

10: FOOTPRINT in the SAND

The trajectory of Western medicine from 1800 hinged on developments in our understanding of extraordinary complexities at the interface of biology and society. Success impacted on our life expectancies, and our identities.

Before 1600 Europe had seen Cathar, Waldensian, Lollard, and Hussite movements, and religious revivals, with many convinced the End of Time was near. Concerns about Satan and all his works led to witch-hunts and an Office of the Inquisition. Identities were at stake in these crises; would we be among the damned or the saved? Luther's 1517 proclamation split Christian identities, leading to savage wars and a rise of national identities.

Charles I's decapitation marked a point at which a hierarchy fractured. *Hieros* refers to a primacy of the moral or sacred in society and a need for justice and benevolence. Till then, the discretion of a monarch underpinned justice and the care of others, making hierarchy another word for top-down government. In the new world, something else was needed.

Supported by the role of techniques in triggering science, Descartes, Locke, and Kant filled the void with the ideal of an autonomous subject reasoning in a detached way about our place in the universe. This individual wouldn't take the word of the Ruler as gospel. In this dispensation, the requirements of justice and benevolence led to constitutional government, the idea of universal human rights, an independent judiciary, the development of contracts and later welfare systems.

A Romantic reaction insisted this vision fell short of what was needed. The decapitation of Louis XVI indicated that liberal civilization was a thin crust beneath which molten lava swirled. The detached approach, the romantics said, was taking us into a world of instruments, procedures, and bureaucracy. We must supplement philosophy and science with something else. Some turned to Nature, others to Art, some to the People, others to forces rolling through history that religion had harnessed but technocracy seemed less able to grapple with.

Techniques and procedures embody an intelligible element, an algorithm. Everything that functions from bacteria and viruses to thermostats and computers must have an intelligible basis. Is there more to humanity than a collection of intelligible elements? In caricature form, science and technocracy says no. Marxism and psychoanalysis were in this sense romantic. Semi-religions reborn in a scientific age. Their technical aspects gave the appearance of science, but the materialism of dialectical materialism and the libido of psychoanalysis were mystical concepts rather than entities with a precise meaning.

As Charles' and Louis' heads came off, medical colors began to replace religious colors. Contagion which had encompassed the spread of social deviance, such as homosexuality and drug abuse, would be restricted to infectious conditions. In the 1860s, ideas about how biology might lead to social degeneracy facilitated the first descriptions of schizophrenia, colored Lombroso's *L'Uomo Delinquente*, the first study of psychopaths, and underpinned racism and eugenics. In the 1920s, the establishment of departments of health were an early marker for bureaucratic totalitarianism.

By 1960 health was poised to replace religion in shaping our identities. Authenticity had become the keyword which, rather than having a spiritual reference, increasingly meant being psychologically adjusted and now means physically adjusted. As the health universe embraced all of life, we gained bodies we were responsible for. As life became a commodity, we looked for

the warranty we came with. And as healthcare turned into health services, pressure grew on us as consumers to establish and manage our identities where before our selves had stemmed from the communities in which we lived.

The Tyranny of Numbers

Periodic starvation has been culturally sanctioned for millennia, and the 2016 Nobel Prize for medicine endorsed the idea that fasting may be good for us. In the 1870s when fasting was still religiously sanctioned, a new condition, anorexia nervosa was described in France. It affected women more than men. It increased in frequency through the twentieth century and increased exponentially in the 1960s, throwing up variants such as bulimia nervosa, where weight is controlled by purging and vomiting. Its prevalence in Western settings, grounded speculation on the changing roles of women in the West, the role of child abuse, and trauma.

None of these theories explain anorexia nervosa any better than its link to weighing scales. It emerged with the first weighing scales for people. It became more frequent when the life insurance industry linked weight to health, and public weighing scales began to carry ideal weight norms pinned to them, with beauty linked to these norms. It mushroomed in the 1960s as weighing scales migrated into homes. As weighing scales spread, it spread.

Scales, like stopwatches or any measuring instrument, offer a tool through which we can attempt to control an aspect of our identities. Measurement becomes maladaptive, even life-threatening, if we measure one aspect of our lives intensely and neglect all else. Just as social conditions and constitutional differences interact with microbes to produce infections, social conditions and temperaments interacting with intense measurement can infect our identities.

