

Dying for a Cure: Foreword

The Oscar nominated movie *The Changeling* starts with a clip saying it is a true story – not just based on a true story. In it the horrors of psychiatry are portrayed, pretty well as they have been since *One Flew over the Cuckoo's Nest*, through the forced administration of Shock Therapy (ECT) – even though the heroine's incarceration happened 10 years before ECT was invented.

When the historical detail is so flagrantly wrong, presumably what's going on is based on a calculation that ECT inflicted in this way will best epitomize the fears of today's viewers about psychiatry. But in fact forced treatment with ECT is now vanishingly rare. In regular psychiatric practice insiders, both staff and patients, are much more likely to fear forcible and indefinite medication with long-acting antipsychotic injections – a treatment that is more clearly brain damaging and likely to turn a person into a zombie than ECT.

But in terms of the greatest amount of damage done to the greatest number of people, the real abuses, the real dramas, lie in outpatient, or voluntary, or primary care treatment with drugs like the antidepressants. Where ECT when given punitively, as has happened in the past, might be compared to rape as an instrument of War, in countless outpatient and primary care settings an abuse quite comparable to the sexual abuse of children or sexual harassment happens – much more common than wartime rape and probably much more destructive.

The pink section papers of a Mental Health Act aren't in evidence when we are prescribed an antidepressant. We are free to walk out the door after a consultation, and we think as a consequence that there is nothing to worry about.

But these drugs are available on prescription only, and when we go for treatment we are linked inescapably to the prescriber. In the ordinary course of events for most of us, going to the doctor is like going to the bank manager or the head teacher – we feel a few inches tall, absurdly grateful for the smallest signs of favour, and often completely forget what we had meant to say. This situation is compounded if things begin to go wrong after some treatment starts, when the doctor may quickly seem like our only way out. We become ever more dependent on him, and grateful.

We are unaware we are heading into a medical version of Stockholm syndrome – the puzzling state where hostages are often close to being in love with those who have taken them hostage. If the difficulties we develop are caused by the treatment and the doctor doesn't recognise that what he has done or is doing is wrong for us, then we become almost hostages to fate.

It can be extraordinarily difficult for any of us to distinguish between the almost identical anxieties, insomnias, and morbid thoughts that these treatments can cause even in healthy volunteers and the anxieties, insomnias and morbid thoughts that may stem from the illness or problem we took to the

doctor in the first instance. It becomes effortless for the doctor to blame any developments or worsening on our original problem, rather than his treatment. With much less going for them, surgeons did just this – blamed the victim – faced with the evidence of memory problems after cardiac surgery, psychotherapists did it in the face of evidence that memories of abuse were sometimes false, and psychiatrists routinely do it when patients get hooked on antidepressants or tranquilizers or get tardive dyskinesia or diabetes from antipsychotics.

In addition to things getting worse for us when a treatment goes wrong, we can become isolated astonishingly quickly. If we approach someone for help, we have to first risk the stigma of being seen to have a mental problem and then also risk being stigmatised as a loser. We risk incomprehension – even if we approach mental health professionals, none of whom are likely to take our side rather than the doctor's. We risk the next prescription being increased to root out the lingering traces of our illogical thinking. No one will call this a reprisal. If for some reason, we are listened to and treatment stops and we get worse, no-one is likely to counsel patience to help see us through what might well be a withdrawal syndrome.

The ultimate bind is that our questions will be put in the weighing scales against the scientific answers and found wanting, and what self respecting doctor in an evidence based medicine era will want to be seen to go against the evidence. Can all the guidelines be wrong? There is no-one on our side who is likely to point out that the so-called scientific evidence has been carefully constructed by pharmaceutical companies, who suppress trials that don't suit their interests, and who selectively publish data from trials so that even a trial that has shown a drug fails to work and can trigger suicide can be transformed into a trial that shows unparalleled evidence of efficacy. No one to point out that pretty well all the trials published in even the best journals are likely to be ghostwritten. No-one to point out in the case of the antidepressants that pharmaceutical companies have moved dead bodies around in a manner that may well be fraudulent. No-one to point out that lawyers and others looking after the interests of pharmaceutical companies regularly take advantage of medical innumeracy to hide even more dead bodies simply by constructing trials so the results will not be statistically significant.

As in other areas of abuse, if we wait for the abusers to recognise the problem we are likely to wait for ever. As in so many other areas from Enron to sexual abuse, it is likely to be women who will blow the whistle. And this is the background against which Rebekah Beddoe's *Dying for a Cure* needs to be read. She outlines a drama of seduction, increasing personal confusion, family bewilderment, and finally survival against the odds. But she is also offering a Manifesto.

What she describes will seem unbelievable to many – although not to those who have been through the "system". Could it happen here in Britain in 2009? Absolutely. Countless dramas of this sort happen in British clinics every day – and not just within the mental health domain. Any area of

medicine that has a large number of currently on patent pharmaceuticals, for respiratory or cardiac or other conditions, can be infected in the same way. The truth is that as 2009 slides into 2010 and beyond we are increasingly less likely to get good medical care – by which I mean when a doctor cares enough about her patient to put their welfare first even if this means taking on an employing organisation, or the medical or scientific establishment.

Dying for a Cure calls out for a movie to be made of it – but we are likely to be waiting a long time for some future Clint Eastwood or Spike Lee prepared to take on this challenge. What stops them? In contrast to ECT, the problems found in Dying for a Cure are ones in which we are all complicit. This makes the project difficult but also adds to the interest. If movie directors are not prepared to take on the challenge, as a matter of honour they should desist from making movies like *The Changeling* or *Girl Interrupted*, which in fact play a part in perpetuating the kinds of abuse that Rebekah Beddoe outlines so vividly here.