Original Article

Limitations in the bioethical analysis of medicalisation: The case of love drugs

Nathan Emmerich

School of Politics, International Studies and Philosophy, Queen's University Belfast, Belfast BT7 1NN, UK.
E-mail: n.emmerich@qub.ac.uk

Abstract A number of articles concerning the idea of 'love drugs' have recently appeared in the bioethical literature. While, as yet, the idea is little more than science fiction, such drugs have been positioned as 'neurotechnologies' that will offer us the opportunity to enhance our marriages. Following a classically liberal approach, the strategy has been, first, to argue that there is no reason individuals should be prevented from using such drugs if they wish to use them, and, second, to adduce reasons why individuals might be morally motivated to do so. This work has been followed by a paper that considered whether such drugs will 'medicalise' love and, if so, whether any (bio)ethical implications follow from their potential to do so. In response, this article argues that traditional forms of bioethical analysis are ill placed to fully grasp the moral dimension of medicalisation. Using the concepts of biomedicalisation, theraputicisation and moralisation I attempt to show that bioethical scholarship can be considered part of these social processes, and, properly understood, they imply that our social, cultural and political norms, such as those that inform our conception of love and intimacy, are subject to change. As a result a more biopolitical approach is to be recommended.
Social Theory & Health (2016) **14,** 109–128. doi:10.1057/sth.2015.20;
published online 8 July 2015

Keywords: bioethics; medicalisation; love drugs; enhancement; biopolitics; social norms

Introduction

A significant feature of recent scholarship in (applied philosophical) bioethics has been a concern for human enhancement. For the most part such analysis starts with current, and often suggestive, scientific research but subsequently focuses on biomedical technologies and innovations rooted in *anticipated* scientific discoveries. Such discussions extrapolate from current knowledge in order to speculate about future technologies on the basis of future scientific

discoveries, which may not be realized. Furthermore, the imagined technologies may or may not take the precise form supposed or function with the degree of precision supposed. Recent arguments concerning love drugs provide a case in point (Savulescu and Sandberg, 2008; Earp *et al*, 2012, 2013, 2014, 2015a, 2015b; Wudarczyk *et al*, 2013). On the basis of our current knowledge of oxytocin, vasopressin and the neuroscience of 'love' (or, perhaps more accurately, 'pair-bonding behaviours') these papers imagine future neurotechnological advances that will facilitate an array of interventions. They then proceed to examine these 'science fictions' from the point of view of applied (or practical) ethics.[1] While these papers, and the enhancement discourses of applied ethics more generally, conclude that there are few ethical barriers to pursuing these technologies, they show a relatively limited awareness of the 'bigger picture' regarding the complex relationship between science, technology and society.

The most recent addition to the literature on love drugs concerns the issue of medicalisation (Earp *et al*, 2015a).[2] Here Earp *et al* consider whether it is ethical to pursue research into love and to develop love-related neurotechnologies if one consequence of doing so will be its medicalisation. However, their analysis, like applied (bio)ethics more generally, displays a limitation characteristic of the discipline: their prospective ethical analysis of the medicalisation of love is socially, culturally and historically unreflexive. Consistent with the perspective of other bioethicists (for example, Minerva, 2012; Parens, 2013) they adopt the view that the consequences of medicalisation may be good or bad. Having adopted this perspective it is difficult to subsequently consider any medicalising process as 'unethical' (in the sense of 'right' or 'wrong'), at least not without further substantive argument. While the authors then consider various aspects of what they take to be the likely consequences of the medicalisation of love, they nevertheless conclude that the concerns they consider do not present an ethical barrier to the development of love drugs.

It is clear that human love is such that its normative structure, social institutionalisation and cultural shape vary significantly across sociological, anthropological and historical spaces (Coontz, 2006; Illouz, 2012; May, 2012). Given that medicalisation is a sociological process, the medicalisation of love will contribute to the ongoing socio-cultural development of love, marriage and intimacy. Such changes are, therefore, implicated in the underlying morality and ethics of love. I would suggest that because the consequence of this social, cultural and historical process is to alter the normative dimension of the phenomena they affect then the kind of analysis offered by applied philosophical (bio)ethics must, at best, be seen as inherently incomplete. The suitability of applied ethics to such evaluations must, therefore, be called into question. While one cannot abandon the ethical analysis of new technologies conducted on the basis of an unknowable future, this is only part of the moral question raised by

such technologies. The problem is that, for the most part, they are unreflexive with regard to the sociological, anthropological and historical dimensions of its object – in this case 'love'[3] – and the consequences that such analyses might have for the object being considered. Any ethical analysis of 'medicalisation' must be conducted in a manner that is socially, culturally and historically reflexive. Using the example of love drugs, this article articulates a broader perspective for such evaluations.

Thus, rather than comment on or engage with their substantive (bio)ethical analysis this article focuses on three facets of medicalisation – biomedicalisation, theraputicisation and moralisation. Before doing so it is worth making a few preliminary points. Bioethicists or, rather, 'applied ethicists'[4] have a tendency to think of social process and phenomena – for example, medicalisation, biomedicalisation and pharmaceuticalisation (Minerva, 2012) – as ontologically distinct. While such distinctions are analytically fruitful, few sociologists would consider them anything but entangled.

Given this view, my conception of medicalisation is such that it overlaps with those of biomedicalisation, theraputicisation and moralisation. Indeed one could suggest that these four processes are variously entangled and that the pursuit of a particular perspective results in one process becoming the analytic and conceptual focus while the others are left somewhat implicit and neglected. However, while research that focuses on bio/medicalisation can examine the contours of theraputicisation or moralisation without making explicit use of the terms, it remains the case thattaking each of these terms as an explicit focus can facilitate a more finely grained and fully sociological analysis than is currently the case in the existing literature on love drugs.

