Involuntary Mental Hospitalization: A Crime against Humanity

Thomas Szasz

Thomas Szasz is the world's foremost critic of the tendency of his own profession, psychiatry, to incarcerate people forcibly in order to improve their mental health. In this selection, he defends a libertarian position, arguing that society commits people to mental institutions not to help them but as an exercise in power. He also makes an analogy between this practice and slavery.

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I

For some time now I have maintained that commitment—that is, the detention of persons in mental institutions against their will—is a form of imprisonment; that such deprivation of liberty is contrary to the moral principles embodied in the Declaration of Independence and the Constitution of the United States; and that it is a crass violation of contemporary concepts of fundamental human rights.[1] The practice of "sane" men incarcerating their "insane" fellow men in "mental hospitals" can be compared to that of white men enslaving black men. In short, I consider commitment a crime against humanity.

Existing social institutions and practices, especially if honored by prolonged usage, are generally experienced and accepted as good and valuable. For thousands of years slavery was considered a "natural" social arrangement

for the securing of human labor; it was sanctioned by public opinion, religious dogma, church, and state; it was abolished a mere one hundred years ago in the United States; and it is still a prevalent social practice in some parts of the world, notably in Africa.[2] Since its origin, approximately three centuries ago, commitment of the insane has enjoyed equally widespread support; physicians, lawyers, and the laity have asserted, as if with a single voice, the therapeutic desirability and social necessity of institutional psychiatry. My claim that commitment is a crime against humanity may thus be countered—as indeed it has been—by maintaining, first, that the practice is beneficial for the mentally ill, and second, that it is necessary for the protection of the mentally healthy members of society. . . .

II

What is the evidence that commitment does not serve the purpose of helping or treating people whose behavior deviates from or threatens prevailing social norms or moral standards; and who, because they inconvenience their families, neighbors, or superiors, may be incriminated as "mentally ill"?

1. The Medical Evidence.

Mental illness is a metaphor. If by "disease" we mean a disorder of the physicochemical machinery of the human body, then we can assert that what we call functional mental diseases are not diseases at all.[3] Persons said to be suffering from such disorders are socially deviant or inept, or in conflict with individuals, groups, or institutions. Since they do not suffer from disease, it is impossible to "treat" them for any sickness.

Although the term "mentally ill" is usually applied to persons who do not suffer from bodily disease, it is sometimes applied also to persons who do (for example, to individuals intoxicated with alcohol or other drugs, or to elderly people suffering from degenerative disease of the brain). However, when patients with demonstrable diseases of the brain are involuntarily hospitalized, the primary purpose is to exercise social control over their behavior;[4] treatment of the disease is, at best, a secondary consideration. Frequently, therapy is nonexistent, and custodial care is dubbed "treatment."

In short, the commitment of persons suffering from "functional psychoses" serves moral and social, rather than medical and therapeutic, purposes. Hence, even if, as a result of future research, certain conditions now believed to be "functional" mental illnesses were to be shown to be "organic," my argument against involuntary mental hospitalization would remain unaffected.

2. The Moral Evidence.

In free societies, the relationship between physician and patient is predicated on the legal presumption that the individual "owns" his body and his personality.[5]

The physician can examine and treat a patient only with his consent; the latter is free to reject treatment (for example, an operation for cancer).[6] After death, "ownership" of the person's body is transferred to his heirs; the physician must obtain permission from the patient's relatives for a post-mortem examination. John Stuart Mill explicitly affirmed that "each person is the proper guardian of his own health, whether bodily, or mental and spiritual."[7] Commitment is incompatible with this moral principle.

