

COSMETIC PSYCHOPHARMACOLOGY

MAKEOVER

Peter D. Kramer

In this excerpt from Chapter 1 of his landmark book, *Listening to Prozac*, Kramer, a psychiatrist, reflects upon his experience with several patients who took the anti-depressant Prozac in the first few years after it entered the market. He gives special emphasis to the case of a remarkable, resilient woman, Tess, who originally sought help for depression but got far more from the drug than she or Kramer anticipated. As Kramer explains, individuals on Prozac sometimes not only overcome depression (or some other psychiatric condition such as obsessive-compulsive disorder or anxiety), but also transform into different sorts of people. These patients are not only restored to normal health and functioning; the effect of the medication extends to transforming their personalities—in the case of Tess, enhancing her “social popularity, business acumen, self-image, energy, flexibility, sexual appeal.” In view of such transformations of personality, Kramer coins the now popular term “cosmetic psychopharmacology.” While transformations such as these may seem obviously welcome, Kramer contends, they also raise a panoply of difficult professional, social, and philosophical issues. These issues include the proper role of the doctor, the continuity of human selves, the meaning of mental illness, the plasticity of diagnostic categories, the components of personal identity, the relationship between biochemistry and achievement, and the role of drugs—both legal and illegal—in a stressful, competitive culture. Prozac, Kramer concludes, forces us to question conventional thinking about all of these issues.

My first experience with Prozac involved a woman I worked with only around issues of medication. A psychologist with whom I collaborate had called to say she was treating a patient who had accomplished remarkable things in adult life despite an especially grim childhood; now, in her early thirties, the patient had become clinically depressed. Would I see her in consultation? My colleague summarized the woman's history, and I learned more when Tess arrived at my office.

Tess was the eldest of ten children born to a passive mother and an alcoholic father in the poorest public-housing project in our city. She was abused in childhood in the concrete physical and sexual senses which everyone understands as abuse. When Tess was twelve, her father died, and her mother entered

a clinical depression from which she had never recovered. Tess—one of those inexplicably resilient children who flourish without any apparent source of sustenance—took over the family. She managed to remain in school herself and in time to steer all nine siblings into stable jobs and marriages.

Her own marriage was less successful. At seventeen, she married an older man, in part to provide a base outside the projects for her younger brothers and sisters, whom she immediately took in. She never went to the movies alone with her husband; the children came along. The weight of the family was always on her shoulders. The husband was alcoholic, and abusive when drunk. Tess struggled to help him stop drinking, but to no avail. The marriage soon became loveless. It collapsed once the children—Tess's siblings—were grown and one of its central purposes had disappeared.

Meanwhile, Tess had made a business career out of her skills at driving, inspiring, and nurturing

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others. She achieved a reputation as an administrator capable of turning around struggling companies by addressing issues of organization and employee morale, and she rose to a high level in a large corporation. She still cared for her mother, and she kept one foot in the projects, sitting on the school committee, working with the health clinics, investing personal effort in the lives of individuals who mostly would disappoint her.

It is hard to overstate how remarkable I found the story of Tess's success. I had an image of her beginnings. The concrete apartment in which she cared for her younger brothers and sisters was recently destroyed with great fanfare on local television. Years earlier, my work as head of a hospital clinic had led me to visit that building. From the start, it must have been a vertical prison, a place where to survive at all could be counted as high ambition. To succeed as Tess had—and without a stable family to guide or support her—was almost beyond imagining.

That her personal life was unhappy should not have been surprising. Tess stumbled from one prolonged affair with an abusive married man to another. As these degrading relationships ended, she would suffer severe demoralization. The current episode had lasted months, and, despite a psychotherapy in which Tess willingly faced the difficult aspects of her life, she was now becoming progressively less energetic and more unhappy. It was this condition I hoped to treat, in order to spare Tess the chronic and unremitting depression that had taken hold in her mother when she was Tess's age.

