

**Creative Works**  
**The Dream:**  
**Freud & Szasz In Conversation**

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**Abstract**

A humorous, fictional but academic conversation between two of psychiatry's giants Sigmund Freud and Thomas Szasz. Or is it a dream? Through their animated dialogue and critique of each other's theories is elicited a contrasting exploration of their conceptual differences. The dialogue canvases: the origins of psychiatry; the medical-scientific approach to mental illness and the medicalization of the language of psychiatry; psychiatry as science vs. the social construction of mental illness; hysteria; the causes of mental illness; patients' social responsibility vs. illness; the unconscious mind; sublimation of individual freedom vs. metarules of society and coercion vs. treatment. The conversation demonstrates the sharp contrasts between the seminal works of both theorists; on the one hand Szasz's *The myth of mental illness: Foundations of a Theory of Personal Conduct* and Freud's *Studies in hysteria* (with Breuer) and *Civilization and its discontents*.

**Keywords:** Freud, Szasz, psychiatry, mental illness

Sigmund Freud's work in *Studies on Hysteria* (1893) [the *Studies*] launched the concept of mental illness as a medical diagnosis and introduced us to the idea of the subconscious. Thomas Szasz's work, *The Myth of Mental Illness* (1961), galvanized a reexamination of psychiatry, critiques the medicalization of mental illnesses and perceives of mental illness as a social construction. The ensuing is a critical text analysis presented as a humorous but scholarly fictional dialogue between these seminal theorists. The use of fictional dialogue allows each work to be used as a lens to view the other. The juxtaposition of these authors' ideas highlights the tension in their divergent views and invites a new way of critically examining their ideas. The dialogue highlights the controversies that arise in the origins of psychiatry and whether hysteria is a medical condition or a social choice. Our two authors explore whether patients are socially responsible for their actions or whether actions can be excused based mental illness. They explore the tension of involuntary psychiatric interventions vs. personal autonomy. Lastly, they discuss whether society's discontents arise due to sublimation of individual freedom leading to neurosis, as Freud claims, or a result of lack of mastery of societies metarules, as Szasz opines. Their conversation offers us greater insight into these controversies.

Although Freud wrote at the turn of the last century, and Szasz published nearly a lifetime later, the debate between the two remains salient over a half-century later. It is a debate that continues to be germane to critical disability studies and the study and practice of sociology, psychology and psychiatry.

(Note: To distinguish the speakers, Freud's comments appear in regular font and Szasz's are italicized.)

## The conversation

We find Thomas Szasz at his desk in his Syracuse, New York home late one September evening circa 2011. It is a modest, 1950's, suburban house, typical of its time. The residence is a short drive to the State University of New York's Upstate Medical University, where Professor Szasz lectured. Szasz is at his computer writing his latest screed about psychiatry. We hear a voice from the shadows.

Freud: Are you bashing my work again?

*Szasz: Who's there?*

Freud: Who do you think?

*Szasz: Who is it?*

Freud: I would have thought you would recognize my Viennese accent.

*Szasz: I don't know anyone from Vienna.*

Freud: Are you sure? I am quite well known in many circles. I think you have read some of my work.

*Szasz: I have? Step out where I can see you.*

Freud: (Stepping out of the shadow). I think you know me, yaw.

*Szasz: How did you get in here?*

Freud: I have a very strong id, or maybe you do, but that is for another conversation.

*Szasz: Who let you in? You must be one of the new grad students. Who put you up to imitating Herr Freud? I must say that you look remarkably like him.*

Freud: My dear fellow, I have not been a grad student since 1881, in Vienna. Those were the days, with such uncharted territory still ahead.

*Szasz: All right, enough. Who are you?*

Freud: I am I. It is Jung who thinks we are different people in different places. I had such hope for Carl and he disappointed me, just as you have.

*Szasz: What are you talking about? Enough already! Who are you?*

Freud: I am sure you know in your subconscious, but If you need me to say it, I am Dr. Sigmund Freud, not quite in the flesh, though I think I look remarkably well given that I have been deceased since 1939.

*Szasz: That is impossible. I must be dreaming. It must be something I ate.*

Freud: Yes, one should never eat bratwurst before bed. You know, I did quite a lot of work on interpreting dreams, but that is not exactly what I am here to talk about. Do you mind if I smoke? (He pulls out a cigar from his vest pocket and sits down in an armchair across from Szasz's).

