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Can there be a 'cosmetic' psychopharmacology? Prozac unplugged: the search for an ontologically distinct cosmetic psychopharmacology

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Abstract

'Cosmetic psychopharmacology' is a term coined by Peter Kramer in his 1993 best-seller, *Listening to Prozac*. It has come to refer to the use of psychoactive substances to effect changes in function for conditions that are either normal or subclinical variants. In this paper, I ask: What distinguishes an existential ailment from clinical depression, or either of those from normal depressed mood, melancholic temperament, dysthymia or other depressive disorders? Can we reliably distinguish one from the other? Are the boundaries of illness and disorder really so distinct? If not, how can we know that treatment of 'depression' with Prozac in any given instance constitutes a cosmetic as opposed to, say, a medical or clinical use of psychopharmacology – a distinction that seems to turn on our ability to clearly differentiate the clinical from the cosmetic. If we cannot reliably distinguish between such conditions, can we even have a cosmetic psychopharmacology that is not a form of malpractice, broadly speaking? What if we unplugged Prozac from all the amplitude and hype that resulted in *Listening to Prozac* becoming an instant best-seller and simply asked whether or not we can clearly distinguish an appropriate cosmetic use of Prozac for 'depression' from an inappropriate cosmetic use of Prozac, and both of those from Prozac's appropriate clinical, that is, non-cosmetic uses? If we cannot make these distinctions, perhaps it is too early to say there can be such a thing as a cosmetic psychopharmacology.

Keywords: cosmetic psychopharmacology, Prozac, depression, melancholia, drug cartography.

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Introduction

If a patient is not tearful, inappropriately guilty, having trouble concentrating, losing sleep, losing weight, thinking about death or suicide – in short, if she is not clinically depressed – yet she responds to an antidepressant, then what exactly is that antidepressant treating? A personality disorder? Unhappiness? Existential dread? . . . What if Prozac does, in fact, treat existential ailments? What if it really does make a person feel less alienated, less fearful of death, more at home in the world, more certain about how to live a life? Is there anything wrong with this? (Carl Elliott, 1999a, in *The Last Physician: Walker Percy & the Moral Life of Medicine*, pp. 60–61)

Carl Elliott asks a good question: What, indeed, would be wrong with that? Apart from issues of malpractice perhaps, at least in some cases, what is wrong with prescribing an antidepressant for someone who is not depressed but rather is merely – as if this were not difficult enough – alienated, fearful of death, ill at ease in the world and uncertain of the purpose in life? Certainly, some of what is wrong is that this sort of 'existential ailment', whether spiritual, rooted in biology, or both, is part of the human condition. To exist as a human being is to have the capacity to question the meaning and purpose of life, and to know and fear the inevitability of death. This is not disease or disorder. This is a reasonable, natural, expectable, normal, if you will, response to shifts in frameworks of meaning, or to problematic social conditions in troubled times: 'Some kinds of responses to the world are reasonable even when they are disturbing . . . . For all the good that antidepressants do, there remains the nagging suspicion that many of the things they treat are in fact a perfectly sensible response to the strange times in which we live' (Elliott, 1999a; p. 68).

Here and elsewhere, Elliott (1999a, 1999b, 2000, 2003, 2004), who is a bioethicist, expresses his concerns about the medicalization of human unhappiness, an insidious development implicit even in Elliott's use of the term 'existential ailment', and about the implications of a cosmetic psychopharmacology to treat it. 'Cosmetic psychopharmacology' is a term coined by Peter Kramer in the introduction to his much-praised, and much-maligned,[1] 1993 best-seller, *Listening to Prozac*. It is his 'mnemonic' for what he observed as Prozac's effect in transforming the selves of even non-depressed individuals – leaving them 'better than well' and more 'socially attractive' (Kramer, 1993; p. xvi). In Elliott's (2004) words, '[Kramer] was referring to the way psychoactive drugs could be used not just to treat illnesses but to improve a person's psychic well-being . . . [to move] a person from one normal state to another' (p. 1). To summarize, the term has come to refer to the use of psychoactive substances like Prozac to effect changes in function for conditions that are either normal or subclinical variants (Sperry & Prosen, 1998). These are conditions, in other words, that are either clearly not medical conditions – rather, are spiritual or existential conditions, or perhaps are merely part of the human condition – or that might turn out to be medical but are still too subtle to detect as existing medical conditions, or that might turn out to be medical once a sufficiently advanced biomedicine can locate the proper disease category.

What might be wrong with prescribing Prozac, or any of the other new- or old-generation antidepressants,[2] for an existential ailment is an important and intriguing philosophical question – and it begs many

[1]Elliott (2000) calls it a 'splendid book' (p. 8) while Rothman (1994) writes: 'Were *Listening to Prozac* a package insert, it would never get FDA approval . . . To the extent that Kramer is typical of his generation of physicians, it is plain that trusting the medical profession to be strict gatekeepers before therapies, new or otherwise, is foolhardy. Anybody who expects physicians to save us from ourselves, or from the worst imaginable abuses of twenty-first century medical interventions . . . had better start searching for alternatives' (p. 34).