In this essay, I take each term in turn. First, in response to Earp *et al*'s use of the term medicalisation to indicate a future consequence of love drugs, I take up the term 'biomedicalisation' to focus on the present and consider the sociocultural consequences of the bioethical debate about love drugs. Second, I examine Illouz's (2008) analysis of intimate relationships and her suggestion that our emotional lives have become subject to the discourses of therapy, or 'theraputicised'. While some aspects of this theraputicisation, such as marriage counselling, can be considered forms of medicalisation, not all aspects can be so described. Indeed Illouz considers modern life to be marked by a therapeutic ethos, a social consequence of psychology and its related discourses. This ongoing cultural and psycho-social development has normative implications that, again, call into question the kind of prospective (bio)ethical analysis of medicalisation offered in the case of love drugs.

Third, while many processes of medicalisation – such as those relating to alcoholism, addiction and homosexuality – have been accompanied by developments in the moral framing of these phenomena, not all cases of medicalisation

involve explicit processes of (de)moralisation. Nevertheless, in thinking about the social context and consequences of love drugs, there is reason to think that the culturally normative framework of love and intimacy will be impacted, not least because they appear to contribute to ongoing developments and changes. In order to show that this is the case for intimate relationships, I first pursue the idea that the understanding of intimate relationships found in the bioethical discourse on love drugs reflects contemporary norms and ideals centred on what Giddens (2013) called the 'pure relationship' and the 'democratisation of intimacy'. These ideas connect with Illouz's views regarding the theraputicisation of our emotional lives. I argue that existing bioethical discussions of drugs for love have significant potential to further these developments and may already be doing so. Academic and public discourses have the potential to contribute to social and cultural changes in our normative understanding of intimate relationships and, therefore, to their 'moral' (re)construction. Furthermore, insofar as these ideas contribute to the ongoing (re)development and (re)construction of our contemporary ideology of intimacy – the basis for their social normativity – they have socio-political consequences.

Given this view, applied ethical analysis of love drugs and the potential medicalisation of love can provide part of the ethical picture, but not all of it. An explicitly ethico-political analysis is also required. I therefore conclude with the suggestion that the philosophical tools of applied ethics are insufficient, and perhaps unsuited, for the proper ethical analysis of sociological processes such as medicalisation and its analogues. This is because such a task requires us to recognise that the social norms of intimate relationships are not fixed, and that an (ethical) analysis of such norms has the potential to alter them. This is incompatible with the methodological assumptions of applied (bio)ethics as a form of politically neutral analysis. If we are to understand the consequences of researching, inventing and making use of love drugs as fully as possible we must draw on the critical – which is to say, socially and culturally reflexive – tools of history, sociology and anthropology. These disciplines can provide a basis for the proper assessment of the medicalisation of love, albeit one that cannot offer explicit normative guidance on the matter as it proceeds from within an alternative conception of 'ethics', one that might be characterised as biopolitical.

Biomedicalisation

As introduced by Clarke *et al* (2003), the notion of biomedicalisation updates and expands that of medicalisation. It is conceived so as to address various facets of 'techno-science', such as the way that the distinction between 'basic' and

'applied' science – or, to put it another way, between 'Mode 1' and 'Mode 2' knowledge – is becoming increasingly blurred. The concept also enables the critical analysis of medicine and medical research to be conducted in the light of various recent socio-historical changes and cultural developments, including the social and economic organisation of health care and bioscientific research. Nevertheless, it should not be considered a mere expansion of, and replacement for, medicalisation. Certainly, social processes previously understood through the lens of medicalisation have not been left untouched by the development of techno-science; as the social world changes and develops, so do the processes that produce social change and development. Thus, if we reconsider 'love drugs' through attending to the specificities of biomedicalisation, we may find that additional insights emerge.

The ethical analysis of a potential technology and the possibility that it might result in the medicalisation of some aspect(s) of our lives expresses the following concern: *if* the attempt to develop neurochemical love therapies is successful *then* what might the consequences be? Thus, the medicalisation of love is not understood to be an *existing* social process but something that *might* occur in the future if the relevant scientific and technological research succeeds. However, a central feature of biomedicalisation is that the potential applications and technologies that may result from scientific research increasingly influence the direction of basic scientific research. Given that debates regarding love drugs exhibit this feature – it is clearest in an article published in 'Current Opinion in Psychiatry' (Wudarczyk *et al*, 2013)[5] – this suggests we focus our attention on present developments.

My view is that, at least to some degree, the bio/medicalisation of love has already commenced. It is present in the (bio)ethical analysis of love drugs, not least because this debate does not offer an ethical assessment of an as yet unrealised neurotechnology alone, but also seeks to set an agenda for research. Furthermore, if we consider the way that the ideas surrounding love drugs have been taken up in public discussions, we can see that speculations about near-future technologies are not merely the preoccupation of academics but can capture the public imagination. Unsurprisingly, the idea of a drug for love is no exception: there has been a reasonably extensive public discussion of the idea that love is a neurochemical phenomenon and something that may become subject to manipulation via biotechnological intervention. Furthermore, the idea appears to have found a fair degree of favour. In this context we might note Rose and Abi-Rached's (2013) suggestion that the neuromolecular gaze is not restricted to neuroscientists or even academics. Increasingly it is something that is taken up within broader cultural discourse. The lesson is, I think, clear: our cultural understanding of love now includes a neuromolecular aspect and, in no small part, does so *because* of existing, but speculative, bioethical analysis of

neurotechnologies for love. This demonstrates that bioethical scholarship can be implicated in processes of biomedicalisation. It cannot be considered as entirely independent from such process and is, therefore, entangled with both developing scientific knowledge and broader cultural developments.

This point deserves further examination. Medicalisation and biomedicalisation are terms for the conceptualisation of social processes and developments. Academic discussions and their cultural dissemination can constitute part of these processes, even if the possibilities they examine are highly speculative. As is the case with much science fiction, the idea of a drug for love is based on scientific extrapolation. And as in much of the best science fiction, such extrapolations can prove accurate and present-day discussions may aid us in preparing for future challenges. However, considering such technologies in advance of them becoming a scientific or technological reality can have implications for the reorientation of our contemporary perspectives and, therefore, not only the cultural context of their discovery but the cultural context in the absence of their discovery. Neurological discourses are increasingly common, and the idea that we are our brains is taking root within our culture. Deliberately echoing Foucault's nation of the medical gaze, Rose and Abi-Rachid's (2013) account of the neuromolecular gaze suggests that it is a style of thought (pp. 41–46). However, just as the medical gaze is not restricted to medical professionals, the neuromolecular gaze is not the sole purview of neuroscientists or neurologists. It is an intellectual perspective that can be taken up by any one, and turned on a variety of human activities.

