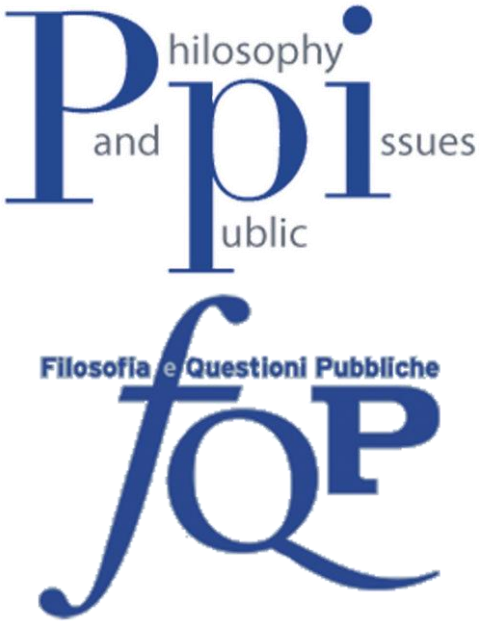
SYMPOSIUM

PSYCHEDELIC RELATIONSHIP ENHANCEMENT



NO LOVE DRUGS TODAY

BY

ROBBIE ARRELL

© 2020 – *Philosophy and Public Issues (New Series)*, Vol. 10, No. 3 (2020): 45-60
Luiss University Press
E-ISSN 2240-7987 | P-ISSN 1591-0660

[THIS PAGE INTENTIONALLY LEFT BLANK]

No Love Drugs Today

Robbie Arrell

Love is the Drug: The Chemical Future of Our Relationships by Brian D. Earp and Julian Savulescu feels, in some ways, like the culmination of a fascinating philosophical debate the authors set in motion more than a decade ago about the prospects of using biotechnology to enhance love. In other ways, though, the book marks a new beginning, which will hopefully see their work break new ground and bring these ideas to wider audiences than ever before. In particular, what Earp and Savulescu have to say about MDMA-enhanced relationship counselling, the prospect of which takes centre stage in the book, strikes me as deserving of the widest audience there is. In that respect, I found the authors' arguments to be utterly compelling and was left quite convinced of the sensibleness and necessity of tearing down barriers to research that might one day enable the reintroduction of MDMA and psychedelics as legitimate therapeutic tools.

Unfortunately, however, incorporating MDMA into therapy regimes as an adjunct to relationship counselling is not a potential option likely to be made available to the masses anytime soon. So, as compelling as this aspect of Earp and Savulescu's project is, it is still necessarily speculative for the most part. But as Earp and Savulescu stress throughout the book, it would be a mistake to

 Philosophy and Public Issues (New Series), Vol. 10, No. 3 (2020): 45-60
Luiss University Press
E-ISSN 2240-7987 | P-ISSN 1591-0660

think that the prospect of love drugs in general is just some far flung possibility best left to the pages of science fiction. In fact, as they point out, "love-altering drugs are already here, partly in the form of understudied side effects of widely used prescription medications" (Earp and Savulescu 2020, 71). In other words, many already-existing prescription drugs being taken for the purposes of treating symptoms of acknowledged diseases or disorders rooted in individual biology are already affecting not just those individuals themselves, but also their relationships with their romantic partners. In this respect, at least, "existing biotechnologies are already capable of altering love, whether positively or negatively, through a variety of more- or less-direct routes" (*ibid.*, 64). Thus,

> love drugs and anti-love drugs are not some made-up possibility for the future: biotechnologies are currently available that can have an enhancing or degrading effect on the neurochemical bonds that underlie romantic love, and these could possibly be used to help maintain some good relationships and end some bad ones (*ibid.*, 149).

In this paper, I deny Earp and Savulescu's claim that "love-altering drugs are already available and some are in widespread use" (*ibid.*, 149-150). In doing so, I don't mean to deny their point that it is "a scandal that we don't know more about the effects of these drugs (good or bad) on our romantic partnerships, due to an exclusive focus on individuals and their private symptoms in clinical studies" (*ibid.*, 14). A lot of the prescription medications people take affect their relationships in various ways, both good and bad. We should be studying this. What I do deny, though, is that what these drugs affect is love.