3. The Historical Evidence.

Commitment practices flourished long before there were any mental or psychiatric "treatments" of "mental diseases." Indeed, madness or mental illness was not always a necessary condition for commitment. For example, in the seventeenth century, "children of artisans and other poor inhabitants of Paris up to the age of 25 . . . girls who were debauched or in evident danger of being debauched," and other "misérables" of the community, such as epileptics, people with venereal diseases, and poor people with chronic diseases of all sorts, were all considered fit subjects for confinement in the Hôpital Général.[8] And in 1860, when Mrs. Packard was incarcerated for disagreeing with her minister-husband, the commitment laws of the State of Illinois explicitly proclaimed that "married women . . . may be entered or detained in the hospital at the request of the husband of the woman or the guardian . . . without the evidence of insanity required in other cases."[9] It is surely no coincidence that this piece of legislation was enacted and enforced at about the same time that Mill published his essay *The Subjection of Women*.[10]

4. The Literary Evidence.

Involuntary mental hospitalization plays a significant part in numerous short stories and novels from many countries. In none that I have encountered is commitment portrayed as helpful to the hospitalized person; instead, it is always depicted as an arrangement serving interests antagonistic to those of the so-called patient.[11]

III

The claim that commitment of the "mentally ill" is necessary for the protection of the "mentally healthy" is more difficult to refute, not because it is valid, but because the danger that "mental patients" supposedly pose is of such an extremely vague nature.

1. The Medical Evidence.

The same reasoning applies as earlier: If "mental illness" is not a disease, there is no medical justification for protection from disease. Hence, the analogy between mental illness and contagious disease falls to the ground: The justification for

isolating or otherwise constraining patients with tuberculosis or typhoid fever cannot be extended to patients with "mental illness."

Moreover, because the accepted contemporary psychiatric view of mental illness fails to distinguish between illness as a biological condition and as a social role,[12] it is not only false, but also dangerously misleading, especially if used to justify social action. In this view, regardless of its "causes"—anatomical, genetic, chemical, psychological, or social—mental illness has "objective existence." A person either has or has not a mental illness; he is either mentally sick or mentally healthy. Even if a person is cast in the role of mental patient against his will, his "mental illness" exists "objectively"; and even if, as in the case of the Very Important Person, he is never treated as a mental patient, his "mental illness" still exists "objectively"—apart from the activities of the psychiatrist.[13]

The upshot is that the term "mental illness" is perfectly suited for mystification: It disregards the crucial question of whether the individual assumes the role of mental patient voluntarily, and hence wishes to engage in some sort of interaction with a psychiatrist; or whether he is cast in that role against his will, and hence is opposed to such a relationship. This obscurity is then usually employed strategically, either by the subject himself to advance *his* interests, *or* by the subject's adversaries to advance *their* interests.

In contrast to this view, I maintain, first, that the involuntarily hospitalized mental patient is, by definition, the occupant of an ascribed role; and, second, that the "mental disease" of such a person—unless the use of this term is restricted to demonstrable lesions or malfunctions of the brain—is always the product of interaction between psychiatrist and patient.

2. The Moral Evidence.

The crucial ingredient in involuntary mental hospitalization is coercion. Since coercion is the exercise of power, it is always a moral and political act. Accordingly, regardless of its medical justification, commitment is primarily a moral and political phenomenon—just as, regardless of its anthropological and economic justifications, slavery was primarily a moral and political phenomenon.

Although psychiatric methods of coercion are indisputably useful for those who employ them, they are clearly not indispensable for dealing with the problems that so-called mental patients pose for those about them. If an individual threatens others by virtue of his beliefs or actions, he could be dealt with by methods other than "medical": if his conduct is ethically offensive, moral sanctions against him might be appropriate; if forbidden by law, legal sanctions might be appropriate. In my opinion, both informal, moral sanctions, such as social ostracism or divorce, and formal, judicial sanctions, such as fine and imprisonment, are more dignified and less injurious to the human spirit than the quasi-medical psychiatric sanction of involuntary mental hospitalization.[14]

3. The Historical Evidence.

To be sure, confinement of so-called mentally ill persons does protect the community from certain problems. If it didn't, the arrangement would not have

come into being and would not have persisted. However, the question we ought to ask is not *whether* commitment protects the community from "dangerous mental patients," but rather from precisely *what danger* it protects and by *what means?* In what way were prostitutes or vagrants dangerous in seventeenth century Paris? Or married women in nineteenth-century Illinois?

