called mental diseases—not merely inconclusive

but incoherent. Why this is so is summarized, once again in schematic form, below.

- If the physician addresses disease as somatic pathology, the direct or primary goal of treatment is ameliorating or curing the disease that causes the patient's symptoms/suffering. The desired (normalizing) response of the body, measured by objective methods, is the sole criterion for the efficacy of the intervention. Subjective improvement in the patient's well-being is the dividend paid by this investment.
- If the physician addresses disease as psychopathology, the goal of treatment and the criterion for its efficacy depend on whether the subject is a voluntary or involuntary patient. If he is a voluntary patient, the direct or primary goal of treatment (psychotherapy) is to make him feel better. The subjective response of the patient is the sole criterion for the efficacy of the intervention. If he is an involuntary patient, the direct or primary goal of treatment (civil commitment and coerced drugging) is to make others feel better (about the patient or about being relieved of him). The subjective response of others (psychiatrists, relatives) is the sole criterion for the efficacy of the intervention.

DISEASE IS A DISVALUE

Megone attributes to me the absurd view that "this meaning [that disease is bodily malfunction] can be given *without incorporating any evaluative terms*" (189, emphasis added). Then he argues that because the concepts of bodily illness and mental illness are both evaluative, both belong in the same class of literal diseases. That the concept of disease contains an evaluative element is self-evident, especially when the disease is caused by a living organism. Thus, while a syphilitic infection is a disease for the human host, it is health for the microbe, *Treponema pallidum*. Conversely, the disease and death of the parasite is the health of the host: giving the patient an antibiotic—making the pathogenic microorganisms sick so that the immune system can kill them—is a treatment. When we want to grow microbes in the laboratory, our interest and tactics are the reverse, the health and growth of the microorganism. The crucial difference between lesion *qua* bodily disease and behavior *qua* mental disease is not that one is a value-free

biological fact and the other a value-laden social construct. Both are value-laden social constructs. Prizing health more highly than illness, however defined, is a value judgment. The crucial difference between bodily disease and mental disease is that what counts as a somatic pathology is based on a judgment of how the *body ought to function*, whereas what counts as psychopathology is based on a judgment of how the *person ought to function*. For example, presbyopia may or may not be classified as a bodily disease, and homosexuality may or may not be classified as a mental disease. If we fail or refuse to make these elementary distinctions between literal and metaphorical diseases, we deceive ourselves and others not only about the differences between literal (somatic) treatments (influencing the body), and metaphorical (mental) treatments (influencing the person), but also about the differences between *medical treatments* (for example, performing an appendectomy for acute appendicitis) and *medical interventions* (for example, performing an abortion terminating a healthy but unwanted pregnancy).

PSYCHIATRY, COERCION, AND LAW⁴

Megone ignores that psychiatry is, in effect, a branch of the law. He writes: "Thus the abuse of psychiatry can now be explained as arising from the abuse of the concept of rationality" (199). The phrase "abuse of psychiatry" is, to say the least, a very poor choice of words: it is not psychiatry that is abused, it is people who are abused by psychiatrists, *qua* psychiatrists. This happens because psychiatrists, as agents of the state, have the legal authority to use force, a fact psychiatrists conceal by justifying interventions imposed on persons against their will as "treatments"; these so-called treatments are called "abuses" by their contemporary critics (or by psychiatrists in retrospect). The concept of rationality has nothing to do with the use/abuse of involuntary psychiatric interventions (except as a rationalization for the exercise of psychiatric power). I maintain—as I have argued elsewhere in works Megone ignores—that the abuse of

psychiatric power is rooted in the legitimacy and use of psychiatric power (Szasz 1974, 1989, 1988, 1997, 1993, 1994, 1998b). Psychiatrists have always maintained that when they deprive a person of liberty by incarcerating him in an insane asylum—euphemistically called a “hospital”—they are protecting his health rather than infringing his freedom. Megone subscribes to this justification of coercive psychiatric paternalism. He states:

In contrast with Szasz, it [Fulford’s views on mental illness, which Megone shares] also shows why such compulsory treatment can be justified at least for some patients. The basic justification (and explanation) is that mental illness, on this account, can incapacitate the agent from rational belief formation or rational choice. [h]ere the patient will lack a basic requirement for the realization of autonomy. This supports the view that compulsory treatment of mental illness, rather than infringing autonomy, may in fact facilitate its recovery. (199)