In the 1840s, a thinning of bone density was linked to fractures in a small number of people and labelled osteoporosis. In the 1980s, the advent of bone scanners and their dissemination by companies marketing bisphosphonates created a socially rather than a clinically defined condition. The new diagnosis happens decades earlier than the traditional one, with even teenage girls now aware of it. It leads to maladaptive behaviors, such as increased inactivity. Rather than a poison that brings about benefits, bisphosphonate drugs make serious fractures more rather than less likely, a not surprising consequence of abnormally thickening bones.

In Type II diabetes, a premium on monitoring blood glucose levels by machinery can lead to a loss of the ability to read our own bodies. This combined with aggressive treatment to keep sugar levels within narrow bands has increased the incidence of hypoglycemic (low sugar) episodes. We are told we must achieve tight control of raised sugar levels or risk losing our eyesight or feet, rare in Type II diabetes. We are not told that hypoglycemic episodes can cause dementia. By doing as we are told, we help doctors meet targets set by health service providers. They have stopped helping us lead the lives we want to live.

Measurement linked disorders will become more common in an era of Health Apps geared to map our heart and brain waves, and fluctuations in our moods and attitudes. Every variation from the average can be portrayed as risky. Even without a marketing overlay, these Apps will cause difficulties for many. The Marketers, poised in the wings, are aware that measuring throws up data for which, "because you're worth it", their drug or technique can be an answer. Apps are more likely to be the drop of ink that clouds an identity; more likely to create dis-ease than liberate us from disease.

The Tyrannies of Beauty and Brains

Hair loss in men can be immensely distressing. It often begins when appearances are most

important. The distress stems in part from the premium our culture puts on the superficial. Internet forums for men grappling with hair loss reveal bitterness, misogyny, and confusion at a “vanity” the sufferer never expected. Those affected obsessively self-monitor. Their obsessions are neither delusions, nor obsessive-compulsive, but can be equally debilitating.

The distress may be aggravated by sensory changes when the rate of hair loss is greatest. Accounts of rapid hair loss talk of periods when the crisis passes, perhaps when a reduced rate of loss allows the conflict to slip out of awareness. Strategies to take control, such as shaving hair off, help some.

New options such as treatment with finasteride (Propecia) or transplants have emerged. While these restore hair, part of the benefit may stem from a restoration of agency. This availability of treatments, while helpful in individual cases, has probably done something to reconfigure hair loss as a medical disorder. When is it appropriate to support a turn to finasteride or transplants and when not? Finasteride is not harmless: it can cause permanent sexual dysfunction. It needs as much wisdom to know when to use it, as it does to know when nose-straightening, breast augmentation or reduction, or vulvoplasty may help. Yesterday’s wisdom may not be today’s. Viagra, for instance, swept aside a clinical wisdom that once stressed the need to grapple with the psychodynamics of impotence.

Propecia and Viagra mark a new domain in which enhancement is possible and where we have to negotiate identities. Can we distinguish a medical use of stimulants for hyperactivity, or HRT for menopausal symptoms, from the use of these drugs in efforts to keep up with others? Medicine and surgery traditionally restored us to our place in the social order. Plastic surgery, HRT, and stimulants enable competition for places in the social order.

Our increasingly unequal world has put a premium on education. Tiger parents now push children to tick the boxes that will ensure entry to degree courses to ensure their future. University students increasingly take psychotropic drugs that, like glasses for short-sightedness, they perceive as managing glitches holding them back from being themselves. This is an intensification of the ‘gardening’ process Western nations turned to in the 1930s.

Should the management of dis-eases like these and the treatment of disease be funded in the same way? What does healthy aging now mean?

The Tyranny of Identity

A diagnosis of a terminal condition can plunge us into a mismatch between our hopes and plans and the exigencies of our situation, an identity crisis. Faced with an option for chemotherapy, identity issues shape the choice of whether to opt for quality of life or a brief extension of life. In the 1970s, clinicians dealt with these concerns, but even in palliative care they now default to antidepressants.

