The Case against Psychiatric Coercion

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"To commit violent and unjust acts, it is not enough for a government to have the will or even the power; the habits, ideas, and passions of the time must lend themselves to their committal."

—ALEXIS DE TOCQUEVILLE (1981, 297)

Political history is largely the story of the holders of power committing violent and unjust acts against their people. Examples abound: Oriental despotism, the Inquisition, the Soviet Gulag, the Nazi death camps, and the American war on drugs come quickly to mind. Involuntary psychiatric interventions belong on this list.[1]

When Tocqueville referred to "unjust acts," he was speaking as a detached observer, viewing state-sanctioned violence as an outsider. From the insider's point of view, state-sanctioned violence is, by definition, just. The Constitution of the United States, for example, recognized involuntary servitude as a just and humane economic policy. Throughout the civilized world people now recognize involuntary psychiatry as a just and humane therapeutic policy. Making use of the fashionable rhetoric of rights, a

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1. Unless the context calls for a restricted use of the words psychiatry and psychiatrist, I use these terms to refer to all mental health professions and professionals.

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prominent psychiatrist describes adding the "right to treatment" to the existing criteria for assessing civil commitment as a "policy more realistically and humanely balancing the right to be sick with the right to be rescued" (Treffert 1996).

The fact that the psychiatrist is authorized to use force to impose the role of mental patient on legally competent persons against their will is prima facie evidence that the psychiatrist possesses state-sanctioned power. In 1913, Karl Jaspers ([1913] 1963)[2] acknowledged the unique importance of this element of psychiatric practice. 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)

The systematic exercise of force requires legitimation. Formerly, Church and State, representing and implementing God's design for right living, performed this function. Today, Medicine and State perform it. W. H. Auden ([1962] 1968) put it thus:

> What is peculiar and novel to our age is that the principal goal of politics in every advanced society is not, strictly speaking, a political one, that is today, it is not concerned with human beings as persons and citizens, but with human bodies.... In all technologically advanced countries today, whatever political label they give themselves, their policies have, essentially, the same goal: to guarantee to every member of society, as a psychophysical organism, the right to physical and mental health. (87)

So long as the idea of mental illness imparts legitimacy to psychiatric coercion, the myriad uses of psychiatric compulsions and excuses cannot be reformed, much less abolished. Hence, for those opposed to psychiatric coercion, the principal adversary is its legitimacy.

The Varieties of Power

In social affairs, power is usually defined as the ability to compel obedience. Its sources are coercion from above and dependency from below. By coercion I mean the legal or physical ability to deprive another person of life,

2. Jaspers later abandoned psychiatry for philosophy.

liberty, or property, or to threaten such "punishment." By dependency I mean the desire or need for others as protectors or providers.[3] "Nature," observed Samuel Johnson ([1709–84] 1981), "has given women so much power that the law has very wisely given them little" (172). The sexual control women wield (over men who desire them) is here cleverly contrasted with their legal subservience (a condition imposed on them by men).

Because the definition of power as the ability to compel obedience fails to distinguish between coercive and noncoercive means of securing obedience, it is imprecise and potentially misleading. For example, when Voltaire exclaimed, Écrazez l'infâme! he was using the word l'infâme to refer to the power of the church to incarcerate, torture, and kill people, not to the influence of the priest to misinform or mislead the gullible. The distinction I draw here is not novel, yet needs to be stated and restated. As the American philosopher Alfred North Whitehead ([1933] 1961) put it, "[T]he intercourse between individuals and between social groups takes one of these two forms, force and persuasion. Commerce is the great example of intercourse by way of persuasion. War, slavery, and governmental compulsion exemplify the reign of force" (83).

I use the word force to denote the power to harm, or threaten to harm, another,[4] and the word influence to refer to obedience secured by money or other rewards or temptations. The potency of force, symbolized by the gun, rests on the ability to injure or kill the Other, whereas the potency of influence rests on the ability to gratify the Other's desires. By desire I mean the experience of an unsatisfied urge, for example, for food, drugs, or sex. The experience is painful; its satisfaction is pleasurable. Individuals who depend on another person for the satisfaction of their needs (or whose needs or desires can be aroused by another) experience the Other as having power over them. Such (though not such alone) is the power of parents over their children, of doctors over their patients, of Circe over Ulysses. In proportion as we master or surmount our desires, we liberate ourselves from this source of domination.

