The Linacre Quarterly

Volume 71 | Number 2 Article 5

May 2004

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Selective Serotonin Reuptake Inhibitors and Cosmetic Psychopharmacology: Ethical and Deontological Dilemmas

by

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It is nothing new to resort to psychoactive substances in the absence of any pathology or subclinical condition in order to enhance or improve one's performance. After all, various substances have been used in sport, study, and work activities and even hallucinogenic effects have been noted.

This matter has come up again after increasing dispersion of anti-depression products among those who are neither depressed nor dysthymic subjects.

Studies in neurochemistry and neurophysiology have highlighted that the brain tone depends on the production of a specific substance, serotonin, which is, after some time, removed from blood circulation (reuptake) by specific nervous receptors, so as to extinguish its effects. A rapid drop of this substance is responsible for certain kinds of depression, anxiety, suicidal tendencies, chronic pain, compulsive eating, sleeplessness, irritability[1], and aggressive behavior.[2]

For this reason, medications that inhibit serotonin reuptake from blood circulation have been produced. These medications maintain the high level of serotonin which means a good mood (euthymia), sound sleep, appetite satiation, and pain relief. Some individuals who were committed to spiritual meditation were initially reluctant to take a drug because it might "contaminate their mind"; they also did not agree with the idea that the "dark of the soul" — depression — should be treated pharmacologically.

However, they report that they have found not only relief but spiritual growth as a result of using these products.[3]

Brain serotonin levels, therefore, apparently are a part of what determines several aspects of human personality —especially the affective and motivational ones. This was confirmed through examination of patients with a history of impulsively violent behavior (e.g., arsonists, criminals, people who die by violent suicide). They showed low brain serotonin levels. Pharmacological interventions that increase cerebral serotonin levels can lead to a reduction of hostility and violent outbursts in aggressive psychiatric patients.

The most well-known selective serotonin reuptake inhibitor is Prozac (the commercial name of fluoxetine), which was put on the market as an antidepressant in 1987. Up to 1994 it had been used by nearly 11 million people, more than half of them in the United States.[4]

Among the many reasons that patients use Prozac are the relative absence of side effects (limited to nausea, diarrhea, and sexual dysfunction) compared to other tricyclics also used as antidepressants; and its fast action. In fact, the effects sought through use of Prozac appear after only two to three weeks, whereas psychotherapy requires something like two to three *years*. One could ask: Why spend the time, money, and energy to undergo psychotherapy if the same result, indeed better results, can be reached by simply and autonomously taking a pill which has no side effects?

Deontological and Ethical Dilemmas

From an ethical and deontological point of view, the administration of a selective serotonin reuptake inhibitor in subjects showing symptoms of clinical depression seems to correspond completely to the therapeutic principle, although an utter replacement of psychotherapy involves a pure biologist view of psychiatric diseases. Thus, origins of mental disease would be explained through anatomical-clinical alterations of the brain, rather than through traumas that eventually are present in memory (as a matter of fact, such traumas may represent a determining factor in some kinds of mental disease).

The case of healthy people who ask for Prozac in order to enhance their mood and work performance is quite a different matter. There are obviously different opinions about that, the disagreement being a consequence of one's idea of nature and the human condition.[5]

There are at least two possible perspectives. The first, which could be defined briefly as the "sorrow perspective," assumes that life is not characterized by continuous happiness, contentment, and well-being, rather by a struggle filled with pain, disappointment, grief, and mourning. Therefore, sorrow must be considered a privileged state that we do not

have to eliminate. The second assumes that life can and should be as fulfilling as possible. Therefore, pain, anxiety, and sadness are symptoms that can and should be alleviated by whatever means possible.

As a consequence, the first perspective maintains that Prozac would rob life of a fundamental aspect, namely the possibility of facing difficulties, pain, and anxiety. These experiences are considered typical of the human condition, therefore should be embraced rather than deleted by psychoactive substances. This has been called "pharmacological Calvinism", which implies that any quick cure by a chemical substance — without pathologies — should be considered suspect, and even dehumanizing.

It would be suspect because these medications reduce the demand for psychotherapy and it would be dehumanizing because they replace the interpersonal relation between patient and therapist with a pill. Perhaps, the basic fear is also that these medications would be trivialized and used for hedonistic reasons.