For most of the twentieth century it was accepted that adolescents became semi-psychotic as they struggled to find their place in the world. The traction Erving Goffman, and R.D. Laing had in the 1960s hinged on a growing importance of identity. These agonies, once seen as important, are likely now to lead to a psychotropic drug prescription.

If identity issues became overwhelming, we could once get away to another set of expectations. A century ago, Archibald Belaney moved from England to Canada and became Grey Owl. With the development of television, there was interest in things Native American and Grey Owl featured as an exemplar of the Native way of life and its emphasis on conservation. When it was

discovered, after his death, he was English, he was regarded as a fraud. Ethnic Dysphoria Disorder, a recently invented term, is not an historical curiosity. Rachel Dolezal's claim to be African American worked for years but came unstuck in 2015. She too was regarded as a Fake.

Many religious vocations have likely been driven by similar needs. The sense of being a fraud, or the felt risk of being outed as a fraud, are tied to identity issues with many successful women afraid of exposure as imposters.

Since 1960, these issues have come to their clearest focus in gender "politics". While several states we might now call transgender date back centuries and some filled a social niche, before 1970 gender was a grammatical notion. The modern story began in the 1950s with new technical possibilities. Pierre Deniker, of chlorpromazine fame, describing one of the first cases in 1955 predicted the new media would put a trans-sexual option on the radar for an increasing number of people at odds with themselves or their situation.

Just as with the sensory input in hair loss, a physiological input may drive a desire for radical change. But whether biologically or socially driven, in transgender cases, the level of distress in being at odds with what feels like a truer identity compares with the distress faced by people with obsessions or psychoses. Getting involved in a gender reassignment program may help some in part, as with finasteride, because of the element of control it offers.

The force-field around gender is dynamic. Early transgender programs soon faced new non-binary states. Where the bulk of those involved initially were older men, by 2010 there was an emerging epidemic of rapid onset gender dysphoria among young women. This had cult-like features reminiscent of the Children of God and Moonies of the 1960s. Young people with any self-doubts faced pressure to decide about their identity immediately, paying no heed to non-believers, branded as transphobic.

Regulatory bodies began claiming transgender states are no more a disease than homosexuality. But rather than leaving people alone to be who they are, the regulators required clinicians to "treat" these dis-eases with hormones, especially if anyone threatened suicide. Doctors were told that requests to delay puberty with hormone-antagonists, like leuprolide, which have shocking side effects, should be undertaken without question.

This is the 1960s turned inside out. The labels are the condition. The issues are so complex and fast moving that nothing can ever be shown to work, yet mandatory guidelines for these conditions that need judicious input, emerged. Anyone raising questions about transgender states, even gay activists concerned about latent homophobia, risked being No Platformed.

There is a limit version of trans-states – apotemnophilia. An individual with this condition feels they will be more themselves without an arm or a leg. The idea that abnormal bodily sensations might underpin this was recognized in the 1890s. Following amputation, some report feeling better. The Internet now enables those affected to find and support each other, but it equally risks seducing some into thinking their dis-ease stems from this source. Without a realization that dis-ease may stem from existential discontent or abnormal physical sensations and states in between, some of us risk surgery we might regret.

The Forgotten Man has a core discontent that for centuries, perhaps millennia, has led to a turn to religion and politics. It's difficult to draw a line between what health/identity sites on the Internet do now and what religious sects and political movements have done for centuries. Will a consumption of body modifiers slake this thirst for something else?

Autistic Spectrum Disorders (ASD) is another happening. Autism is a serious medical disorder that emerged in the twentieth century. ASD diagnoses exploded after 1990. Some parents seek a diagnosis for social advantage. Others checking criteria on the internet tick enough boxes to make a diagnosis, which presented to a health professional may confirm a diagnosis of ASD - as professionalism has been so hollowed out practitioners are unable to counter horoscopes like this. Meanwhile, 'neurodiversity' became fashionable enough to feature in situation comedies about lovable nerds (and their transparents).

As the wars between Protestants and Catholics, or Sunni and Shia show, struggles around identity can be vicious. Battlelines are now drawn between those who celebrate and those unwilling to celebrate gender diversity. Some neurodiverse individuals berate the parents of autistic children for drawing attention to the real disabilities of their children. This is a modern Gnosticism. An identification as Christian without buying into a Crucifixion.