It is significant, moreover, that there is hardly a prominent person who, during the past fifty years or so, has not been diagnosed by a psychiatrist as suffering from some type of "mental illness." Barry Goldwater was called a "paranoid schizophrenic"; Whittaker Chambers, a "psychopathic personality"; Woodrow Wilson, a "neurotic" frequently "very close to psychosis";[15] and Jesus, "a born degenerate" with a "fixed delusional system," and a "paranoid" with a "clinical picture [so typical] that it is hardly conceivable that people can even question the accuracy of the diagnosis."[16] The list is endless.

Sometimes, psychiatrists declare the same person sane *and* insane, depending on the political dictates of their superiors and the social demand of the moment. Before his trial and execution, Adolph Eichmann was examined by several psychiatrists, all of whom declared him to be normal; after he was put to death, "medical evidence" of his insanity was released and widely circulated.

According to Hannah Arendt, "Half a dozen psychiatrists had certified him [Eichmann] as 'normal.' " One psychiatrist asserted: "his whole psychological outlook, his attitude toward his wife and children, mother and father, sisters and friends, was 'not only normal but most desirable'. . . And the minister who regularly visited him in prison declared that Eichmann was 'a man with very positive ideas.' " After Eichmann was executed, Gideon Hausner, the attorney general of Israel, who had prosecuted him, disclosed in an article in *The Saturday Evening Post* that psychiatrists diagnosed Eichmann as " 'a man obsessed with a dangerous and insatiable urge to kill,' 'a perverted, sadistic personality.' "[17]

Whether or not men like those mentioned above are considered "dangerous" depends on the observer's religious beliefs, political convictions, and social situation. Furthermore, the "dangerousness" of such persons—whatever we may think of them—is not analogous to that of a person with tuberculosis or typhoid fever; nor would rendering such a person "non-dangerous" be comparable to rendering a patient with a contagious disease non-infectious.

In short, I hold—and I submit that the historical evidence bears me out—that people are committed to mental hospitals neither because they are "dangerous" nor because they are "mentally ill," but rather because they are society's scapegoats, whose persecution is justified by psychiatric propaganda and rhetoric.[18]

4. The Literary Evidence.

No one contests that involuntary mental hospitalization of the so-called dangerously insane "protects" the community. Disagreement centers on the nature of the threat facing society, and on the methods and legitimacy of the protection it employs. In this connection, we may recall that slavery, too, "protected" the community: it freed the slaveowners from manual labor.

Commitment likewise shields the non-hospitalized members of society: first, from having to accommodate themselves to the annoying or idiosyncratic demands of certain members of the community who have not violated any criminal statutes; and, second, from having to prosecute, try, convict, and punish members of the community who have broken the law but who either might not be convicted in court, or, if they would be, might not be retrained as effectively or as long in prison as in a mental hospital. The literary evidence cited earlier fully supports this interpretation of the function of involuntary mental hospitalization.

IV

I have suggested that commitment constitutes a social arrangement whereby one part of society secures certain advantages for itself at the expense of another part. To do so, the oppressors must possess an ideology to justify their aims and actions; and they must be able to enlist the police power of the state to impose their will on the oppressed members. What makes such an arrangement a "crime against humanity"? It may be argued that the use of state power is legitimate when law-abiding citizens punish lawbreakers. What is the difference between this use of state power and its use in commitment?

In the first place, the difference between committing the "insane" and imprisoning the "criminal" is the same as that between the rule of man and the rule of law:[19] whereas the "insane" are subjected to the coercive controls of the state because persons more powerful than they have labeled them as "psychotic," "criminals" are subjected to such controls because they have violated legal rules applicable equally to all.