Dependence, Domination, and Psychiatry

The paradigmatic exercise of psychiatric coercion is the imposition of an ostensibly diagnostic or therapeutic intervention on subjects against their will, legitimized by the state as protection of subjects from madness and protection of the public from the mad. Hence, the paramount source of

3. The spheres of legitimacy of power and dependency are defined by law, custom, and tradition.

4. The legally unauthorized use of force is a felony.

psychiatric domination is force. Its other source is dependency, that is, the need of the powerless for comfort and care by the powerful. Involuntary psychiatric interventions rest on coercion, voluntary psychiatric interventions on dependency. It is as absurd to confuse or equate these two types of psychiatric relations as it is to confuse or equate rape and mutually desired sexual relations. I oppose involuntary psychiatric interventions not because I believe that they are necessarily "bad" for patients but because I oppose using the coercive apparatus of the state to impose psychiatric relations on persons against their will. By the same token, I support voluntary psychiatric interventions, not because I believe that they are necessarily "good" for patients but because I oppose using the power of the state to interfere with contractual relations between consenting adults (Szasz 1982).[5]

When people suffer from disease, oppression, or want, they naturally seek the assistance of persons who have the knowledge, skill, or power to help them or on whom they project such attributes. In ancient times, priests, whom people believed to possess the ability to intercede with powerful gods, were the premier holders of power. For a long time, curing souls, healing bodies, and relieving social-economic difficulties were all regarded as priestly activities.[6] Only in the last few centuries have these roles become differentiated, as Religion, Medicine, and Politics, each institution being allotted its "proper" sphere of influence, struggled to enlarge their scope and power over the others.

The separation of church and state represents a sharp break in Western political history. Although still paying lip service to an Almighty, the U.S. Constitution is, in effect, a declaration of the principle that only the state (government) can exercise power legitimately and that the sole source of its legitimacy is the "happiness of the people" ensured by securing "the consent of the governed." Gradually, all Western states have adopted this outlook. The Argentinean poet and novelist Adolfo Bioy Casares (1986) satirized the resulting "happiness":

> Well then, maybe it would be worth mentioning the three periods of history. When man believed that happiness was dependent upon God, he killed for religious reasons. When man believed that happiness was dependent upon the form of government, he killed for political reasons. After dreams that were too long, true night-

5. Some psychiatric critics, opposing the use of psychiatric drugs, electric shock treatment, or psychotherapy, advocate the legal prohibition of these methods or relationships on the ground that people need protection from the "exploitation" intrinsic to the practice of psychiatry and psychotherapy. I regard state-sanctioned "protection" from psychiatric treatment as just as patronizing as state-sanctioned protection from psychiatric illness. Both are state-imposed denials of the basic human right to engage in, or refrain from, making contracts.

6. Jesus and Mother Teresa still project this sort of image.

> mares…we arrived at the present period of history. Man woke up, discovered that which he always knew, that happiness is dependent upon health, and began to kill for therapeutic reasons. (7)

Among these therapeutic reasons, the treatment of mental illness occupies a unique place.

Human beings are intensely susceptible to two types of unpleasant experiences: anxiety-and-guilt and pain-and-suffering. Each is a virtually inexhaustible source of dependency, on soul doctors, body doctors, or both. Religion, by providing myth and ritual, relieves people of anxiety-and-guilt and promises a tranquil eternal life in the hereafter. Medicine, by providing diagnosis and treatment, relieves people of pain-and-suffering and promises a healthy and endlessly extended life on earth. How does psychiatry fit into this picture?

The practice of the branch of medicine we call "psychiatry" began with the confinement of troublesome persons in madhouses. As a result, two symmetrical populations came into being: the kept, called "madmen" or "mad women," and the keepers, called "mad-doctors." During the eighteenth century, the idea of insanity and the institution of the insane asylum became established as important—indeed, socially indispensable—medico-legal concepts and methods of social control. Soon, law, medicine, and popular opinion came to see the insane asylum as the proper place for housing persons authoritatively declared (diagnosed as) insane. Initially, few people were troubled because the situation of the insane in the asylum resembled the situation of the prisoner in jail. The philosophy of the Enlightenment undermined this complacency, projecting the idea of human rights onto the center stage of Western history. Depriving mental patients of liberty had to be reconciled with society's ostensible devotion to human rights. This task was accomplished partly by conflating and confusing the concept of illness (a bodily condition) with the concept of incompetence (non compos mentis, a legal concept and, subsequently, a "mental" condition) and partly by subsuming civil commitment under the rubric of the state's police power, that is, its duty to protect the public from "dangerous" persons (lawbreakers). This dual justification of psychiatric coercion has remained essentially constant for almost 300 years (Szasz 1994).

