Normality, Therapy, and Enhancement

What Should Bioconservatives Say about the Medicalization of Love?

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Abstract: According to human enhancement advocates, it is morally permissible (and sometimes obligatory) to use biomedical means to modulate or select certain biological traits in order to increase people's welfare, even when there is no pathology to be treated or prevented. Some authors have recently proposed to extend the use of biomedical means to modulate lust, attraction, and attachment. I focus on some conceptual implications of this proposal, particularly with regard to bioconservatives' understanding of the notions of therapy and enhancement I first explain what makes the proposal of medicalizing love interesting and unique, compared to the other forms of bioenhancement usually advocated. I then discuss how the medicalization of love bears on the more general debate on human enhancement, particularly with regard to the key notion of "normality" that is commonly used to define the therapy–enhancement distinction. This analysis suggests that the medicalization of love, in virtue of its peculiarity, requires bioconservatives to reconsider their way of understanding and applying the notions of "therapy" and "enhancement." More in particular, I show that, because a non-arbitrary and value-free notion of "therapy" cannot be applied to the case of love, bioconservatives have the burden of either providing some new criterion that could be used for drawing a line between permissible and impermissible medicalization, or demonstrating that under no circumstances—including the cases in which love is already acknowledged to require medical intervention—can love fall within the domain of medicine.

Keywords: enhancement; therapy; normality; bioconservatism; love

Introduction

According to human enhancement advocates, it is morally permissible (and sometimes morally obligatory) to use biomedical means to modulate or select certain biological traits in order to increase peoples' welfare, even when there is no pathology to be treated or prevented. Earp, Savulescu, and Sandberg have recently proposed to extend the use of biomedical means to modulate those biological functions that characterize the sphere of "love,"[1] namely, lust, attraction, and attachment.[2] In this article I follow these authors in using the term "love" to refer to any of these three functions or combinations thereof. Although love certainly is more complex than its neurobiological conceptualization suggests, these three functions can reasonably be thought to fall within any plausible understanding of love. Examples of "medicalized" love include the use of biomedical means to reduce attraction toward violent partners[3] or to

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enhance attachment in couples who, for various reasons (e.g., for the sake of their children), wish to improve their relationship.[4] Because the biochemical modulation of love combines the two aspects of (1) using biomedical means and (2) improving the welfare of not-necessarily-pathological individuals, it can be considered a form of human bioenhancement under the best understanding of "enhancement"—that is, an increase of overall well-being rather than an augmentation of single capacities or functions.[5,6]

Whereas the medicalization of love has so far been discussed with regard to its psychological or sociological implications, here I want to focus on some of its conceptual implications, particularly with regard to bioconservatives' understanding of the notions of therapy and enhancement. By "bioconservatives" I mean, very loosely, those who for various reasons are opposed to human enhancement and are therefore very likely to be opposed to the medicalization of (nonpathological) love as well. Admittedly, dubbing anyone opposed to enhancement simply as bioconservative might not do justice to the variety of possible reasons for opposition. There is, for example, an important difference between being opposed to enhancement because of some particular value attributed to human nature or to our feelings about altering human nature[7,8,9]—which are recognizably conservative stances—and being opposed to enhancement because of concerns about equality and social justice[10,11]—which are further from the core values of the modern conservative tradition.[12] However, what all these opponents of human enhancement have in common is that they draw the line for the permissibility of biomedical intervention at the boundary between what they consider to be therapy and what they consider to be enhancement (regardless of what reasons they offer to justify the moral relevance of the distinction). The term "*bio*conservative" is used here exclusively to indicate the conservative aspect represented by the normative value attached to the traditional therapy–enhancement distinction; it does not refer to any other aspect that in one sense or another might be considered conservative.

I first explain what makes the proposal of medicalizing love interesting and unique, compared to the other forms of bioenhancement usually advocated. I then discuss how the medicalization of love bears on the more general debate on human enhancement, particularly with regard to the key notion of "normality" that is commonly used to define the therapy–enhancement distinction. This analysis suggests—or so I shall argue—that the medicalization of love, in virtue of its peculiarity, requires bioconservatives to reconsider their way of understanding and applying the notions of therapy and enhancement. More particularly, I show that, because a nonarbitrary and value-free notion of therapy cannot be applied to the case of love, bioconservatives have the burden of either providing some new criterion that could be used for drawing a line between permissible and impermissible medicalization or demonstrating that under no circumstances—including the cases in which love is already acknowledged to require medical intervention—can love fall within the domain of medicine.

