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Introductory

The title of this book, *Happy-People-Pills for All*, is not offered as some bait and switch tactic. So, yes, to put it bluntly, I am arguing for a future where there is a cheap and readily available supply of happiness-boosting pills for everyone. Having spoken and written on this subject for a few years now, I know all too well that many readers, at least initially, will be skeptical. Indeed, some will even recoil in horror at the idea. However, I hope to show in this introductory chapter that the idea is at least worthy of consideration. By the end of the book I hope you will be asking where you can obtain your dose of happy-people-pills.

1.1 The Ends: Greater Happiness

The happy-people-pills for all project has both a means and an end. The means is to use pharmacology; the end is to increase our happiness. Surely the end or goal is innocent enough. The desire for happiness seems unquestionable; we are all accustomed to hearing testimony as to the importance of happiness in our lives. The refrains "I just want you to be happy," "I just want my children to be happy," "I'm not looking to be rich or famous, just happy" are common. There seems to be no reason to doubt the sincerity of such sentiments, and they seem to attest to the utmost importance of happiness in our lives.

Colloquially we might refer to our slightly tipsy colleagues at the staff party as getting 'happy,' but I am not proposing intoxication for all (at least

Happy-People-Pills For All, First Edition. Mark Walker.

not in this work). Rather, by 'happy' I mean what I take people to mean when they make the remarks we just noted, e.g., "I just want my children to be happy." To be sure, I'm not suggesting that the nature of happiness is transparent – far from it. The meaning of happiness figures prominently in this work; indeed, there is an entire chapter devoted to the subject. But even at this preliminary stage it may help to say something on the topic.

The term 'happiness,' I argue in Chapter 3, has both an affective and a cognitive component. The primary affective component is that of positive moods and emotions. In this sense, you are happy if your moods tend to be described by such terms as 'joy' or 'contentment.' A person who experiences frequent positive moods and emotions we would say is a happy person. The cognitive aspect is related to being pleased. So, for example, if walking my dog pleases me, then I may be said to be happy. Happiness in this sense is cognitive because it says something about my view about walking my dog: I find it pleasing. Of course there are many things that we may find pleasing; there are a huge number of ways to fill in the blank in "I am pleased that _____." The cognitive component of happiness is that the fact that I have a certain mental state – "being pleased," happiness – is not the object that fills in the blank. If one enjoys a cold beer on a hot day, it would be wrong to say that happiness *is* a cold beer. Happiness is to be understood as being pleased *by* the cold beer. The beer is the cause of the pleasure, not the pleasure itself. Thus, the happiest amongst us are those most often in a positive mood and who are frequently pleased with the things they are thinking about. The unhappiest are those who experience sadness and other negative emotions, and who take little pleasure in what they are thinking about. As noted, we will discuss happiness in more detail below; the hope here is to have sketched it sufficiently to see that I am attempting to capture what we mean by 'happy' in claims such as, "I just want my children to be happy." It is the wish for them that they generally be in a positive mood and take pleasure in their lives. The wish for happiness for our loved ones is not for a life of intoxication.

With this understanding of happiness in hand, it may seem that we should revisit the wish "just to be happy." Positive moods and being pleased about what we are thinking about may not seem enough. We will consider the question of the role of happiness in the good life in Chapter 4, and I will argue that there are good reasons to think there is more to the good life than happiness. The upshot is that I will recommend that we should hope for more than "only to be happy." Still, I believe that happiness is a very important component of the good life. In any event, whether we think

there is more to the good life than happiness (as I do), or we think there is nothing more to the good life than happiness, we should recognize the value of the goal of happy-people-pills, making people happier. As noted, the wish translates into hoping for more frequent positive moods and being more pleased. And this is precisely what happy-people-pills promise: more positive moods, and as a consequence, to be more pleased about things.

1.2 The Means: Pharmacology

No doubt it is the means, that is, popping pills, rather than the end, happiness, of the happy-people-pills-for-all project that most people object to. The idea of taking pills to increase happiness is one that we are familiar with: it is a common practice (at least in many Western nations) of health care practitioners to prescribe various mood-altering pharmacological agents. We have seen a veritable army of antidepressants enter the psychiatrist's medicine chest: drugs like Sertraline, Escitalopram, Fluoxetine, and Bupropion go by trade names that are household words: 'Zoloft,' 'Lexapro,' 'Prozac,' and 'Wellbutrin,' to mention but a few. One would have had to be living in a very deep cave for many years to be unaware of the scientific and philosophical controversies that have swirled around the practice of prescribing antidepressants. A large number of academic and popular works have repeatedly asked: Do the drugs work? Are they over-prescribed? Are they under-prescribed? Do people become dependent? Do antidepressants simply mask the underlying psychological or social causes of depression? While these questions are important, they are not our main concern. We are after bigger game: the use of pharmacological agents to boost the moods of both those diagnosed as depressed and those in the so-called ''normal'' or ''healthy'' range of happiness

Invariably, talk of enhancing the happiness of those not clinically depressed invokes images or vague memories of Huxley's *Brave New World*, where citizens regularly take the fictional happy-pill 'soma' as a matter of course. The stereotype suggests taking mood enhancers is not like being intoxicated but equivalent to becoming an emotional zombie. Again, this is not the sort of happiness I am advocating, and combating this stereotype is a going concern of this work.