In the first section, I spell out the claim that, in order for your beloved to enjoy your love, you must provide them with care. In section two, I reconstruct an example of Earp and Savulescu's in which you are prescribed an SSRI that has the effect of making it

so that you are unable to provide your beloved with your care. As I argue in section three, however, the denouement of the authors' SSRI example – "Change in biology, change in love: proof of principle" (Earp and Savulescu 2020, 60) – relies on a *non sequitur*, the result being that their example falls short of proving what it claims to. The upshot, as I explain in the final section, then, is this: if one assumes that love drugs, in order to qualify as such, must affect the love partners have for one another, then no existing medications commonly prescribed to treat individualized conditions of the kind Earp and Savulescu focus on can properly be called love drugs.

I

Love Actually

So, what is love? That is, of course, an enduringly contested philosophical question, and one Earp and Savulescu are understandably reluctant to commit themselves on, mainly, as they write, "because we don't want our analysis of particular cases to depend on which theory of love you happen to agree with" (2020, 19). That being said, they do appear willing to endorse two minimal features of love. The first is that "any plausible theory of love would recognize that it has, at minimum, a dual nature" (*ibid.*), comprising both a psychosocial dimension and a biological dimension. The second is that "true love, whatever else it is, is something that requires genuinely caring about (and trying to promote) the other person's well-being" (*ibid.*, 59) out of a non-instrumental special concern for them (see also Earp 2019). As interesting as theories of love's dual nature are (see, e.g., Jenkins 2017), I do not wish to comment on the plausibility of them here. Instead, I want to think through some of the implications of the second of these claims.

This claim, to reiterate, says that, in order for you to enjoy the good of my love, I must provide you with the good of my care. This good of care plays out, I will assume, as a special concern for your well-being over and beyond the care I have for that of all persons generally, typically finding its expression in my partial treatment towards you. But my care for you must not be motivated by any old contingent reason. If, for example, I provide you with the good of my care, but only because you are super wealthy (such that, were you to lose all your riches, I'd be out the door in a flash), then I doubt we would want to say that you genuinely enjoy my love at all. And, crucially, I suspect many would think this, even despite the fact that you actually do enjoy my care, and foreseeably will continue to, so long as you remain rich and I a shameless gold-digger.

All of which is just to say that love belongs to the class of goods which Philip Pettit (2015) describes as robustly demanding; i.e., goods that require not only that things be thus and so as things actually are in the here and now, but also that they be thus and so robustly, across a range of non-actual scenarios in which you/I/circumstances are somewhat altered. More precisely, a particular good is robustly demanding or "rich" (Pettit's shorthand for robustly demanding, which I shall adopt henceforth) if its realisation requires robust provision of corresponding robustly undemanding "thin" goods, where the provision of which is indispensably explained by considerations of the goods-recipient (Pettit 2015, 11-14). With respect to love in particular, then (there are many other rich goods besides love), the basic idea is this: Your enjoying (the rich good of) my love requires that I provide you with (the corresponding thin good of) my care. Crucially, however, in order for you truly to enjoy (the rich good of) my love, it will not be enough that I provide you with (the corresponding thin good of) my care merely actually, as things stand. For you to genuinely enjoy (the rich good of) my love, it must also be the case that (i)

you would enjoy (the thin good of) my care even were you/I/circumstances somewhat altered; and (ii) considerations of you play a uniquely indispensable role in explaining my robust provision of (the thin good of) the care you enjoy from me (Pettit 2015; Arrell 2017, 409).