[2]To treat depressive disorders, we now have a long list of new- and old-generation antidepressant medications, including the selective serotonin reuptake inhibitors (SSRIs), the norepinephrine dopamine reuptake inhibitors (NDRIs), the selective serotonin norepinephrine reuptake inhibitors (SNRIs), the serotonin-2 antagonists/reuptake inhibitors (SARIs), the noradrenergic/specific serotonergic antidepressants (NaSSAs), the non-selective cyclic antidepressants (including tricyclics, tetracyclics and dibenzoxazepine), the irreversible monoamine oxidase inhibitors (MAOIs) and the reversible inhibitor of MAO-A

others. First of all, no one seriously questions the appropriateness of treating clinical depression with Prozac. 'Major depression can be lethal', writes Elliott (1999a). 'Up to 15 percent of patients who have major depression commit suicide. For such people, antidepressants can be lifesaving'. Obviously, he is not concerned about the use of antidepressants by those people. What worries him about Prozac is not its use to treat 'illnesses' per se, but rather the possibility that the 'ills' for which Prozac is so often prescribed are 'part and parcel of the lonely, forgetful, unbearably sad place where we live' (Elliott, 2000; p. 8). If so, then something important is lost when we try to medicate away such distress. It is to this Wyatt-Brown (1999) refers when he notes (in *Inherited Depression, Medicine, and Illness in Walker Percy's Art*) that 'pain and ordeal had their indispensable uses' (p. 116) and that 'Dostoevsky taught . . . that [existential] "suffering is an evil, yet . . . through the ordeal of suffering one gets these strange benefits of lucidity, of seeing things afresh" ' (Percy 1985; p. 116). It is fair and accurate to say that Prozac has both legitimate and illegitimate uses. Determining which is which and what is cosmesis and what is medical treatment (or is cosmesis now the same as medical treatment?) has become quite problematic, at least for some philosophers and psychiatrists. Clearly, in order to say that a cosmetic psychopharmacology exists, or is even a legitimate possibility, those who use Prozac to treat disease and disorder must be able to distinguish between the 'ills' that are part and parcel of our unbearably sad world – for which the prescription of Prozac then becomes a cosmetic psychopharmacology – and the medical 'illness' called clinical depression for which the prescription of Prozac is simply an instance of applied psychopharmacology.

So, here are the questions that concern me: What distinguishes an existential ailment from clinical depression – or either of those from depressed mood, alienation, melancholia, dysthymia, or other depressive disorders? (This is not so simple a question as it first seems.) Can we reliably distinguish one from the other? Are the boundaries of illness and disorder really so distinct? If not, how can we know that treatment of 'depression' with Prozac in any given instance constitutes a cosmetic as opposed to, say, a medical or clinical use of psychopharmacology? In other words, how would we know a cosmetic psychopharmacology when we saw one? Is it anything other than inappropriate prescriptive practice, meaning it falls outside the boundaries of the current accepted psychiatric standards of care?

Whether an antidepressant is used clinically or cosmetically seems to turn on our ability to clearly differentiate the clinical from the cosmetic, that is, to differentiate normal depressed mood and the existential ailments that can produce such moods – along with, say, bad marriages and stressful jobs – not only from melancholic temperament but also from clinical depression, dysthymia and the depressed mood that accompanies so many other appropriately diagnosed psychiatric disorders.[3] If we cannot reliably distinguish between such conditions, and thereby determine whether an antidepressant is medically indicated or not, can we even have a cosmetic psychopharmacology – defined as a psychopharmacology for normal variants that uses Prozac to, e.g. 'help

(RIMA). This does not include an equally long list of mood-stabilizing medication often used in conjunction with antidepressants to treat bipolar depression (See Bezchlibnyk-Butler & Jeffries, 2004). 'Prozac' is used in this paper to denote any antidepressant available to treat a depressive 'condition', but particularly those new-generation, low side-effect and high safety profile antidepressants, like Prozac, that ushered in the era of so-called 'cosmetic psychopharmacology'.

[3]Depressed mood can be symptomatic, e.g. of the personality disorders, post-traumatic stress disorder (PTSD), other anxiety disorders, schizoaffective disorder, bipolar illness and substance abuse. In addition, it is hugely stressful to be mentally ill. Almost any psychiatric disorder can be accompanied by depressed mood – not to mention of course, that major depression can co-occur with almost any other psychiatric diagnosis. Sorting all this out can be extremely complex. More often than we care to admit, there is no way to know in any given clinical instance whether treatment with an antidepressant is appropriate or not – except to try it and see whether a patient's symptoms remit. Despite its considerable scientific advances, this may be one of psychiatry's ugly, little secrets – that so much of what it does is still just trial and error.

frazzled parents cope with their kids or to make chronic loners stop fearing rejection' (Nichols, 1994; p. 36) – that is anything other than psychiatric malpractice, broadly (not legally) speaking? Certainly, a psychiatric practitioner who is either inexperienced, inept or disreputable can prescribe Prozac to someone who is not clinically depressed, who does not have any other diagnosable psychiatric disorder, or whose mood is not depressed secondary to some other appropriately diagnosed psychiatric disorder – someone who simply wants, e.g. to be a better salesman (Sperry & Prosen, 1998; p. 55) or to more successfully negotiate a union contract (Kramer, 1993; pp. 1–21). But what distinguishes a cosmetic psychopharmacology of this sort from inept or unethical psychiatric practice, or one lacking a scholarly evidence base, which is not to say that if an evidence base existed for cosmetically treating 'frazzled parents' and 'chronic loners' with Prozac that such practice is proper, that is, morally sound?