Though I had learned some of this story before my consultation with Tess, the woman, when I met her, surprised me. She was utterly charming.

I have so far recounted Tess's history as if it were extraordinary, and it is. At the same time, people like Tess are familiar figures in a psychiatrist's practice. Often it will be the most competent child in a chaotic family who will come for help—the field even has a name for people in Tess's role, "parental children," and a good deal is written about them. Nor is it uncommon for psychiatric patients to report having had a depressed mother and an absent father.

What I found unusual on meeting Tess was that the scars were so well hidden. Patients who have struggled, even successfully, through neglect and

abuse can have an angry edge or a tone of aggressive sweetness. They may be seductive or provocative, rigid or overly compliant. A veneer of independence may belie a swamp of neediness. Not so with Tess.

She was a pleasure to be with, even depressed. I ran down the list of signs and symptoms, and she had them all: tears and sadness, absence of hope, inability to experience pleasure, feelings of worthlessness, loss of sleep and appetite, guilty ruminations, poor memory and concentration. Were it not for her many obligations, she would have preferred to end her life. And yet I felt comfortable in her presence. Though she looked infinitely weary, something about Tess reassured me. She maintained a hard-to-place hint of vitality—a glimmer of energy in the eyes, a sense of humor that was measured and not self-deprecating, a gracious mix of expectation of care and concern for the comfort of her listener.

It is said that depressed mothers' children, since they have to spend their formative years gauging mood states, develop a special sensitivity to small cues for emotion. In adult life, some maintain a compulsive need to please and are thought to have a knack for behaving just as friends (or therapists) prefer, at whatever cost to themselves. Perhaps it was this hypertrophied awareness of others that I saw in Tess. But I did not think so, not entirely. I thought what I was seeing was a remarkable and engaging survivor, suffering from a particular scourge, depression.

I had expected to ask how Tess had managed to do so well. But I found myself wondering how she had done so poorly.

Tess had indeed done poorly in her personal life. She considered herself unattractive to men and perhaps not even as interesting to women as she would have liked. For the past four years, her principal social contact had been with a married man—Jim—who came and went as he pleased and finally rejected Tess in favor of his wife. Tess had stuck with Jim in part, she told me, because no other men approached her. She believed she lacked whatever spark excited men; worse, she gave off signals that kept men at a distance.

Had I been working with Tess in psychotherapy, we might have begun to explore hypotheses regarding the source of her social failure: masochism grounded in low self-worth, the compulsion of those

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abused early in life to seek out further abuse. Instead, I was relegated to the surface, to what psychiatrists call the phenomena. I stored away for further consideration the contrast between Tess's charm and her social unhappiness. For the moment, my function was to treat my patient's depression with medication.

I began with imipramine, the oldest of the available antidepressants and still the standard by which others are judged. Imipramine takes about a month to work, and at the end of a month Tess said she was substantially more comfortable. She was sleeping and eating normally—in fact, she was gaining weight, probably as a side effect of the drug. "I am better," she told me. "I am myself again."

She did look less weary. And as we continued to meet, generally for fifteen minutes every month or two, all her overt symptoms remitted. Her memory and concentration improved. She regained the vital force and the willpower to go on with life. In short, Tess no longer met a doctor's criteria for depression. She even spread the good word to one of her brothers, also depressed, and the brother began taking imipramine.

But I was not satisfied.

It was the mother's illness that drove me forward. Tess had struggled too long for me to allow her, through any laxness of my own, to slide into the chronic depression that had engulfed her mother.

Depression is a relapsing and recurring illness. The key to treatment is thoroughness. If a patient can put together a substantial period of doing perfectly well—five months, some experts say; six or even twelve, say others—the odds are good for sustained remission. But to limp along just somewhat improved, "better but not well," is dangerous. The partly recovered patient will likely relapse as soon as you stop the therapy, as soon as you taper the drug. And the longer someone remains depressed, the more likely it is that depression will continue or return.