The contemporary multitude of intellectual disciplines that have been subject to the prefix 'neuro' – such as neuroethics, neurolaw, neurotheology, neuroaesthetics and neuroeconomics – stand as a case in point, as does the (bio)ethical analyses of love at play in the arguments presented by Earp *et al.* We might suggest that they are not primarily concerned with 'love' but with 'neurolove' and, therefore, not with the ethics of love but with 'neuro-ethics of neuro-love'. Certainly part of their discussion concerns the broader idea(l) of love and its socio-cultural institutionalisation in marriage, but their view places limitations on the nature of love; it is primarily considered as a neurological phenomenon. Given the gaze that is guiding the analysis, it is unsurprising that they conclude there is little of ethical concern if such neuroenhancements were to become reality. Nevertheless, as is the case with other neuro-prefixed domains, the idea that love is a neurochemical phenomenon has social consequences. Whether or not the proposed drug for love becomes a reality, these papers, and broader discussions of the ideas presented within them, are contributing to the contemporary bio/medicalisation of love and intimate relationships. They are contributing to a cultural reconceptualization of love as, at least in part, a *neuro* phenomenon.

The idea of biomedicalisation has further implications. Rather than being focused on restoring a patient to good health via interventions that purport to cure illness and disease – as is largely the case with medicalisation – biomedicalisation involves extending the jurisdiction of medicine to cover the promotion and governance of health (Clarke *et al*, 2003). As such, biomedicalisation's concerns reorientate our understanding of health to encompass what Downing (2011) calls biohealth. While health is the antithesis of sickness, illness or being unwell, biohealth has no antithesis; it is not restricted to our present state but encompasses our uncertain futures including 'risk factors' and 'lifestyle'. As far as biohealth is concerned we are all sick or, rather, we could always act to provide ourselves with a healthier future. Arguments for love drugs exhibit a concern for biohealth as, without suggesting that anyone is ill or diseased,[6] they lay claim to the future health benefits of not only those in committed relationships but the children raised within these contexts (Savulescu and Sandberg 2008; Earp *et al*, 2012). However, love drugs do not guarantee these health benefits directly but do so through decreasing the likelihood of relationship breakdown, thereby offsetting the risk of their occurrence and their potentially negative consequences. Consistent with the biomedicalisation thesis our obligations to be healthy have taken on a distinctly moral hue (Clarke *et al*, 2003, p. 171). Rather than being a way to restore us to 'normality', drugs for love offer a kind of moral improvement; they are a way for us to customise our neurobiologies so as to meet particular socio-cultural and normative ends – albeit ends that are presented as consistent with the dominant understanding of our evolutionary past (Earp *et al,* 2012). As such, their use will be subject to contemporary norms while, at the same time, representing a potential challenge to those norms. As a result they – and their bioethical discussion – will likely contribute to a reconfiguration of those norms.

The perspective of biomedicalisation – and, for that matter, of contemporary enhancement discourses and practices – suggests that love drugs are more likely to be used proactively, to actively 'take charge' of oneself, and thereby offset the risk of marital problems before they occur. Love drugs would, I think, be adopted as a prophylactic, a kind of vaccination or immunisation, and not merely as a response to relationship difficulties. The existing bioethical analysis would suggest that such use is likely to be unethical as professional marriage counsellors do not supervise untroubled relationships and, on pain of 'medicalisation' (or, perhaps more accurately, 'theraputicisation'; see next section), are unlikely to be inclined to do so. It is also unlikely that we would willingly submit to such supervision. One might object that the same thought can be applied to our inclinations to use love drugs at all. However, as suggested, the normative basis of intimate relationships is subject to change. As the neuromolecular gaze becomes more widespread, the possibility that we might make 'off-label' use of

love drugs increases. Indeed, Earp *et al* cite an example that suggests that some people already use drugs – in this case anti-depressants – to dampen, if not control, their sexual desire. Nevertheless, the 'private' nature of intimate relationships is such that our cultural resistance to professional supervision is likely to prove durable. Arguments for the use of love drugs suggest that they are seen as a kind of moral enhancement of our evolved, and therefore *natural*, psycho- or neurobiology. In presenting this case, the claims they are making are representative of the biomedicalisation, and not simply medicalisation, of love.

Theraputicisation

Quite obviously both medicalisation and biomedicalisation imply a process of theraputicisation; if something becomes medicalised then, at least in theory, it is susceptible to some therapeutic intervention. However, the notion of therapy and theraputicisation is broader than the notion of medical treatment. Indeed, the term theraputicisation has primarily been used to refer to the social and cultural discourses surrounding the psy-sciences and what Rose (1991) calls 'the social consequences of psychology' (p. 91). Throughout the twentieth century 'the self' became increasingly subject to forms of reflexive examination. Our emotions have become 'objects' that can be subject to rational reflection, evaluation and explanation. However, while the consequences of psychology are much greater than the advent of 'self-help', the widespread influence of this phenomenon provides the clearest example of the way in which we, and our everyday lives, have come to be understood, and understand ourselves, in psychological and psychotherapeutic terms. The nature of human 'being' – our subjectivity – has been fundamentally reconfigured by the psy-sciences. As the work of Illouz (1997, 2012) demonstrates, this reconfiguration is particularly pertinent to modern love. She argues that love, our personal relationships and our conception of self, have all become positioned within the 'therapeutic ethos', something she considers to be a feature of modernity more generally (Illouz, 2008).