Freud: Chairs were much more ornate in my day. I am here to talk to you about your denigration of psychoanalysis. What do you have to say?

*Szasz: I obviously have much to say. First, you follow your mentor Charcot in calling malingerers hysterics and dressing hysterics up as science.*

*There is no reason to believe that every person who complains of being ill or who looks ill or who is disabled –or who manifests all three of these features - must also have a psychochemical disorder of his body! This does not deny the possibility that there may be a connection between such complaints and bodily diseases. The nature of this connection, however, is empirical, not logical. Once this is clear, it becomes a matter of scientific and social choice whether we prefer to emphasize the similarities – and place hysteria in the category of illness; or whether we prefer to emphasize the differences and place it in the category of nonillness” (Szasz 1974, 25).*

*My criticism of Charcot was his “covert use of scientific prestige to gain certain social ends” (Szasz 1974, 30), being the “acceptance of the phenomena of hypnotism and hysteria by the medical profession in general” (Szasz 1974, 30).*

Freud: Charcot was a beginning not an end, my good doctor. I had many teachers and collaborators over my career, including Meynert, Bruke, Fleiss, Breuer, Blueler, Junge, Adler, but you seem to ignore all these other men of science (Strachey 1974). As I said, Charcot was a starting place. I used hypnosis for differential diagnosis, and “[t]he success of the treatment confirmed the choice of diagnosis” (Freud & Breuer 1974, 65) but you ignore that I was not immune to progress, and that I did move away from hypnotic suggestion, to free association (Strachey 1974). What I do is not so unlike what you do with your patients, I would assume.

You forget that these were nascent studies, that these were primitive, initial considerations of mental illness. We had little in the way of diagnostic technology (Webster 1996). As I state in my *Studies on Hysteria*, “Even today I regard them not as errors but as valuable first approximations to knowledge which could only be fully acquired after long and continuous effort” (Freud 1974, 50). Our works on hysteria have been described as “pre-psychoanalytical,” and “the embryonic moment of psychoanalysis” (Bowlby, 2004, xvi-xvii).

If I had not discovered the unconscious and the neurotic symptoms resulting from the conflict between unconscious impulses and conscious impulses you would probably be a plumber today. There would be no schools of psychology for you to teach at or psychiatric techniques for you to criticize. There would be no psychoanalysis and therefore no psychoanalysts (Bowlby 2004). The entire enterprise of psychiatric medicine may not even exist today.

*Szasz: Yes, the “therapeutic state” (Szasz 1984), where everyone one who claims to be depressed is instantly medicated. But we can talk of that later.*

*In fact, I claim that we should, “abandon the entire medical approach to mental illness and substitute new approaches for it appropriate to the ethical, political, psychological, and social problems from which psychiatric patients suffer and which psychiatrists ostensibly seek to remedy” (Szasz 1974, 79). I say this on the basis that your and Breuer’s patients were not necessarily hysterical, but simply “unhappy or troubled”, not unlike my own, expressing their distress through bodily complaints (Szasz 1974, 74). In fact, you do “not actually identify and treat disease of organisms or bodies” (Szasz 1974, 73).*

Freud: Yes, I understand there are some effective pharmaceuticals that have been developed since my day. I actually published the first inquiry into the use of cocaine for medical purposes (Strachey 1974).

With respect to treatment, however, that is incorrect;

we found, to our great surprise at first, that each individual hysterical symptom immediately and permanently disappeared when we had succeeded in bringing clearly to light the memory of the event by which it was provoked and in arousing its accompanying affect, and when the patient had described that event in the greatest possible detail and had put the affect into words (Freud & Breuer 2004, 10).

Language becomes a substitute for action (Freud & Breuer 2004), “abreacting” trauma by allowing the strangulated effect, which caused by a suppressed memory, to escape into normal consciousness (Freud & Breuer 2004, 19).

