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Introduction: The Medical Model as the Ideology of the Therapeutic State

Ronald Leifer

Ithaca, New York

The modern, therapeutic state came into existence as a result of the political transformation from Rule of Man to Rule of Law. This transformation carries with it an internal contradiction: while people value individual freedom under Rule of Law, they wish for a greater degree of social control than is provided by law. Under the ideology of the medical model, psychiatry provides this extra-legal social control. Politically, this model justifies the involuntary incarceration of those people not found guilty of crimes but regarded as strange, threatening or dangerous. This justification rests on switching from the moral model of behavior, which implies choice and responsibility, to a causal-determinist model which implies no choice and non-responsibility. This socially useful deception blinds us to ourselves and to the nature of our personal and public problems, while rendering us less capable of intelligently discussing and dealing with these problems.

Modern psychiatry can be adequately understood only from the broad perspective of history, political sociology, and the dynamics of the human mind. Indeed, there is an intrinsic connection between modern psychiatry and the democratic revolutions now erupting in the communist societies of eastern Europe and elsewhere. These contemporary revolutions have their roots in the French Revolution and in the rise of the modern state, and before that in the relative pluralism of the Athenian aristocracy, and prior to both in the profound and ambivalent wish for freedom of every human heart.

The growing protests of survivors of involuntary psychiatric confinement and treatment are also a contemporary expression of the spirit of freedom and the desire for democratic change. These survivors are rising against their opressors with no less vigor of spirit and no less moral and political justifica-

Requests for reprints should be sent to Ronald Leifer, M.D., 115 DeWitt Park Apartments, Ithaca, New York 14850.

tion than the oppressed citizens of modern totalitarian states. There are strong similarities in the political context of the inmates of Pinel's lunatic asylum, the Russian dissidents who are diagnosed as "sluggish schizophrenic" and incarcerated in a Gulag, and the involuntary patient in the modern American psychiatric hospital.

These three seemingly disparate historical situations are all manifestations of the Therapeutic State. The term "therapeutic state" may be misleading if we infer that anything called "therapeutic" must be beneficial. On the contrary, the term is a political euphemism used to frame certain motives and actions of the state as benevolent, in the image of the medical model. The medical model is the official ideology of the therapeutic state. To understand the therapeutic state and the political function of the medical model, it is helpful to sketch a broad outline of political history.

Psychiatry and the Rise of the Therapeutic State

Two general forms of human government existed prior to the birth of the modern state. Original, primitive human "communities" consisted mainly of coalitions of families and clans into small groups in which every member had a face to face interaction with every other member. At the head of each clan stood a respected elder or cluster of elders whose knowledge, wisdom and status were perceived as essential for the survival of the group. Authority was hierarchical, as in the family. The elders and the priests guided the group, with the cooperation and participation of more ordinary members. All social functions – birth, child-rearing, social control, food-gathering and distribution, marriages, funerals, justice, etc. – were performed by the community under the aegis of the community's religion.

Over time, as the human population grew and communities came into contact and commerce with one another, large settlements developed along the banks of fertile rivers and the crossroads of trade routes. These settlements amalgamated into cities and civilizations. Early societies governed themselves by means of competing clans ceding authority to a superordinate king in whose persona was vested the power to rule the merged populations. Although pockets of democracy have existed throughout history, in most regions of the world a sovereign king ruled with supreme authority or by Divine Right. Laws were issued by royal decree, and enforced by armed militia. For obvious reasons, this form of government is known as Rule of Man.

The eighteenth century democratic revolutions in Europe and America replaced Rule of Man by Rule of Law. (Today, the democratic revolutions in Communist countries, as the earlier democratic revolutions against absolute monarchy, also involve a political transformation to Rule of Law.) This transformation carries with it social and political contradictions which are

projections of a profound ambivalence inherent in the ordinary human mind, an ambivalence whose understanding is essential to appreciate the major social function of modern psychiatry.