The idea that 'love' has become subject to the discourses of therapy is clearest when we consider the phenomenon of couples counselling or marriage guidance. Given the role that 'talking therapies' have played in the medicalisation of alcoholism and various other forms of addiction and addictive behaviours, the emergence of this approach to the repair and maintenance of intimate relationships is clearly a form of medicalisation. However, the idea that intimate relationships have become subject to the discourses of psychological therapies can be extended if we consider the degree to which intimate relationships have *themselves* come to be considered therapeutic. This point is present in the articles

under discussion as they draw on evidence to connect intimate relationships and the health and well-being of those who are not only in, but who are raised in, the context of such relationships (Savulescu and Sandberg, 2008; Earp *et al*, 2012). This claim is then used to position the neuroenhancement of love as ethical insofar as it promotes the health and well-being of couples and the children they raise.

This point can be given greater meaning if we consider how 'therapeutic discourses' are implicated in and constitutive of modern concepts of intimacy. Giddens (2013) argues that, in the modern era, intimacy has become 'democratised' (Chapter 10). As demonstrated by the decriminalisation of homosexuality and, subsequently, the legalisation of gay civil partnerships/marriage, the ideology of marriage is now committed to a particular vision of equality. The cultural specificities of romantic love and romantic relationships, ideas and ideals of a particular socio-historical context are being transmuted into something he calls 'confluent love' and the pure relationship. The latter is defined as:

> [A] social relation entered into for its own sake, from what can be derived by each person from a sustained association with another, continued insofar as it is thought by both parties to deliver enough satisfactions for each individuals to stay within it. (Giddens, 2013, p. 58)

What is distinctive or significant about modern love is not so much the romantic notion of the other person, but the relationship itself. Intimate relationships no longer bring about the mutual alignment of goals and projects. Rather, such alignment is a condition of, if not love, then the continued pursuit of the relationship. The pure relationship is pursued only insofar as it provides an opportunity for the mutual fulfillment of the individuals concerned. The relationship itself is, of course, a mutually shared end of its constitutive individuals. Intimate relationships are not only a context for self-realisation but also a form of self-realisation. They may even be seen as an essential component for the full realisation of self, a notion that should not be mistaken for a claim about our biological teleos but, rather, our cultural conception of intimacy and the role accorded to it in regard to self, authenticity and adulthood (cf. Mintz, 2015, Chapter 2).[7] This view is fundamentally influenced by the discourses of psychology, and, as a result, terms like self-realisation and intimacy can be seen as code words for 'health' and 'well-being' (Illouz, 2008, pp. 172–174). Furthermore, impediments to self-realisation and intimacy become seen as barriers to health and, potentially, forms of illness that can therefore be subject to (psycho) therapeutic intervention. Given that the pure relationship is, in part, dedicated to the pursuit of intimacy and mutual self-realisation, it is, itself, a site for the discourses of therapy. As such, our relationships have become restructured along psychotherapeutic lines, within which we are 'enjoined to transform

emotions into cold cognitions' (Illouz, 2008, p. 142). The therapeutic ethos bids us to alienate ourselves from our emotional lives, to take a step back, to reflect, analyse and contemplate rather than, simply, to feel. Adopting such a reflexive posture towards our emotions is a condition for the realisation of the pure relationship, not least because it is a prerequisite for the democratisation of intimacy. As Giddens (2013) suggests, 'free and open communication is the *sine qua non* of the pure relationship. The relationship is its own forum. Self-autonomy is the condition of open dialogue with the other' (p. 186). As Illouz (2008) suggests, in modernity, the 'skills required for a good marriage are equivalent to the skills required to conduct business or even international diplomatic negotiations' (p. 219). Democratising intimacy means our private lives are becoming restructured and reorganised in accordance with the values, ideals and norms of the public sphere.

Such analyses are, in my view, highly illuminating, and one could pursue such literature further. However, we must curtail this largely exegetical discussion in order that we might return to the point at hand. In the first instance we might note that these developments have, in effect, created the conditions for the idea of a drug for love to emerge. The social institution of 'marriage' has become increasingly distinct from a range of other concepts – such as sex, monogamy, sexuality, reproduction, family and intimacy – that used to be entangled at the level of our cultural understanding. One can adduce a number of 'reasons' for this development, such as the privatisation of religion; the cultural acceptance of homosexuality; and the liberation of sex from reproduction wrought by contraceptive technologies. However, rather than standing in a unidirectional causal relationship, these, and similar changes, mutually reinforce one another. Loosening the bonds between sex, sexuality, monogamy, reproduction, family and intimacy has contributed to the decline of religion, the moral reevaluation of homosexuality and the socio-cultural acceptability of contraception. As the cultural ideal of love has become 'purified' –and as a consequence has overtaken romance – it has become increasingly possible to think of it as a neurochemical phenomenon. The way that intimate relationships are now understood has facilitated a cultural acceptance of – or, at least, interest in – the reductive evaluation of love offered by the neurosciences and its interpreters. In previous eras the idea that the pair-bonding behaviours of different voles could provide us with fruitful information regarding our own intimate relationships or the nature of love could not have gained the kind of purchase that it clearly has today. What has changed is not simply the advent and widespread acceptance of an evolutionary picture of 'human nature'. Rather, it is that the social conditions required for the idea of love drugs to take hold within our collective cultural imaginations have come about. Furthermore, they are, precisely, those documented by Giddens and Illouz.

In this view scientifically reductive attitudes and theories regarding love are cultural phenomena, not only insofar as they inform the socio-political discourses of intimacy but also because they are themselves informed by such discourses and ideologies. Such claims are not meant to deny the validity of current neuro-scientific research into love, merely to point out that, as with any form of scientific research, it occurs within a particular socio-historical period from which it cannot be divorced. If we are to fully comprehend the nature and social impact of such scientific perspectives – particularly those that are rooted in the human sciences – they should not be considered in isolation from their broader cultural context. That said, much of the work at hand is not so much 'scientific' as 'bioethical'. Current scientific knowledge provides nothing more than a basis for extrapolation and, one might add, the exercise of our imaginations. We might then consider whether and how existing bioethical arguments, and not just the neuroscience presented within them, are related to broader sociological developments in intimate relationships.