Let’s assume for a moment what you say is correct. It seems to me, that the same can be said of your work. At any rate, as you would know, my work did not stop with *Studies on Hysteria*. As I stated before, “[t]he developments and changes in my views” even during the brief “course of thirteen years of work”, as between the first and second edition of *Studies*, had “been too far-reaching for it to be possible to attach them to my earlier exposition without entirely destroying its essential character. Nor have I any reason for wishing to eliminate this evidence of my initial views” (Freud 2004c, 3). Furthermore, Dr. Breuer and I expressly stated in *Studies* that we do not cure hysteria, but have developed a therapeutic advantage (Freud as cited in Strachey 1974), “that this has brought us nearer to an understanding only of the mechanism of hysterical symptoms and not of the internal causes of hysteria. We have done no more than touch upon the aetiology of hysteria” (Freud & Breuer 2004, 20). I don’t see why this is any different than any other medical condition, subject to research.

*Szasz: That is the point. When we discover the cause of a mental disease, typically it ceases to be a mental illness and becomes a physical illness. “[N]o doubt there are diseases that they do not know how to detect today. But it is one thing to admit this, and quite another to maintain that, because of these historical facts, that persons psychiatrists now call schizophrenic suffer from an as yet undetectable form of organic disease, and it is only a*

*matter of time and research until medical science discovers the lesions 'responsible' for this disease" (Szasz 1974, 84).*

Freud: My dear sir, Breuer and I see therapy as 'cathartic', and that the illness could be stimulated in this way "suggests that the illness . . . [is] not primarily organic or hereditary" (Bowlby 2004, viii). Breuer postulated a physical cause to hysteria. He analogized that,

a great number of physical processes, such as the secretion of saliva or tears, variations in the action of the heart, and so on, it is possible and plausible to assume that the same process can equally well trigger by ideas as by peripheral or other non-physical stimuli. The opposite needs to be proved and we are still very far short of that. Indeed, it seems certain that many phenomena termed hysterical are not caused by ideas alone" (Breuer 2004, 191–192).

He talked of a number of possible physical causes, such as "tonic excitation" (197). For my part, I am convinced, that the case studies in *Studies on Hysteria* and many subsequent cases I have analyzed and treated, "produce a confirmation of the physical mechanism, of hysterical phenomena proposed by us, simply because the analysis revealed that these cases were, simultaneously, sexual neuroses" (Freud 2004a, 262).

While you protest much, and while from a sociological perspective you have made a contribution, your works are somewhat disfavored. I understand they are not taught much (Oliver 2006); whereas my works on hysteria have had a bit of a renaissance; reprised by a number of academics under the rubric of "new hysteria" (Bowlby 2004, xv).

Do you have any sacra tort, per chance?

*Szasz: Syracuse is not exactly known for its Viennese pastries. I must also protest the way you and your cadre conflate medical and psychological language. "[T]o speak of . . . 'organic symptoms' and to place them in the same category as hysterical pains and paralyses is a misuse of language" (Szasz 1974, 85). Moritz Schlick said it well, "The so called 'psycho-social problem arises from mixed employment of both modes of representation in one and the same sentence" (Schlick 1935, 403).*

Freud: You are correct. I spoke of "illness" and of "the psychology of ordinary life", sexuality and science (Bowlby 2004, xxvii). I answered this initially in the *Studies* itself.

I have not always been a psychotherapist, but was trained like other neuropathologists to use local diagnosis and electro-prognosis. I myself still find that the case histories that I write read like novellas and lack, so to speak, the serious stamp of science. I have consoled myself with the thought that the nature of objects rather than my own personal preference is clearly responsible for this; local diagnosis and electrical reactions are simply not effective in the studying of hysteria" (Freud 2004b, 164–165).

You are no doubt familiar with my later writings, where I expressly said we must recollect that all our provisional ideas in psychology will presumably one day be based on an organic structure (Lear 2005). This accounts for my synthesis of psychological and biological ideas. I had no doubt that science would in time correct my errors. We had limited neuroscience in our time, leaving us to speculate in many regards, but faith in the corrective power of scientific progress allowed for a bold hypothesis (Lear 2005).

*Szasz: We will have to agree to disagree. I do not believe that mental patients, particularly hysterics, suffer from illnesses, symptoms, causes, and are subject to medical treatments. Rather, they need to change their life orientations. The way to treat them is to see them as imitating illness and to understand and translate the special idiom of body signs into ordinary language (Szasz, 1974).*

Freud: Of course we do disagree. I do not think you can divorce psychoanalysis from science and medicine. Yes. Yes. I know all about your proto-language analysis, and no matter what you call them, they are still symptoms.