This argument rests squarely on a misrepresentation of the primary criterion for involuntary mental hospitalization (civil commitment): it is not irrationality, it is not mental illness, and it is not treatment; instead it is *dangerousness, to self and/or others*. Megone’s metaphysical analysis of the idea of mental illness obscures this quintessential element of the concept. The following vignette is illustrative. On April 15, 1998, the Associated Press reported:

John W. Hinckley, Jr., who has been looking for a way out of a mental hospital almost since he was sent there for the attempted assassination of President Reagan [in 1982], has been denied one more bid for monthly visits with his parents. Taking note of the testimony that Hinckley had become infatuated with a pharmacist at St. Elisabeths Hospital in Washington, just as he once had been with actress Jodie Foster, an appeals court on Thursday upheld a lower court’s ruling that Hinckley, after 16 years of treatment, remains “a dangerous individual with a history of deception.” (*Syracuse Herald-Journal* 1998, A3)

To underscore the connections among mental illness, dangerousness, and the use of legitimate coercion—intrinsic to the concept of mental illness but not physical illness—I cite from the “Philosophical Foreword” to K.W.M. Fulford’s *Moral Theory and Medical Practice* (1989), by

Mary Warnock, a distinguished British philosopher. Professor Warnock writes: “Dr. Fulford defends the concept of mental illness; and he argues convincingly that there can be theoretically sound moral justification for committing the mentally ill to hospital against their wishes, in some cases” (vii). The use of force to prevent suicide, Fulford argues, “shows just how compelling is the *moral intuition under which most compulsory treatment is carried out*. This moral intuition, furthermore, is one which is shared worldwide, legislation similar to the United Kingdom’s Mental Health Act 1983 existing in many other countries” 188, emphasis added). Significantly, Fulford continues, “Certainly, there is *something* about mental illness in virtue of which it seems (to many) to fall intuitively within the principle of compulsory treatment. But there is no Physical Health Act corresponding to the Mental Health Act 1983, for there are no physical illnesses, in respect of which the compulsory treatment of a fully conscious adult patient of normal intelligence would be justified in the interests of the patient’s own health and safety” (191). In addition to supporting the use of psychiatric coercion to reduce the “risk of suicide,” Fulford also supports its use to reduce the “risk of homicide.” He writes: “The Othello syndrome is not uncommon clinically. It is also important, with compulsory treatment in mind, because it is one of the few psychiatric conditions known to be definitely associated with an increased risk of homicide” (204). Fulford’s defense of the traditional justifications for the uses of psychiatric coercion and Warnock’s support of his views illustrate—as if such illustration were needed—how thoroughly intertwined are the notions of mental illness, the risks of suicide-homicide, the legal non-accountability of the *mentally ill*, and the *psychiatric obligation* to protect society from the “dangerous mental patient”: each of these elements seems to have a separate existence, yet in fact each is a part of a larger *gestalt*, each entailing, explaining, and justifying the other. A typical report in the *Sunday Times* (London), urging more frequent recourse to psychiatric coercion, informs the reader: “Every two weeks, on average, a murder is committed

by someone who is seriously mentally ill. Each year about 1,000 disturbed people commit suicide" (Driscoll 1998). Nevertheless, Megone essentially ignores the suicide-homicide prevention function of psychiatry and the indispensable role *mental illness* plays in justifying that function.

It is precisely the near-universal belief in *mental illness* as a bona fide disease that "causes" murder and suicide, and in psychiatric coercion as a rational method for preventing such deeds, that have led me to compare the institution of involuntary psychiatry to the institution of involuntary servitude, call it *psychiatric slavery*, and urge its abolition (Szasz 1961, 1998c). Nothing less than this can annul the stigma of mental illness and resolve the dubious status of psychiatry as a medical specialty: *mental illness* means "dangerousness" (mad-ness), and often vice versa. Hence, the person diagnosed as "mentally ill" is burdened with a profoundly discrediting attribute. Unless the consequences of the diagnosis are radically altered, mental illness must remain an intrinsically stigmatizing concept. C. S. Lewis—whose views I consider more relevant to psychiatry than those of Aristotle—rejected psychiatry's self-serving psychiatric rationalizations, which Megone makes his own. Lewis (1970) wrote:

But do not let us be deceived by a name. To be taken without consent from my home and friends; to lose my liberty; to undergo all those assaults on my personality which modern psychotherapy knows how to deliver; to know that this process will never end until either my captors have succeeded or I grown wise enough to cheat them with apparent success—who cares whether this is called Punishment or not? Of all the tyrannies a tyranny sincerely exercised for the good of its victims may be the most oppressive. To be "cured" against one's will and cured of states which we may not regard as disease is to be put on a level with those who have not yet reached the age of reason or those who never will; to be classed with infants, imbeciles, and domestic animals. (290, 292)

THE FUNCTION OF THE MENTAL HOSPITAL: RESTRAINT OR TREATMENT?

Megone does not acknowledge that an intrinsic function—I would say primary function—of the mental hospital has always been, and continues to be, the psychiatric segregation and control

of socially undesirable persons, typically because they are deemed to pose a "danger" to the "health of society." This contention is confirmed by the entire history of psychiatry; by the history of so-called psychiatric abuses in National Socialist Germany and the Soviet Union; and by the continued use, in Western countries, of the use of psychiatric sentences and psychiatric facilities for imprisoning individuals whose detention cannot be justified as punishment for crime. Recent opinions by justices of the Supreme Court amply support this interpretation. In *Foucha v. Louisiana*, Justice Clarence Thomas (1992) asserts that it is constitutional to confine a "sane but dangerous insanity acquittee." Why? Because

unlike civil committees, who have not been found to have harmed society, insanity acquittees have been found in a judicial proceeding to have committed a criminal act. In this very case, the panel that evaluated Foucha in 1988 concluded that there was "never any evidence of mental illness or disease since admission." The trial court, of course, concluded that Foucha was "presently insane," at the time it accepted his plea and sent him to Feliciana [a forensic psychiatric institution in Louisiana].

Thomas concludes that "although his [an insanity acquittee's] mental disease may have greatly improved, he may still be dangerous because of factors in his personality and background other than mental disease. Also, such a standard [permitting involuntary mental hospitalization of a sane person] provides a means for the control of the occasional defendant who may be quite dangerous but who successfully feigned mental disease to gain acquittal." In the more recent case of *Kansas v. Leroy Hendricks* (*New York Times* 1997), which has received much media attention, the Court reaffirmed this opinion, declaring that "[s]tates have a right to use psychiatric hospitals to confine certain sex offenders once they have completed their prison terms, *even if those offenders do not meet mental illness commitment criteria*" Collins 1997, 29, emphasis added). These rulings and the practices they authorize establish, beyond a shadow of a doubt, that while *de jure*, the mental hospital system functions as an arm of the medical profession, *de facto*, it functions as arm of the state's law-

enforcement system. The practices thus authorized do not represent *the abuses of psychiatry*; on the contrary, they represent the *proper uses of psychiatry*, sanctioned by tradition, science, medicine, law, custom, and common sense.

Despite mountainous evidence to the contrary, Megone implies that compulsion is rarely used in psychiatry. He states: "Compulsory treatment can be justified at least for *some patients*" (199, emphasis added). The truth is that, in the United States alone, each year hundreds of thousands of persons are subjected to psychiatric coercions. In addition, many persons submit to psychiatric interventions under the threat of psychiatric compulsion, and their status is then counted as "voluntary." Megone's distortion of the reality of psychiatric practice goes deeper still. To suggest that psychiatric coercion is a rarity is not just untrue, it is an inversion of the actual legal-social context of contemporary psychiatric practice: the psychiatrist who insists on having a consensual relationship with a "mental patient" risks his practice being construed, *ex post facto*, as *professional negligence*: the psychiatrist who fails to coercively hospitalize and drug a patient who proves to be "dangerous to himself" by committing suicide or to report to the authorities a patient who proves to be "dangerous to others" by killing someone risks being the target of malpractice litigation for respecting his *voluntary, competent patient's* autonomy and confidentiality (Bruni 1998, 35 and 40; Szasz 1982). It must be noted that Megone, like most psychiatrists justifying psychiatric coercions, blurs the distinctions between mental illness and legal incompetence. Minors, even if their *de facto* mental competence is uncontested, are considered legally incompetent. In contrast, people said to be suffering from a mental illness are nowadays generally considered mentally competent: they live independently, receive their own disability payments, spend their monies as they see fit, marry and divorce, and so forth. Furthermore, physicians cannot treat competent adults without their consent, (incompetent) minors without the consent of their guardians (typically, the parents), and incompetent adults (disabled by medical illness from making decisions) without the consent of their guardians