What if we unplugged Prozac from all the amplitude and hype that resulted in *Listening to Prozac* becoming a blockbusting, instant best-seller,[4] and that continues to spawn debate, and simply asked whether or not we can clearly distinguish an appropriate cosmetic use of Prozac for 'depression' from an inappropriate cosmetic use of Prozac, and both of those from Prozac's appropriate clinical, that is, non-cosmetic uses? If we cannot make these distinctions, perhaps it is too early to say there can be such a thing as a cosmetic psychopharmacology. Peter Kramer (in Cooper, 1994) states that what makes cosmetic psychopharmacology cosmetic is that it moves a person from 'one normal, but unrewarded, state to another normal, better rewarded state'. However, if we cannot unambiguously determine that the 'unrewarded state' from which one has been moved to that other normal, 'better rewarded state' was, in fact, normal, how can we say this is an instance of cosmetic psychopharmacology? Where at least some mental states are concerned, including depressive states, it is occasionally hard to distinguish between normal and abnormal.

Depression as normal mood or mood disorder?

How are we to tell when a depressed state is normal or abnormal, healthy or unhealthy? In fact, what do we mean when we say someone is depressed or has depression? It seems we must know what depression is if we are to determine whether treatment of it with Prozac constitutes an instance of cosmetic psychopharmacology. Walter Glannon (2003a) notes that most psychiatrists conceptualize depression, at least the more severe types that clearly constitute psychiatric illness, as a disorder of the mind arising from dysfunctions in the brain. He conceptualizes mind as mental states generated and sustained by the brain and consisting in the capacity for cognitive states (e.g. beliefs), conscious affective states (i.e. emotions) and unconscious affective states (e.g. emotional memories) that can arouse physiologic responses when triggered by external events. Although mental states arise from brain physiology, they have a subjective quality and representational content – i.e. they are about something and are uniquely meaningful to the person who experiences them – that cannot be explained in terms of the brain alone. Glannon thus rejects the reductive materialism that undergirds so much of biological psychiatry. This perspective assumes that consciousness and other forms of mentality are not simply caused by neurological processes in the brain; rather, they simply are neurological processes and therefore can be explained entirely in terms of the material or physical structures and functions of the brain: 'But insofar as our mental states have a subjective phenomenology, and insofar as

[4]Rothman (1994) writes that *Listening to Prozac* made the best-seller lists 'before it was so much as advertised or reviewed' (p. 34). In the Afterword to the 1997 edition, Kramer himself calls *Listening to Prozac* 'more than a best-seller . . . the talk of the nation . . . a cultural icon' (pp. 315–316): 'Coverage spanned the media, including *People*, *The Washington Post*, *Oprah*, *Good Morning America*, and *National Public Radio*. At *The New Yorker*, the book inspired one cartoon after another . . . The *New York Times*' banner headline for its year-end summary of the arts was "Listening to 1993" ' (pp. 315–316). The book made Peter Kramer famous. It spawned something called 'the Prozac debate' and dozens more books. Some of us are still engaged in this debate.

their content involves features of the social and natural environment, the mind cannot be explained entirely in terms of the objective physical properties of the brain and body' (Glannon, 2003a; pp. 244–245).

Depression, then, even the so-called clinical kind that Prozac can sometimes treat so well, is always more than reductive materialism would have it. It is never simply biological, although it may be at least, or perhaps even mostly biological. Biological models in themselves are inadequate to explain or treat complex clinical phenomenology (Brendel, 2003a). It sounds right to me that depression results not only from brain and body dysfunction but from mental states as well. If so, factors external to the brain must be considered to properly diagnose and treat the disorder – if it is a 'disorder' – because, again, the mental states that figure in its aetiology have a subjective quality and representational content that reflect the social and natural environment (Glannon, 2003a). My depression is about something; and for me it may not be about, primarily at least, a deviation from normal brain physiology. In other words, a biochemical disturbance in neural transmission at the cellular level may be a factor in my depression, but so is the reality that I live in a dangerous neighbourhood, have no job, no health insurance and no adequate childcare, do not have the resources to move to a better neighbourhood, and increasingly feel helpless and worthless. Perhaps I have come to believe my situation is hopeless. As a single mother, underemployed, poorly dressed, with unmanicured hands and an old car, perhaps I feel unable to 'approximate the currently fashionable ideal of the assertive, confident, resilient, romantically satisfied producer and consumer' (Parens, 2004; p. 27).[5] Whether I have a diagnosable mood disorder or not, might it not be normal, reasonable and expectable to feel depressed under these circumstances? Would we then be using Prozac for cosmetic purposes in medicating this 'normal' state? Or, is it an 'abnormal' state, or only 'abnormal' if it is, or might be accompanied by some kind of biochemical deviation from normal physiology? Here, Prozac may or may not be a necessary intervention; but it clearly will not be sufficient.

> Psychiatric drugs . . . only treat the symptoms of mental disorders; they do not treat the underlying causes . . . Given the role that beliefs and emotions play in the sequence of events leading to depression, [Prozac] is insufficient because therapeutic intervention must also take place at the mental level where the sequence is initiated'. (Glannon, 2003a; p. 250)

Nevertheless, someone is suffering; Prozac might help. It will do no good to simply wait for social conditions to change.