Tess said she was well, and she was free of the signs and symptoms of depression. But doctors are trained to doubt the report of the too-stoical patient, the patient so willing to bear pain she may unwittingly conceal illness. And, beyond signs and symptoms, the recognized abnormalities associated

with a given syndrome, doctors occasionally consider what the neurologists call "soft signs," normal findings that, in the right context, make the clinical nose twitch.

I thought Tess might have a soft sign or two of depression.

She had begun to experience trouble at work—not major trouble, but something to pay attention to. The conglomerate she worked for had asked Tess to take over a company beset with labor problems. Tess always had some difficulty in situations that required meeting firmness with firmness, but she reported being more upset by negotiations with this union than by any in the past. She felt the union leaders were unreasonable, and she had begun to take their attacks on her personally. She understood conflict was inevitable; past mistakes had left labor-management relations too strained for either side to trust the other, and the coaxing and cajoling that characterized Tess's management style would need some time to work their magic. But, despite her understanding, Tess was rattled.

As a psychotherapist, I might have wondered whether Tess's difficulties had a symbolic meaning. Perhaps the hectoring union chief and his foot-dragging members resembled parents—the aggressive father, the passive mother—too much for Tess to be effective with them. In simpler terms, a new job, and this sort especially, constitutes a stressor. These viewpoints may be correct. But what level of stress was it appropriate for Tess to experience? To be rattled even by tough negotiations was unlike her.

And I found Tess vulnerable on another front. Toward the end of one of our fifteen-minute reviews of Tess's sleep, appetite, and energy level, I asked about Jim, and she burst into uncontrollable sobs. Thereafter, our meetings took on a predictable form. Tess would report that she was substantially better. Then I would ask her about Jim, and her eyes would brim over with tears, her shoulders shake. People do cry about failed romances, but sobbing seemed out of character for Tess.

These are weak reeds on which to support a therapy. Here was a highly competent, fully functional woman who no longer considered herself depressed and who had none of the standard overt indicators of depression. Had I found her less

remarkable, considered her less capable as a businesswoman, been less surprised by her fragility in the face of romantic disappointment, I might have declared Tess cured. My conclusion that we should try for a better medication response may seem to be based on highly subjective data—and I think this perception is correct. Pharmacotherapy, when looked at closely, will appear to be as arbitrary—as much an art, not least in the derogatory sense of being impressionistic where ideally it should be objective—as psychotherapy. Like any other serious assessment of human emotional life, pharmacotherapy properly rests on fallible attempts at intimate understanding of another person.

When I laid out my reasoning, Tess agreed to press ahead. I tried raising the dose of imipramine, but Tess began to experience side effects—dry mouth, daytime tiredness, further weight gain—so we switched to similar medications in hopes of finding one that would allow her to tolerate a higher dose. Tess changed little.

And then Prozac was released by the Food and Drug Administration. I prescribed it for Tess, for entirely conventional reasons—to terminate her depression more thoroughly, to return her to her “premorbid self.” My goal was not to transform Tess but to restore her.

But medications do not always behave as we expect them to.

Two weeks after starting Prozac, Tess appeared at the office to say she was no longer feeling weary. In retrospect, she said, she had been depleted of energy for as long as she could remember, had almost not known what it was to feel rested and hopeful. She had been depressed, it now seemed to her, her whole life. She was astonished at the sensation of being free of depression.

She looked different, at once more relaxed and energetic—more available—than I had seen her, as if the person hinted at in her eyes had taken over. She laughed more frequently, and the quality of her laughter was different, no longer measured but lively, even teasing.

With this new demeanor came a new social life, one that did not unfold slowly, as a result of a struggle to integrate disparate parts of the self, but seemed, rather, to appear instantly and full-blown.

“Three dates a weekend,” Tess told me. “I must be wearing a sign on my forehead!”