The Peculiarity of the Medicalization of Love

The forms of human enhancement usually proposed target biological traits that are already largely medicalized. Normally, enhancement advocates propose to extend the use of biomedical means beyond some *established* therapeutic function. For example, it has been

proposed to use biomedical means to improve the cognitive capacities of individuals whose IQ is already in the normal range, or to improve our normal moral dispositions, particularly empathy, or to make athletes physically fitter than normal. All the physiological functions targeted by such enhancements can have a clearly pathological form that is usually medically treated, such as cognitive impairments, sociopathy, physical disabilities, or physiological dysfunctions. Lust, attraction, and attachment, on the other hand, do not have a pathological expression that is objectively measurable and definable—although, as we shall see, they can be pathologized by other, nonmedical, standards. As a consequence, because medical intervention is traditionally associated exclusively with pathologies, these functions of love are not traditional targets of medical interventions—hence their proposed medical*ization*. This is what makes the medicalization of love different from other forms of enhancement: the medicalization of love is about medicalizing a whole aspect of human biology (almost) *ex novo.*

To be sure, there are some forms of love that are considered pathological by the scientific community and are agreed to require medical treatment. However, the conceptualization of love-related atypical behaviors or interests as pathologies is often arbitrary and problematic. The distinction between mere paraphilias and paraphilic *disorders* in the last edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM)[13] illustrates well the conceptual difficulty of pathologizing love-related aspects of human neurophysiology.[14,15] The eight "paraphilic disorders" listed in DSM-5 (voyeuristic, exhibitionistic, frotteuristic, sexual masochism, sexual sadism, pedophilic, fetishistic, and transvestic disorders) were chosen on the basis of the following diagnostic criteria: "a *paraphilic disorder* is a paraphilia that is currently causing distress or impairment to the individual or a paraphilia whose satisfaction has entailed personal harm, or risk of harm, to others."[16] In a separate, explanatory document, the American Psychiatric Association (APA) further specifies that people with paraphilias are to be diagnosed with a paraphilic *disorder* if (1) they "feel personal distress about their interest, not merely distress resulting from society's disapproval" and/*or* (and the disjunction is worth noting here) (2) "have a sexual desire or behavior that involves another person's psychological distress, injury, or death, or a desire for sexual behaviors involving unwilling persons or persons unable to give legal consent."[17] These criteria imply that a particular atypical sexual interest or behavior is—or is not—to be considered a disorder depending on external circumstances that are unrelated to the sexual interest or to any other neurophysiological state of the individual. Such circumstances include, for example, the threshold for "legal consent" or the negative consequences experienced by third parties (which depend on third parties' personal circumstances, and not only on the psychiatric state of the paraphilic individual).

Take a specific type of paraphilic interest like pedophilia, for example. The DSM-5 states that if pedophiles "report an absence of feelings of guilt, shame, or anxiety about these impulses and are not functionally limited by their paraphilic impulses . . . , and their self-reported and legally recorded histories indicate that they have never acted on their impulses, then these individuals have a pedophilic sexual interest but not pedophilic disorder."[18] There is an evident element of arbitrariness in this demarcation criterion: if someone who *does* act on his pedophilic impulse does not have significantly

negative consequences for his psychological well-being (apart from guilt, shame and anxiety, which might well be socially determined), it is not clear why the pedophilic interest and behavior should be considered pathological (although someone might well consider them morally wrong or disgusting). Nor can the arbitrariness be eliminated by appealing to the negative consequences for third parties, which, as we have seen previously, the DSM-5 uses as criterion for the pathologization of paraphilias. For example, the DSM-5 states that "many dozens of distinct paraphilias have been identified and named, and almost any of them could, by virtue of its negative consequences for the individual or for others, rise to the level of a paraphilic disorder."[19] Applied to pedophilia, this criterion entails that the very same case of pedophilia is or is not pathological depending on the consequences for the child. But, once again, such consequences depend also on the psychological state of the child, and not only on the psychiatric condition of the pedophile.