The fundamental ambivalence is that people love and desire both freedom and social order. These are mutually limiting, however. When freedom increases in society, so does turbulence. On the other hand, a stable, tranquil, virtuous social order requires the restriction of civil liberties and rights. Rule of Man provides a greater degree of (overt) social control than Rule of Law. Indeed, the function and justification for tyranny has always been the call for social order. The absolute monarch could enforce public order and obedience through arbitrary arrest and detention of any citizens and seizure of their property. The democratic revolutions of the past two centuries, which instituted Rule of Law, ended this totalitarian system of social and political control by limiting the power of the state. Rule of Law provides that an individual cannot be deprived of life, liberty or property unless convicted of violating the law by a jury of peers on the basis of evidence presented according to strict rules of procedure. These rules severely limit the state's power to control and regulate its citizens.

The transformation to Rule of Law created the problem that while people value freedom under Law, they also demand a greater degree of social control and order than is provided by Rule of Law. Therein lies the historical mission of public psychiatry. *The main social function of public psychiatry is to provide a mechanism for covert, extra-legal social control without violating the principle of Rule of Law.* This is accomplished by redefining deviant and undesirable conduct as mental illness.

This semantic and ideological revision occurred during what official psychiatric history calls The First Psychiatric Revolution. According to this version of history, Philippe Pinel introduced democracy and science – the twin hallmarks of the French Revolution – into the asylums of Paris. He introduced democracy by liberating *some* of the inmates of the Salpêtrière and Bicêtre. He allegedly introduced science by classifying the inmates according to the prevailing psychiatric diagnoses of the times.

This version of history is an ideological apology for the political function of psychiatry as an instrument of covert social control. By focusing on the few – celebrated inmates liberated by Pinel rather than the many detained by him on the grounds that they were suffering from mental diseases – psychiatry is depicted as liberal and humane rather than as an institution of covert social control. Although official psychiatry describes Pinel's psychiatric classification as a scientific advance, Pinel did nothing scientific. He merely imitated the emerging scientific medicine by redefining the inmates of the asylum as ill, *by fiat* (Szasz, 1961, 1963).

The First Psychiatric Revolution marks the inauguration of the medical

model of psychiatry, the chief ideological justification for psychiatry's political function of social control. The arbitrary authority to classify and control people, taken away from the absolute monarch by the democratic revolution, had now been granted to the alienist.

The Medical Model as Ideology

Redefining deviance as mental illness requires a covering ideology to justify what otherwise would be seen as the unconstitutional confinement of innocent persons. The medical model of psychiatry serves as such an ideology. The term "ideology" is used here in the classical sense as defined by Karl Mannheim (1929) to refer to a set of ideas which justifies and promotes certain prevailing interests – in this case, the public interest in an extra-legal form of social control. The medical model is well suited as ideology because it *appears* to represent the most authoritative and reliable source of knowledge, namely, science, as well as the most benevolent and compassionate branch of science, namely, medicine.

The medical model can function as an ideology because using it switches explanations of human action from the commonly used moral model to a causal-determinist (medical) model. This switch in semantics promotes a transformation of perceptions which converts the person labelled as mentally ill into the kind of object upon which psychiatrists represent themselves as qualified to act (Goffman, 1961).

There are basically two models for explaining human action (Louch, 1966). We explain "normal" behavior – our own and that of others – in moral terms, that is, in terms of the conventional purposes and meanings attached to people's actions. For example, if we were to meet a friend crossing the street and we wished to understand his actions, we might ask him where he was going and what he intended to do. If he told us he was going to the grocery to buy some milk we would be satisfied with his explanation and feel that we understand his actions. Psychologically normal behavior is behavior we can explain in terms of conventional goals and conventional means for achieving those goals.

We think of people as bad or deviant, but not necessarily abnormal, when their behavior violates social conventions. For example, if a man marries a woman for her money we might think that person is greedy and exploitative and we would judge him to be an immoral, or bad, person. If our friend whom we met crossing the street tells us he is being chased by the police, we would wonder what law (or convention) he had broken. In both cases, however, whether the actions are conventional or unconventional, they are intelligible with reference to conventional goals and means of pursuing them.