This account of love as robustly demanding may seem philosophically obtuse at first blush. And yet, the intuition it is channelling is one that I think many of us share, whether we realise it or not, at least if poetry and song are any indication of popular sentiment. Consider, for example, William Butler Yeats's poem *For Anne Gregory*:

> Never shall a young man,
> Thrown into despair
> By those great honey-coloured
> Ramparts at your ear,
> Love you for yourself alone
> And not your yellow hair.
>
> But I can get a hair-dye
> And set such colour there,
> Brown, or black, or carrot,
> That young men in despair
> May love me for myself alone
> And not my yellow hair.
>
> I heard an old religious man
> But yesternight declare
> That he had found a text to prove
> That only God, my dear,
> Could love you for yourself alone
> And not your yellow hair.
> *For Anne Gregory*, by William Butler Yeats

Translated into the somewhat less poetic terms set out above, it seems that, in order for Anne to truly enjoy the love she yearns for from you (assuming you are one of her young suitors thrown into despair by those great honey-coloured ramparts at her ear), she desperately requires that (i) she would enjoy (the thin good of) your care even were she/you/circumstances somewhat altered (e.g., if her hair were not yellow, but brown, or black, or carrot). And, also, that (ii) considerations of her – Anne – play a uniquely indispensable role in explaining your robust provision of (the thin good of) the care she enjoys from you (i.e., that you may love her for herself alone, and not her yellow hair). And poor Anne, it seems, is far from alone in wrestling with these sorts of questions. The Beatles similarly wanted to know: "What would you do if I sang out of tune? Would you stand up and walk out on me?" as well as wondering "Will you still need me, will you still feed me / When I'm 64?" More recently, Lana Del Rey felt compelled to ask: "Will you still love me / When I'm no longer young and beautiful? Will you still love me / When I've got nothing but my aching soul?" while Brian Nhira asked "Would you love me when it's hard / And our life's fallen apart? If the things that we once knew are long gone?" And perhaps the forerunner of them all—Carol King – once pondered: "Will you still love me tomorrow?" or "will my heart be broken / When the night meets the morning sun"

The underlying thought that these literary and popular culture musings are all gesturing towards is hopefully clear enough. If the sun coming up, or my losing the ability to sing in tune, or perhaps my youthful good looks, or my hair, my fame, my fortune, etc., is sufficient to cause your love for me to lapse, then on most accounts of what love is, we are inclined to think it never deserved the name to begin with. Which suggests, perhaps surprisingly, that whether or not I enjoy your love actually – in this, "the real world," so to speak – depends, in a very real sense, on how things are in non-actual scenarios, or "other possible worlds." For, should it

turn out to be true, say, that you would stand up and walk out on me if, counterfactually, I couldn't sing in tune, the conclusion to be drawn is not just that you wouldn't love me *then* (in the non-actual scenario in which I have lost the ability to sing in tune), but crucially, rather, that you don't love me *now*; that, indeed, you don't, and perhaps never really did, love me at all. As such, even though I may actually enjoy the thin good of your care, that is not sufficient to make it the case that I enjoy the rich good of your love actually.

Hopefully, this account of love should be broadly acceptable to Earp and Savulescu, who describe themselves as being "somewhat less concerned about whether a given state of desire, attraction, etc., is deserving of the label "love," than with whether it is causing net [benefit or] harm to oneself or someone else" (2016, 94). Because, for me to enjoy from you the rich good of your love just is for me to realise a net gain in the amount of good I enjoy relative to what it would be if your provision of care were motivated, not by uniquely indispensable considerations of me/my welfare, but, by merely contingent considerations. Thus, whilst there is a straightforward sense in which your being appropriately disposed towards me may make you more likely to provide me with the good of your care, and may even enable you better to know and recognise the kind of care I need of you, there is something more at stake here. For, on Pettit's line, your being thus disposed serves a further distinct function, which is ontological as opposed to practical or epistemological. On this view, acting from an appropriate disposition enables the creation of a whole other layer of goods – i.e., robustly demanding goods – that are otherwise unrealisable (Pettit 2012, 10). Thus, it is in fact only as a result of your being appropriately disposed that the rich good of your love I rely upon exists.