Within weeks of starting Prozac, Tess settled into a satisfying dating routine with men. She had missed out on dating in her teens and twenties. Now she reveled in the attention she received. She seemed even to enjoy the trial-and-error process of learning contemporary courtship rituals, gauging norms for sexual involvement, weighing the import of men’s professed infatuation with her.

I had never seen a patient’s social life reshaped so rapidly and dramatically. Low self-worth, competitiveness, jealousy, poor interpersonal skills, shyness, fear of intimacy—the usual causes of social awkwardness—are so deeply ingrained and so difficult to influence that ordinarily change comes gradually if at all. But Tess blossomed all at once.

“People on the sidewalk ask me for directions!” she said. They never had before.

The circle of Tess’s women friends changed. Some friends left, she said, because they had been able to relate to her only through her depression. Besides, she now had less tolerance for them. “Have you ever been to a party where other people are drunk or high and you are stone-sober? Their behavior annoys you, you can’t understand it. It seems juvenile and self-centered. That’s how I feel around some of my old friends. It is as if they are under the influence of a harmful chemical and I am all right—as if I had been in a drugged state all those years and now I am clearheaded.”

The change went further: “I can no longer understand how they tolerate the men they are with.” She could scarcely acknowledge that she had once thrown herself into the same sorts of self-destructive relationships. “I never think about Jim,” she said. And in the consulting room his name no longer had the power to elicit tears.

This last change struck me as most remarkable of all. When a patient displays any sign of masochism, and I think it is fair to call Tess’s relationship with Jim masochistic, psychiatrists anticipate a protracted psychotherapy. It is rarely easy to help a socially self-destructive patient abandon humiliating relationships and take on new ones that accord with a healthy sense of self-worth. But once Tess felt better, once the weariness lifted and

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optimism became possible, the masochism just withered away, and she seemed to have every social skill she needed.

Tess's work, too, became more satisfying. She responded without defensiveness in the face of adamant union leaders, felt stable enough inside herself to evaluate their complaints critically. She said the medication had lent her surety of judgment; she no longer tortured herself over whether she was being too demanding or too lenient. I found this remark noteworthy, because I had so recently entertained the possibility that unconscious inner conflicts were hampering Tess in her dealings with the labor union. Whether the conflicts were real or illusory, the problem disappeared when the medication took effect. "It makes me confident," Tess said, a claim I since have heard from dozens of patients, none of whom had been given a hint that this medication, or any medication, could do any such thing.

Tess's management style changed. She was less conciliatory, firmer, unafraid of confrontation. As the troubled company settled down, Tess was given a substantial pay raise, a sign that others noticed her new effectiveness.

Tess's relations to those she watched over also changed. She was no longer drawn to tragedy, nor did she feel heightened responsibility for the injured. Most tellingly, she moved to another nearby town, the farthest she had ever lived from her mother.

Whether these last changes are to be applauded depends on one's social values. Tess's guilty vigilance over a mother about whom she had strong ambivalent feelings can be seen as a virtue, one that medication helped to erode. Tess experienced her "loss of seriousness," as she put it, as a relief. She had been too devoted in the past, at too great a cost to her own enjoyment of life. . . .

There is no unhappy ending to this story. It is like one of those Elizabethan dramas—Marlowe's *Tamburlaine*—so foreign to modern audiences because the Wheel of Fortune takes only half a turn: the patient recovers and pays no price for the recovery. Tess did go off medication, after about nine months, and she continued to do well. She was, she reported, not quite so sharp of thought, so energetic, so free of care as she had been on the medication, but neither was she driven by guilt and obligation. She

was altogether cooler, better controlled, less sensible of the weight of the world than she had been.