The moral model of human action (in contrast to the medical model) implies

and recognizes two vital attributes of human character: freedom and responsibility. To say that behavior is purposive and conventional is to imply that it is freely chosen, that one conventional goal is valued and chosen over others. It implies also that the means of achieving those goals are valued and freely chosen. This model of human action has been compared to a game (Szasz, 1961) because human actions have goals which are achieved by following (or violating) established rules. In the game of life, if one chooses to pursue prohibited goals (such as a man having sex with his daughter) or to pursue conventional goals by prohibited means (such as stealing money instead of earning it), one is held responsible for one's actions and required to submit to the judgment of law or social convention. When the moral model is used to explain human behavior, it is assumed that the person has the capacity for free choice and is responsible and is accountable for his or her actions.

The medical model, on the other hand, is deterministic and explains human actions in terms of antecedent causes. These causes may be biochemical, social, psychological or historical. We might explain the behavior of a man getting married as the result of a hypomanic episode, social pressure, or a fixation on his mother. The desire to binge-eat can be viewed deterministically, as a consequence of depression, rather than morally, as an attempt to evade the pain of life. Similarly, a flight into religious fantasy can be interpreted as the result of dopamine deficiency instead of as a search for meaning in a world of diluted meanings. From the perspective of the medical model, the "cause" of disturbing behavior is mental illness rather than the failure or the refusal of the individual to conform to conventional goals and means for achieving them.

The medical model is used to describe people whose behavior is disturbing to the conventional social order and fits neither acceptable explanations of behavior or acceptable explanations of social conventions. The notorious case of John Hinckley is a good example. It is psychologically "normal" to attempt to assassinate a president for political reasons, but not in order to be noticed and admired by a woman. Defining a political assassination as a symptom of mental illness would invalidate the political dissent that motivated the act by defining the action as irrational, involuntary and caused rather than as rational and freely chosen. Democratic societies value dissent and, recognizing the occasional justification for political assassination, define it as crime rather than as a socially invalid act. To regard Hinckley's motivation as valid would, in effect, declare "open hunting" on all public figures whose heads might serve as personal trophies. In primitive hunting societies, displaying the head of an enemy or a totem animal would signify the power of the hunter. In modern societies, however, which are plagued by ethnic and class conflict, to sanction assassination as legitimate trophy hunting would initiate political chaos. These examples illustrate how the designations "psychological normality and

abnormality" specify the acceptable and conventional boundaries within which the game of life is played. The conventional violation of conventional rules is regarded as sane and draws penalties. The unconventional violation of conventional rules is labelled insane and results in being thrown out of the game.

Another example can be drawn from the religious sphere. It is well known that "schizophrenic" symptomatology often takes religious form. But what is sane religion and what is insane? It is considered sane to pray to an invisible God whose existence cannot be objectively demonstrated. If that God answers back, however, it is a symptom of mental illness. Praying is socially safe. The claim to have heard God's voice is a threat to society, however, because it might be used to authorize socially controversial or destructive actions. Society cannot tolerate such usurpation of its authority and, thus, designates hearing God's voice as a symptom of mental illness rather than an authentic event.

Therein lies the distinction between sanity and madness. Sane behavior is socially meaningful and is described with the moral model. Insane behavior is drained of its social meaning by describing it in the causal-deterministic language of the medical model. In sum, people whose behavior places them outside the boundaries of conventional good and evil are diagnosed as mentally ill. Their behavior is explained in terms of causes which shape it rather than in terms of their extraordinary purposes and their strange manners of pursuing them.

The use of the causal-deterministic model to explain human action is a political decision because any human behavior can be viewed and explained either as caused or as freely chosen. Most modern psychology explains normal *and* abnormal human behavior with some version of the causal-deterministic model, while classical social science used primarily the moral-purposive model. From the perspective of the moral model, so-called mentally ill people are likely to pursue unconventional goals through conventional means, to pursue conventional goals through unconventional means, or both.