Claims regarding the ethical acceptability of love drugs are predicated on the notion of marital autonomy (Savulescu and Sandberg, 2008; Earp *et al*, 2012). Given the broader theoretical and conceptual developments in the bioethical conception of autonomy, one might have thought that an exegesis of 'marital autonomy' would be given in terms of relational autonomy. However, this does not seem to be the case. Marital autonomy is not considered to be 'greater than the sum of its parts'; *it is* the sum of its parts: it is constituted by the individual autonomy of the individuals concerned. The authors do not present a couple's decision to take love drugs as a collective process but as two individual ones. This exactly mirrors developments in the socio-political 'ideals' of the pure relationship. The therapeutic nature of the pure relationship, and of 'emotional' discourses more generally, requires us to set ourselves aside and take 'rational' decisions. A passionate or 'hot' decision to take love drugs to 'save' one's marriage would be impermissible as it would not meet the criteria for ethical use. Instead decisions to take love drugs must be taken in the cold light of reason and reflection. Ironically, then, caring about one's relationship too much would seem to be a barrier to its neurochemical enhancement, at least insofar as it prevents one 'taking a step back' and reflecting on the situation in the way prescribed by both therapeutic discourses and existing bioethics analyses.

The ironies of the requirement to step away from one's emotional life and make a rational decision are clearest in the case of 'anti-love bioetechnology' (Earp *et al*, 2013). The central example in this essay is of a woman who is unable to leave an abusive partner, whom she still loves. However, it appears that she is able to decide rationally to take an anti-love treatment, the effect of which will be that she will cease to love, and will therefore leave, her partner. One wonders whether this really can be the case. Could one really be unable to leave a partner

autonomously but, at the same time, be able to decide autonomously to take some drugs the consequence of which would be the same? In this example there is a bifurcation of 'cognition' and 'affect', or 'reason' and 'emotion', one that is echoed by both the therapeutic ethos and the ideals of contemporary (bio)ethics. At one and the same time we are considered highly susceptible to our emotions while also being enjoined to put them – and ourselves – to one side and reflect on our 'true', which is to say rationally or reflectively endorsed, desires and, in so doing, consider what we 'should' do to pursue them. This demand has a distinctive 'ethics', moral character or 'ethos'. Various of the examples presented in these papers position us as being at the mercy of our (biological) emotions; examples include 'being unable to leave an abusive partner who we still love', 'being easily led by lust' or 'becoming indifferent to a partner we once loved'. Nevertheless, we are also presented as being in a position to respond to these situations, to step beyond them, through the power of reason.

While I would challenge this picture, it cannot be rejected outright. Rather, I think we should more directly acknowledge the particular *ethics* (or 'politics') of such emotional distancing and the 'therapeutic' objectification of the affective self. Certainly the therapeutic ethos has been involved in positive developments in the ideology of intimacy, most notably the acceptance of homosexual relationships. However, it is increasingly common to find emotions and rationality being dichotomized, with the former being denigrated in favour of the latter. Arguments for love drugs present an account in which our emotions will become increasingly subject to control via rational means. Nevertheless, our emotional lives are intrinsic to what makes us human. Subjecting them to forms of neurotechnological control may result in forms of alienation, from our collective humanity and our own subjectivity or 'being'.

Before turning to the topic of moralisation there is a final form of theraputicisation in the arguments for love drugs that is worth considering. Part of the justification for love drugs lies in the empirical claim that children develop 'better' in the context of a two-parent family. In short, the parental relationship plays a therapeutic role in the psycho-social development of children. First, as Mintz (2015) points out, not only is this a relatively modern phenomenon but the particular weight attached to such parental responsibilities, and detached from wider social influences, is a highly contingent cultural fact. However, we need not go into the details of whether this is a biological or cultural phenomenon, or the contribution that the increasingly 'fractured' nature of community in the context of modernity might make to such empirical findings. Instead, we might consider whether the neuroenhancement of love is an 'individualised' and biotechnological solution to sociological 'problems' that have been generated by social changes and developments in our cultural norms. In recent times the nuclear family has, if not *emerged*, then at least become an increasing concrete

structure of contemporary society. This has occurred alongside the loosening of broader social structures, including those of extended family ties, and increasing levels of cultural and community liquidity. Given the negative connotations attached to the idea of social engineering and the fact that individualisation is a signature aspect of modernity, the idea(l) of the nuclear family might prove to be the widest point for the collective application of therapeutic discourses, at least outside of 'group therapy'. In this context the health of the parental relationship is being connected to the healthy psycho-social development of offspring. Consequently, the enhancement of intimacy becomes the enhancement of family life as well as the current and future well-being of the children being raised in this context. Such a perspective raises further questions about the nature of marital – or familial – autonomy and, therefore, the ethics of love drugs. It also raises questions about the moralisation of love and family, something to which I now turn.

Moralisation

The concept of medicalisation is often directly linked to changes in moral perspective. Consider the role of medicalisation in altering our moral evaluations of homosexuality, alcoholism and addiction more generally. Given these examples we might associate medicalisation with demoralisation as the medical perspective of these phenomena has fundamentally altered our moral judgements (Martin, 2006). However, if we take a broader – sociological rather than philosophical – view of morality and consider it to be the normative structures of a society or culture, its *ethos* we might say, then we cannot countenance a simplistic distinction between moral and medical phenomena. The medicalisation of addiction and homosexuality did not result in, merely, their 'demoralisation' but their remoralisation – it contributed to a renewal of the normative framework within which they are viewed, understood and 'evaluated'. In this view morality is the ethos of particular social contexts or fields, and a term that aims to encapsulate the influential cultural values, norms and principles that structure our lives. The nature of applied or practical ethics is such that it is a form of reasoned evaluation, applicable to a relatively restricted domain. The idea of morality as ethos has a much broader scope that includes the evaluative taxonomy, perspective and 'gaze' of medicine and 'therapy' more generally. Given that Illouz claims the *therapeutic ethos* as characteristic of modernity, we should understand her as suggesting that the sociological process of theraputicisation (and, therefore, medicalisation) has distinctively *moral* consequences. As such, theraputicisation and medicalisation are intimately connected to the social process of moralisation.