(chosen by the patients in advance directives or appointed by courts). The guardians of *medical patients* are *never* the physicians who treat them. The point is that, in medicine, treatment decisions for *incompetent patients* are made by their guardians, not their physicians; whereas in psychiatry, *competent patients* are routinely treated against their will, treatment decisions being routinely made for them by their treating psychiatrists (whose decisions are, if necessary, routinely rubber-stamped by judges).

Sooner or later we must confront the glaring *disparity*, between the legal status of medical and mental *patients* (Szasz 1998c). This disparity is usually justified on the ground that medical diseases, unlike mental diseases, are unlikely to impair the patient's competence to elect or reject treatment (which Megone calls making "irrational choices"). Patients with sarcoma are assumed to remain in possession of their mental faculties, but patients with schizophrenia are not. Medical patients are therefore treated as contracting moral agents, medical hospitals and (non-psychiatric) physicians do not physically prevent patients from leaving medical hospitals,⁵ and hence are never accused of imprisoning them. Mental patients, however, are often treated as if they were minors or unconscious; mental hospitals and psychiatrists regularly prevent mental patients from leaving mental hospitals and hence are often accused of imprisoning them (*Syracuse Herald-Journal*, 1996, A9).

THE RIGHT TO REJECT MEDICAL INTERVENTION

In Western culture, it is a well-established medical, moral, and legal principle that a person's body belongs to him and therefore medical intervention *without the permission of the patient* is tantamount to assault and battery. In 1891, in an often-cited decision, the United States Supreme Court ruled that "[n]o right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to possession and control of his own person, free from all restraint or interference of others. The right to one's person may be said to be a right of complete

immunity: to be let alone" *Union Pacific Railroad* 1891).

In 1928, Justice Louis D. Brandeis repeated that famous phrase. He stated: "The makers of our Constitution sought to protect Americans in their beliefs, their thoughts, their emotions, and their sensations. They conferred, as against the Government, the right to be let alone—the most comprehensive of rights, and the right most valued by civilized men" (Brandeis 1928).

It is difficult to reconcile these opinions with the practices of coercive psychiatry, unless we assume that a diagnosis of mental illness automatically removes the "patient" from the class of human beings called "persons" (Szasz 1998d). Even that interpretation is rendered untenable in the light of an opinion, handed down by Chief Justice (then Circuit Judge) Warren Burger in 1964, declaring that the right to be let alone attaches as well to the "irrational" decisions of "irrational" patients. In a landmark decision concerning the constitutionality of letting Jehovah's Witnesses reject life-saving blood transfusion, Burger cited Brandeis's famous admonition and then added: "Nothing in this utterance suggests that Justice Brandeis thought an individual possessed these rights only as to *sensible* beliefs, *valid* thoughts, *reasonable* emotions, or *well-founded* sensations. I suggest he intended to include a great many foolish, unreasonable, and even absurd ideas which do not conform, such as refusing medical treatment even at great risk" (Burger 1964). Like the Jehovah's Witness who rejects life-saving treatment for reasons right for him but wrong for others, the mental patient rejects coercive psychiatric treatment for reasons right for him but wrong for others. If the former has a constitutional right to do so, why not also the latter?

Ostensibly, mental patients are incarcerated because they are ill and need treatment. Actually, they are incarcerated because they are (considered to be) dangerous. This piece of hypocrisy—that psychiatrists sometimes candidly acknowledge—is crucial to maintaining the legal (constitutional) legitimacy of involuntary mental hospitalization. In a well-researched study on the "Factors associated with the conditional release of persons acquitted by reason of insanity," Lisa A.