In locating depression and hence a cosmetic psychopharmacology, Martin (2003) points out the importance of distinguishing between depression as a mood and depression as a mood disorder. As a mood, depression is a 'state of low spirits, typically involving painful and low affect' (p. 255). Of course, not all negative, low moods are depressions. It is 'difficult to distinguish depression from grief, sadness, gloom, and a host of additional ways to feel down' (p. 255). Depressed persons are not always sick, and depressed moods are not all bad. They can be important in connection with questions of value, identity and even moral insight: '[Depressed moods] involve negative evaluations of ourselves, major events in our lives, life in its entirety, or the values that have been guiding us' (p. 255) but can lead to a process of evaluation and revaluation that is essentially healthy.

In contrast, depression as a mood disorder is by definition pathologic, even though categories of mood disorder fluctuate in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* (American Psychiatric Association, 2000) with every edition, and there are many additional states of suboptimal health in which *DSM* criteria are only partly met, not to mention that the notion of pathology is itself understood in terms of values – 'the values of health and, indirectly, moral values that define what is culturally acceptable' (Martin, 2003; p. 255). Clarity about definitions and distinctions is essential to gaining clarity about what is being assessed, explained and treated with Prozac by psychiatry and psychobiology. Such clarity is important in determining what is unhealthy or not, and in understanding the continuum between

[5]Parens refers to Peter Kramer's 'abundant evidence' (p. 27) in *Listening to Prozac* that a cosmetic psychopharmacology can do exactly that – help people 'better approximate' currently fashionable social and cultural ideals.

health, suboptimal health and full-blown disorders. Our choice of terminology reflects our attitudes: 'If we think of negative low moods as inherently undesirable then we will tend to use the word *depression* to connote sickness. If we discern value in many negative low moods we will be more likely to use the word *depression* to refer to a broad range of moods, most of which are normal and some of which are pathologic' (p. 258). The term 'cosmetic psychopharmacology' reflects a certain attitude, too. I am just not sure it is an attitude based on clear ontological distinctions between health and illness, depressed mood and depressive disorder, or treatment and enhancement.

Stretching the boundaries of illness

The boundary between health and illness has never been distinct. In fact, social scientists cannot agree that there is a boundary. Are health and illness discrete categories, where you either meet criteria for a disease and thus are ill, or you do not and hence are well? Or, do health and illness exist on a continuum where the boundary between the two is not a line but an entire region with its own indistinct borders? Here, health slides into illness and illness slips back into health almost imperceptibly such that you are not clearly ill or well until you are closer to the extremes of the continuum. Keyes (2002) offers a third option and conceptualizes two separate continua for mental health and mental illness. One can be more or less healthy at the same time that one is more or less ill. Mental health is not merely the absence of mental illness, nor is it simply the presence of high levels of subjective well-being. Rather, mental health conceptualized as a continuum between flourishing and languishing is a complete state consisting of both the relative presence of mental health symptoms and the relative absence of mental illness symptoms. In this schema, the absence of mental health (languishing) is a risk factor for clinical depression (Keyes, 2002).

To make matters more complex, social scientists, medical doctors and philosophers cannot agree on exactly what illness, or disorder is, in part because disorder lies on the boundary between the natural world and the constructed social world (Wakefield, 1992). The biological psychiatrist defines disorder as deviation from normal brain physiology (Olson, 2000). The philosopher may discuss disorder as a moral phenomenon – an essential suffering, the result of which one's life falls short of being a satisfactory or 'good' life in some non-biological sense – and where the appropriate treatment is that species of moral education called 'psychotherapy' (Matthews, 1999a, 1999b). The social scientist details disorder as (1) pure value concept; (2) whatever professionals treat; (3) statistical deviance; (4) biological disadvantage; (5) distress or disability; or (6) harmful dysfunction. Wakefield prefers to conceptualize disorder as the latter, where 'harmful' is a value system based on social norms, and 'dysfunction' is a scientific term referring to the failure of a mental mechanism to perform a natural function for which it was designed by evolution. A mental disorder thus exists whenever a person's internal mental – biological and psychological – mechanisms fail to perform their functions as designed by nature and this impinges harmfully on a person's well-being as defined by social values and cultural meanings (Wakefield, 1992). The relevant function at issue with either existential ailments or depressive disorders is the exercise of effective agency, which can be more or less impaired.

> When the impairment becomes severe, the psychiatrists' *DSM* defines it as [an illness] based on sociocultural standards for normal or accepted behavior. But neither psychiatrists nor sociocultural standards are the final word. Insofar as values are at stake, there is some legitimate domain within which individuals can reasonably make their own assessments, according to their own values, of [illness] and unhealthiness. (Martin, 1999; p. 282)

In other words, my melancholy may be such that a psychiatrist sees a harmful dysfunction (depressive disorder) and recommends Prozac – or does not see a harmful dysfunction, empathizes with my existential plight, and puts his prescription pad away – but within certain limits I have some say. I am the one who feels ill, well or something in between. I am the arbiter of my own suffering. I get to participate in the decision that my melancholy is disorder, or a normal response to disordered times. The question is: What do we call it when neither I nor my psychiatrist is

sure that what I have, although I may feel decidedly unwell, is an illness or a disorder, but we elect to try Prozac anyway? Is this cosmetic psychopharmacology? And if we try Prozac, and it mitigates my suffering such that my overall functioning and the quality of my life on my own account are undeniably improved, is this a cosmetic and not, or not also, a clinical use of Prozac? (A more important question, perhaps, is whether we have done something 'wrong'). Perhaps I may rightfully question whether this is an instance of cosmetic psychopharmacology, which by definition involves the use of Prozac to move me from one normal state to another normal state, because I hardly experienced the painful and debilitating state from which I was moved as 'normal'.