Of course, even if you are not appropriately disposed towards me – e.g., it is not considerations of me that play the uniquely

indispensable role in explaining your provision of care for me, but considerations of the wealth you hope to inherit from me when I die – I may still on balance prefer that situation to one in which you aren't around at all. I still enjoy the thin good of your care actually, after all, which is perhaps better than nothing. But if it is considerations of me and not merely my money that move you to care for me, then I enjoy all of these same goods and more. For then, as well as the thin goods of care you provide me with, I also enjoy, as a constitutive consequence of your being appropriately disposed to provide me with your care robustly, the rich good of your love. This being so, placing a premium on the desirability of rich love understood as a robustly demanding good should hopefully be acceptable to even the purest of "welfare-oriented enhancement theorists" (2020, 181) like Earp and Savulescu.

II

"Change in biology, change in love: proof of principle"

Let's suppose then that for it to be true that you love someone, you must care about them and have a special concern for their well-being in the sorts of ways just described. Now imagine, as Earp and Savulescu do at one point:

> that you take a drug that makes it so you *don't* care about your partner's feelings in some or all of those senses, much less their overall well-being. Or perhaps you do care, but only in some abstract, cognitive sense that doesn't correspond to the appropriate motivations or behavior. Suppose you can see that your partner is very upset about something, for example, but their being upset doesn't strike you as all that important (as long as you are taking this drug) (Earp and Savulescu 2020, 59-60, original emphasis).

Does such an awful-sounding drug really exist? "Yes, it does," according to Earp and Savulescu: "It's called a selective serotonin reuptake inhibitor, or SSRI, and it's the most commonly used drug to treat depression" (*ibid.*, 60). Not everyone who takes SSRIs experiences this kind of diminished emotional responsiveness. But, as Earp and Savulescu point out, given that part of the point of SSRIs – at least when prescribed for depression—is precisely to "blunt" one's emotions and maladaptive feelings of sadness, it is not surprising that they sometimes simultaneously diminish one's ability to care about other people's feelings as well (*ibid.*).

This brings us back, then, to the crux of the point Earp and Savulescu set out to establish with this example:

> What if one of those other people is your romantic partner? Remember that we are assuming that caring about your partner's feelings is one of the bare-bones necessary ingredients of true love. If your very capacity to do this is sufficiently degraded by an SSRI, over a long-enough period of time, then the drug will by definition change your love for your partner—potentially to the point that it no longer counts as love at all. Change in biology, change in love: proof of principle (*ibid.*, 59-60).

Assuming that "true love, whatever else it is, is something that requires genuinely caring about (and trying to promote) the other person's well-being" (2020, 59), and that being on SSRIs does indeed make it the case that you don't care about your partner's feelings, Earp and Savulescu's argument looks about as watertight as they come. And, if anything, the account of the rich good of love fleshed out in the last section would seem only to add yet more grist to their mill. For, if your partner's enjoyment of the rich good of your love requires minimally that you care about them and their feelings robustly, then a drug-induced change in your biology that makes you less likely to care about them does indeed seem suggestive of the denouement of the authors' SSRI example:

"Change in biology, change in love: proof of principle" (Earp and Savulescu 2020, 60). And yet, as it turns out, the argument proves nothing of the sort.

III

Love is not love which alters as it ill health finds

Suppose you take an afternoon power nap to try to help improve your mood and functioning. And suppose also that sleeping changes your biology, and one effect of this change in your biology is that your partner doesn't enjoy from you the same quality of care while you are sleeping as they otherwise do (i.e., when you are awake). Should we conclude from this that your being asleep will by definition change your love for your partner? I think we should not. Being asleep, it is true, will make it the case that your partner doesn't enjoy from you the same quality of care as they do when you are awake, but it wouldn't seem to follow from this that being asleep changes your love for your partner. And the reason why, is simply because the scenario in which you are asleep is not one across which it would be reasonable for your partner to require your provision of the thin good of your care to be robust, in order that they may enjoy the rich good of your love. To see this, imagine you and your partner find yourselves having a conversation that unfolds thus:

> Your partner: "Would you still give me the same quality of care that you do now, if you were not awake (as you are actually), but sleeping?"
> You: "Errrr, no!?".
> Your partner: "I knew it! You awful swine! You don't love me at all!"