This analysis suggests that whether or not certain paraphilias are to be considered psychiatric disorders turns out to be a value judgment, which might respond to pragmatic, or even ethical, requirements—for example, the need to accommodate legal boundaries or to protect children. But as far as medical criteria go, these types of judgments are arbitrary and indeed quite uncommon as demarcation criteria for pathologization. It is unusual (to say the least) in medicine that the very same state is or is not considered a pathology depending on contingent, external circumstances.

The blurred boundary between paraphilias and paraphilic disorders exemplifies how the lack of clearly defined pathological conditions makes love peculiar in the landscape of proposed enhancements. There is love that causes suffering, love that endangers the individual, or love that may lead to pathological conditions, but the idea that love itself can be pathological is based more on value judgments or arbitrary, perhaps intuitive, decisions than on objective medical criteria.

Advocates of human enhancement and of the medicalization of love will not be troubled by the lack of a clearly definable pathological form of love, because they consider the use of biomedical means permissible even if no pathology is present, as long as the use of such means improves the welfare of the individual and is autonomously chosen by the individual. However, the peculiar aspect of love has some important implications for the way bioconservatives may argue against the medicalization of love. Let's address this point in greater detail.

Normality and Love

Because proponents of enhancement advocate the extension of the scope of medicine beyond the traditional boundaries of therapeutic interventions, the contemporary debate on human enhancement has often been focused on the normative significance of the distinction between therapy and enhancement. Therapy is commonly understood as the use of medicine to restore the *normal* functions of our organism.[20,21] Consequently, the notion of normality is crucial when assessing the permissibility of expanding medicine's boundaries in the way proponents of enhancement—including the medicalization of love—suggest. Whether the distinction between therapy and enhancement is normatively significant—that is, whether or not medicine *should* be merely therapeutic—turns on the issue of the normative status of normality, or, more precisely, of "normal functioning."[22,23] For those

who oppose enhancement, normality is a normative concept: what is normal, and no more than what is normal, is what medicine should aim to restore or preserve.[24,25] For those who are in favor of enhancement, on the other hand, normality is a *merely* statistical concept defined by standard deviations of certain physiological parameters from the population mean.[26] Taking a merely statistical notion as a relevant criterion for assessing the permissibility of medical interventions is considered by many an arbitrary decision.[27,28]

We can see that there are two issues at stake here. One is descriptive: we need to define pathology—as opposed to normality—and therapy—as opposed to enhancement. The second issue is normative: we need to assess the permissibility of biomedically enhancing the normal, or, in other words, of going beyond therapy. Whatever the reasons offered by bioconservatives for considering the distinction normatively significant, there must be a distinction to be drawn in the first place. Therefore, for any proposed medical intervention—including in the spheres of lust, attraction, and attachment—bioconservatives need a notion of normality to eventually claim that that is the boundary of permissible medical intervention.

Normality is a fishy concept, but often we can easily tell what is normal from what is pathological. Often our intuition matches the merely statistical understanding of normality, especially when neurophysiological parameters can be objectively measured: blindness, deafness, and diabetes, for example, represent statistically significant deviations from typical human functions. In other cases, however, defining normality is extremely difficult, and inevitably arbitrary. As discussed previously, the case of love is an instance of this latter type of case. Defining a criterion for pathologizing love, or for normality in the sphere of love (which is the same thing), is problematic for several reasons.

First, because it would be difficult to assign objectively measurable values to lust, attraction, and attachment, the statistical definition of normality could not be applied to the case of love as easily and precisely as in the case of objectively measurable pathologies like deafness, blindness, or diabetes. Besides, because we would also need a criterion for determining which atypical functions can be considered pathological and which ones cannot—for example, we do not want being red headed or blue eyed to count as pathological states—we would have to be very careful in this choice, too. In a famous and authoritative paper, Christopher Boorse[29] defined "health" in terms of statistically significant deviation from the population mean of those biological functions that contribute toward survival and reproduction. Applied to the sphere of love, this criterion would have the implication of including homosexuality in the category of pathologies, something that goes against the APA's 1973 decision to exclude homosexuality from the list of psychiatric disorders.