The second perspective starts from the assumption that suffering in itself does not engender human growth and self-transformation. On the contrary, permitting and encouraging suffering is considered sadistic, since medications like Prozac can prevent suffering, may allow us to be more creative and alive, and can even change our behavior and our sense of constraint.

Some years ago, P. Kramer published a book, an immediate best-seller, with the evocative title of *Listening to Prozac*,[6] concerning the replacement of psychotherapy with psychopharmacology in depressive pathologies. According to Kramer, the difference of opinion about these drugs was a consequence of the different ideas of mental disease. Does the problem have a biological or cultural basis? For Kramer, mental disease has biological origins only; in fact, Prozac restores patients — even the healthy ones — to their apparently original and biologically determined state, freeing them from the inhibitions (constraints) of their life experiences and family nurturance (influence). It almost seems as if patients regain their "true selves."

B. Knutson et al., who also agree with the biological view of mental disease, studied the effects of selective interventions on cerebral functioning.[7] They assigned paroxetin — another potent selective serotonin reuptake inhibitor — to 51 psychophysically healthy patients, establishing that such medications may modulate some personality characteristics also in normal individuals, particularly hostile behavior, as against placebo control subjects. However, the authors themselves do not preclude the possibility that there could be a social influence on patients' behavior. Therefore, it would be convenient to join the biological with the cultural component.

This solution is indeed the most balanced answer to the question and the most appropriate to the characteristics of human personality.

But the Kramer approach gives rise to several problems. How can we distinguish between the biological and the social? Can we compare the improvement obtained through the introduction of a pill with the long and accurate personal approach of a patient working with the help of a psychotherapist? Because Prozac is an anti-depressant, and two-thirds of depressed people are women, do we not run the risk of enforcing women's aggression and self-ambition skill levels, which are typical to the male gender and necessary in a postindustrial, service-oriented economy?

This question leads us to reconsider the problem of assigning a growth hormone to short children with normal hormonal levels (constitutional shortness). Can we consider shyness, in the Prozac case, and shortness, in this second case, as diseases?

A reply to the question is still awaited. The point is: although "pharmacological Calvinism" is to be rejected in total, whereas psychotherapy is to be viewed as the most helpful treatment for minor depression and anxiety, medication can speed treatment and engender self-transformation on its own.[8] As a consequence, it is necessary to keep an open mind while critically evaluating the issue of cosmetic pharmacology, specifically when addressing patients' requests.

Another Point of View

We believe Sperry and Person's view is not the right one. As a matter of fact, the point should be: What usually justifies a specific medical act?

The answer is and can only be: the presence of a pathology and the expectation of curing it, when no other intervention is possible. Thus, we totally agree with the assignment of a selective serotonin reuptake inhibitor to patients suffering from clinical mental disease or distress. We cannot justify its use in the absence of clinical disease or distress, for the purpose of enhancing performance.

Quite obviously, it could be objected that since we are speaking of a drug which, according to our present knowledge, does not have side effects and makes the patient feel better, that its hedonistic use should also be acceptable. However, it is also true that an increase of serotonin level in the brain, responsible for performance enhancement, can be attained through such natural methods as increasing essential fats in one's diet, exercise, or even restful, restorative sleep, all without any medication. In addition, we should ask ourselves whether the use of a selective serotonin reuptake inhibitor does not cover over, once more, the real causes of disease such as personal and/or familiar dissatisfaction, therefore fulfills the needs induced by mass media influence, social permissivism, and industry or business.

Our perspective is not a "pharmacological Calvinism", because the opposition to the progressive dependence on medication does not originate from a condemnation of any pleasure (some pleasures are not symptoms of disorder), but from the observation that pleasure is healthy and constructive if it refers to the person's values and goes with the normal, not artificially produced, development of human personality.

Physicians, and especially psychiatrists, have a particular responsibility for preventing this increasing pharmacological dependence. They have to see it as their precise duty to refuse any connivance and complicity either to patients' requests or to industrial profit. In addition, the whole of society must reflect upon the origins of human dissatisfaction (affective conflicts within families, social and environmental obstacles, lack of values, etc.), instead of quietly accepting artificial remedies that actually conceal social inefficiency.

In conclusion, we can say that real prevention proceeds from commitment to education, to life and health values, and from the responsibility to ourselves and to others. The responsibility to others is crucial, since we must not forget that the more we spend on voluptuary pharmacology, the less we have at our disposal for real therapies directed to sick people who do require them.

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