Legitimizing Psychiatric Coercion

A crucial moment in the legitimation of modern psychiatric coercion occurred in central Europe during the early decades of this century.[7]

7. The introduction of antipsychotic drugs in the 1950s further legitimated psychiatric coercion. Today, it is reinforced by brain-scanning methods allegedly demonstrating that mental

Although psychiatry and psychoanalysis arose as distinct and separate enterprises, they soon merged into a union that proved to be fateful for the future of the "mental health services" industry. Collaboration between Eugen Bleuler and Sigmund Freud and their followers created this union.

Bleuler was born in 1857 in Switzerland. After a successful career in psychiatry, in 1889 he became the head of the famed Burghölzli, the public mental hospital in Zürich. Unlike most psychiatrists, Bleuler wanted to know his patients as persons. Finding the psychiatric dogma of his day useless for that purpose, he looked to Freud's writings for help. By 1902, he had read The Interpretation of Dreams[8] and made three complimentary references to it (Ellenberger 1970; Clark 1980). Two years later he initiated contact with Freud, writing him "that he and all his staff had for a couple of years been busily occupying themselves with psychoanalysis and finding various applications for it" (Jones 1953–57, 2:30).

In his biography of Freud, Ernest Jones commented: "Because of the increasingly prominent position Bleuler held among psychiatrists, Freud was eager to retain his support" (1953–57, 2:72). Then, displaying his incomprehension of psychiatric history, he added: "Unfortunately, this state of affairs [friendship between Freud and Bleuler] did not endure…. His [Bleuler's] interests then moved elsewhere, from psychological to clinical psychiatry" (73). This statement is wrong. Bleuler had always been a clinical psychiatrist, never relinquished his interest in the psychological understanding of patients, and never renounced his appreciation of psychoanalysis. In 1907, replying to his critics, Bleuler wrote:

> I consider that up to the present the various schools of psychology have contributed extremely little towards explaining the nature of psychogenic symptoms and diseases, but that…psychoanalysis offers something towards a psychology which still awaits creation and which physicians are in need of in order to understand their patients and to cure them rationally. (Bleuler 1914, 26)

In 1925, in a 17 February letter to Freud, Bleuler expressed this point even more strongly: "Anyone who would try to understand neurology or psychiatry without possessing a knowledge of psychoanalysis would seem to me like a dinosaur—I say 'would seem' not 'seems,' for there no longer are such people, even among those who enjoy depreciating psychoanalysis!" (Bleuler 1925, 117).

In his epochal work, Dementia Praecox or the Group of Schizophrenias,

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diseases are brain diseases that, nevertheless, ought to be treated by psychiatrists rather than by neurologists.

8. The Interpretation of Dreams was published in 1900, the watershed date in the history of psychoanalysis.

Bleuler courageously incorporated a psychoanalytic perspective in his interpretation of the behavior of schizophrenic patients. The following example is illustrative. A woman patient declares that "she is Switzerland." Bleuler ([1911] 1950) wrote: "She says, 'I am Switzerland.' She may also say, 'I am freedom,' since for her Switzerland means nothing else than freedom" (429). The patient's "symptom" reveals that she is protesting against her confinement; Bleuler's use of this example reveals that he recognized the legitimacy of her protest.

This is not the place to dwell on Bleuler's monumental work. Suffice it to note that although he defined schizophrenia as a "disease [that] is characterized by a specific type of alteration of thinking, feeling, and relation to the external world" (150), his foregoing remarks show that he recognized that schizophrenic "thinking" was a type of poetry and protest as well.[9] However, by pathologizing the schizophrenic's behavior, Bleuler undermined that common-sense judgment and the psychiatric response to it: persons incarcerated in the mental hospital were made to appear as medical patients suffering from a disease; the psychiatrist incarcerating them was made to appear as a medical doctor treating a disease; and the power relations between them were buried more deeply than ever.