The second difference between these two proceedings lies in their professed aims. The principal purpose of imprisoning criminals is to protect the liberties of the law-abiding members of society.[20] Since the individual subject to commitment is not considered a threat to liberty in the same way as the accused criminal is (if he were, he would be prosecuted), his removal from society cannot be justified on the same grounds. Justification for commitment must thus rest on its therapeutic promise and potential: it will help restore the "patient" to "mental health." But if this can be accomplished only at the cost of robbing the individual of liberty, "involuntary mental hospitalization" becomes only a verbal camouflage for what is, in effect, punishment. This "therapeutic" punishment differs, however, from traditional judicial punishment, in that the accused criminal enjoys a rich panoply of constitutional protections against false accusation and oppressive prosecution, whereas the accused mental patient is deprived of these protections.[21]

To support this view of involuntary mental hospitalization, and to cast it into historical perspective, I shall now briefly review the similarities between slavery and institutional psychiatry. (By the use of the term "institutional psychiatry" I refer generally to psychiatric interventions imposed on persons by others. Such interventions are characterized by the complete loss, on the part

of the ostensible client or "patient," of control over his participation in his relationship with the expert. The paradigm "service" of institutional psychiatry is, of course, involuntary mental hospitalization.)[22]

V

Suppose that a person wishes to study slavery. How would he go about doing so? First, he might study slaves. He would then find that such persons are generally brutish, poor, and uneducated, and he might accordingly conclude that slavery is their "natural" or appropriate social state. Such, indeed, have been the methods and conclusions of innumerable men throughout the ages. Even the great Aristotle held that slaves were "naturally" inferior and were hence justly subdued. "From the hour of their birth," he asserted, "some are marked for subjection, others for rule."[23] This view is similar to the modern concept of "psychopathic criminality" and "schizophrenia" as genetically caused diseases.[24]

Another student, "biased" by contempt for the institution of slavery, might proceed differently. He would maintain that there can be no slave without a master holding him in bondage; and he would accordingly consider slavery a type of human *relationship* and, more generally, a *social institution,* supported by custom, law, religion, and force. From this point of view, the study of masters is at least as relevant to the study of slavery as is the study of slaves.

The latter point of view is generally accepted today with regard to slavery, but not with regard to institutional psychiatry. "Mental illness" of the type found in psychiatric hospitals has been investigated for centuries, and continues to be investigated today, in much the same way as slaves had been studied in the ante-bellum South and before. Then, the "existence" of slaves was taken for granted; their biological and social characteristics were accordingly noted and classified. Today, the "existence" of "mental patients" is similarly taken for granted; indeed, it is widely believed that their number is steadily increasing.[25] The psychiatrist's task is therefore to observe and classify the biological, psychological, and social characteristics of such patients.[26] This perspective is a manifestation, in part, of what I have called "the myth of mental illness," that is, of the notion that mental illnesses are similar to diseases of the body;[27] and, in part, of the psychiatrist's intense need to deny the fundamental complementarity of his relationship to the involuntary mental patient. The same sort of complementarity obtains in all situations where one person or party assumes a superior or dominant role and ascribes an inferior or submissive role to another; for example, master and slave, accuser and accused, inquisitor and witch.

The fundamental parallel between master and slave on the one hand, and institutional psychiatrist and involuntarily hospitalized patient on the other, lies in this: in each instance, the former member of the pair *defines* the social role of the latter, and *casts* him in that role by force.

VI

Wherever there is slavery, there must be criteria for who may and who may not be enslaved. In ancient times, any people could be enslaved. Bondage was the usual consequence of military defeat. After the advent of Christianity, although the people of Europe continued to make war upon each other, they ceased enslaving prisoners who were Christians. According to Dwight Dumond, "the theory that a Christian could not be enslaved soon gained such wide endorsement as to be considered a point of international law."[28] By the time of the colonization of America, the peoples of the Western world considered only black men appropriate subjects for slave trade.