Callahan and Eric Silver, state that: "[t]he public concern is clearly about dangerous persons, regardless of mental health status. Few object to releasing individuals who are mentally ill and not dangerous" (149). In other words, mental patients are imprisoned to prevent them from committing "dangerous" acts (murder, suicide); they are not hospitalized to prevent them from spreading dangerous diseases (infections).

This view is consistent with the fact that the disparity between the legal statuses of patients with mental diseases and brain diseases is independent of whether mental diseases are or are not brain diseases. Prior to World War II, neurosyphilis was still a common disease. Most patients with paresis—general paralysis of the insane—were confined in mental hospitals against their will. At the same time, most patients with other neurological ailments—brain tumors, multiple sclerosis, Parkinsonism—were not placed in mental hospitals at all. The reason was that patients with paresis, like other "insane" persons, often exhibited "disordered" thoughts, feelings, and behaviors, but most patients with other brain diseases did not. In other words, mental patients (the "insane") were confined against their will primarily because they *misbehaved*, not because they were sick. This continues to be the case.

The dilemmas that mental patients pose for themselves, their families, and society could easily be resolved by adapting the familiar advance directive to the circumstances of psychiatric patients and their caretakers. I proposed such a "psychiatric will" in 1982, crafting it especially for the needs of mental patients who face the prospect of future involuntary treatment (Szasz 1982). Modeled on the last will and the health proxy (advance directive), this instrument was intended to transcend the problems created by so-called psychiatric crises or emergencies; that is, situations in which the patients' involuntary treatment is justified by their being deemed dangerous to themselves and/or others. Like the last will, the psychiatric will becomes operative only *after* the subjects' *legal status* has undergone the change they anticipate: The final testament becomes effective only after the testator is *officially declared dead*; the psychiatric will would become

effective only after the subject was *officially declared a mental patient (dangerous to himself and/or others)*. Executing such a document would be of special interest to, and help for, individuals who have undergone an episode of involuntary psychiatric hospitalization and treatment; they would have first-hand experience with the interventions they might want to request or reject in the future, should they be deemed to require psychiatric care. Like the last will, the psychiatric will would be valid only if executed by persons considered legally competent at the time of signing it. In the United States, adults are *presumed* to be competent until declared incompetent, just as defendants are *presumed* to be innocent until proven guilty. The psychiatric will, as outlined above, has so far aroused more interest in Europe, especially Germany, than it has in the United States.

Indeed, American writers on advance directives rarely consider the situation of psychiatric patients; when they do consider it, it is to promote the patients' consent to treatment rather, not to protect their right to refuse it. For example, Bruce Winick, an attorney specializing in the mental patient's right to refuse treatment, declares that when the psychiatrist's decision is to treat, the patient's refusal is, *ipso facto*, suspect: "When the objection is to a therapeutic intervention—hospitalization or conventional treatment—recommended by the patient's therapists, there also may be reason to at least question whether the refusal of such treatment might be antitherapeutic and inconsistent with their welfare. [However,] the use of such instruments by mental patients [may be] therapeutically advantageous" (398–99). Such prejudgment destroys the usefulness of the advance directive as a device for protecting the mental patient's right to self-determination. In psychiatry, unlike in other medical specialties, tradition sanctions the use of involuntary treatment. Hence, the principal use of advanced directives in psychiatry must be to help patients avoid unwanted interventions.

RATIONALITY, IRRATIONALITY, AND LIBERTY

"Aristotle's account," Megone concludes, "vindicates the concept of mental illness by developing the view that the distinctively human good life is a life of reason" (196). I share Aristotle's and

Megone's view that a good life is a life of reason. However, millions of people do not share that view, do not live lives of reason, may not even know what that idea means. Surely, it would be absurd to say that, merely on that account they are ill, suffering from a disease that belongs in the same logical class as acute appendicitis. I fail to see how a good life as a life of reason has anything to do with the legitimacy of psychiatric coercion. Is living a bad life—defined as a "life of unreason"—a (bodily) illness? Is it susceptible to medical treatment? Does it justify *psychiatrists* to deprive people of liberty?