The latter part of the twentieth century saw significant changes in our understanding of love, marriage and intimate relationships. Over a relatively short period of time divorce not only became more common, it became destigmatised, as did the related phenomenon of single motherhood. There has also been a revolution in the social acceptance of homosexuality and homosexual relationships. Such changes are, of course, to be welcomed. However, we should not now take them for granted. Particularly when children are involved, divorce remains a morally charged occurrence, and the idea that couples should try to stay together for the sake of the children continues to have currency. Indeed arguments for the neuroenhancement of love promulgate the idea; an empirical justification for staying together for the sake, which is to say heath or well-being, of the children is presented as giving reason for the permissibility use of love drug (Earp *et al*, 2012). Similar arguments have previously been used to question the morality of homosexual couples raising children, and these same arguments could be used to call into question fertility treatments for single women. However, my point is not to imply that these arguments are ethically questionable, but rather to suggest that findings regarding the well-being of children are highly susceptible to changes and developments in the organisation of society. We might question whether the advent of love drugs is likely to promote such changes or whether they will contribute to a hypostatisation of the *status quo*. If the latter, we might consider whether the social pressure placed on couples with children to stay together will increase or decrease and what consequences this might have for the 'autonomous' use of love drugs. At minimum, we must consider whether love drugs have the potential to contribute to the remoralisation of marriage and the restigmatisation of divorce. We might wonder whether their use will become socially normative.

We might also consider the impact love drugs might have for monogamy and our moral evaluation of this socio-cultural institutionalisation of human sexuality. It is becoming increasingly clear that the developing norms of homosexuality reflect those of heterosexuality. Even if it is now 'serial', monogamy remains the ideological cultural norm and, in most fields, the socially recognised context for sexual relationships. However, it is also clear that there is an increasing, or increasingly visible, diversity of practices or 'lifestyles' when it comes to intimacy and sexuality. For some, 'monogamy' is a matter of emotional intimacy, and their sexual practices, either as a couple or as individuals, are not necessarily limited in the same way. For others emotional intimacy need not, it seems, be confined to a single relationship. Such lifestyles challenge social norms and can provoke a variety of responses in others, including responses that reflect negative moral evaluations. Depending on how society and love drugs develop it is conceivable that such drugs will come to be seen as a form of medical treatment for supposed sexual deviancy. Considering the related argument regarding the ethical

acceptability of treating homosexuality (Earp *et al*, 2014), raising this possibility is not mere hyperbole. Imagine if neurotechnology that could impact human sexuality had existed in the 1950s, or even in the 1980s or 1990s. Reflecting on the past, present and future of human sexuality is challenging. However, there is, I think, significant potential for love drugs to 'normalise' a particular vision of human sexuality and intimate relationships. Some might consider this normalisation to be morally justified while others may dissent. However, whether implicitly or explicitly, our contemporary moral and ethical perspective(s) on monogamy informs the applied (bio)ethical analysis of love drugs. This is, of course, an unavoidable facet of the task. However, they also inform our scientific facts and, in particular, the way medicine and evolutionary biology are interpreted in the context of bioethical discourse.

With regard to the latter point it is worth considering the potential of evolutionary psychology to not only reflect, but also be informed by, a distinctive political or 'ethico-political' perspective. The analysis of love drugs proceeds on the basis of what we might call the standard model of the evolution of human reproductive strategy. The model suggests that time-limited monogamy has emerged as a point of equilibrium in differential mating strategies of males and females. As a reproductive strategy monogamy is not 'really' monogamy; it involves individuals 'cheating'. However, despite this, the ideal of monogamy is, evolutionarily speaking, naturalised. This view facilitates the connection between 'pair-bonding' and 'love', as well as providing a basis for a 'default natural ethic' predicated on our 'evolved psychobiologies' (Earp *et al*, 2012, p. 573). In this way the idea and ideology of monogamy is presented as something that can be legitimately rescued from the limitations placed upon it by our bodies via neuroenhancement technologies.

This standard model is not, however, the only possible explanation. An alternative model rejects monogamy and argues that early humans were more promiscuous and collectively sexual than current mores would find palatable (Ryan and Jetha, 2010). We can, without reservation, acknowledge the political or ethico-political motivations of such accounts; embedded in these perspectives is a clear wish to contribute to the reconfiguration of modern sexuality. However, this acknowledgement should not be taken to simply undermine these accounts but, instead, can be turned back onto the standard model. We might consider the degree to which our political perspectives are influencing the interpretation of evolution. Certainly gendered variations in sexual jealousy, for example, need not be seen as, simply, an 'evolutionary' phenomenon (cf. Paul *et al*, 1996). The arguments for love drugs contribute to a particular 'cultural configuration' of intimacy; that it happens to reflect the existing ethos and its social norms cannot be ignored. Given the social normative nature of love, monogamy and marriage, it is not surprising that contemporary accounts of human evolution reflect current

norms. Indeed, as the love drug arguments show, the level of affinity is remarkable. After all, the suggestion is that with only a few minor tweaks to our brain chemistry we all have the chance to live happy, monogamous and *pair-bonded* lives. While I am, of course, being somewhat insouciant with regard to the caveats attached to these arguments the point nevertheless remains. It is not that the alternative model is political while the standard model is apolitical: both are influenced by the socio-politics of love; both are, at least potentially, culturally normative; and both invite a moralised reading of the body. Furthermore, it is difficult to imagine that we will resist the potential of biomedical and neurochemical technologies to pursue such therapeutic, moral and socio-cultural imperatives. The advent of such technologies will invite us to engage in the reconstruction, or 'enhancement', of our psychobiologies in the light of our substantive ethico-political perspectives. The worry is that the naturalisation of such perspectives will not be a neutral confirmation of their objectivity, but a political validation of their ideological power.