After about eight months off medication, Tess told me she was slipping. "I'm not myself," she said. New union negotiations were under way, and she felt she could use the sense of stability, the invulnerability to attack, that Prozac gave her. Here was a dilemma for me. Ought I to provide medication to someone who was not depressed? I could give myself reason enough—construe it that Tess was sliding into relapse, which perhaps she was. In truth, I assumed I would be medicating Tess's chronic condition, call it what you will: heightened awareness of the needs of others, sensitivity to conflict, residual damage to self-esteem—all odd indications for medication. I discussed the dilemma with her, but then I did not hesitate to write the prescription. Who was I to withhold from her the bounties of science? Tess responded again as she had hoped she would, with renewed confidence, self-assurance, and social comfort.

I believe Tess's story contains an unchronicled reason for Prozac's enormous popularity: its ability to alter personality. Here was a patient whose usual method of functioning changed dramatically. She became socially capable, no longer a wallflower but a social butterfly. Where once she had focused on obligations to others, now she was vivacious and fun-loving. Before, she had pined after men; now she dated them, enjoyed them, weighed their faults and virtues. Newly confident, Tess had no need to romanticize or indulge men's shortcomings.

Not all patients on Prozac respond this way. Some are unaffected by the medicine; some merely recover from depression, as they might on any antidepressant. But a few, a substantial minority, are transformed. Like Garrison Keillor's marvelous Powdermilk biscuits, Prozac gives these patients the courage to do what needs to be done. . . .

No doubt doctors should be unreservedly pleased when their patients get better quickly. But I confess I was unsettled by [another patient's] enthusiasm, and by Tess's as well. I was suspicious of Prozac, as if I had just taken on a cotherapist whose charismatic style left me wondering whether her magic was wholly trustworthy.

The more rational component to my discomfort had to do with Tess. It makes a psychiatrist uneasy

to watch a medicated patient change her circle of friends, her demeanor at work, her relationship to her family. All psychiatrists have seen depressed patients turn manic and make decisions they later regret. But Tess never showed signs of mania. She did not manifest rapid speech or thought, her judgment remained sound, and, though she enjoyed life more than she had before, she was never euphoric or Pollyannaish. In mood and level of energy, she was "normal," but her place on the normal spectrum had changed, and that change, from "serious," as she put it, to vivacious, had profound consequences for her relationships to those around her.

As the stability of Tess's improvement became clear, my concern diminished, but it did not disappear. Just what did not sit right was hard to say. Might a severe critic find the new Tess a bit blander than the old? Perhaps her tortured intensity implied a complexity of personality that was now harder to locate. I wondered whether the medication had not ironed out too many character-giving wrinkles, like overly aggressive plastic surgery. I even asked myself whether Tess would now give up her work in the projects, as if I had administered her a pill to cure warmheartedness and progressive social beliefs. But in entertaining this thought I wondered whether I was clinging to an arbitrary valuation of temperament, as if the melancholy or saturnine humor were in some way morally superior to the sanguine. In the event, Tess did not forsake the projects, though she did make more time for herself.

Tess, too, found her transformation, marvelous though it was, somewhat unsettling. What was she to make of herself? Her past devotion to Jim, for instance—had it been a matter of biology, an addiction to which she was prone as her father had been to alcoholism? Was she, who defined herself in contrast to her father's fecklessness, in some uncomfortable way like him? What responsibility had she for those years of thralldom to degrading love? After a prolonged struggle to understand the self, to find the Gordian knot dissolved by medication is a mixed pleasure: we want some internal responsibility for our lives, want to find meaning in our errors. Tess was happy, but she talked of a mild, persistent sense of wonder and dislocation.

My discomfort with Tess's makeover had another component. It is all very well for drugs to do small things: to induce sleep, to allay anxiety, to ameliorate a well-recognized syndrome. But for a drug's effect to be so global—to extend to social popularity, business acumen, self-image, energy, flexibility, sexual appeal—touches too closely on fantasies about medication for the mind. Patients often have extreme fears about drugs, stemming from their apprehension that medication will take over in a way that cannot be reversed, that drugs will obliterate the self. For years, psychiatrists have reassured patients that medication merely combats illness: "If the pills work," I and others have said, "they will restore you to your former self. I expect you to walk in here in a few weeks and say, 'I'm myself again.'" Medication does not transform, it heals.