The medical model of human behavior blurs the distinction between body and mind, and between happenings and doings. Happenings occur independently of human will, as physical illness does. Doings are motivated actions. The medical model views the mind as a part of the body, as a happening, and views moral actions invested with moral meanings by the subject or others as morally neutral events. This characteristic of the medical model makes it particularly useful as an ideology for covert social control, for the model makes it appear not only that the individual is not acting freely and intelligibly by holding certain values and pursuing certain goals, but that the individual may be actually *incapable* of free and responsible action. This belief is then used to justify depriving people of their rights and confining them against their will. Thus, the medical model serves as an ideology for

the historic psychiatric function of providing a covert, extra-legal form of social control in societies governed by Rule of Law.

The Medical Model and Psychiatric Identity

Sigmund Freud changed the history of psychiatry in many ways, among others by inventing psychotherapy and instituting the private practice of psychiatry between consenting adults. Psychotherapy serves a different social function than the control of deviance. Psychotherapy evolved from the religious function of spiritual guidance, or "the cure of souls" (Nelson, 1965; Rank, 1941). With the decline of religion, the cure of souls evolved into ethical and moral guidance and, with the rise of modern psychology in the late nineteenth century, into psychological guidance.

In its ideal form, psychotherapy does not serve the function of social control and so has no need for the medical model. Nevertheless, Freud wanted to be viewed as a scientist and he often adopted the frameworks of the physical and biological sciences to understand the "symptoms" of his private patients. As a result, he struggled with the medical model, complaining that his case histories – which he wished would appear as scientific as medical case histories – often sounded like novels. Freud remained ambivalent about the proper classification of psychotherapy as medicine or secular pastoral work (Freud, 1927).

Eventually, the introduction of psychoanalysis, depth psychology, and humanistic psychology led to a profound split between those who served the function of social control and those who served the function of spiritual guidance. This split became most profound in the early 1960s. On one hand, psychiatrists working in the state mental hospitals began to use recently discovered drugs to control and manage psychiatric inmates. These chemical tools for controlling behavior spurred hopes that scientific research in brain physiology would result in new insights into the biological causes and the medical cures of mental illness. On the other hand, psychoanalytically oriented psychotherapists were turning to the humanities and social sciences for new understandings of mental and emotional problems. Increasing numbers of non-medical psychotherapists, particularly social workers and psychologists, were entering private practice and transforming psychotherapy into a non-medical enterprise that more closely resembled education and the New Age religion than classical medical treatment.

This split in the social practices and theoretical orientations of psychiatry generated a crisis in psychiatric identity. Psychiatrists – long sensitive to being regarded as second class citizens by their medical colleagues – began to resent and resist the increasing tide of non-medical competitors and their non-medical ideas. Heated arguments ensued in professional psychiatric circles about the

contradiction in psychiatric identity. Is psychiatry a medical science which uses the medical model to understand the causes and treatments of mental disease? Or is it a social art which employs the insights of sociology, anthropology, psychology, political science, etc., to understand and help clients deal with problems in living? This question had urgent practical consequences. Aside from competition between medical and non-medical practitioners, academic psychiatrists in medical schools feared that if their programs slanted too strongly toward the humanities and social sciences, they would lose credibility as well as funding from government agencies for psychiatric research and training.

At the department of psychiatry of the State University of New York, Syracuse, this crisis of psychiatric identity reached explosive proportions. In 1961, Thomas Szasz had just published his now classic book, *The Myth of Mental Illness*. Szasz also openly criticized coercive psychiatric practices, particularly involuntary psychiatric confinement. Ernest Becker, an anthropologist hired by this psychoanalytically oriented department to teach social science to psychiatric residents, was working on new, non-medical understandings of depression and schizophrenia (Becker, 1962, 1963, 1964, 1969, 1973). I was a junior, non-tenured member of that department at the time, working on my own contribution to the "new psychiatry" (Liefer, 1969).