But Bleuler, who was honestly seeking the truth, did not let the matter rest there. In 1919, when his reputation as a psychiatrist was second to none in the world, he wrote a book, now virtually forgotten, that is largely a denunciation of psychiatric power. He wrote: "Many a case of 'latent' schizophrenia is diagnosed as total in all certainty. Never does it occur to the doctor to consider all the consequences: confinement of the patient to a mental institution, deprivation of civil rights, abandonment of his profession, etc." ([1919] 1970, 115). Who spoke of the civil rights of mental patients in those days? Not Freud. Not psychiatrists. But Bleuler did. In the final paragraph of his book on schizophrenia, he commented on "the most serious of all schizophrenic symptoms…the suicidal drive":

> I am even taking this opportunity to state clearly that our present-day social system demands great and entirely inappropriate cruelty from the psychiatrist in this respect. People are being forced to continue to live a life that has become unbearable for them for valid reasons; this alone is bad enough. However, it is even worse, when life is made increasingly intolerable for these patients by using every means to subject them to constant humiliating sur-

9. The points I wish to emphasize here are, first, that thinking, feeling, and relating to the external world are, prima facie, not matters of medical concern; and second, that whatever an "alteration of thinking and feeling" might be, it is patently an inadequate justification for depriving a person of liberty.

veillance. ([1911] 1950, 488)

Bleuler must have felt more than a little guilty to have advanced so disingenuous a disclaimer. No one forces a person to become a jailer confining criminals or to become a psychiatrist confining mental patients.

The Moral Suicide of Psychoanalysis

Notwithstanding the sloppy scholarship of many psychiatric historians, it is important to remember that Sigmund Freud was not a psychiatrist. In late nineteenth-century Europe, the term "psychiatrist" meant a physician working in the public mental hospital system. Because Jews were barred from employment in state bureaucracies, they could not be psychiatrists and hence could not force people to be their unwilling patients.

Not only was Freud not a psychiatrist, most psychiatrists viewed his writings as inimical to psychiatry. For example, the prominent German psychiatrist Franz von Luschan blamed "Bleuler for his astonishing behavior in helping to promulgate the epidemic [i.e., psychoanalysis]" (Jones 1953–57, 2:119). Psychiatrists objected to Freud's writings not because he opposed involuntary psychiatric interventions; in fact, he enthusiastically supported psychiatric excuses and coercions (Szasz [1976] 1990, 136–37). Instead, they disapproved of Freud's work because they wanted to see themselves as physicians with a professional identity firmly anchored in neurology and neuropathology; and because they wanted to see their patients as suffering from bona fide diseases, that is, bodily abnormalities with physical causes independent of the sufferer's personal history. By introducing a new set of disease-causative agents—namely, the patient's life history (especially "traumas" suffered during childhood)—Freud spoiled this purely physicalistic conception of etiology and pathology.[10] At the same time, he reinforced the established social prestige of psychiatry with the seemingly scientific prestige of psychoanalysis. The psychiatric profession now became a mighty river, formed by the confluence of two large tributaries: the state hospital system, confining and caring for some of the injured and injurious members of society in institutions; and the theory and practice of psychoanalysis, offering a system of interpreting behavior and counseling to non-institutionalized, fee-paying individuals. As a result of this expansion, psychiatric power became more impervious to criticism than ever.

Although I offer no new information concerning the collaboration

10. Depending on one's point of view, one might also say that Freud improved these concepts. In any case, by adding psychogenesis to somatogenesis, and psychogenic diseases (for example, perversions) to somatogenic diseases (for example, pneumonia), Freud expanded the conceptual categories of etiology and pathology.

between Bleuler and Freud, the inference I draw concerning its impact on the history of psychiatry is, I believe, novel. Historians of psychiatry and psychoanalysis have overlooked how Freud's coveting the blessings of psychiatry combined with Bleuler's perceptive use of psychoanalytic insights reinforced the legitimacy of the psychiatric enterprise, which had previously labored under a cloud of scientific and civil-libertarian suspicion. Consider the evidence.

