

Unrequited

Neurochemical Enhancement of Love

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Abstract: I raise several concerns with Earp and colleagues' analysis of enhancement through neurochemical modulation of love as a key issue in contemporary neuroethics. These include: (i) strengthening their deflation of medicalization concerns by showing how the objection that love should be left outside of the scope of medicine would directly undermine the goal of medicine; (ii) developing stronger analysis of the social and political concerns relevant to neurochemical modulation of love, by exploring and suggesting possible counters to ways in which 'wellbeing' may be used as a tool of oppression; (iii) providing reasons to support a broad need for ecological investigation of, and indeed ecological education concerning, neurotechnology; (iv) suggesting ways in which philosophy, and the humanities more broadly, remain directly relevant to responding effectively to issues in contemporary neuroethics.

Keywords: Philosophy; humanities; neuroethics; love; neurotechnology

In their article "The Medicalization of Love," Earp and colleagues do much helpful work in responding to the broad concern that the development and use of neurochemical modulation would—problematically—lead to the "'medicalization' of human love and heartache." They are right to draw attention to the ambiguity surrounding use of the term "medicalization." Their work to clarify the precise way(s) in which medicalization might count as a legitimate source of ethical concern, and to identify its potential scope as a problem, is commendable. Yet some important issues remain unresolved within, or neglected by, their analysis. In this essay, I identify some of these issues, following the order of their argument in their article, and propose some ways forward.

Earp and colleagues rightly point to the importance of well-being as a goal for both treatment and enhancement in the context of love, and they defend the prudence of neuromodulation access on the basis of well-being. Their two main

claims deflating medicalization worries that depend on some distinction between treatment and enhancement are as follows: (1) we should understand medicine according to a new model as focused on quality of life and well-being and as promoting coequal patient-professional relationships, rather than as paternalistic and focused on the treatment of disease, and (2) we should understand treatment as the application of medical technology in pursuit of well-being, rather than with reference to pathology. This position is becoming well established in the available literature on enhancement ethics. Recently, for example, Einer Elhauge has similarly suggested that the treatment–enhancement distinction makes little normative sense and is inherently unsustainable, in significant part because "the medical treatment limit has a hard time holding in the face of perceptions that a broader range of persons can benefit from a medical intervention" than those persons identified via the disease-focused model of medicine.¹

As Earp and colleagues also note, attention to loving relationships is already implicated in medicine via physical health and longevity, and further treatment modalities for relationship health are ethically defensible—and laudable—if relationship dysfunction is a contributing factor to serious health problems such as heart disease.²

This dimension of Earp and colleagues' argument could have been further strengthened. Sustaining the objection that love should be left outside of the scope of medicine would directly undermine the goal of medicine. Imagine, for example, that a person plans to begin a relationship with a new partner and wishes to understand and work to alleviate any health limits on her capacity to engage in the new relationship, or indeed to understand ways in which the new relationship may improve her health. If the patient's physician refused to treat patients whose health concerns were linked—even potentially—to love on the ground that love is beyond the scope of medicine (yet patients would be provided the same care absent the context of love), then she would be undermining the need for reasonable honesty between physician and patient, as the patient may end up lying or omitting information in discourse with her doctor or other care provider when pursuing access to healthcare. As Iezzoni and colleagues remark, "open, transparent, and bidirectional communication is the foundation of patient-centered care," and because "communication shapes interpersonal relationships between patients and physicians through mutual trust and empathy" and is recognized as having potentially therapeutic implications, there is now a movement in medicine toward care based on empathic, culturally competent communication.³ The physician in such a case would also limit the efficacy of medicine by

discouraging her patient from seeking out care providers about health concerns even tangentially relating to love. Notice that this holds even if we retain the treatment–enhancement distinction and a traditional understanding of the goal of medicine as treatment of disease—though, as mentioned earlier, there are already good reasons to abandon both of these.⁴