Megone does not tell us what the difference is, if any, between a bad choice and an irrational choice. Nor does he acknowledge that his account conceals the fact that in a dialogue between a patient and a psychiatrist, the psychiatrist's judgment of what is rational *a priori* overrides the patient's judgment of it. A psychiatrist could hardly conclude that the choice a patient makes with which he concurs is irrational. However, he could conclude that the patient's mere refusal to talk to him is evidence of irrationality and severe mental illness. Xavier Amador (1997), professor of psychiatry at Columbia University College of Physicians and Surgeons, testified under oath that [then] Unabomber suspect Theodore Kaczynski's "refusal to submit to prosecution testing [by psychiatrists] was proof of his illness [schizophrenia]" (A18). Let us not fool ourselves. Evaluating what counts as "rational choice" is not a medical matter. Physicians receive no training and possess no expertise in separating rational choices from irrational choices (assuming that such skill and expertise exist). There is no self-evident justification for coercively controlling persons whose conduct authorities judge to be unreasonable (but non-criminal). The problem the Unreasonable Man poses to the Reasonable Man is an ancient political-philosophical conundrum that modern man has reframed to make it look as if it were a psychiatric (medical) problem, susceptible to a therapeutic solution. This is a dangerous illusion.

MENTAL ILLNESS IS MODERNITY'S MASTER METAPHOR

In his response to my comments, Megone (1998b) restates the crux of his thesis as follows:

Szasz appears not to appreciate the point of the appeal to this Aristotelian framework. However, the whole point of the appeal to Aristotle's function argument is to show that there is a coherent definition of (human) illness, as fundamentally an incapacitating failure in functionally explicable development of rational capacities, which applies *equally to both physical and mental illness*. Such an account vindicates the concept of mental illness as having *literal application*, rather than being a metaphorical extension of the concept of physical illness. (223, emphasis added)

Megone attempts to analyze the concept of mental illness as if it were a matter of Aristotelian philosophy. I appreciate Megone's effort, but reject his conclusions. *Although it may be tempting to analyze the concept of mental illness as if it were a medical or philosophical matter, I believe it is primarily a legal and social matter.* The Eucharist was the Master Metaphor of the Catholic Theological State. Mental Illness is the Master Metaphor of the modern Therapeutic State. The proper model for understanding the idea of mental illness is the idea of the Eucharist. For centuries, the Roman Catholic Church served as the moral underpinning of the Western social order. Its institutions and interventions legitimized relations between rulers and ruled and regulated the daily lives of men, women, and children. Crucial to the legitimacy of that ideological-political order was the miracle of the Eucharist: the consecrated wafer and wine of the Sacrament are, *literally*, the body and blood of Christ. That "understanding" is still an integral part of Catholic religious belief. The fact that these objects *are not* body and blood—but that Catholics must believe, or pretend to believe, that they are—is the whole point of the matter.⁶ Today, psychiatry serves as the moral underpinning of the Western social order. Its institutions and interventions legitimize relations between rulers and ruled and regulate the daily lives of men, women, and children. Crucial to the legitimacy of this ideological-political order is the fiction of the equivalence of brain and mind: the consensus-constructed Mental Illness of Psychiatry is, *literally*, a brain disease. The fact that it is *not* a brain disease—but that every normal citizen of the Therapeutic State must believe, or pretend to believe, that it is a brain disease—is the whole point of the matter.

NOTES

1. I use the terms *disease* and *illness* interchangeably.
2. I shall show that pathologists and psychopathologists assign different *literal meanings* to the term *disease*.
3. The criterion of what counts as a mental disease also differs from psychiatric authority to psychiatric authority, depending on the practical interest the particular authority seeks to advance.
4. Megone does not consider my objections to psychiatric excuses, which I regard as the mirror images of psychiatric coercions.
5. The temporary restraint of a delirious—for example, post-operative—patient differs so radically from the months- and years-long restraint of the mental patient that I reject the validity of an analogy between the two situations.
6. During his trip to Africa in April 1998, President Clinton received Holy Communion. For this he was criticized by John Cardinal O'Connor, whose criticism, in turn, was rejected by White House spokesman Mike McCurry as due to the Cardinal's lack of familiarity with the Southern African bishops' "doctrinal attitude toward the Holy Eucharist." In response, the editors of *National Review* reasserted the correct Catholic position, as follows: "Not only must the communicant be free from serious sin, but he must also share the Catholic understanding of the Real Presence of Christ in the Eucharist." (10).

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