In his 1914, "On the History of the Psychoanalytic Movement," Freud (1953–74) wrote: "A communication from Bleuler had informed me…that my works had been studied and made use of in the Burghölzli…. I have repeatedly acknowledged with gratitude the great services rendered by the Zürich school of Psychiatry in the spread of psychoanalysis" (14:26–27). What did Freud mean here by "psychoanalysis"? Clearly, he could not have meant that its subjects must be voluntary clients, an element that he had identified nine years earlier as intrinsic to the practice of psychoanalysis. In 1905, Freud had declared: "Nor is the method applicable to people who are not driven to seek treatment by their own sufferings, but who submit to it only because they are forced to by the authority of relatives" (1953–74, 7: 263–64, my emphasis). If so, psychoanalysis was even less applicable to people forced to submit to "it" by the authority of policemen, judges, and psychiatrists.

It is reasonable to infer that in reference to his alliance with the psychiatrists at the Burghölzli, Freud did not use the word psychoanalysis to identify a voluntary relationship between a healer and his subject but rather a body of ideas associated with his name. This interpretation is supported by his remark that "Jung successfully applied the analytic method of interpretation to the most alien and obscure phenomena of dementia praecox [schizophrenia], so that their sources in the life-history and interests of the patient came clearly to light. After this, it was impossible for psychiatrists to ignore psychoanalysis any longer" (1953–74, 14:28, my emphasis).

As we know, it was not at all impossible for psychiatrists to ignore psychoanalysis, if the term includes respect for the current life history and civil rights of the patient. Indeed, Freud himself led the legions that joyously proceeded to ignore the most obvious life historical event in the life of the schizophrenic patient: namely, that a psychiatrist is depriving him of liberty. I have called attention elsewhere to Freud's glaring neglect of Schreber's incarceration. In 1976, I wrote:

> In his most famous study of schizophrenia, the Schreber case, Freud devotes page after page to speculations about the character and causes of Schreber's "illness," but not a word to the problem posed by his imprisonment or his right to freedom. Schreber, who

> was "psychotic," questioned the legitimacy of his confinement, and Schreber, the madman, sought and secured his freedom. Freud, who was a "psychoanalyst," never questioned the legitimacy of Schreber's confinement, and Freud, the psychopathologist, cared no more about Schreber's freedom than a pathologist cares about the freedom of one of his specimens preserved in alcohol. (Szasz 1988b, 39)

The writer and literary critic Gabriel Josipovici (1988) reminds us that "We do not decipher people, we encounter them" (307). The psychiatrist's power to coerce the patient negates the possibility of a humane encounter between them. Indeed, interpreted as a command, the rule that we should not decipher but encounter the Other violates the canons of psychiatry and the laws of the Therapeutic State. To remain a psychiatrist, the psychiatrist must view his client as a "patient" afflicted with a dangerous "mental disease," and himself as a physician whose task is not only to treat mental diseases but also to incarcerate innocent patients deemed to be "dangerous" and exculpate guilty patients deemed to be innocent by reason of insanity. No amount of semantic transfusion from the vocabulary of psychoanalysis can, or was intended to, alter these elementary facts of psychiatry, characteristic of twentieth-century life in free and totalitarian societies alike.

I want to offer some additional observations concerning Freud's contributions to the enhancement and legitimation of psychiatric power. In 1914, in his essay "On Narcissism," Freud wrote: "Patients of this kind [schizophrenics]...display two fundamental characteristics: megalomania and diversion of their interest from the external world—from people and things. In consequence of the latter change, they become inaccessible to the influence of psychoanalysis and cannot be cured by our efforts" (1953–74, 14:74). Characterizing the schizophrenic as a person who, by turning away from "things and people," deprives himself of the benefits of psychoanalytic treatment is like characterizing the atheist as a person who, by turning away from God, deprives himself of the benefits of religious salvation. Instead of acknowledging that the schizophrenic's avoidance of the ministrations of a psychoanalyst is a decision, similar to a person's decision to avoid the ministrations of a chiropractor or Christian Science healer, Freud defined it as itself a symptom of schizophrenia and implied that if the schizophrenic were willing to submit to the analyst, psychoanalysis could cure him.