Earp and colleagues acknowledge that medicalization may involve ethically problematic surveillance and social control, and/or oppressive normalization of forms of monogamy (specifically, heterosexual cisgender). They commit to the following views, based on discussion of previous criticism of their work by Gupta and by Purdy: (1) Purdy's view that policymakers should consider technological innovations as complements to (not replacements for) social change; (2) a characterization of Gupta's view that "individual/structural and biological/social factors are co-constitutive"; and (3) Gupta's claims that individual biotechnological and social interventions might best be integrated and that when further combined with measures to prevent social normalizing effects, biotechnological innovations may promote human flourishing.⁵ Instead of simply avoiding new technologies, therefore, Earp and colleagues suggest two strategies to support ethical deployment: (1) anticipate potential problems and modify the relevant contexts (social, legal, or other) in which such technologies would be implemented and (2) focus on well-being as the goal of medicine, so that medical intervention is seen as a complement to social change.

Earp and colleagues' argument does not do enough to address social and political concerns relevant to the neurochemical modulation of love. It makes sense to focus on well-being rather than disease treatment as the goal of

medicine when seeking to eliminate the basis of the treatment–enhancement distinction, but Earp and colleagues’ doing so does not eliminate the possibility that well-being itself could be used as a tool of oppression, for example, by being defined, discussed, or pursued clinically in ways that reinforce forms of privilege, such as white cisgender wealthy heteronormativity. Even though Earp and colleagues do recognize and advocate social context modification and affirm some of Gupta’s recommendations, such as “passing certain restrictions on the activities of drug companies and making changes to the curricula of medical education programs,” their strategies in the argument at hand tend to gloss over the diversity of possible contexts in which neurochemical modulation technology might be deployed, and the associated challenges that these contexts present.⁶

Gupta makes seven specific recommendations regarding neurotechnology implementation and sexual diversity that are worth listing in full:

- 1) Include education about sexual diversity (including BDSM, asexuality, and polyamory) in medical and mental health curriculums.
- 2) Institute professional practice guidelines requiring professionals who are prescribing these treatments to also provide their patients with information about sexual diversity and referrals to appropriate sexual communities (i.e., the BDSM community).
- 3) Require drug companies to undertake qualitative evaluations of the effects of these drugs and require the Food and Drug Administration (FDA) to consider this research in decision making so drug treatments are evaluated according to more holistic criteria.
- 4) If drug companies wish to advertise a drug directly to consumers, they should be required to spend an equal amount of money advertising all of the other medically approved treatment options for that particular condition.
- 5) The government should increase the allocation of research funds for sociological and anthropological research on sexual issues.
- 6) The Centers for Disease Control and Prevention (CDC) or another government organization should undertake public education campaigns designed to educate the public about sexual diversity.
- 7) Comprehensive sexual education should be required in all public schools, and the sex education curriculum should include information about sexual diversity.⁷

To these recommendations, I would add the following: (1) regular retraining for healthcare providers and revisiting of the possible effects of unconscious biases; (2) monitoring of those licensed to supply the relevant technologies; (3) accountability to nongovernmental agencies involving members of relevant minority communities; (4) widening other aspects of diversity education and training to incorporate attention to economic, ethnic, religious, age, disability, and linguistic diversity; (5) increasing public understanding of the value of arts and humanities education and research to understanding the diversity of conceptions of love as these are relevant to health; and (6) increasing government funding for such research. Possible deployment contexts may present fundamental challenges to the fair and equitable access to medicine depending on the type of (tiered) healthcare provision operational in any given country, assuming of course that healthcare is accessible at all. Groups vulnerable to

institutional and systemic oppression in the context of the neurochemical modulation of love worldwide might include persons living with disabilities, adolescents who are of an age to give sexual consent yet below the age of majority (in, e.g., the United Kingdom, where the age of sexual consent is 16, whereas the age of majority is 18), and elderly people and immigrants—both of whose cultural background or competence in their healthcare provider's language may involve concepts of, and ways of talking about, love and loving relationships that may be very different from those that healthcare providers expect. In the case of immigrants, their presence in any society as potential or actual lovers of citizens is already usually subject to governmental monitoring and control by virtue of their immigrant status and by virtue of health status checks and requirements for permanent residence in the country of the beloved.