Powered by a search for identity, the speed with which transgender and neurodiverse stories have unfolded suggests a religious revival of yesteryear. Untouched by drug, device and therapy markets, these conditions force us to confront the fact that we cannot simply blame Pharma for our difficulty in knowing whether to turn to politics, religion, or health.

Direct to Identity Adverts

Our search for identity drives the marketing of drugs from Prozac to Viagra. This is clearly seen in drug adverts, which like pornography might throw up options we have not considered but basically work on our pre-existing desires.

Humira was the best-selling drug in the world in 2018. Linked to a monoclonal antibody, it was one of the first biologic drugs. This novel mechanism justified an eye-watering price when it came on the market in 2003, for severe rheumatoid arthritis, a state rare enough to enable Humira's development as an Orphan Drug. It became a best-seller by pushing the envelope to psoriasis and other conditions despite causing an acquired immune deficiency syndrome that, like AIDS, can leave us at risk of opportunistic histoplasmosis, tuberculosis, and other infections as well as unusual cancers. The company knew about these hazards while running adverts featuring women wanting to wear bathing suits or backless dresses but inhibited from doing so by minor psoriatic blemishes at the base of a hairline.

In the wake of Humira, other high-cost biologics have been marketed for skin conditions. The marketing is almost entirely about identity; the physiological effects of the drug are close to irrelevant. It trades on the insights of Erving Goffman on illness and identity, in a way that equally effective non-drug treatments for acne and psoriasis never did. Panels of patients with genital psoriasis are convened to advise marketers on how to encourage us to grasp control by identifying as psoriatic (or bipolar, or at risk from our lipid levels or bone densities).

Taking Valium in the 1970s was pleasant but a sign of weakness. Taking Prozac in the 1990s was less pleasant but it told others we were in control. We now embrace the asylum as our new home. The claim of the 1950s drugs that emptied the asylums was that we would recover because they cured our disorders. Out of the asylum, some of us recovered in a different sense -- we no longer defined ourselves by our disorder. Modern marketing outdoes the witches in Macbeth by holding out the promise of barely effective medicines to our ears, while breaking it to our hope by making it impossible for us to recover in either the first or the second sense.

Life without a "condition" is becoming rare. In the 1960s, antipsychiatry branded psychoses as

political rather than medical events. Now both medicine and antimedicine embrace dis-ease as a health rather than a political issue. Even the drug-free are affected. Efforts to market drugs for sexual functioning, for instance, change our expectations about clitoral sensitivity and erections, in the process redefining the experience of lovemaking. The use of Apps fine-tuned to our emotional states will aggravate this.

The alienation of the Forgotten Man does not stem from companies extracting value from our biologies as capitalism extracted value from land or labor. Companies are not scouring our biology ever more thoroughly. It is our dis-ease that is being mined. Trading on life's burdens, we are offered sacramental means of salvation. Our selves have become a brand we have to manage.

In the Line of Fire

In war, soldiers in fugue states may end up densely amnesic, with symptoms but without abnormalities on testing, or, as Beecher found, feeling less pain than expected from serious injuries. These phenomena led some doctors into psychiatry after World War II and others into family medicine where they face requests to certify sick-leave or prescribe medication often without a clear basis.

Even among psychiatrists, who prescribe SSRIs almost regardless of diagnosis, there is a bias toward seeing these phenomena as mental. The patients are diagnosed as somatising, or emotionally unstable, codes for hysteria.

In the 1990s, the concept of Medically Unexplained Symptoms (MUS) emerged, with estimates that MUS show up in a third of family medicine and half of secondary care presentations. Peripheral neuropathies and gynecological symptoms are particularly common along with back pains, headaches, abdominal pain, and fatigue. Women present more often than men, even discounting their greater overall use of healthcare.

It was hoped MUS might capture a middle ground and enable physicians and patients faced with symptoms to acknowledge uncertainty. But, physicians default into viewing MUS as somatization, and patients default into anger at a medical system that can't diagnose them or hints their condition is psychological (unreal).

