Psychotropic Hedonism vs. Pharmacological Calvinism
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Published by: The Hastings Center
Stable URL: http://www.jstor.org/stable/3561398
Accessed: 05-07-2015 09:58 UTC
When new drugs clash with old ideas

Psychotropic Hedonism vs. Pharmacological Calvinism

Psychotropic drugs are changing the way we look at medicine – and at society

By GERALD L. KLERMAN

The introduction of effective psychotropic drugs for clinical treatment of mental illness has had immediate, direct and important consequences for mental health care. There has been a shift from hospital to community-based programs. The deleterious effects of hospitalization have been minimized, and in some instances, eliminated by the use of open-door techniques and restriction of the adverse practices such as seclusion and restraint. We see shorter periods of hospitalization and decreased stigma attached to mental illness. With the broadened definition of mental illness, larger segments of the population now are seeking help from mental health professionals. Much social deviance, previously regarded as legal, is being redefined as mental ill health. Hopefully, psychopharmacologic agents will prove useful in altering behavior deviance such as alcoholism, drug addiction, and perhaps even crime and delinquency.

These changes have had consequences not only for the health care system but also for our cultural orientation and values—especially for the definition of deviance itself and the type of stigma to be attached to various forms of deviant behavior. I have identified four moral and social issues which I believe we must face: (1) the "right" to treatment, (2) the dilemmas of involuntary treatment of mental disorders by drugs or other techniques, (3) the emergence of new forms of social disability and chronicity for mental patients in the community, and (4) the controversy over whether or not we are becoming an overly medicated society.

The right to treatment

A number of court rulings are establishing the right to treatment for patients hospitalized in public mental institutions. The availability of effective therapeutic techniques has accelerated a dramatic shift in orientation of mental institutions from purely custodial care to active treatment and the question is being raised whether any patients should be admitted to these hospitals without demonstration that active treatment will be provided. These court cases have highlighted a long-term conflict in the relationship of mental hospitals to the larger society, the conflict between their custodial and therapeutic functions. Too often, psychiatric institutions have been used as disguised or even overt forms of social control. In the late 18th and 19th centuries, the emergence of mental hospitals for this purpose represented a major humanitarian advance and so long as there were not active effective treatments, the distinction between these functions was not as clear as it has now emerged. Psychotropic drugs have contributed greatly to the reduction of custodialism and to the liberalization of institutional practices. There has been a rise in therapeutic optimism.
among professionals, and a rise of expectations among patients, their families, and most significantly, the legal system that treatment will be provided. If the right to treatment is established and incorporated in law, then a number of questions will arise about the adequacy of resources made available for treatment programs and about alternative procedures that will need to be established for handling socially deviant and illegal behavior by persons with mental illness.

The dilemmas of involuntary treatment

Closely related to the issue of the patient’s “right” to treatment are the dilemmas associated with involuntary treatment in psychiatry.

Unlike other medical specialties under certain conditions, psychiatry has the legal power and social sanction to coerce patients to accept treatment. This is not an absolute power, since it has been controlled by the process of legal commitment. In recent decades, the commitment power and the attendant ability to coerce treatment have been under attack. Currently, the leading spokesman for critics of involuntary treatment is T. Szasz, who has challenged the procedures of involuntary treatment on intrinsic moral grounds and has pointed out various abuses.

The intrinsic moral issue arises from the dilemma that certain forms of antisocial and deviant behavior are the direct consequences of mental illness, whether these illnesses are the manifestation of established brain disease, personal development, or unknown etiology. Two behaviors which produce the most difficult dilemmas are the deluded and paranoid patient who is hostile, angry, destructive, or threatening, for whom psychotropic medication will provide calming and normalizing effect, and the intensely depressed and suicidal patients where treatment with drugs or convulsive therapy reduces the suicidal drive and ameliorates the severity of depression. In these two situations, the moral dilemma arises when the psychiatrist and other staff assume responsibility for decision making and treat the patient even though the patient may expressly deny wanting treatment or may attempt to avoid it.

A problem related to involuntary treatment arises when “informed consent” is advocated. Under what circumstances can psychiatric patients be considered to have “rational” knowledge, understanding, and free will to give truly informed consent as to their agreement for a treatment or for the refusal of treatment? These issues will become more intensified as new drugs become available with a wider range of indications, particularly those which may reduce aggressive behavior or modify sexual activity or procreation.

As psychiatric treatments have become more effective, the tendency has grown to widen the definition of mental illness, particularly in the nonpsychotic conditions whose only manifestations may be changes in emotional states such as increased anger, depressive mood, anxiety states as behavior which deviates from social norms. There is likely to be a further blurring of boundaries between conventional definitions of social deviance and mental illness.

We have already seen this process occur in alcoholism and in drug abuse and also increasingly in the juvenile delinquency and in criminal behavior, as predicted by Samuel Butler in his utopian novel, Erewhon. Many fear that the power of involuntary treatment will be granted to custodial facilities in the name of “mental health” and that psychotropic drug treatment will be used as a form of social control. Since abuse of these powers has occurred in the U.S.A. in previous periods and probably is occurring in other nations, such as the U.S.S.R., political dissension and social nonconformity may be defined as mental illness and treated coercively with medication.