While the apparent increase in the diversity of sexual practices might be taken to mitigate the concern that the moral imperative of monogamy will be renewed, we might look to the moralisation of other 'biopsychosocial' phenomena, particularly the notions of health and well-being. The idea that health is a moral or normative idea(l) belies the idea that we need not be concerned with the thought that the medicalisation of love is part of 'the pathologisation of everything' (Earp *et al*, 2015a). This is because, or so the authors suggest, psychotropic enhancements do not aim at curing an identified disease or illness but at improving our 'quality of life' or 'well-being'. In the absence of a specified pathology there can be no process of pathologisation. However, the pathologisation of everything suggests something more than pathologisation *per se*. The idea that 'everything' is pathologised is not simply a function of the proliferation of specific pathologies. Rather, what would be required is a discourse within which the human body, or species, is a fundamentally flawed object – the idea that it is, in some way, not fit for purpose. Discussions of love drugs start from this evolutionary premise; they are founded on the claim that we are unsuited to the kind of medium- to long-term monogamy that is (i) required for the raising of 'healthy' children and (ii) distinctly problematic when the modern ideal of love meets the contemporary human lifespan. They are even clearer in related debates concerning whether or not 'humanity' is sufficiently equipped to address the ethical challenges that lie ahead (Persson and Savulescu, 2008). Thus, the fact that a therapy exists as some form of enhancement – which is to say as a 'treatment' for 'normality' – proves, rather than disproves, the view that the pathologisation of everything is a real concern. It is further confirmed when the authors quote Synofzik to the effect that running, sunbathing and eating chocolate are all 'treatments' for the alleviation of 'a depressive mood' (Earp *et al*, 2015a).

This claim reflects the fact that our contemporary ethos renders normal behaviour, and our psychobiological responses, 'therapeutic'. From the perspective of biohealth (Downing, 2011), discourses of enhancement are not simply therapeutic in the traditional sense. The traditional aspiration of therapy – health – is superseded by a medicalised reconceptualization, one that announces the era of biomedicalisation and biohealth (Downing, 2011, p. 2). It is the theraputicisation of everything that indicates that everything has the potential to be pathologised.

Discourses of enhancement, and their associated therapies, are clearly implicated in a value-laden view of 'being human'. As such, love drugs do not simply aim at our 'well-being' but at something broader, something we might call our *moral well-being*. Moral debates surrounding human enhancement are, in general, divided along the traditional political fault line of conservatives and liberals or progressives. However, there is a strong sense in which the hinterland of both is genealogically informed by a basic Christian moral trope: the fall of man. This difference is that where the bioconservatives think we should accept our flawed nature, bioprogressives think we should attempt to fix, or even transcend, our humanity. In recent times mainstream evolutionary perspectives have called into question our ability to act consistently both morally and rationally. Such perspectives continue to press home the basic message of Darwinism: humanity is just another animal. Enhancement discourses hope to rescue us from this fall and current discussions of drugs for love are a good example of this dynamic. Our biological capacity for love is presented as flawed. The proposed neurotechnologies suggest that these flaws can be subject to a technological reconstruction, that they – or *we* – can be 'hacked' at a neuromolecular level and in such a way that our neurobiological potential can be made to accord with the moral requirements imposed by our cultural ideals. In such discourses, evolutionary psychology and neuroscience points the way to our salvation: to be resurrected as 'post-humans'. To take the title of a recent thesis with a similar message regarding moral progress, neurotechnologies like love drugs promise to make us into the better angels of our natures (Pinker, 2012). Any such form of moral progress is socio-political, and so are its (bio)ethics.

Conclusion

The purpose of my argument has been to show that sociological processes such as medicalisation, biomedicalisation, theraputicisation and moralisation change the nature of what, normatively speaking, we are and how we understand ourselves. This calls into question prospective (bio)ethical analyses, such as those concerning love drugs, where social norms are not only subject to change but will likely be changed by the neurotechnology being analysed. The nexus of the problem

reflects Gellner's suggestion that '[w]hat one consents to depends on what one is, and what one is, in the end, springs from the society which has formed one' (Gellner, 1992, p. 193). Love drugs and neuroenhancement technologies more generally aim to restructure, reorganise and otherwise alter the society within which we are formed, reformed and conduct our lives. Debates and discussion of these phenomena are already doing so. As such they have an essentially socio-political dimension. Whether or not one consents to using love drugs is not a matter of autonomous choice, at least not simply so. Rather, it is a question of the socio-cultural construction of love, marriage and self. Given this view, then, we must conclude that (bio)ethical concerns about the medicalisation of love cannot be fully addressed by mainstream – applied or practical – bioethics. Social processes require critical socio-analysis. It is erroneous to think that such forms of engagement merely provide 'the facts' for a subsequent ethical examination. Instead such endeavours should be reconceptualised as forms of ethico-political critique. The conclusion is, I think, unavoidable: bioethical debates – and not just the topics of such debates – are in need of biopolitical analysis. Such perspectives will not offer the kind of action-guiding conclusions that make philosophical bioethics so appealing. Rather, rooted in historical, sociological and anthropological research, they will be critical, cryptonormative and, in many cases, undermine the socio-cultural neutrality and philosophical objectivity of applied or practical bioethics. They will, however, increase, rather than decrease, our understanding of the bioethics of medicalisation, not least because it allows us to represent (and reconsider) bioethics as a discourse, one that is implicated in sociological processes of bio/medicalisation, theraputicisation and moralisation.

About the Author

Nathan Emmerich is a visiting research fellow in the School of Politics, International Studies, and Philosophy at Queen's University Belfast. His interests lie with the social, cultural, and political role(s) played by bio- and applied ethics.

Notes

1 While the imagined biochemical neurotechnology, the 'love drugs', can be considered the *science fiction* presented in these papers, there is, as any science fiction aficionado will realise, always an accompanying '*social fiction*'. In this instance the operative social fiction is that the use of these drugs will occur in the world as it is today or, rather, as it is today in Western neo-liberal democracies. The socio-cultural fiction receives rather less attention than the scientific fictions both with regard to the case at hand and the enhancement discourses of (applied) bioethics more generally.