As the delicate art of clinical medicine took shape between 1800 and 1900, it enabled some physicians to keep a door open to uncertainty. Adopting the medical model, they viewed what presented in clinical settings in a particular way even though this approach did not lead to immediate answers. We, who came to them for help, may have been able to let them do this because there was less expectation that a ready answer was at hand and both they and we were less constrained by tests.

Clinical medicine is now in a precarious position. Through to 1960 clinicians continued to observe subtle abnormalities of the kind that had been the hallmark of medicine. But clinical observation is drying up, with a turn to doing, aggravated by an increasing array of tests, Freud's message that words in clinics don't mean what they might appear to mean, and company abilities to block publication of treatment effects (chapter 11).

If we take symptoms involving our skin, senses, gut, or muscles to a doctor today, s/he will know little more about these systems than we knew one hundred years ago. Many patients with burning feet, strange sensations around their body, food intolerance, or pain syndromes have MUS. Given our increasing exposure to chemicals and pharmaceuticals, whose effects are

largely unexplored, these complaints could be a gateway to new discoveries. The War indicated that part of the clinical art lies in recognizing the contribution of context to the expression of symptoms, and the role of a cultural pool of symptoms into which we dip when grappling with distress. Whatever it was about the 1950s context, it was possible for doctors then to put new occupational injuries on the map and recognize the role of toxins and medicines in causing birth defects and adverse events. If these are not being explored now, we should look to the context in which physicians operate.

This should be but is not a golden age of clinical medicine. It is not possible to publish cases linking a new condition to a current treatment. New phenomena like asexuality, or permanent sexual dysfunction following treatment with antibiotics, isotretinoin, or finasteride are missed or dismissed. People presenting with numb genitals, following which they lose libido, or sensory and emotional numbing that leads to depersonalization, suggest there is more of us in our bodies and less in our “minds/brains” than our current cognitive-centricity concedes. But these leads to Who or What we are do not fit with current marketing or service plans.

Hyper-reality

In 1961 Erving Goffman brought identity center-stage. In *Gender Advertisements* (1976) he anticipated the major features of Direct-to-Consumer Advertising of medicines. This now \$6 billion industry focuses primarily on women and risk states. Goffman framed adverts as hyper-ritualization, something borrowed from daily life which exaggerated becomes more real than reality. A fetish. Women are transformed into Madonna or whore.

Hyper-reality is central to Brands and Identities. While there was a ritual to taking a 1960s drug, drug effects were anchored in a flesh and blood world. Treatment could go wrong. By 1990 branded drugs had stepped back from this world and become sacraments or fetish objects. Nothing could go wrong. Up to the 1960s, our selves arose in part from communities where others knew our strengths and weaknesses and where we came from. By 1990 we had identities, that like brands, cannot permit internal contradictions. We exist in an already saved state, unless held back by some chemical or psychic glitch in need of treatment.

In 1980, DSM III flung an operational bridge across the divide between the biological and social sides of medicine. Like many management processes, however, operational criteria give the appearance rather than the substance of solutions. Before 1980 two opposing camps struggled for the soul of medicine. Both camps are now unidimensional, operational criteria adherent.

Like adverts, operationalism has become more real than reality as the Trauma DSM brought into being demonstrates. The 1980 criteria for Post-traumatic stress disorder (PTSD) stated the trauma should be exceptional and compromise most people’s function. The push to establish the new disorder came from US military veterans, many of whom were morally conflicted. It did not come from Holocaust survivors, the Vietnamese, the Irish, or others savaged by invaders.

Once let loose from the committee room, Trauma became a badge of identity. It fanned the flames of a growing concern with sexual abuse during childhood. For some Trauma became the cause of every psychiatric disorder from schizophrenia to anxiety. The bandwagon was temporarily checked in the mid-1990s by a series of legal verdicts against therapists for recovering memories of abuse that hadn’t happened.

Trauma recovered momentum with a study on Adverse Childhood Experiences (ACEs) published in 1998 in the *American Journal of Preventive Medicine*, showing that children experiencing physical, sexual, or emotional abuse or neglect, or witnessing domestic violence,

substance abuse, relationship break-up, familial mental illness or incarceration of a family member, were more likely to have nervous disorders, high risk behaviors including alcohol and drug abuse, and health conditions from diabetes to heart attacks. The more events, the more likely later conditions.