Second, if we decided to define normal love in nonstatistical terms, we would have to commit to either arbitrariness or some substantial value judgment about what love should and should not be, as the previous discussion about the pathologization of paraphilias in DSM-5 shows. But if we want to draw a line arbitrarily, then the impermissibility of medicalizing love beyond arbitrarily defined therapy boundaries would of course be itself arbitrary: Earp and colleagues might respond by accepting the normative relevance of the therapy–enhancement distinction, but also by setting the bar for what counts as therapy higher than any arbitrarily chosen point, and no nonarbitrary

demarcation criterion could be used against them. As for bringing value judgments into the descriptive distinction between pathology and normality (and consequently between therapy and enhancement), this would entail the risk of begging the question of what justifies the normative relevance of that distinction for the scope of medicine. The risk is that the same values used to justify the normative relevance of the distinction could be used to draw the distinction in the first place. Besides, any attempt to ground the therapy–enhancement distinction in the sphere of love on value judgments would be subject to an "objection from relativism": different cultures or circles would apply different values, with the consequence that we would have to accept the fact that homosexuality is considered a pathology in certain societies or groups, such as the Catholic Church—in fact, in peer-reviewed publications Catholic scholars have dubbed homosexuality "same-sex attraction disorder."[30]

What Should Bioconservatives Say about the Medicalization of Love?

We have seen that, traditionally, the scope and limits of medicine are defined by the aim to restore or preserve levels of well-being up until *normal*, that is, nonpathological, levels. However, we have also seen that, in the case of love, a notion of normality and of pathology cannot be applied without arbitrariness or without appealing to some value judgment. In other words, the peculiarity of love, that is, the fact that a pathological form of love is not objectively and nonarbitrarily measurable, implies that a descriptive therapy–enhancement distinction cannot be drawn. We do not have a clear, objective notion of normality and of pathology to be used as threshold for the permissibility of medical interventions. Lack of such a boundary implies that, *if* the biomedical modulation of love is ever permissible, it is permissible in all those cases in which an individual suffers because of love and in which medicine could alleviate the suffering, *unless some other demarcating criterion is provided*. We are thus in the position to answer the question as to what bioconservatives should say about the medicalization of love: bioconservatives should either claim that no medical intervention is ever permissible in the sphere of lust, attraction, and attachment or provide a different demarcation criterion for permissible biomedical intervention in these spheres. In any case, the burden of proof is shifted back onto bioconservatives. Notice that this burden demands them to provide a descriptive, not a normative, criterion: bioconservatives are required to provide this criterion regardless of what reasons they eventually offer for justifying its normative relevance for the scope of medicine.

Bioconservatives might want to define therapy by appealing to a concept that has been lurking behind the discussion about normality—namely, the concept of health. It might be proposed, in other words, that the scope of medicine should only be that of preserving or restoring health. Although this view might at a first glance appear close to the bioconservative approach, the problem here for bioconservatives would be to define "health" in a way that serves their purposes. This task turns out to be quite difficult. Health can be, and has been, defined in terms of statistical normality,[31] but we have seen that normality (either statistical or value based) cannot be applied to the case of love in order to define therapeutic interventions. Alternatively, one might appeal to the WHO's canonical definition of health as "a state of complete physical, mental and social well-being and not merely

the absence of disease or infirmity."[32] However, on the basis of this definition, *if we stipulate that medicine should be about preserving or restoring states of health*, then the situations in which Earp and colleagues propose to medicalize love would indeed fall within the legitimate scope of medicine. For example, a situation in which someone is attached to, or attracted to, a violent partner; one in which someone suffers from unrequited love in a way that significantly affects his or her well-being; or one in which couples experience lack of attachment or communication but still care about their relationship are all unhealthy conditions according to the WHO's definition of health. Therefore, the medicalization of these forms of love would count as therapy according to the WHO's definition. Once again, because enhancement advocates do not see the therapy–enhancement distinction as normatively relevant, calling their proposed medicalization (of love or of anything else) "therapy" would not make any difference to them. But if bioconservatives want to be able to appeal to the therapy–enhancement distinction, they would have to provide either an alternative definition of health or some other concept that can be used to draw a descriptive demarcation line between therapy and enhancement. Alternatively, they might want to argue that, as far as love is concerned, no medical intervention is ever permissible, not even in those cases in which love is already acknowledged to require medical intervention. Whichever option they choose, they certainly have some conceptual work to do if they want to meet the challenge posed by proponents of the medicalization of love.

Notes

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