A related issue is that Earp and colleagues' analysis of medicalization seems to assume that possible users of neurochemical modulation technology are rational individuals who consider proposed treatments objectively, and who prioritize and decide on relevant treatments accordingly—yet this is not a safe assumption.⁸ Taking rational individuality for granted may further entrench the oppression of less advantaged social groups in the context of medicalizing love. As Ami Harbin notes, feminist scholars have consistently pointed out that “medicalization is not the work of medical professionals alone: it is the product of the participation of many individuals (family, friends), institutions (schools, workplaces), and systems (justice systems, social-security systems).”⁹ Moreover, as Susan Dodds argues, cool-headed rationality is something of a bioethical myth: many people make healthcare decisions “in a

state of confusion” when influenced by “a number of internal and external pressures, including pain, discomfort, worry, and concern for others.”¹⁰ I think it is uncontroversial to claim that love may involve all of these pressures—not least, confusion—and therefore suggest that more attention to what autonomy might mean in the context of neurochemical modulation of love within and across diverse communities of lovers is needed.

Notice that these proposals are in keeping with clinical concerns already presented in Earp and colleagues' previous scholarship. As Wudarczyk and colleagues note, in a study written as part of Earp and colleagues' broader project on neurochemical modulation of love, the “ecological” validity of oxytocin needs to be studied, along with administration alongside psychological and behavioral interventions; moreover, “oxytocin should only be administered when it is based on sound ethical reflection, in the context of a structured treatment plan, with the careful guidance of a professional trained in counseling.”¹¹ When this proposal is considered with concerns about rational autonomy and social, institutional, and systemic medicalization in mind, the broad need for ecological investigation and indeed ecological education is clear.

Earp and colleagues discuss the concern that “drug-based interventions might introduce psychological or behavioral inconsistencies in the person or couple being enhanced—possibly interfering with the sense that it is the ‘same person’ (or relationship) through time.” They are right to claim that it is an empirical question whether inconsistencies would be introduced via drug intervention, but their response to the issue of inconsistency is limited to asking further questions concerning the scope of inconsistency and pointing out that our true selves are to some

extent inconsistent. Here they might have further bolstered their defense of neurochemical intervention against this personal identity worry by employing Marya Schechtman's concept of empathic access.¹² Schechtman summarizes the concept as follows,

Empathic access involves a situation where the original psychological make-up is, in an important sense, still present in the later, psychologically-altered person. The earlier beliefs, values and desires are recognized as legitimate, and are given, so to speak, a vote in personal decision making. If there is anything that it can mean to persist through change, certainly it would be this.¹³

As Schechtman goes on to clarify, empathic access is not the exact recreation of emotional states; it is the ability to call these states up from a first-person perspective and a "fundamental sympathy for the states which are recalled in this way."¹⁴ In the case of love, this may provide some reassurance for individuals and couples undergoing neurochemical intervention and other therapies: if a feeling of love can be called up and recalled with sympathy, in a manner recognizable to the individual and associated partner(s), there is at least some hope that the intervention is not problematically mind altering. Notice too that this appeal to contemporary metaphysics further supports my earlier claim for the contemporary bioethical relevance of the humanities, specifically including philosophy.

In the conclusion to their argument, Earp and colleagues explore whether resistance to neurochemical modulation of love is based on the intuitive lack of appeal of the medicalization of love or on suspicion of the notion of reducing romantic love to chemicals.

They suggest that such intuitions are grounded in a strong divide between humanistic and scientific ways of seeing the world. In response, they encourage us to consider that if there is both beauty and wonder to be found in a scientific approach to understanding love, then the medicalization of love might open up new ways of seeing love as a rich and beautiful human experience and—following work by Fromm—might even help us to become more accomplished at practicing the art of participating in loving relationships.¹⁵