When faced with a medication that does transform, even in this friendly way, I became aware of my own irrational discomfort, my sense that for a drug to have such a pronounced effect is inherently unnatural, unsafe, uncanny.

I might have come to terms with this discomfort—the unexpected soon becomes routine in the world of pharmacology. But Tess's sense of dislocation did not disappear immediately, and her surprise at her altered self helped me to understand the more profound sources of my own concern. The changes in Tess, which I saw replicated in other patients given Prozac, raised unsettling issues.

Many of these were medical issues. How, for example, would Prozac affect the doctor's role? To ameliorate depression is all very well, but it was less clear how psychiatrists were to use a medication that could lend social ease, command, even brilliance. Nor was it entirely clear how the use of antidepressants for this purpose could be distinguished from, say, the street use of amphetamine as a way of overcoming inhibitions and inspiring zest.

Other questions seemed to transcend any profession, to bear directly on the way members of our culture see themselves and one another. How were we to reconcile what Prozac did for Tess with our notion of the continuous, autobiographical human self? And always there was the question of how society would be affected by our access to drugs that alter personality in desirable ways.

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I wondered what I would have made of Tess had she been referred to me just before Jim broke up with her, before she had experienced acute depression. I might have recognized her as a woman with skills in many areas, one who had managed to make friends and sustain a career, and who had never suffered a mental illness; I might have seen her as a person who had examined her life with some thoroughness and made progress on many fronts but who remained frustrated socially. She and I might suspect the trouble stemmed from "who she is"—temperamentally serious or timid or cautious or pessimistic or emotionally unexpressive. If only she were a little livelier, a bit more carefree, we might conclude, everything else would fall into place. . . .

Confronted with a patient who had never met criteria for any illness, what would I be free to do? If I did prescribe medication, how would we characterize this act?

For years, psychoanalysts were criticized for treating the "worried well," or for "enhancing growth" rather than curing illness. Who is not neurotic? Who is not a fit candidate for psychotherapy? This issue has been answered through an uneasy social consensus. We tolerate breadth in the scope of psychoanalysis, and of psychotherapy in general; few people today would remark on a patient's consulting a therapist over persistent problems with personality or social interactions, though some might object to seeing such treatments covered by insurance under the rubric of illness.

But I wondered whether we were ready for "cosmetic psychopharmacology." It was my musings about whether it would be kosher to medicate a patient like Tess in the absence of depression that led me to coin the phrase. Some people might prefer pharmacologic to psychologic self-actualization. Psychic steroids for mental gymnastics, medicinal attacks on the humors, antiwallflower compound—these might be hard to resist. Since you only live once, why not do it as a blonde? Why not as a peppy blonde? Now that questions of personality and social stance have entered the arena of medication, we as a society will have to decide how comfortable we are with using chemicals to modify personality in useful, attractive ways. We may mask the issue by defining less and less severe mood states as pathol-

ogy, in effect saying, "If it responds to an antidepressant, it's depression." Already, it seems to me, psychiatric diagnosis had been subject to a sort of "diagnostic bracket creep"—the expansion of categories to match the scope of relevant medications.

How large a sphere of human problems we choose to define as medical is an important social decision. But words like "choose" and "decision" perhaps misstate the process. It is easy to imagine that our role will be passive, that as a society we will in effect permit the material technology, medications, to define what is health and what is illness.

Tess's progress also seemed to blur the boundary between licit and illicit drug use. How does Prozac, in Tess's life, differ from amphetamine or cocaine or even alcohol? People take street drugs all the time in order to "feel normal." Certainly people use cocaine to enhance their energy and confidence. "I felt large. I mean, I felt huge," is how socially insecure people commonly explain why they abuse cocaine or amphetamine. Uppers make people socially attractive, obviously available. And when a gin drinker takes a risk, we are tempted to ask whether the newfound confidence is not mere "Dutch courage."