To fight the threat to the medical model posed by this group of critics and innovators, Paul Hoch, Director of the New York State Department of Mental Hygiene and representing the state psychiatrists, ordered Marc Hollander, who was both Director of the Syracuse State Psychiatric Hospital *and* Chairman of the Department of Psychiatry at Upstate Medical Center, to forbid Szasz to teach or lecture at the State hospital (which was the seat of the academic department of psychiatry). Becker and I and a few others protested. Hollander fired Becker for criticizing him. Because of his association with Szasz and his own assault on the medical model, Becker was blackballed from academic psychiatry and, after a long, peripatetic career, found an appointment at the University of Vancouver; he died prematurely in 1974, two months before receiving the Pulitzer Prize for *The Denial of Death* (see Leifer, 1986). Szasz, who was tenured, successfully fought Hollander's attempts to suppress him. As a result, Hollander resigned. His successor, David Robinson, refused to renew my appointment on the grounds that my forthcoming book, *In the Name of Mental Health*, would give the impression that Syracuse was an "anti-psychiatry" center and that the National Institute of Mental Health would refuse to grant funds for research and training. These acts of repression and punishment for those who deviated from the official line and criticized coercive psychiatry, represent only some of psychiatry's continual efforts to reassert its medical identity and reaffirm the medical model as an ideology for the extra-legal control of behavior.

The direction psychiatry has taken from this conflict is clear. Psychiatry has made every effort to affirm its medical identity. In all the public media and in professional writings and talks, psychiatrists assert repeatedly, as if it were a scientific fact, that "mental illness is like any other illness." Organized psychiatry has engaged in a massive campaign to convince the public that advances in medical science have discovered the physiological causes of such "real" diseases as mania, depression, schizophrenia, panic, and even obsessive compulsive disorders. This campaign has been so successful that most people do indeed believe that mental illnesses are biological entities which exist independently of human perceptions and labelling strategies.

We must, however, continue to insist on pressing a number of difficult questions to the intellectual community about the scientific validity of the medical model and the legitimacy of the political functions of psychiatry. Regarding the mind as a part of the body and explaining human behavior in terms of genetics and brain physiology raises serious logical, ethical and political problems (Leifer, 1989; Ryle, 1949). Law, the dramatic arts and our ordinary understanding of human situations depend on the use of the moral model of human behavior. If behavior were always described with the causal-determinist model, choice and responsibility would become meaningless terms. No one could be held accountable for his or her actions, and the drama of our lives would lose significance. This problem is not sufficiently discussed, in my opinion, because open dialogue on this issue would undermine the medical identity of psychiatrists and would call into question the morality of using the medical model as an ideology to justify social control.

Moreover, how can we respect an allegedly scientific medical model when it is used to justify extra-legal confinement and involuntary pharmacological assault? How can we respect the objectivity of psychiatry when the primary conceptual model of psychiatrists serves their interests to be viewed as physicians (who have a monopoly, or at least a substantial advantage, in the billion dollar mental health field)? There are conflicts of interest here, as surely as if a racist were asserting as scientific fact the superiority of his or her race. Psychiatrists have a prejudicial interest in the medical model. Their very identity as medical doctors depends upon it. Society, as I have argued, also has a vested interest in the medical model.

The pharmaceutical industry also benefits enormously from the claim that mental illnesses have biological causes and can be treated with drugs. The medical model converts "drugs" into "medicines." Psychiatrists and drug companies both benefit from their intercourse – the first because the image of doctors prescribing medicines to treat mental illnesses bolsters the medical model, the second because their "medicines" sell. Is it proper for pharmaceutical companies to finance academic research, to advertise in psychiatric journals, to sponsor allegedly scientific conferences, and to advertise the medical model

along with their products? Is it proper for psychiatrists to promote the use of drugs made by companies which, in turn, reinforce the medical model of psychiatry? Undoubtedly, drugs may positively or negatively influence mental states and behavior. This, however, does not imply that "abnormal" mental states are caused by physiological factors. I question the propriety of the relationship between academic, allegedly scientific, psychiatry and the pharmaceutical companies which profit from the medical model which they subsidize.

The Costs of the Medical Model of Psychiatry

We pay a high price for the social and political advantages of the medical model. We deceive ourselves about the social, political, moral and psychological nature of the problems we define as medical-psychiatric. This self-deception cripples our intelligence and renders us less capable of understanding and implementing effective measures to deal with these problems.