If your partner were to react this way, you would I think be well within your rights to wonder whether they have gone temporarily insane. For you see, or at least intuit, the *non sequitur*.

Taking a nap and taking SSRIs for clinical depression are of course very different, but the mistake of inferring a change in love from a change in care wrought by their biological effects is not. Suppose you take medication to help improve your mood and functioning. And suppose also that the medication changes your biology, and one effect of this change in your biology is that your partner doesn't enjoy from you the same quality of care while you are under the influence of emotion blunting SSRIs that they otherwise do (i.e., when you are not under the influence of emotion blunting SSRIs). Should we conclude that your being under the influence of SSRIs "will by definition change your love for your partner"? For the same reason as before, I think we should not. The premises both here and in the napping case are about care, while the conclusions are about love. As such, they simply don't speak to each other in the requisite fashion they should, unless the goods of love and care are held to be one and the same good, which, as we saw in section one, they are not. This is easily illustrated once more by imagining how the corollary conversation with your partner might go in this scenario:

> Your partner: "Would you still give me the same quality of care you give me now, if you were not in good mental health (as you are actually), but clinically depressed and under the influence of SSRI medication that made it so you couldn't give me the same quality of care you give me now?
> You: "Errrr, no!?".
> Your partner: "I knew it! You awful swine! You don't love me at all!"

Again, such an exchange would, I suspect, leave you wondering whether your partner has perhaps become a little unhinged.

A change in your biology may effect a change in the quality of care you provide your loved one with, and perhaps even cause it to lapse, as in the cases under discussion here. But, before we can say that a change or lapse in care translates into a change in love, we need to know whether the scenario in which the change or lapse occurs is one across which it is reasonable to require care to be robust in the first place. For, although we require that your provision of care be robust across a range of possible scenarios in which I/you/circumstances are different, we do not require robustness across *all* possible scenarios. Admittedly, distinguishing the scenarios in which provision of the thin good of your care is required for me to enjoy the rich good of your love from those in which it is not, is a complicated task, and one I am not convinced even Pettit manages to tackle in a satisfactorily non-circular manner (Pettit 2015, 14-31; Arrell 2017, 411). But we don't need to settle that issue definitively to be able to see that some scenarios are such that it would be quite absurd to require your care to be robust across them, in order that I may enjoy your love actually. And one such scenario, is that in which you are ill and on medication that obstructs or disables your ability to care for me. As with being asleep, what being under the influence of antidepressant medication "will by definition change" is not your love for me, but merely your capacity to provide me with the same quality of care you otherwise do.

As suggested in the title of this section, which is a play on Shakespeare's famous line "Love is not love/ Which alters when it alteration finds", ill-health is an "alteration" across which many of us believe loving care should be robust. For it to be the case that my wife Emilie, for example, genuinely enjoys the rich good of my love, it must also be the case that my care for her would not lapse in the event that she were to fall ill. In this respect, it is perfectly reasonable for her to require that my care for her be robust, say, across a scenario in which she is diagnosed with clinical depression

and prescribed emotion blunting SSRIs, even if as a result she cannot care for me as she normally does. But for Emilie to require that my care for her be robust across a scenario in which *I* am diagnosed with clinical depression and am prescribed emotion blunting SSRIs that temporarily disable or obstruct my capacity to care for her as I normally do, does not seem reasonable in the slightest. Moreover, to conclude that I no longer *love* her the same then, on account of the fact that I am unable to provide her with the care I otherwise would were my capacity to do so not obstructed by factors I have no real control over, seems quite mistaken to me. In the context of alterations like these, at least, I think that what we might say is that my love alters not either, when it alteration finds in me.

IV

Who Cares?