*Szasz: You do?*

Freud: I happen to have a lot of time on my hands now, so I read quite a lot. At any rate, your theory is interesting sociology, however unduly skeptical of psychiatry. I give you your due, for your accomplishments in patient advocacy but your continued insistence on mental illness as a myth ignores the medical progress of your own time.

*Szasz: You have many critics as well (Tanabe, 2013). Many support my criticism, that your theory's logical conclusion is a society in which we do not treat individuals as responsible persons but instead treat them as irresponsible patients (Szasz 1974).*

Freud: Not so, nothing is more responsible than liberating oneself from debilitating psychological symptoms. But if you mean to say, that I believe there is an unconscious aspect to the mind, that causes a repressed consciousness, to not always be conscious or in control of one's actions (Tanabe, 2013), yes. The mind does act to defend itself from traumatic experience.

*Szasz: But if there are these irrational forces, where a person is excused from responsibility for their actions; we then have a world where we replace responsibility with illness. "[T]he issue or question for the patient becomes to what extent is he willing to recognize his evasion of responsibility often expressed as symptoms" (Szasz as cited in Carey 2000). "The goal is to assume more responsibility and therefore gain more liberty and more control over one's life" (Szasz as cited in Carey 2000).*

Freud: That is the indirect goal, which is accomplished by the direct goal of treating symptoms. We differ, in that my assertions are backed by clinical evidence, whereas your assertions seem more semantic. You may ask Anna O, Emmy von N., and the other of my patients in the cases we present in the *Studies*, if they did not improve. A recent discussion of my work put the nay saying this way; "[m]uch of the criticism of psychoanalysis as



extravagant - as well as much of the emptiness of academic debates – occurs because theoretical terms are invoked in isolation, cut off from clinical reality” (Lear 2005, 9). You forget that, I also listened to human suffering and that my theories are grounded in resolution of symptoms (Lear, 2005).

You complain about the impact of psychology on society, but society creates discontent in its citizens by sublimating the individual’s freedom (Freud 1961), in exchanging “a portion of happiness for a portion of security” (Freud 1961, 100). As a result, “[i]t was discovered that a person becomes neurotic because he cannot tolerate the amount of frustration which society imposes on him in the service of its cultural ideals” (Freud 1961, 59).

*Szasz: Our understanding of societal rules is not so different. I also talk about the rules of society, but instead of leaving off with neurosis, I offer the idea of creating metarules, or, rules about rules formed from our ability of abstraction, as a way to cope with the compulsion of social rules on the individual. “Acquiring such understanding constitutes a form of mastery. Only by practicing what may be called the metarule attitude – which is actually a special case of scientific attitude applied to the domain of rules – can we acquire a secure yet flexible integration of rules as behavior regulating agencies” (Szasz 1974, 161). People do shape their own destinies to some extent, “no matter how much they might bewail the superior forces of alien wills and powers” (Szasz 1974, 151).*

Freud: Again, we are going to have to disagree. Metarules just sound like a way to reframe the treatment of neurosis.

Any espresso?

*Szasz: I am a terrible host, but I have never hosted a specter before, particularly one I am so antithetical towards.*

Freud: Are you sure I am a specter? If I am, this is a neat trick for a sceptic.

*Szasz: You mentioned your theory’s being grounded in clinical research, but you cannot escape that there is a normative element to how you interpret your data. You are “a moralist in the guise of science” (Szasz 1974, 153). “Virtually all behavior with which the psychoanalyst and psychiatrist deal is learned behavior. Since such behavior cannot be properly described or analyzed without dealing explicitly with norms and standards that regulate it, and goals it seeks to attain, psychoanalytical theory is foreordained to be unable to offer an adequate account of such conduct” (Szasz 1974, 153-154). Mental illness must then be socially constructed (Grohol, 2012), with a self-sustaining self-interested cadre of the psychiatric industry.*

Freud: I have always maintained neurosis is ultimately biological (Hacking 1999). I believe that I have been entirely objective in this regard. As I have said, what our method lacks in scientific sounding analysis it makes up for in, “in-depth portrayal of the workings of the inner life” (Freud 2004b, 164-165), which “does allow me to gain a kind of insight into the



course of hysteria” (Freud 2004b, 164–165). This lack of scientific sounding analysis may account for your discomfort.