New technologies like Prozac inevitably challenge our definitions of health and illness, stretching their margins and further blurring the boundaries between normal variation (health) and pathology (illness) (Elliott, 1999b).

> Before various reproductive techniques . . . were developed, infertility was simply a fact of nature; now that it can be treated, it is a medical problem. Before the invention of the lens, poor vision was simple a consequence of getting old. Now it is something to be treated by a medical specialist. (p. 26)

Indeed, notes Elliott, doctors now treat an array of conditions that no one considers illnesses with enhancement technologies[6] by which no one is particularly troubled: 'minoxidil for baldness, estrogen for postmenopausal women, cosmetic surgery for people unhappy with their looks, acne treatment for self-conscious teenagers' (p. 26). And Prozac, he might as well add, for existential angst – and obsessive-compulsive behaviour, shyness, separation anxiety, sexual perversion, and a whole lot more that may or may not be illness or disorder.

[6]Elliott (1999b) writes that the term enhancement technology 'generally refers to the use of medical technologies not to cure or control illness and disability, but to enhance human capacities and characteristics . . . [including] the use of Prozac and other antidepressants for shyness, a compulsive personality or low self esteem' (p. 27).

Categories of illness, especially mental illness, are constantly changing; and they tend to proliferate dramatically once new treatments hit the market (Elliott, 2004). The boundaries of any one of those shifting, proliferating, expanding categories remain elusive. They depend on time, space, cultural context, landscapes of care and the particularities of individual lives (say, any given patient's moral framework and any particular prescriber's educational background). The elusive difference between treatment and enhancement adds another layer of complexity: 'Illness and health, disability and difference, cure and enhancement: it is a mistake to think there can be rigid distinctions here . . . [W]hat counts as an illness or a disability – or on the other hand, as normal biological variation – will . . . depend on its cultural and historical location' (Elliott, 1999b; p. 48). My point, exactly. If we cannot clearly distinguish health from illness, disability from difference, cure from enhancement – and the clinical from the cosmetic – then how are we to recognize a cosmetic psychopharmacology when we see one? How are we to know when to use Prozac, and when to, say, call a priest?

A case for Prozac – or something else?

This is how Sperry & Prosen (1998) pose the dilemma:

> Would you as a psychotherapist prescribe or refer for a medication evaluation an individual who was not clinically depressed nor even dysthymic, but requested Prozac – or another selective serotonin reuptake inhibitor (SSRI) – because he believed it would make him a better salesman? Would you prescribe or refer someone with dysthymic features who complained that her 'depression was interfering with my ability to meditate'? Or, would you prescribe or refer for a medication evaluation someone with obvious symptoms of major depression that were in the moderate to severe range? (p. 55)

Let's say that an expert psychiatric evaluation results in no psychiatric diagnosis for the salesman seeking to enhance his personal and professional persona with Prozac. He does not have a clinical, i.e. major depression and cannot be diagnosed with dysthymia, or minor depression; personality disorder,

where depression is a character trait or forms the core of an essentially depressed self; or any other psychiatric or medical condition for which depressed mood is so often adjunctive. He most certainly does not have a melancholic temperament and suffers no more than occasional, normal depressed mood when he fails to make an important sale. He does not see himself as 'ill', nor does his caregiver, and he wants only to boost his performance as a salesman. I feel confident in asserting that most expert psychiatric providers would not endorse his request. Were a prescriber to offer Prozac, I suppose one could call that an instance of cosmetic psychopharmacology, but it is most certainly also malpractice, broadly and potentially even legally speaking. If this is cosmetic psychopharmacology, then cosmetic psychopharmacology cannot be a legitimate prescriptive practice. To even call it cosmetic psychopharmacology is to confer some legitimacy to the practice in much the same way calling a certain type of socially and medically acceptable cosmetic surgery does. This is a legitimacy that it does not deserve. I am therefore disinclined to call this an instance of cosmetic psychopharmacology. Let's just call it inept or substandard care.

Let's turn to the person on the other side of Sperry & Prosen's (1998) dilemma. Here, an expert psychiatric evaluation results in a diagnosis of major depression for a young woman who has begun to wake up at 4 AM every morning feeling exhausted, despondent, nauseous with a visceral form of free-floating anxiety and unable to shake off thoughts of death – her own, her mother's, her pet's, even the supposed deaths of starving children the world over who cannot find enough to eat. She is herself unable to eat and has lost 16 pounds in the last 3 weeks. Food tastes like sawdust and its sensation in her stomach triggers severe anxiety about losing her tenuous hold on self-control and possibly committing suicide. Violent, frightening images of death by gunshot wound to the head intrude on her consciousness.[7] Uncle![8] Enough said. No one can dispute the use of Prozac to treat depression of this sort. It is the sort of case that causes a philosopher like Erik Parens, in an eloquent essay on the use of Prozac for so-called cosmetic purposes (Parens, 2004), to pause and pointedly, rather emphatically insert into the text: 'Please note: Kramer [referring to the author of *Listening to Prozac*] is not anxious about using Prozac to treat clinical depression, nor am I' (p. 22). There can be no cosmetic psychopharmacology, it seems, at either margin of this dilemma.