I have argued that Earp and Savulescu move too quickly from the claim that drugs taken to treat individual symptoms can affect the quality of care in relationships, to the claim that they affect love. To some, however, this may seem like philosophical quibbling of the highest order. Had, for example, the authors foregone the rhetorical force of vibrant talk of "changes in love" or "love-affecting" interventions and strictly confined themselves instead to boring, beige talk of changes in quality of care or relationship-affecting interventions, then it may seem like I would have nothing left to complain about. And, in a sense, that is true. For, such a step-down would effectively concede the very thing I have been suggesting: if a requirement of drugs qualifying as love drugs is that they affect the *love* people in a romantic relationship have for one another, and not just the quality of care they show each other, then none of the currently existing, more or less common, legal prescription drugs Earp and Savulescu reference at

various points in their book are love drugs. To quote my own title (!): No Love Drugs Today. If, however, the authors were to choose instead to double-down, so that all that is required for drugs to qualify as love drugs is that they affect merely the quality of care romantic partners provide each other with, then all drugs are love drugs, given the right context, in which case the very notion of love drugs is rendered meaningless.

And yet, sometimes, what Earp and Savulescu write suggests they might be okay with the all-encompassing account, as when they say:

> In our view, if a drug can shape motivations and behavior in ways that make it nontrivially more (or less) likely that love will come about or survive, then we're happy to call it a love drug (or an anti-love drug), even if it doesn't affect love directly. Alcohol offers a simple illustration. It may be the oldest and most popular love drug around (Earp and Savulescu 2020, 62).

But I think that, if it were to turn out that this is all it takes to be a love drug, it would leave me feeling quite underwhelmed, a little bit like I felt when I discovered that the "Anti-Loneliness Ramen Bowl" was just a bowl with a built-in iPhone dock.

To be clear, the point of this commentary is not to deny that circumstances in which your partner develops an illness for which they require medication will take a toll on your relationship; or, that your partner's capacity to care for you may be diminished when they are ill and/or medicated. Nor is the point to deny that presently available prescription medications that people are taking to treat conditions like depression, anxiety, PTSD, etc., are capable of affecting love directly, as opposed to merely indirectly. The point, rather, is that they don't affect *love* at all. If your partner, or your parent, or your child, or your friend is diagnosed with a debilitating illness, and either as a consequence of their condition,

or the medication they are prescribed to treat it, you find that you don't enjoy from them the same kind of care you did before they fell ill, it would belie a strain of egomania unbecoming indeed to infer from this that they don't love you the same anymore. Indeed, even at the cruel limits, where illness and medication make it the case that one's beloved's care will never return, I'm inclined to think that something, even if only an echo, of love endures. At least, I hope that, should I ever get Alzheimer's, for example, and as a result become quite uncaring and perhaps even cruel and unkind towards Emilie, she wouldn't take that to mean that I didn't love her to the end. But maybe that's just the old romantic fool in me clinging to the dewy notion that some remnant of love exists quite apart from and beyond the reach of biology and the bounds of our skin.

Inter-Disciplinary Ethics Applied (IDEA) Centre

University of Leeds

References

Arrell, Robbie. 2017. "The Robust Demands of the Good: Ethics with Attachment, Virtue, and Respect, by Philip Pettit," *Australasian Journal of Philosophy* 95, 2: 408-411.

Earp, Brian D. 2019. "Love and enhancement technology." In C. Grau & A. Smuts (eds), *Oxford Handbook of Philosophy of Love*. Available online ahead of print at http://www.oxfordhandbooks.com/view/10.1093/oxfordhb/97

80199395729.001.0001/oxfordhb-9780199395729-e-36 [accessed: 30/08/2020].

Earp, Brian D. and Savulescu, Julian. 2016. "Is There Such a Thing as a Love Drug? Reply to McGee," *Philosophy, Psychiatry, & Psychology* 23, 2: 93–96.

_____. 2020. *Love is the Drug: The Chemical Future of Our Relationships*. Manchester: Manchester University Press.

Jenkins, Carrie. 2017. *What Love is: And What It Could Be*. New York: Basic Books.

Pettit, Philip. 2012. "A Question for Tomorrow: The Robust Demands of the Good," *Les ateliers de l'éthique/The Ethics Forum* 7, 3: 7-12.

_____. 2015. *The Robust Demands of the Good: Ethics with Attachment, Virtue, and Respect*. Oxford: Oxford University Press.