In fact, it is people from Tess's background—born poor to addicted and dependent parents, and then abused and neglected—who are most at risk to use street drugs. A cynic may wonder whether in Tess's case drug abuse has sneaked in through the back door, whether entering the middle class carries the privilege of access to socially sanctioned drugs that are safer and more specific in their effects than street drugs, but are morally indistinguishable in terms of the reasons they are taken and the results they produce. I do not think it is possible to see transformations like Tess's without asking ourselves both whether street-drug abusers are self-medicating unrecognized illness and whether prescribed-drug users are, with their doctors' permission, stimulating and calming themselves in quite similar ways.

More unsettling to me than questions of definition—licit versus illicit—was an issue raised by Tess's renewed professional success: how might a substance like Prozac enter into the competitive world of American business? Psychiatrists have begun to recognize a normal or near-normal mental

condition called "hyperthymia," which corresponds loosely to what the Greeks called the sanguine temperament. Hyperthymia is distinct from mania and hypomania, the disorders in which people are grandiose, frenetic, distractible, and flawed in their judgment. Hyperthymics are merely optimistic, decisive, quick of thought, charismatic, energetic, and confident.

Hyperthymia can be an asset in business. Many top organizational and political leaders require little sleep, see crises as opportunities, let criticism roll off their backs, make decisions easily, exude confidence, and hurry through the day with energy to spare. These qualities help people succeed in complex social and work situations. They may be considered desirable or advantageous even by those who have quite normal levels of drive and optimism. How shall we respond to the complaint that a particular executive lacks decisiveness and vigor? By prescribing Prozac? In Tess's work, should the negotiators on the union side be offered Prozac, too? The effect of Prozac on Tess's style in her corporate work—and [another patient's] in his architectural practice—raises questions about how a drug that alters personality might be used in a competitive society.

Nor is it possible to witness Tess's transformation without fearing that a drug like Prozac might bolster other unfortunate tendencies in contemporary culture. Even Prozac's main effect in Tess's treatment—the relief it provided from social vulnerability—might, in societal terms, prove a mixed blessing. Tess had come for medication treatment only after a prolonged effort at self-understanding through psychotherapy. But I could imagine a less comfortable scenario: A woman much like Tess, abused and neglected in childhood, though not fully aware to what extent and to what effect, seeks treatment in a society that prefers to ignore victimization and that values economy over thoroughness in health care; the woman seems subdued and angry, is discontented for reasons she cannot easily put into words. By what means will her doctor attempt to help her? Would Prozac, alone, be enough?

But my central concern, as I watched Tess's story unfold, involved her personhood. Tess had every right, on the basis of both childhood experience and unhappiness in adult life, to be socially vul-

nerable in adulthood. But once she had taken Prozac, she—and those who knew her—had to explain her newfound social success on medication. If her self-destructiveness with men and her fragility at work disappeared in response to a biological treatment, they must have been biologically encoded. Her biological constitution seems to have determined her social failures. But how does the belief that a woman who was abused as a child and later remains stuck in abusive relationships largely because of her biologically encoded temperament affect our notions of responsibility, of free will, of unique and socially determinative individual development? Are we willing to allow medications to tell us how we are constituted?

When one pill at breakfast makes you a new person, or makes your patient, or relative, or neighbor a new person, it is difficult to resist the suggestion, the visceral certainty, that who people are is largely biologically determined. I don't mean that it is impossible to escape simplistic biological materialism, but the drama, the rapidity, the thoroughness of drug-induced transformation make simplicity tempting. Drug responses provide hard-to-ignore evidence for certain beliefs—concerning the influence of biology on personality, intellectual performance, and social success—that heretofore we as a society have resisted. When I saw the impact of medication on patients' self-concept, I came to believe that even if we tried to understand these matters complexly, new medications would redraw our map of those parts of the self that are biologically responsive, so that we would arrive, as a culture, at a new consensus about the human condition.