2 This article is due to be published in the *Cambridge Quarterly of Health Care Ethics* and, in a first for this prestigious journal, it will be accompanied by number of commentaries and responses.
3 Indeed, we might go further and suggest that the dominant bioethical methodology, that of applied philosophical ethics, is *studiously unreflexive* with regard to the sociological, anthropological and historical phenomena. As with medicalisation, phenomena that fall within the ambit of these disciplines are dismissed as contingent, as being neither necessarily good nor necessarily bad.
4 For the most part, my critique is levelled at 'applied' or 'practical' ethics rather than 'bioethics'. The latter is a multi- and inter-disciplinary field, which admits of a variety of scholarly activities and perspectives. Some of these endeavours involve ethical analysis (for example, feminist ethics) and still others are more descriptive or empirical (for example, sociology, anthropology and history) while, nevertheless, maintaining some form of critical (cryptonormative or 'ethico-political') intent. These forms of enquiry are not subject to the criticisms levelled at applied ethics or, at least, not to the same degree. However, none have yet addressed the topic of 'love drugs'. Furthermore, they do not tend to place the discourse of applied ethics alongside the objects of their concern as I have sought to do in this essay.
5 Addressed to those conducting neuroscientific research into oxytocin it presents an attempt to set an agenda for future research. It explicitly argues that researchers ought to further examine the neurochemistry of love in order that love drugs can be developed.
6 One could suggest that the authors of these papers are indeed suggesting that we, the human race, is in some sense ill, diseased or otherwise deficient. More specifically, one might construe them as suggesting that we are, as a consequences of our evolutionary development, morally deficient or flawed, at least insofar as we are unable to live up to the moral commitments generated by monogamy, an ideal of sexual intimacy that is both an evolutionary norm and culturally mandated normative practice. However, considering such suggestions to be a 'diagnosis' clearly goes beyond the realm of medicine and health and takes us into the realm of biomedicine and biohealth.
7 One might give further momentum to this point and hyphenate the word real-ized so as to suggest that intimacy is rendered real by the social forms of mutual recognition that attend such relationships. Such recognition renders us real to ourselves as well as each other, and thereby facilitates a form of authenticity that is otherwise unachievable.

References

Clarke, A.E., Shim, J.K., Mamo, L., Fosket, J.R. and Fishman, J.R. (2003) Biomedicalization: Technoscientific transformations of health, illness, and US biomedicine. *American Sociological Review* 68(2): 161–194.

Coontz, S. (2006) *Marriage, A History: How Love Conquered Marriage*. New York: Penguin USA.

Downing, R. (2011) *Biohealth. Beyond Medicalization: Imposing Health*. Eugene, OR: Pickwick Publications.

Earp, B.D., Sandberg, A. and Savulescu, J. (2012) Natural selection, childrearing, and the Ethics of marriage (and divorce): Building a case for the neuroenhancement of human relationships. *Philosophy & Technology* 25(4): 561–587.

Earp, B.D., Sandberg, A. and Savulescu, J. (2014) Brave new love: The threat of high-tech 'conversion' therapy and the bio-oppression of sexual minorities. *AJOB Neuroscience* 5(1): 4–12.

Earp, B.D., Sandberg, A. and Savulescu, J. (2015a) (Online First). The medicalization of love. *Cambridge Quarterly of Healthcare Ethics*. http://journals.cambridge.org/action/displayIssue?jid=CQH&tab=firstview.

Earp, B.D., Wudarczyk, O.A., Foddy, B. and Savulescu, J. (2015b) Addicted to Love: What is love addiction and when should it be treated? *Philosophy, Psychiatry, & Psychology*, https://www.academia.edu/3393872/Addicted_to_love_What_is_love_addiction_and_when_should_it_be_treated, accessed 28 April 2015.

Earp, B.D., Wudarczyk, O.A., Sandberg, A. and Savulescu, J. (2013) If i could just stop loving you: Anti-love biotechnology and the Ethics of a chemical breakup. *The American Journal of Bioethics* 13(11): 3–17.

Gellner, E. (1992) *Reason and Culture: A Sociological and Philosophical Study of the Role of Rationality and Rationalism*. Oxford, UK: Blackwell.

Giddens, A. (2013) *The Transformation of Intimacy: Sexuality, Love and Eroticism in Modern Societies*. California, USA: Stanford University Press.

Illouz, E. (1997) *Consuming the Romantic Utopia: Love and the Cultural Contradictions of Capitalism*. Berkeley, CA: University of California Press.

Illouz, E. (2008) *Saving the Modern Soul: Therapy, Emotions, and the Culture of Self-Help*. California, USA: University of California Press.

Illouz, E. (2012) *Why Love Hurts: A Sociological Explanation*. Cambridge, UK: Polity.

Martin, M.W. (2006) *From Morality to Mental Health: Virtue and Vice in a Therapeutic Culture*. New York, USA: OUP.

May, S. (2012) *Love: A History*. New Haven, CT: Yale University Press.

Minerva, F. (2012) Medicalisation, biomedicalisation and farmaceutisation from a sociological and from a bioethical perspective. *Salute e Società* 11(2): 177–181.

Mintz, S. (2015) *The Prime of Life: A History of Modern Adulthood*. Cambridge, MA: Belknap Press.

Parens, E. (2013) On good and bad forms of medicalization. *Bioethics* 27(1): 28–35.

Paul, L., Foss, M.A. and Baenninger, M.A. (1996) Double standards for sexual jealousy. *Human Nature* 7(3): 291–321.

Persson, I. and Savulescu, J. (2008) The perils of cognitive enhancement and the urgent imperative to enhance the moral character of humanity. *Journal of Applied Philosophy* 25(3): 162–177.

Pinker, S. (2012) *The Better Angels of Our Nature: A History of Violence and Humanity*. London: Penguin.

Rose, N. (1991) Experts of the Soul. *Psychologie und Geschichte* 3(1/2): 91–99.

Rose, N. and Abi-Rached, J.M. (2013) *Neuro: The New Brain Sciences and the Management of the Mind*. New Jersey, USA: Princeton University Press.

Ryan, C. and Jetha, C. (2010) *Sex at Dawn: The Prehistoric Origins of Modern Sexuality*. New York, USA: Harper.

Savulescu, J. and Sandberg, A. (2008) Neuroenhancement of love and marriage: The chemicals between Us. *Neuroethics* 1(1): 31–44.

Wudarczyk, O.A., Earp, B.D., Guastella, A. and Savulescu, J. (2013) Could intranasal oxytocin be used to enhance relationships? Research imperatives, clinical policy, and ethical considerations. *Current Opinion Psychiatry* 26(5): 474–484.