Psychotherapy is a good example of how the medical model may handicap. If the psychotherapy patient is viewed as medically sick, his or her symptoms or problems are seen as caused by some agency external to his or her will – unfortunate genes, errant biochemistry, a malfunctioning family, a malevolent mother, and so on. How can these factors then be changed by the patient's own efforts? If psychotherapy is to be effective, individuals must take their lives into their own hands, take responsibility for becoming aware and changing themselves – for accepting reality, for exercising self-discipline and restraint, for choosing constructive rather than destructive attitudes and actions. The medical model interferes with this task, and hence interferes with psychotherapy. It blinds us to ourselves and the nature of our suffering, and promotes a distorted, irresponsible attitude toward life.

The problem of drug addiction also highlights the confusion surrounding the medical model. Viewed through this model, addiction is a disease, the cause of which is variously attributed to the drug-pusher, the drug itself, genetic predisposition, psychological stress, social conditions, and so on. When the addict undergoes treatment, however, the model reverts to a strong version of the moral model: the addict is held strictly responsible for his or her habits, attitudes, actions and life-style. Arguably, the function of the medical model is to excuse the addict from responsibility and provide a social alternative to the harsh and futile criminalization of the addict. If drugs were decriminalized, the medical model of addiction would be not only unnecessary but also counterproductive.

Another situation in which the medical model solves certain social problems at the price of blinding and crippling us lies in the control of unruly children. If a child falls outside of the conventions established by the school

as normal, the child is likely to be diagnosed as mentally ill. Hyperactivity, now called ADD or Attention Deficit Disorder, is a good illustration. A "normal" child is expected to sit in the classroom quietly and attentively for eight hours a day without creating a disturbance. Some children are not interested in what or how the schools teach, or they are bored with their teachers, or preoccupied by erotic or aggressive feelings, or by problems at home. If a child is distracted, or temperamentally active and inclined to engage in physical activity, he or she is vulnerable to being diagnosed as "having ADD" and assigned to a "special" class with other "special" children, and to receive medication. In other historical societies, a hyperactive child could be a champion hunter and hero to the people. In the modern school, such a child is an anachronism. Rather than view the situation as one in which the school is too rigid to adapt itself to the needs of the child, the medical model sees the child as unable to adapt to the needs of the school. This facilitates the management of students while leaving the school immune to criticism.

The medical model also serves as an ideology for the control and management of the elderly. When old people are confined to nursing homes which do not provide adequate care, companionship or activities, they usually become depressed and disoriented. They are then seen as suffering from mental illnesses and subsequently medicated. Rather than viewing the problem in terms of the economics and other inadequacies of nursing care for the elderly, the problem is defined in terms of psychiatric problems of the institutionalized aged.

Another example of the use of the medical model to solve a social problem concerns the control of inmates in overcrowded prisons using psychiatric drugs. The director of the New York State prison system recently announced that, due to overcrowding, prison inmates will be double bunked ("New York," 1990). At the same time, the Supreme Court ruled that prison inmates may be given psychiatric drugs without their consent ("Court Upholds," 1990). Ironically, people convicted and imprisoned for selling illegal drugs in an essentially voluntary transaction may now have psychiatric drugs forced on them by the state.

In sum, while the medical model is politically useful as an ideology to disguise social control as benevolent caring, we pay the price of blinding ourselves to ourselves. To the extent that we view humanity through the lenses of "scientific" psychiatry, we shall see ourselves as objects whose structure, character and functions are slavishly determined by laws of cause and effect. It follows then, that our fate is in the hands of experts who justify their power as both scientific and benevolent. This point of view, working hand in hand with the powerful, bureaucratic "therapeutic" state, can lead us down the dangerous path.

Far from representing the finest human thinking, the medical model ac-

tually represses creative ways of understanding and taking responsibility for ourselves and our lives. The medical model stands for constricted consciousness and the standardization of behavior. Here is the question I would like to see addressed in public debates: Is an extra degree of social control, one that often hurts and humiliates people, worth the price of endarkenment and enfeeblement? At a time when the human species is threatened with self-extinction, can we afford to blind and cripple ourselves with a politically convenient deception?

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