What about in the middle? Let's take a look at the person with dysthymic features who complains that her depression is interfering with her capacity to meditate. By virtue of those dysthymic features, this person is likely to be chronically depressed, irritable, fatigued and unable to enjoy life. She may or may not have sleep or appetite disturbances, but is likely to suffer from low self-esteem and perhaps even chronic feelings of worthlessness and purposelessness. Let's suppose her dysthymic features have not reached the diagnostic threshold for dysthymic disorder which, according to the *DSM,* is a mood disorder – a type of clinical depression although not clinical depression itself – for which there is a growing body of clinical evidence that endorses antidepressants along with psychotherapy as a form of treatment. Inasmuch as we are treating a type of clinical depression, I would not consider this to be an instance of cosmetic psychopharmacology. To move even closer to the middle of this dilemma in search of a legitimate, or shall I say, an ontologically distinct cosmetic psychopharmacology, suppose the person with dysthymic features, for whom meditation is an important adaptive mechanism and may be one of her few remaining pleasures, has a melancholic temperament. She has always been prone to pessimism and dark moods. It is part of who she is. It is normal for her to be darkly pessimistic and depressed. However, not being able to effectively meditate constitutes an existential crisis for her in that it takes away part of her purpose in living, and she experiences this existential crisis as an illness, if only in the metaphysical sense. Shall we give her Prozac, and if we do, does this finally constitute a cosmetic use of psychopharmacology? As Sperry & Prosen (1998) write, in all likelihood practitioners would split their vote on this issue. Why is that?

[7]These details are taken from an actual case history.

[8]In some cultures, one cries 'Uncle!' when one's arm has been sufficiently twisted such that no further persuasion is needed.

The problem of suffering

Why can we not be certain that giving Prozac to the person whose depressed mood is interfering with her ability to meditate constitutes an instance of cosmetic psychopharmacology? In a sense, we are back to our beginning: if this is an existential ailment, what is wrong with treating it with Prozac? However, this time we ask the question while also wondering whether treating our meditator's existential ailment with Prozac might not be an instance of cosmetic psychopharmacology. There are two important issues here: (1) the inevitability of divergent views on the nature of suffering and its role in the human condition and (2) our continuing uncertainty about the nature of psychiatric illness and the diagnostic system that should classify it.

Sperry & Prosen (1998) discuss the first: they contend that the reason the vote would be split is that the possibility of prescribing Prozac, not just in this but in each of the above instances, evokes different views on human nature, especially different views on the human condition and the role of suffering in the human condition. They find two very distinct perspectives on human nature: 'In one view, life is not meant to be a state of continuous happiness, contentment, and well-being. In fact, life is largely a struggle filled with pain, disappointment, grief, mourning, and sadness. In the other view, life can and should be as fulfilling and actualizing as possible. Pain, anxiety, sorrow, and sadness are symptoms that can and should be alleviated with whatever means possible' (p. 56). On both accounts, suffering is an evil; however, only on the latter account is it to be eliminated whenever, wherever and with whatever (moral) means are available.

On the first account, suffering is a 'privileged' state, and treatment with Prozac for non-clinical (normal) and subclinical (abnormal but also undetectable) conditions 'robs life of its edifying potential for tragedy' (Sperry & Rosen, 1998; p. 56). The experience of sadness, after all, is morally and developmentally necessary for human growth and self-actualization. This is part of what is lost when Prozac is used for cosmetic purposes to treat existential ailments that are part of the human condition. On the second account, suffering in and of itself does not promote growth and self-actualization, or transformation. Chronic depressed mood and purposelessness often serve no useful purpose, especially when they might be eliminated with pharmacotherapy, and most especially when our subject experiences her chronic depressed mood and purposelessness as a form of suffering that she would gladly do without, even if there is a price to be paid. What makes sense as an abstraction from an outside, universal philosophical perspective looks ridiculous when we try to say that the suffering of this particular subject – this real person in real time and space who is having trouble in meditating and feels like she is losing what little joy is left in her life – is suffering that ultimately exists for her own good; is an essential part of the human condition, ignoring that it is her human condition; and should not therefore be medicated away. In addition, the view that depression can be useful and desirable makes light of the fact that most forms of depression involve suffering that consists of significant cognitive, affective and physical dysfunction (Glannon, 2003b). Those forms of depression therefore threaten rather than contribute to meaningful life. Here, the legitimate purpose of antidepressants is not to enhance cheerfulness or social desirability, but to restore people to a normal level of functioning in their lives (Glannon, 2003b). It follows that where Prozac does this, it has served a legitimate clinical as opposed to cosmetic purpose.