*Szasz: My discomfort is that you diagnose hysteria by declaring it mental illness (Szasz 1974). But let’s move on. “I am opposed on moral and political grounds to all psychiatric interventions which are involuntary and on personal grounds to all such interventions which curtail the client’s autonomy” (Szasz 1974, 261). I know with great certainty, civil commitment really means imprisonment and that forced treatment generally means assault (Breeding 2011).*

Freud: Coercion existed long before me, and sadly, may exist long after you. However, you can’t have it both ways. You cannot accuse me of being both pro-treatment and pro-coercion. Obviously, I believe treatment is preferable. Moreover, in fact, I believe my theories have been used in support of a movement to reform the treatment of criminal offenders, including sex offenders, by moving away from punishment to treatment (Fisher 1968).

*Szasz: So, you believe that people are never responsible for their actions and that they should be excused by pleas of insanity?*

Freud: I think you confuse two concepts, not being legally responsible by way of incompetence, and mental illness. The former means the accused does not understand the nature of the proceedings and is unable to instruct legal counsel. This is essentially a legal construct albeit applied by psychiatrists. I, on the other hand, with respect to the latter, maintain that crimes are often committed due to a conflict of natural drives that overtake individual liberty, which are in tension with society’s order, causing guilt and neurosis. It is the guilt that leads to crime. “According to this view, crime is not the result of a criminal personality, but of a poorly integrated psyche” (Bryant 2012). Therefore, being deterministic, crime, and particularly sex crimes, are uncorrectable by punishment (Fisher 1968).

*Szasz: Feminists accuse that line of thought as being “deeply suspect for having highlighted fantasy and desire, rather than brute reality and sexual exploitation” (Forrester 1997, para. 3). And there are many other criticisms of your views in relation to “therapeutic efficacy, questions of scientific explanation, and questions concerning . . . scientific probity” (Forrester 1997, para. 6). Many have had questions about the ethics of psychoanalysis (Forrester 1997). More specifically, several claim that there has been a high level of misdiagnosis with regard to the symptoms of hysteria, with many such symptoms being merely the product of untreated organic illnesses (Webster 1996). Moreover, hysteria has been dropped from the Diagnostic and Statistical Manual of Mental Disorders (DSM), since 1952 (Webster 1996).*

Freud: There are misdiagnoses in every form of medicine, and as for the *DSM*, hysteria is there, in the description of other disorders listed (Webster, 1996).

To the contrary, you have been accused of being too absolute in your views. You ignore known brain diseases and the possibility that the etiologies of other mental diseases have yet

to be determined, as well as the fact that medications work for certain disorders, such as schizophrenia and depression, and that there are certain diseases that can only be identified by behaviors, such as Alzheimer's disease (Sullum, 2005). You also ignored new diagnostic technology that has occurred in your lifetime (Webster, 1996). Most importantly, you raise many issues about psychiatric diagnosis, without offering solutions (Frances 2012) and you leave no hope for cures (Oliver, 2006).

We both suffer from psychiatry being a relatively young science. I have faith, that in time science will satisfy us both, by finding causes and treatments to currently untreatable mental disorders and maybe in doing so, will make mental illness more of a "myth".

At any rate, the hour is late, and I must take my leave and you your "sleep, per chance to dream" (Shakespeare).

### Conclusions

Mental illness, of course, is not a dream. The World Health Organization (2001) estimates that 450 million people suffer from mental or neurological disorders worldwide. A more recent report puts the prevalence of mental health disability globally at more than 970 million people (James, Abate, Abate, Abay, Abbafati, Abbasi, Abbastabar et al. 2017). And while the dialogue is humorous, with intent to be engaging, it is not intended to make light of the serious nature of mental health issues.

The dialogue has illustrated a number of tensions between these seminal theorists' perspectives. The dialogue elicits the controversies as to whether mental illness is a medical condition or a social choice; whether psychiatry is a science and mental illness is clinically proven or whether mental illness is socially constructed reflecting norms and standards of society. These perspectives are still studied, debated and critiqued in critical disability studies, sociology, psychology and psychiatry. Regardless of one's opinion, these controversies are relevant to psychiatry's past and likely to be reflected in its future. But more significantly, these issues are salient to societies' treatment of persons with mental health disabilities.

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