Acute trauma following a disaster is as much a medical emergency as acute lead poisoning. Both can be managed, imperfectly. Both chronic lead poisoning and chronic adversity knock points off an IQ, lead to delinquency and future health conditions, but there is no reliable treatment for either. The largely American literature on both avoids referring to race or class, but experiences such as having a parent imprisoned, like chronic lead poisoning, speak strongly to race and poverty. Being brought up in fractured homes can create a loss of agency that leaves us less well placed to manage our selves afterwards, and at risk of perpetuating a cycle. Findings like this call for collective actions to rejuvenate slums, provide community supports, lift families out of poverty, and to identify and support children at risk. They do not call for trauma-informed therapy.

We need to distinguish between specific toxicity and generic inequality or adversity. A judgment is needed as to whether the difficulties this person, with a history of adversity, has stem from adversity or not. Funneling people with ACEs into programs where they meet therapists who believe trauma is everything, whose practice, now that they can point to evidence that a host of minor adversities can cause problems, cannot be gainsaid, is not a recipe for success. Despite the Recovered Memory story, these programs have little appreciation that the coping styles of some of us involve abilities to provide what a caregiver seems to want. If they want memories of trauma, many of us can convincingly relive things that never happened.

Chelating lead to remove it from the body is necessary in acute lead poisoning. Chelating lead chronically lodged in bones and other organs can do more harm than good. Chelating chronic trauma can become the trauma it seeks to cure.

The failure to exercise clinical judgment in these areas has turned negative or strong emotions, micro-aggression and bullying into mental health issues. These important dis-eases need remedies; social or clinical that is the question.

Biology has become a calling card of traumatology. Cortisol levels are supposedly raised in ACE patients. Elevations of this stress hormone can be loosely linked to heart attacks, diabetes and other health conditions. But this cortisol is as much part of a biobabble as serotonin is. There is a failure to appreciate that biology varies among individuals and that social class and hierarchies are built into our biologies. The resulting variations may bring a disadvantage in certain settings. Intervening in variation, however, is not the same as correcting an abnormality.

In contrast, the Dexamethasone Suppression Test (DST) pointed to an abnormality of cortisol in patients with melancholia but not neurotic depression. It picked out patients likely to respond to tricyclic antidepressants and not SSRIs. Just as with the cortisol of traumatology, EEGs also show inter-individual variations in brain-wave patterns that could be studied endlessly. Like the DST, though, it is the ability of EEG patterns to reveal an abnormality that responds to anticonvulsants that makes EEGs clinically useful. The EEG was too established to be eclipsed by the changing culture around 1980. The DST wasn't established, and its eclipse offers a symbol for the changes this chapter covers.

We are increasingly able to map bodily variations from brain activity to cholesterol fractions, patterns of bone density or ACEs. A complete map of the Risk Empire, the goal of Health

Service Cartographers, however is nothing to do with HealthCare for which the goal of a diagnostic test was to capture a variation malignant enough to warrant intervening with a poison. How long must we wait for our new Risk Maps to get discarded along with Borges' Map of the Empire?

Footprint in the Sand

Freud claimed hysteria was caused by sexual abuse in 1983. Soon after, he recast patient claims from evidence of real events into fantasies stemming from an infantile sexuality. Bringing our fantasy life into view was a breakthrough, and clearly most of our fantasies are not based on real events.

Two real events, however, shaped Freud's new analysis. One was a treatment induced injury suffered by Emma Eckstein, a patient whom Freud referred to Wilhelm Fliess, a surgeon who claimed to be able to control masturbation by removing part of the nasal turbinate bone. The operation left Eckstein with repeated nasal hemorrhages, which Freud argued she produced to get attention.

A prior event primed this explanation. At the time, he asked people in therapy to freely associate. While doing so, one woman, Friday, by his account turned to embrace him. He framed her impulse as a reflection of her desire for her father. Just like finding a footprint in the sand, bumping into rather than just passing by someone, can consternate. Freud retreated from the moment into words. Many wonderful words and astute observations but essentially speculation rather than science with his use of libido having no more anchor in reality than serotonin a century later. He kickstarted a psychobabble.