New forms of chronicity

Another set of consequences arising from the therapeutic success of psychotropic agents is the emergence of new forms of chronicity in the lives of patients formerly hospitalized but now discharged and residing in the community. The issue is to insure the quality of life being lived by these patients. The fear has been expressed that the decline in the numbers of patients in public mental hospitals is only a statistical artifact, not a true gain. Whereas these patients were formerly living lives of quiet desperation as chronic patients in mental institutions, similar patterns of chronic illness and social impairment are being lived by these patients in nursing homes in the case of the aged, or in rooming houses and other marginal residential facilities in the case of chronic psychiatric patients. The effectiveness of the psychotropic drugs has contributed to these trends, since the available agents, particularly the antipsychotic drugs, ameliorate the patients’ severe disturbances, particularly their psychotic thinking, sufficiently so as to allow discharge into the community but the patients are left emotionally blunted, occupationally impaired, and socially isolated.

A related consequence is the concern over the possible impact upon families and local communities of the presence of these discharged patients who are improved but not well. This concern is especially true for the impact of discharged psychotic mothers and fathers upon family life and children.

In large part, these issues are largely empirical since insufficient data are available as to the extent to which the
trends described above do occur. Here further research should clarify many of the issues. Were it in fact true that these consequences do occur, the moral issue would be as to which life style is desired, and what resources our society is prepared to allocate to improve the quality of life for patients discharged into the community but not capable of complete self-sufficiency.

Pharmacological Calvinism vs. Psychotropic Hedonism

Most of the issues described above apply to the use of psychotropic drugs for psychotic or depressed patients. But the most publicized recent discussions have concerned the use of psychotropic agents by relatively normal or mildly neurotic persons with anxiety, tension, depression, insomnia, and related symptoms often associated with the stresses of everyday life in modern industrial society.

This issue has gained prominence, in part, because of the growth in rates of prescription and utilization of psychotropic drugs, particularly the anti-anxiety agents ("minor tranquilizers"). For example, recently available statistics indicate that the production and distribution of psychotropic drugs have become a major component of the pharmaceutical industry. It is estimated that in 1967 almost 180 million prescriptions for psychotropic drugs were written at a cost of almost 700 million dollars.

Figures such as these are impressive because they indicate a wide use of drugs to relieve emotional distress within the population at large. Whether or not this practice constitutes a moral crisis in our society is under debate since many individuals feel that the use of medication for such purposes is misuse. This debate has uncovered a conflict which I have identified between two extreme value orientations: pharmacological Calvinism and psychotropic hedonism. The pharmacological Calvinist view involves a general distrust of drugs used for nontherapeutic purposes and a conviction that if a drug "makes you feel good, it must be morally bad." The dominant American value system concedes and sanctions drug use only for therapeutic purposes and then only under professional supervision by physicians and pharmacists. In this view, abstinence is the highest ideal, the purest route to pharmacological salvation.

It is of note that mental health professionals, especially in the field of psychotherapy, have their own variant of these Calvinist views. Especially among psychoanalysts and other psychotherapists there is the view that any drug use is a "crutch" and that the best way to cure schizophrenia, neurosis, depression is through psychotherapeutic means using verbal insight. The conviction is often held that the use of psychotropic drugs in psychiatric treatment is morally wrong, independent of its efficacy, because it promotes gradual dependency. Drug therapy is thus a secondary road to salvation; the highest road to salvation is through insight and self-determination. This view, although held only by a minority of psychiatrists is also embodied in the popular media's current attempts at drug abuse education. Thus, if a drug makes you feel good, it not only represents a secondary form of salvation but somehow it is morally wrong and the user is likely to suffer retribution with either dependence, liver damage, or chromosomal change, or some other form of medical-theological damnation. Implicit in this theory of therapeutic change is the philosophy of personal growth, basically a secular variant of the theological view of salvation through good works.

While this view may still represent the dominant theme, it has undergone considerable weakening and erosion of support. One source of erosion is the strain resultant from the exemption of alcohol, caffeine, and tobacco from these prohibitions. There is conflict between our espoused values on abstinence and actual behavior. American society's stance on tobacco and alcohol contrasts sharply with its attitudes on marijuana and this inconsistency contributes to the current generation gap and distrust among young people when adults discuss drugs.

A related source of strain derives from advertising, where there has been commercialization of drug terminology, especially from the psychedelic culture. By using the drug trappings, the media glamorize the drug culture and contribute to the view of drug taking as attractive, desirable, and efficacious. In large part, the motivations of the pharmaceutical and advertising industries are economic; their intent is to widen the size of the drug user market by extending the rationale of drug use to include relief of minor symptoms related to emotional stresses.

The most serious challenges to pharmacological Calvinism, however, have come from the youth culture. The current youth culture distrusts adults' authority in the drug area and regards drug taking as part of its general hedonistic view. Achievement is valued less than the immediacy of personal relations. The use of drugs which enhance such relations, as may be the case with marijuana or minor tranquilizers, is not regarded as wrong on any moral or values basis.

Given the likelihood that further advances in pharmacology will increase the effectiveness of drugs in this realm, the values conflict for society is likely to become more intensified.