The criteria for distinguishing between those who may be incarcerated in mental hospitals and those who may not be are similar: poor and socially unimportant persons may be, and Very Important Persons may not be.[29] This rule is manifested in two ways: first, through our mental-hospital statistics, which show that the majority of institutionalized patients belong in the lowest socioeconomic classes; second, through the rarity with which VIPs are committed.[30] Yet even sophisticated social scientists often misunderstand or misinterpret these correlations by attributing the low incidence of committed upper-class persons to a denial on their part, and on the part of those close to them, of the "medical fact" that "mental illness" can "strike" anyone.[31] To be sure, powerful people may feel anxious or depressed, or behave in an excited or paranoid manner; but that, of course, is not the point at all. This medical perspective, which defines all distressed and distressing behavior as mental illness—and which is now so widely accepted—only succeeds in confusing the observer's judgment of the quality of another person's behavior with the observer's power to cast that person in the role of involuntary patient. My argument here is limited to asserting that prominent and powerful persons are rarely cast into the role of involuntarily confined mental patient—and for obvious reasons: The degraded status of committed patient ill befits a powerful person. In fact, the two statuses are as mutually exclusive as those of master and slave. . .

IX

The change in perspective—from seeing slavery occasioned by the "inferiority" of the Negro and commitment by the "insanity" of the patient, to seeing each occasioned by the interplay of, and especially the power relation between, the participants—has far-reaching practical implications. In the case of slavery, it meant not only that the slaves had an obligation to revolt and emancipate themselves, but also that the masters had an even greater obligation to renounce their roles as slaveholders. Naturally, a slaveholder with such ideas felt compelled to set his slaves free, at whatever cost to himself. This is precisely what some slaveowners did. Their action had profound consequences in a social system based on slavery.

For the individual slaveholder who set his slaves free, the act led invariably to his expulsion from the community—through economic pressure or personal harassment or both. Such persons usually emigrated to the North. For the nation as a whole, these acts and the abolitionist sentiments behind them symbolized a fundamental moral rift between those who regarded Negroes as objects or slaves, and those who regarded them as persons or citizens. The former could persist in regarding the slave as existing in nature; whereas the latter could not deny his own moral responsibility for creating man in the image, not of God, but of the slave-animal.

The implications of this perspective for institutional psychiatry are equally clear. A psychiatrist who accepts as his "patient" a person who does not wish to be his patient, defines him as a "mentally ill" person, then incarcerates him in an institution, bars his escape from the institution and from the role of mental patient, and proceeds to "treat" him against his will—such a psychiatrist, I maintain, creates "mental illness" and "mental patients." He does so in exactly the same way as the white man who sailed for Africa, captured the Negro, brought him to America in shackles, and then sold him as if he were an animal, created slavery and slaves.

The parallel between slavery and institutional psychiatry may be carried one step further: Denunciation of slavery and the renouncing of slaveholding by some slaveowners led to certain social problems, such as Negro unemployment, the importation of cheap European labor, and a gradual splitting of the country into pro- and anti-slavery factions. Similarly, criticisms of involuntary mental hospitalization and the renouncing by some psychiatrists of relationships with involuntary mental patients have led to professional problems in the past, and are likely to do so again in the future. Psychiatrists restricting their work to psychoanalysis and psychotherapy have been accused of not being "real doctors"—as if depriving a person of his liberty required medical skills; of "shirking their responsibilities" to their colleagues and to society by accepting only the "easier cases" and refusing to treat the "seriously mentally ill" patient—as if avoiding treating persons who do not want to be treated were itself a kind of malpractice; and of undermining the profession of psychiatry—as if practicing self-control and eschewing violence were newly discovered forms of immorality.[32]

X

The psychiatric profession has, of course, a huge stake, both existential and economic, in being socially authorized to rule over mental patients, just as the slaveowning classes did in ruling over slaves. In contemporary psychiatry, indeed, the expert gains superiority not only over members of a specific class of victims, but over nearly the whole of the population, whom he may "psychiatrically evaluate."[33]