There are at least two reasons why we cannot be certain that giving Prozac to the person whose depressed mood is interfering with her ability to meditate either does or does not constitute an instance of cosmetic psychopharmacology. First, assuming Prozac has worked in this case, in alleviating our subject's suffering and improving her health, well-being and overall functioning, we have remedied a harmful dysfunction as defined by Wakefield (1992). We have treated a disorder, in other words. We have treated what is on our subject's account, and perhaps also on our own account, an illness of sorts – again, if only in the metaphysical sense. The relief of suffering by all appropriate, clinically sound means is a legitimate medical, or more broadly, clinical purpose – as some of those who prescribe medications are not medical doctors but clinicians of another sort. Sec-

ond, we cannot be sure that this is an illness only in the metaphysical sense. Perhaps, it is also physiological. We can no longer assume that certain traits or states, such as irritability, pessimism, a certain darkness of mood or nervous tension, reflect one's basic temperament and are merely part of the human condition (Sperry & Prosen, 1998). In fact, if temperament is part of the human condition, it is part of the biological human condition, for temperament is now known to be biologically based, at least partially heritable and present from birth (Watson, 2000). Perhaps there is something biochemically, physiologically or genetically awry in our meditator's processes of chemical neurotransmission.[9] Who can say that one's irritability, pessimism, darkness of mood and the nervous tension that prevents one from effectively meditating is only metaphysical illness and not, or not also, physical disease – in which case it is harder to label the case an instance of cosmetic psychopharmacology? This lands us squarely on top of the second important issue identified in our search for an ontologically distinct cosmetic psychopharmacology, namely, our continuing uncertainty about the nature of psychiatric illness and the diagnostic system that classifies it.

Descriptivism, causal classification and drug cartography

According to Radden (2003), descriptivism denotes the epistemological approach to classifying mental disorders adopted by the American Psychiatric Association(2000) in its *DSM*. As the term suggests, it describes the clinical features of various psychiatric disorders and thus creates a shared discourse despite competing and incompatible theoretical and aetiological claims about the nature of mental disorder. With a descriptive taxonomy like the *DSM*, illness categories like major depression, dysthymia and melancholia are identified and arranged into sets of observable psychological, physiological and behavioural sign and symptom clusters, or syndromes (Radden, 2003). However, descriptivism comes in two guises: (1) ontological descriptivism, which is the view that categories such as depression refer only to those observable signs and symptoms and not to any underlying causal framework and (2) causal descriptivism, which implies identifiable, underlying causes that give rise to the observable signs and symptoms. On the second analysis, depression refers not only to the observable features of a depressive state but also to its underlying causes (Radden, 2003).

Once again, consider our dysthymic patient with the melancholic temperament who is having difficulty in meditating, and who resides in the middle of that region where an ontologically distinct cosmetic psychopharmacology is most likely to be found. Whether dysthymia and melancholy can be equated for purposes of treatment with clinical depression, for which we have already determined Prozac is a legitimate medical treatment and does not constitute an instance of cosmetic psychopharmacology, depends on whether we adhere to a descriptivist or causal ontology. To adopt descriptivism is to allow the similarities and differences between the respective descriptions of melancholy, dysthymia and major depression to determine whether we are dealing with distinct conditions. To employ a causal ontology is to set aside the descriptive differences and insist that melancholy, dysthymia and depression are variants of the same underlying condition despite differences in appearance (Radden, 2003). Whether we call giving Prozac to our melancholic meditator an instance of cosmetic psychopharmacology or not depends not only on our view of human nature (Sperry & Prosen, 1998) but also on whether our ontological framework is descriptive or causal (Radden, 2003). Given that our current descriptivist methododology for psychiatric nosology does not in fact establish causes, it is

[9]The 'biochemical deficiency', e.g. serotonin deficiency, and 'biochemical imbalance' concepts so often used to explain the biological basis of depressive and other psychiatric disorders is no longer considered adequate to describe either that which is 'awry' in the biologically-based psychiatric disorders, e.g. major depression, bipolar disorder, schizophrenia, schizoaffective disorder, obsessive-compulsive disorder and panic disorder – the list is growing – or that which psychopharmacologic agents 'treat' or 'correct'. (Stahl, 2000).

insufficient for determining what depression is. We can talk about what depression does, but not about what it is (Hansen, 2003). As we are still unable to carefully determine the boundaries and shape of depression, I am skeptical we can actually locate the boundaries and shape of a cosmetic psychopharmacology.

Radden (2003) discusses another interesting distinction. She points out two widespread trends in current psychiatric classification: the first is the tendency to attribute various forms of masked depression to those whose symptom picture is contrary to that portrayed in traditional (Western) classifications, for example, Chinese women who do not feel depressed but whose somatic symptoms are nevertheless taken to indicate an underlying, masked depression, or men in Western society whose acting out, substance abuse and antisocial behaviour similarly are taken as expressive of an underlying, masked depressive disorder. Stimulated by rapid psychotropic drug development, the second trend, called drug cartography, constitutes 'a remapping of psychiatric categories based not on traditional symptom clusters but on psychopharmacological effects' (p. 38).