An indication of the power of medication to reshape a person's identity is contained in the sentence Tess used when, eight months after first stopping Prozac, she telephoned me to ask whether she might resume the medication. She said, "I am not myself."

I found this statement remarkable. After all, Tess had existed in one mental state for twenty or thirty years; she then briefly felt different on medication. Now that the old mental state was threatening to re-emerge—the one she had experienced almost all her adult life—her response was "I am not myself." But who had she been all those years if not herself? Had medication somehow removed a

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false self and replaced it with a true one? Might Tess, absent the invention of the modern antidepressant, have lived her whole life—a successful life, perhaps, by external standards—and never been herself?

When I asked her to expand on what she meant, Tess said she no longer felt like herself when certain aspects of her ailment—lack of confidence, feelings of vulnerability—returned, even to a small degree. Ordinarily, if we ask a person why she holds back socially, she may say, “That’s just who I am,” meaning shy or hesitant or melancholy or overly cautious. These characteristics often persist throughout life, and they have a strong influence on career, friendships, marriage, self-image.

Suddenly those intimate and consistent traits are not-me, they are alien, they are defect, they are illness—so that a certain habit of mind and body that links a person to his relatives and ancestors from generation to generation is now “other.” Tess had come to understand herself—the person she had been for so many years—to be mildly ill. She understood this newfound illness, as it were, in her marrow. She did not feel herself when the medicine wore off and she was recharged by an external stress.

On imipramine, no longer depressed but still inhibited and subdued, Tess felt “myself again.” But while on Prozac, she underwent a redefinition of self. Off Prozac, when she again became inhibited and subdued—perhaps the identical sensations she had experienced while on imipramine—she now felt “not myself.” Prozac redefined Tess’s understanding of what was essential to her and what was intrusive and pathological. . . .

Beyond the effect on individual patients, Tess’s redefinition of self led me to fantasize about a

culture in which this biologically driven sort of self-understanding becomes widespread. Certain dispositions now considered awkward or endearing, depending on taste, might be seen as ailments to be pitied and, where possible, corrected. Tastes and judgments regarding personality styles do change. The romantic, decadent stance of Goethe’s young Werther and Chateaubriand’s René we now see as merely immature, overly depressive, perhaps in need of treatment. Might we not, in a culture where overseriousness is a medically correctable flaw, lose our taste for the melancholic or brooding artists—Schubert, or even Mozart in many of his moods?

These were my concerns on witnessing Tess’s recovery. I was torn simultaneously by a sense that the medication was too far-reaching in its effects and a sense that my discomfort was arbitrary and aesthetic rather than doctorly. I wondered how the drug might influence my profession’s definition of illness and its understanding of ordinary suffering. I wondered how Prozac’s success would interact with certain unfortunate tendencies of the broader culture. And I asked just how far we—doctors, patients, the society at large—were likely to go in the direction of permitting drug responses to shape our understanding of the authentic self. . . .

By the time Tess’s story had played itself out, I had seen perhaps a dozen people respond with comparable success to Prozac. Hers was not an isolated case, and the issues it raised would not go away. Charisma, courage, character, social competency—Prozac seemed to say that these and other concepts would need to be re-examined, that our sense of what is constant in the self and what is mutable, what is necessary and what contingent, would need, like our sense of the fable of transformation, to be revised.

ASPIRIN FOR THE MIND? SOME ETHICAL WORRIES ABOUT PSYCHOPHARMACOLOGY

Carol Freedman

Contrary to the common view that regards emotions as types of pleasure or pain, a view (which she attributes to Kramer) that likens emotional problems to headaches, Freedman argues that emotions—unlike headaches—are ways of interpreting the world and one’s situation in it. If, accordingly, we regard emotional problems as