The economic similarities between chattel slavery and institutional psychiatry are equally evident: The economic strength of the slaveowner lay in the Negro slaves he owned. The economic strength of the institutional psychiatrist

lies, similarly, in his involuntary mental patients, who are not free to move about, marry, divorce, or make contracts, but are, instead, under the control of the hospital director. As the plantation owner's income and power rose with the amount of land and number of slaves he owned, so the income and power of the psychiatric bureaucrat rise with the size of the institutional system he controls and the number of patients he commands. Moreover, just as the slaveholder could use the police power of the state to help him recruit and maintain his slave labor force, so can the institutional psychiatrist rely on the state to help him recruit and maintain a population of hospital inmates.

Finally, since the state and federal governments have a vast economic stake in the operation of psychiatric hospitals and clinics, the interests of the state and of institutional psychiatry tend to be the same. Formerly, the state and federal governments had a vast economic stake in the operation of plantations worked by slaves, and hence the interests of the state and of the slave-owning classes tended to be the same. The wholly predictable consequence of this kind of arrangement is that just as the coalition of chattel slavery and the state created a powerful vested interest, so does the coalition of institutional psychiatry and the state.[34] Moreover, as long as the oppressive institution has the unqualified support of the state, it is invincible. On the other hand, since there can be no oppression without power, once such an institution loses the support of the state, it rapidly disintegrates.

If this argument is valid, pressing the view that psychiatrists now create involuntary mental patients just as slaveholders used to create slaves is likely to lead to a cleavage in the psychiatric profession, and perhaps in society generally, between those who condone and support the relationship between psychiatrist and involuntary mental patient, and those who condemn and oppose it.

It is not clear whether, or on what terms, these two psychiatric factions could coexist. The practices of coercive psychiatry and of paternalistic psychiatrists do not, in themselves, threaten the practices of non-coercive psychiatry and of contracting psychiatrists. Economic relations based on slavery coexisted over long periods with relations based on contract. But the moral conflict poses a more difficult problem. For just as the abolitionists tended to undermine the social justifications of slavery and the psychological bonds of the slave, so the abolitionists of psychiatric slavery tend to undermine the justifications of commitment and the psychological bonds of the committed patient.

Ultimately, the forces of society will probably be enlisted on one side or the other. If so, we may, on the one hand, be ushering in the abolition of involuntary mental hospitalization and treatment; on the other, we may be witnessing the fruitless struggles of an individualism bereft of moral support against a collectivism proffered as medical treatment.[35]

XI

We know that man's domination over his fellow man is as old as history; and we may safely assume that it is traceable to prehistoric times and to prehuman

ancestors. Perennially, men have oppressed women; white men, colored men; Christians, Jews. However, in recent decades, traditional reasons and justifications for discrimination among men—on the grounds of national, racial, or religious criteria—have lost much of their plausibility and appeal. What justification is there now for man's age-old desire to dominate and control his fellow man? Modern liberalism—in reality, a type of statism—allied with scientism, has met the need for a fresh defense of oppression and has supplied a new battle cry: Health!

In this therapeutic-meliorist view of society, the ill form a special class of "victims" who must, both for their own good and for the interests of the community, be "helped"—coercively and against their will, if necessary—by the healthy, and especially by physicians who are "scientifically" qualified to be their masters. This perspective developed first and has advanced farthest in psychiatry, where the oppression of "insane patients" by "sane physicians" is by now a social custom hallowed by medical and legal tradition. At present, the medical profession as a whole seems to be emulating this model. In the Therapeutic State toward which we appear to be moving, the principal requirement for the position of Big Brother may be an M.D. degree.