For example, Brendel (2003b) points to the work of Hudson & Pope (1990) who, based on the response to certain antidepressant medications of eight medical/psychiatric conditions including major depression, bulimia, panic disorder, obsessive-compulsive disorder, attention deficit-hyperactivity disorder, cataplexy, migraine and irritable bowel syndrome, argue that all these disorders may share a common pathophysiologic abnormality and thus could be understood as a single affective spectrum disorder. Similarly, a variety of problems with impulse-control including overeating, gambling, paraphilias and various patterns of alcohol and drug abuse are increasingly regarded as obsessive-compulsive spectrum disorders because Prozac effectively treats them (Radden, 2003). Thus, if Prozac, which acts at the level of gene expression in chemical neurotransmission (Stahl, 2000), effectively treats – apart from whether it should be used to treat – not only major depression but also dysthymia, melancholic personality and existential alienation – and there is at least some evidence to think it does, at least Kramer[10] and Elliott[11] think so – then we might suppose all those conditions constitute variants of the same biologic depressive spectrum 'disorder'. Drug cartography appears to show in sharper relief than the science of biological psychiatry currently warrants what causal classification holds implicit. Nevertheless, if science someday shows that all these conditions do in fact consist in the same depressive spectrum disorder, then there can be no sharp ontological distinctions, at least in the middle of our prescriptive practice dilemma, between that which is said to be cosmetic psychopharmacology and that which is not.

Conclusion: 'a thousand cartwheels'

In truth, I resonate with Elliott's (1999a, 1999b, 2000, 2003, 2004) exquisitely articulated concerns about the medicalization of human unhappiness and the moral implications of enhancement technologies. However, I find cosmetic psychopharmacology – the term, the concept and, to the degree it exists, the practice – suspect for all the reasons articulated above, not the least of which is that the 'conundrum' of cosmetic psychopharmacology is 'necessarily played out at a historical moment, ours, when the categorization of alienation [and other depressive states] remains ambiguous' (Kramer, 2000; p. 14). To some degree, when we treat depression we simply do not know what we are treating and therefore cannot say that this treatment is merely or exclusively cosmetic. Andrew Solomon (2001) sums it up very well: 'The shape and detail of depression have gone through a

[10] *Listening to Prozac* presents numerous instances of supposed personality change in response to treatment with Prozac.

[11] In *Pursued by Happiness and Beaten Senseless: Prozac and the American Dream*, Elliott (2000) writes: 'How many patients [take Prozac for alienation], and whether Prozac actually cures them, remains to be seen. It may be small in comparison to, say, the number who use Prozac for depression. But I take it from my psychiatric colleagues, from the case histories in Kramer's book and others, and from my many friends and acquaintances who have used the drug, that whether it affects alienation is at least an open question' (p. 8).

thousand cartwheels, and the treatment of depression has alternated between the ridiculous and the sublime . . . To understand the history of depression is to understand the invention of the human being as we know and are him [or her]. Our Prozac-popping, cognitively focused, semialienated postmodernity is only a stage in the ongoing understanding and control of mood and character' (p. 286).

In voicing my suspicions about cosmetic psychopharmacology, I have asked far more questions than I have attempted to answer. Yet, I must ask one more. To begin with, for whom is cosmesis most at issue? Who, by and large, uses cosmetics? Who, for the most part, opts for cosmetic surgery? In *Listening to Prozac,* whose personalities and selves are being transformed?[12] For whom, then, does Kramer coin the term 'cosmetic psychopharmacology'? Who, in fact, reports depression in the greatest numbers?[13] Overwhelmingly, the answers to all these questions are: women. To the degree it really exists, is cosmetic psychopharmacology, then, a gendered concept, or gendered practice? Of course, it is beyond the scope of this paper to address the question, but I will note this: Radden (2000, 2003) has examined the relationship between today's depression and the melancholia of old. For hundreds of years, she writes, influenced by Aristotle and almost every subsequent thinker until the 18th century, melancholia carried glamorous associations of intellectual brilliance and later, even genius – associations that are absent from today's conception of depression, where one criterion is poverty of thought: 'Melancholia was the disorder of the man (of genius, of sensitivity, intellect, and creativity), whereas today's depression is both apparently linked with women in epidemiological fact and associated with the feminine in cultural ideas. Depression's gender link is the reverse of the masculine and male associations of melancholia' (p. 40). Is this perhaps why Kramer (2000), who started it all, believes that 'much of the discussion of cosmetic psychopharmacology is not about pharmacology at all – that is to say, not about the technology. Rather, "cosmetic pharmacology" is a stand-in for worries about threats to melancholy' (p. 16). I tend to agree that 'much of the discussion of cosmetic psychopharmacology is not about pharmacology at all', but I do not think the issue is only 'threats to melancholy'. There are other threats at large, and I cannot help but wonder what part is played in this debate by the fact that most of the people requesting or being given Prozac for whatever purposes, cosmetic or clinical, are women.

[12]Kramer's case studies almost exclusively involve women.

[13]DSM-IV-TR indicates that women are at significantly greater risk than men to develop major depression: 'Studies indicate that depressive episodes occur twice as frequently in women as in men' (p. 354); Kessler *et al.* (1994) document that women have higher prevalence rates of affective disorder than men, as well as 'higher prevalences than men of both lifetime and 12-month comorbidity of three or more [psychiatric] disorders' (p. 12); Dohrenwend *et al.* (1992) show that women, unlike men, have higher rates of depression at every level of socioeconomic status; and Mirowsky & Ross (1995) conclude that women not only report greater distress, e.g. depressed mood, anger, sadness, anxiety, malaise and aches, but also genuinely experience more distress than men, suggesting they bear a heavier burden of hardship and constraint and thus revealing their relative disadvantage in American society: 'Overall, women experience distress about 30% more often than men' (p. 449).

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