

# The bioethics of cosmetic psychopharmacology

The term “cosmetic psychopharmacology” was introduced by Peter Kramer in his best-selling volume, “Listening to Prozac”.<sup>1</sup> This is a thoughtful piece on the possibility that psychiatric medications can be used not only for major psychiatric disorders, but also for sub-clinical symptoms, and on the possible consequences for patients, psychiatrists, and society at large. This is not a new issue; barbiturates and benzodiazepines, for example, were earlier seen by some experts as a “pill for every mental ill”, but the broad-spectrum efficacy and relative tolerability of the selective serotonin reuptake inhibitors (SSRIs) have brought significant attention to the implications of cosmetic psychopharmacology. Similar discussion has also taken place in other areas of medicine including genetics and surgery.<sup>2-7</sup>

What should a medical practitioner do when approached by a patient who states that they have read that SSRIs are a major advance in psychiatry, that they suffer from depression (that does not meet criteria for depression or dysthymia) or shyness (that does not meet criteria for social anxiety disorder) or from general dissatisfaction with themselves and their relationships (that does not meet criteria for a personality disorder), and that they would like to at least try out a prescription? This question can be unpacked into several sub-questions, and I will try to address at least some of them in this brief editorial.

First, there is the question of whether the SSRIs are in fact effective in these disorders? It turns out that there is remarkably little evidence on this question. There have been a few studies on the effects of SSRI administration on normal controls<sup>8</sup>, suggesting that perhaps some subtle benefits are visible, but these are short-term studies, and they don't address whether unwanted symptoms change. There is some evidence that SSRIs are effective for so-called minor depressive disorder, but the database is limited.<sup>9</sup> Given the value of SSRIs in dysthymia, social anxiety disorder, and personality disorders, it may be argued by extrapolation that these agents will also be beneficial for sub-clinical symptoms, but again there is little data at hand.

Second, there is the question of whether such treatment is good for society. From a more philosophical perspective, some have argued that society should pay for the treatment of disorders, but that society has no obligation to pay for “enhancement therapies”.<sup>10</sup> But if sub-clinical depression, anxiety, and personality problems are associated with significant disability, and respond to a medical intervention can they really be said not to be disorders? In the case of hypercholesterolaemia, as the risk of increased cholesterol has been appreciated, and as the cost of statins has decreased, so the recommendations about what levels of cholesterol to treat have been consistently lowered.

Third, from a medical perspective, the decision about

whether or not to treat, and certainly about whether or not a medical aid will cover these costs, is the issue of cost-efficacy. This depends on working out the effect size of these agents, and then weighing up the costs of treatment, and the benefits of treatment. So again, this is data that we don't have. But what if the patient responds that he or she is willing to bear the costs of the medication trial, even if a medical aid refuses to cover these? Here we are back on the ground of whether or not it is good to try to use “cosmetic psychopharmacology”, irrespective of data on the current efficacy and cost-efficacy of a particular drug.

I'd suggest that there are 2 broad philosophical and ethical approaches to this debate. The first derives from a classical view of philosophy and ethics, in which philosophy is seen as providing general principles. Specific cases (such as that of the patient seeking cosmetic psychopharmacology with a SSRI) can then be considered against the backdrop of such principles. The problem with this approach is that algorithms and rules are useful for thinking about concepts like squares (all squares are 4 sided figures), but not so useful for thinking about concepts like persons and symptoms (some conditions are typical of psychiatric disorders, others are less so, the boundaries are porous and hard to define).

The second derives from a critical view of philosophy and ethics, which argues vociferously that the classical version doesn't work. The language we use in discussing scientific and medical matters is not value-free, instead it betrays our particular ways of life and social practices. If we say that a condition is a medical disorder, then we imply that it is worth treating (irrespective of cost). If we say that an intervention is an enhancement, then we imply that it is something doctors don't do but rather that it falls in the realm of those interested in what we might call “schmoctering”.<sup>3</sup>

“Schmoctering” is of course extremely popular. Schmocters include for example people who market aromas to improve one's aura, or use steroids to increase an athlete's chances of winning; this is one of the oldest professions, and remains in great demand. Doctors who believe in the classical approach think that schmocters are at best deluded, and at worst, charlatans. Doctors who take the critical approach may think that schmoctering offers some patients better value than doctoring (which is often criticized by this approach as overly technological and reductionist, as having lost its ability to provide people with meaningful interventions).

Society at large follows a similar split. There are those who believe that it is important to strive for self-improvement, and that anything that can be done along these lines is valuable (whether it be education, or using cosmetic surgery or cosmetic psychopharmacology). And then there are those who value tradition and authenticity; if we want to make people happier, we would do better to make sure that they become

active participants in their communities, that they do the hard work of exploring their own minds and motivations, that they use authentic ways of solving their problems.<sup>11</sup> To focus only on the "thin" technological endpoints of symptom recovery misses the "thick" process whereby the method used to achieve change has a range of other consequences.<sup>3</sup>

My own view is that both the classical and critical approaches are partial at best. The classical approach makes a contribution (the principal of "first, no harm" for example is certainly useful), but overly optimistic in thinking that such broad ethical principles lead in a formal, logical way to decisions about how to weigh up different values. The critical approach makes a contribution by pointing out that words are not mirrors of realities (rather they help construct reality) and by indicating to what extent facts and values are intertwined. However, the critical approach runs the risk of arguing that we cannot make reasonable and informed decisions about differences in opinion on scientific and medical matters.

How do we make reasonable and informed decisions about complex medical matters such as the patient discussed earlier? Well, it turns out that medical practitioners do this all the time. In large part, the devil lies in the details, and good medical practitioners are better at figuring these out and weighing them up, than are bad medical practitioners. (My view of schmocters is also detail dependent; some schmocters are really practicing good medicine, eg. vaccination is an enhancement that has deservedly become part of good medical practice; some are just bad medical practitioners; some are helpful to their clients in non-medical ways).

If the patient described earlier gave a history that they had been abused as child, that several previous medical interventions in their own life had also felt abusive, but that Peter Kramer was their last true hope, I would guess that a trial of cosmetic psychopharmacology was not the way to go. Instead, it would be important to build a relationship with the person, and to try and explore why therapeutic interventions were so invariably experienced as negative. This kind of patient highlights the significant limitations of the current evidence base for cosmetic psychopharmacology.<sup>12,13</sup>

If on the other hand, the patient gave a history demonstrating good insight into themselves, of having used different psychotherapies to enhance this insight, of a family history of response to SSRIs and that for them the idea that they could suffer from a neurotransmitter alteration rather than a psychologically based problem was a potentially authentic

one, then I would be happy to prescribe a medication, and to help the patient determine whether there was in fact a good response. There is no a priori ethical reason for always rejecting the use of cosmetic psychopharmacology, and indeed in some cases it may be good medical practice.<sup>14</sup>

## References

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