NOTES

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2. D. B. Davis, *The Problem of Slavery in Western Culture* (Ithaca: Cornell University Press, 1966); see R. Cohen, "Slavery in Africa," *Trans-Action* 4 (January–February 1967), pp. 44–56; R. L. Tobin, "Slavery Still Plagues the Earth," *Saturday Review*, May 6, 1967, pp. 24–25.
3. See T. S. Szasz, *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct* (New York: Hoeber-Harper, 1961); idem, "Mental Illness Is a Myth," *New York Times Magazine*, June 12, 1966, pp. 30 and 90–92.
4. See, for example, A. P. Noyes, *Modern Clinical Psychiatry*, 4th ed. (Philadelphia: W. B. Saunders, 1956), p. 278.
5. T. S. Szasz, "The Ethics of Birth Control; or, Who Owns Your Body?" *The Humanist* 20 (November–December 1960), pp. 332–36.
6. B. D. Hirsch, "Informed Consent to Treatment," in *Tort and Medical Yearbook*, eds. A. Averbach and M. M. Belli (Indianapolis: Bobbs-Merrill, 1961), vol. 1, pp. 631–38.
7. J. S. Mill, *On Liberty* (1859) (Chicago: Regnery, 1955), p. 18.
8. G. Rosen, "Social Attitudes to Irrationality and Madness in 17th- and 18th-Century Europe," *Journal of the History of Medicine and Allied Sciences* 18 (1963), p. 223.

9. *Illinois Statute Book: Sessions Laws,* 15, sec. 10, 1851; quoted in E. W. P. Packard, *The Prisoner's Hidden Life* (Chicago: published by the author, 1868), p. 37.

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12. See T. S. Szasz, "Alcoholism: A Socio-Ethical Perspective," *Western Medicine 7* (December 1966), pp. 15–21.

13. See, for example, A. A. Rogow, *James Forrestal: A Study of Personality, Politics, and Policy* (New York: Macmillan, 1964); for a detailed criticism of this view, see T. S. Szasz, "Psychiatric Classification as a Strategy of Personal Constraint," in *Ideology and Insanity* (Garden City, NY: Doubleday, 1970), pp. 190–217.

14. T. S. Szasz, *Psychiatric Justice* (New York: Macmillan, 1965).

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16. Quoted in A. Schweitzer, *The Psychiatric Study of Jesus* (1913), trans. Charles R. Joy (Boston: Beacon Press, 1956), pp. 37, 40–41.

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18. For a full articulation and documentation of this thesis, see T. S. Szasz, *The Manufacture of Madness: A Comparative Study of the Inquisition and the Mental Health Movement* (New York: Harper & Row, 1970).

19. F. A. Hayek, *The Constitution of Liberty* (Chicago: University of Chicago Press, 1960), especially pp. 162–92.

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21. For documentation, see Szasz, *Law, Liberty, and Psychiatry* and *Psychiatric Justice.*

22. For further discussion, see Szasz, *The Manufacture of Madness,* especially the preface and chaps. 1–9.

23. Davis, *The Problem of Slavery,* p. 70.

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Illness," in *American Handbook of Psychiatry*, ed. S. Arieti (New York: Basic Books, 1959), vol. 1, pp. 175–96.

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28. D. L. Dumond, *Antislavery: The Crusade for Freedom* (Ann Arbor: University of Michigan Press, 1961), p. 4.

29. D. Henderson and R. D. Gillespie, *A Textbook of Psychiatry*, 7th ed. (London: Oxford University Press, 1950), p. 684.

30. A. B. Hollingshead and F. C. Redlich, *Social Class and Mental Illness* (New York: Wiley, 1958).

31. Ibid., pp. xxi, 44, pp. 344–47.

32. See, for example, H. A. Davidson, "The Image of the Psychiatrist," *American Journal of Psychiatry* 121 (October 1964), pp. 329–33; F. G. Glaser, "The Dichotomy Game: A Further Consideration of the Writings of Dr. Thomas Szasz," ibid. (May), pp. 1069–74.

33. See W. Menninger, *A Psychiatrist for a Troubled World* (New York: Viking, 1967).

34. See Davis, *The Problem of Slavery*, p. 193.

35. T. S. Szasz, "Whither Psychiatry?" in *Ideology and Insanity*, pp. 218–45.