Drug Wrecks, from the phocomelia of thalidomide to the spiral fractures caused by bisphosphonates, are now our greatest source of disease and mortality. Badly traumatized, those affected may be unable to raise concerns with their 'abuser'. Trauma focused therapists, people who routinely denounce biomedicine and supposed chemical imbalance in tones Christians reserve for Satan, never engage with this. They never attempt to tackle a power that silences us and them.

Psychotropic drugs are especially pernicious in that treatment induced hallucinations or suicidality can lead to legal detention in hospital. where the treatment that is our illness is forced upon us. Psychologists, nurses, or others, rather than confront prescribers, side-step conflict by claiming they reject the medical model. But it's not possible to claim a drug might cause suicidality, aggression or dependence without a medical model. Drug wrecks are the best evidence for the medical model. In the case of drug wrecks, we are not up against biomedicine but against the branding that fetishes a drug, makes it hyper-real, a sacrament, a fantasy. But who can deal with fantasies now?

We have moved from the Oedipus Complex to the Oedipus Effect. From a world that recognized fantasy and reality could clash to one where the prophecy of the oracle becomes self-fulfilling. "This boy will kill his father" leads to behaviors that ineluctably bring about the horror they were designed to avoid.

Before Freud, trauma produced real and specific wounds, whose edges could be felt. After Freud, the assessment of trauma could not be distinguished from the interpretation of träume (dreams). Reality and fantasy blurred. Now we have a babble of trauma imbalances and chemical imbalances with neither having a footing in considered judgment.

Freud's encounter with Friday prefigured the idea of boundary violations. A therapist should not take advantage of us, should not use a position of power to get us to do what he wants. With the erasure of the boundary between dis-ease and disease the identities of both prescribers and therapists have been disordered and both, increasingly promiscuously, take advantage of us.

The Forgotten Woman

In the 1980s a concern about abusive clergy emerged in Ireland. It led to the fall of the Irish Government and triggered a crisis that engulfed the Catholic Church worldwide. The crisis came to a head during a visit by Jose Mario Bergoglio to Chile in 2018. Facing anger about the Church's failure to confront child abuse, he effectively responded: if you have faith you believe in us [the clergy] but for us to believe in you [the abused] we need proof. The powerful are innocent until proven guilty. The powerless have anecdotes but not evidence.

Substitute prescribers for clergy and drug wrecked for abused and we have *Shipwreck's* central point. A doctor or a therapist confronted now by a patient raising adverse treatment effects recoils like a Freud, or a Pope, facing a footprint in the sand. Bumping into others risks a loss of control and might change an identity.

Sexual abuse is now reported because there has been a loss of deference to former pillars of society. But although drug companies are not popular, our fear of challenging them has grown. Despite increasing talk of bullying and micro-aggression, no-one mentions how nasty doctors get when adverse effects are raised. Powerlessness compromises agency.

The Irish struggling with English power found their efforts portrayed as feminine emotionality in contrast to the masculine rationality of John Bull. Combatting power and its colonizing effects became central to Irish identity. But colonization is not a medical disease. Combatting power is a political matter.

Combatting power should not mean combatting science. Science is visionary. It harnesses techniques but is not technical. It works when shared not when sequestered.

The algorithms we are up against are not science. Operationalism is an ideology not part of science. But the intelligible elements, algorithmic processes, we, the people, have since Charles I put in place with which to govern ourselves can be capitalized and become crushingly powerful, as Google and Facebook now show.

In contrast, what had been valuable but is now suspect is judgment and discretion. Marx was one of the first to note this. While his primary framing was in terms of workers being alienated from their labor, Wall Street picked up on his point that alienation was capitalizable. What from 1860 to 1960 looked like an alienation of workers from the work of their hands, now looks more like an atomization of all of us and a loss of the solidarity that comes from bumping into each other. We no longer meet our doctor, our bank manager, the chef, the owner of the Inn. We are not recognized by anyone. Although increasingly filled with intelligible components, our systems are increasingly lifeless.

There will be no birth of freedom if government of the people, by the people and for the people means following rules even if notionally generated by us the people (governance). Freedom will only come with leadership by us, for us.

A footprint in the sand can't be managed by an algorithm or discourse analysis. It faces us with a judgment call and an embrace of risks.