Although psychiatrists as well as psychoanalysts now treat psychoanalysis as a branch of psychiatry, the truth is that before psychoanalysis was absorbed into psychiatry, the two enterprises were almost antithetical. Politically, the essence of the psychoanalytic relationship was the absence of

the coercions traditionally present in relations between psychiatrists and mental patients. Practically, this meant that the analyst's failure to respect the patient's personal autonomy or the analyst's interference in the client's life was incompatible with the psychoanalytic relationship. The respective aims, values, and practices of psychiatry and psychoanalysis may be summarized as follows:

— To effect a cure, psychiatrists coerce and control their "patients": they incarcerate the (involuntary) victims and impose various unwanted chemical and physical interventions on them.

— To conduct a dialogue, psychoanalysts contract and cooperate with their "patients": they listen and talk to the (voluntary) interlocutors, who pay for the services they receive (Szasz 1988a).

Before psychoanalysis became institutionalized as a profession, the psychoanalytic relationship represented a genuinely new social development, namely, a noncoercive, secular help ("therapy") for problems in living (called "neuroses"). The term "psychoanalysis" then denoted a confidential dialogue between an expert and a client, the former rejecting the role of custodial psychiatrist, the latter assuming the role of responsible, voluntary patient. The psychiatric and psychoanalytic enterprises rested on totally different premises and entailed mutually incompatible practices:

— Traditional psychiatrists were salaried physicians who worked in a mental institution; their source of income was the state; they functioned as agents of bureaucratic superiors and the patient's relatives. Typical mental hospital inmates were poor persons, cast in the patient role against their will, housed in a public mental hospital.

— Traditional psychoanalysts were self-employed professionals who worked in private offices; their source of income was patients; they functioned as agents of the patients. Typical analytic patients were rich persons (usually wealthier than the analyst) who cast themselves in the patient role and lived in their own home or wherever they pleased.

As soon as Freud achieved the recognition he craved, he destroyed the core value of the psychoanalytic relationship. I refer to his assuming the authority of certifying competence in psychoanalysis and requiring that individuals seeking to become psychoanalysts undergo a so-called training analysis. If voluntariness is an essential element of the psychoanalytic rela-

tionship, then a compulsory training analysis is a contradiction in terms.[11]

11. Because children are, by definition, involuntary subjects, child analysis is also a contradiction in terms.

The betrayal of confidentiality intrinsic to training analysis drove a stake through the heart of the role of the psychoanalyst. The result was the destruction of the moral integrity and healing potential of the human encounter called "psychoanalysis" (Szasz 1958, 1960).

"Power Is Not a Means"

For more than forty years I have argued that the institution of psychiatry rests on civil commitment and the insanity defense and that each is a paradigm of the perversion of medical power. If the persons called "patients" break no law, they have a right to liberty. And if they break the law, they ought to be adjudicated and punished in the criminal justice system. It is as simple as that. Nevertheless, so long as conventional wisdom decrees that mental patients must be protected from themselves, that society must be protected from mental patients, and that both tasks rightfully belong to psychiatrists wielding powers appropriate to the performance of these duties, psychiatric power will remain unreformable.

Of course, many people do threaten society: they assault, injure, rob, and kill others. Some are regarded and managed as criminals, others as mental patients. In either case, society needs protection from the aggressors. What does psychiatry contribute to the management of such persons? Civil commitment and the insanity defense: inculpating the innocent and exculpating the guilty. Both interventions authenticate as "real" the socially useful fictions of mental illness and psychiatric expertise. Both create and confirm the illusion that we are coping wisely and well with vexing social problems, when in fact we are obfuscating and aggravating them. Alas, psychiatric power corrupts not only the psychiatrists who wield it and the patients who are subjected to it, but the community that supports it as well.

As Orwell's (1949) nightmarish vision of Nineteen Eighty-Four nears its climax, O'Brien explains the functional anatomy of power to Winston:

> [N]o one seizes power with the intention of relinquishing it. Power is not a means; it is an end. One does not establish a dictatorship in order to safeguard a revolution; one makes the revolution in order to establish the dictatorship. The object of persecution is persecution. The object of torture is torture. The object of power is power. Now do you begin to understand me? (266)

The empire of psychiatric power is more than three hundred years old and grows daily more all-encompassing. But we have not yet begun to acknowledge its existence, much less to understand its role in our society.

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