Although Earp and colleagues' recognition of the value of the human sciences as well as the natural sciences in furthering our understanding of love is promising, there was no argumentative need to frame the debate over neurochemical modulation of love as one in which a divide between the human and natural sciences plays a significant part. Framing ethical debate in terms of such a distinction detracts from this final part of Earp and colleagues' argument, as it produces a caricature—a straw man—that dismisses the value of neuroscience-based technology. The simple point that the humanities and the sciences are both helpful to our understanding and pursuit of meaningful loving relationships would have sufficed here for the purposes of Earp and colleagues' analysis, especially given their consistent emphasis on the importance of well-being. Using Dawkins's reading of lines from Keats's poem *Lamia* to conjure up a distinction between the human and the natural sciences was also unhelpful.¹⁶ Dawkins's reading of Keats is overly literal and thus misleading: when Keats writes of the "mere touch of cold philosophy" and suggests that "Philosophy will clip an angel's wings," he is not—as Dawkins wrongly believes—denying the beauty or imaginative scope of scientific explanation.¹⁷ As Alister McGrath has pointed out,

in these lines, Keats is challenging those who believe that a rainbow can have no symbolic or imaginative meaning purely because it may be analyzed scientifically.¹⁸ Moreover, Keats is pointing to the power of explanation, which may be used for good or for ill and which should not be used lightly, especially wherever the “tender-person’d,” like Lamia—and indeed ourselves—are concerned.

Earp and colleagues missed the opportunity to provide greater affirmation of the capacity of the sciences, arts, and humanities to collaborate effectively in understanding love—and health—in their conclusion. In their future work on love, I urge them to pursue this relationship.

Notes

1. Elhauge E. I’m not quite dead yet—and other health care observations. *Tulsa Law Review* 2014;49:607–26, at 619.
2. See also Wudarczyk OA, Earp BD, Guastella A, Savulescu J. Could intranasal oxytocin be used to enhance relationships? Research imperatives, clinical policy, and ethical considerations. *Current Opinion in Psychiatry* 2013; 26(5):474–84.
3. Iezzoni LI, Rao SR, DesRoches CM, Vogeli C, Campbell EG. Survey shows that at least some physicians are not always open or honest with patients. *Health Affairs* 2012;31(2):383–91, at 384.
4. See note 1, Elhauge 2014. See also Earp BD, Sandberg A, Savulescu J. The medicalization of love. *Cambridge Quarterly of Healthcare Ethics* 2015;24(3):323–36.

5. See Purdy L. Medicalization, medical necessity, and feminist medicine. *Bioethics* 2001;15(3): 248–61. Gupta K. Anti-love biotechnologies: Integrating considerations of the social. *American Journal of Bioethics* 2013;13(11):18–19. See also note 4, Earp et al. 2015, at 330.
6. See Gupta K. Protecting sexual diversity: Rethinking the use of neurotechnological interventions to alter sexuality. *AJOB Neuroscience* 2012;3(3):24–8. See also note 4, Earp et al. 2015, at 328.
7. See note 6, Gupta 2012, at 27.
8. Dodds S. Choice and control in feminist bioethics. In: MacKenzie C, Stoljar N, eds. *Relational Autonomy: Feminist Perspectives on Autonomy, Agency and the Social Self*. Oxford: Oxford University Press; 2000:213–35. McLeod C, Sherwin S. Relational autonomy, self-trust, and health care for patients who are oppressed. In: MacKenzie C, Stoljar N, eds. *Relational Autonomy: Feminist Perspectives on Autonomy, Agency and the Social Self*. Oxford: Oxford University Press, 2000:259–79. Harbin A. Disorientation and the medicalization of struggle. *International Journal of Feminist Approaches to Bioethics* 2014;7(1):99–121.
9. See note 8, Harbin 2014, at 117.
10. See note 8, Dodds 2000, at 217.
11. See note 2, Wudarczyk et al. 2013, at 480–2.
12. Schechtman M. Empathic access: The missing ingredient in personal identity. *Philosophical Explorations: An International Journal for the Philosophy of Mind and Action* 2001;4(2):95–111.
13. See note 12, Schechtman 2001, at 102.
14. See note 12, Schechtman 2001, at 106.
15. Fromm E. *Art of loving*. New York: Perennial Classics; 2000.
16. Dawkins R. *Unweaving the Rainbow: Science, Delusion and the Appetite for Wonder*. New York: Houghton Mifflin Harcourt; 2000.
17. See note 16, Dawkins 2000.
18. McGrath AE. *The Order of Things: Explorations in Scientific Theology*. Oxford: Blackwell; 2006, at 58–9.