At least some reason for thinking that taking pharmacological agents will not result in a society of zombies can be derived from a real-world study conducted by Dr. David Healy. Healy had healthy volunteers – mostly medical professionals – take antidepressants in a ''cross-over'' study. One of

two antidepressants, Zoloft and Reboxetine, were randomly (and blindly) given to participants for two weeks, followed by two weeks off where subjects took nothing – a clean-out period – then the study concluded with participants taking the other antidepressant for two weeks. Healy describes one of the surprising findings:

> Our focus group met two weeks after the study ended. We already knew that almost everyone preferred one of the two drugs. But two-thirds rated themselves as "better than well" on one of the two drugs. Although this was a study of wellbeing, antidepressants weren't supposed to make people who were normal feel "better than well." Not even Peter Kramer had said this. The argument of his famous *Listening to Prozac* was that people who were mildly depressed became better than well. Here, people who had never been depressed were claiming to be in some way better than normal.*

The fact that two thirds of these "normal and healthy" volunteers felt "better than well" is, as Healy intimates, quite startling: "antidepressants weren't supposed to make people who were normal feel "better than well." "

That Healy found the result of this study surprising is perhaps surprising in itself. After all, it seems a fair question to ask: why shouldn't antidepressants make persons in the normal range of happiness, that is, showing no signs of clinical depression, get a mood boost from antidepressants as well? It is hard to be sure but I suspect there is a tendency to think of psychopharmacological agents as falling into one of two categories: repairing mood and other psychological disorders, or cognitively distorting. The latter category would include such substances as alcohol, marijuana, heroin, etc. Antidepressants are in the former category. They treat an ailment just as aspirin treats pain. Aspirin relieves pain but does not boost pleasure: you can't use aspirin to get an enhanced feeling of pleasure. Similarly, according to this line of thought, antidepressants relieve depression but they do not promote positive moods.

However, there is another model we might consider. Rather than think of pharmacological interventions as "relieving" we might think that some interventions "boost," just as giving children injections of growth hormone is thought to boost their height. Typically such injections are provided for children who are projected to be in the "below average" height range,

* Healy, *Let Them Eat Prozac*, 180. A word on the conventions of this book: Substantive notes are at the bottom of the page. Further references and purely scholarly points are marked as endnotes.

and so might be thought of as "relieving" children of the (mostly) social challenges of being far below average height. Of course, injections "relieve" short stature by boosting height. There is no reason to suppose that the same shots might not be given to a child projected to be in the average range to boost them into the above average range. (I'm making a purely theoretical point here; I'm certainly not recommending this.)

So, in thinking about the efficacy of antidepressants there are at least two models we should consider: we might think that antidepressants work by "relieving" patients of depressed states in the way that aspirin relieves pain, or that they boost moods in the way that growth hormone boosts height. Very little work has gone into sorting out which of these is the best model, so it is perhaps not surprising that we should have fallen more or less uncritically into the "relief only" model. I can only conjecture that we may be misled by the name: 'antidepressant.' If 'antidepressants' were more commonly referred to as 'mood boosters,' then I suspect we would be less surprised. Mood boosters could in theory boost the moods of both those diagnosed as clinically depressed and those who are normally happy.

In any event, the point here is to provide some preliminary indication that the suggestion that we ought to boost the moods of the normally happy is not equivalent to the idea that we ought to become wasted zombies. Most of the nineteen participants in the study functioned quite normally. Indeed, one of the primary purposes of the study was to investigate the question of whether the antidepressant Zoloft caused "emotional blunting." Healy summarized the results thus:

> Chasing the question of whether Zoloft caused emotional blunting, half the group said it had given them a "nothing bothers me" feeling. Reactions were split about this: Some liked the effect; others found it made them emotionally dead. Reboxetine, in contrast, didn't seem to make anyone feel indifferent – calm, perhaps, but not indifferent. Its effects were better described as energizing – again, good for some but not for others.[1]

We will discuss the study some more below – as we shall see, the study is certainly not all glad tidings for happy-people-pills. For the moment the take-home message is this: two antidepressants were used in the study, and only one had any "zombie" effect, and only on half the participants. So, the effect is not a necessary consequence of mood boosters. As will be argued, this is not to suggest that we ought to be satisfied with the current stable of antidepressants. Far from it. In Chapter 7 we will outline a research program for creating better, more advanced pharmacological agents.

1.3 The Biological Basis of Happiness

The happy-people-pills-for-all project depends critically on a scientific insight: happiness is rooted in our neurophysiology and neurochemistry, and indeed, to a large degree, in our genes. It is worth thinking a little about what science tells us about the nature of happiness.

First, an admission: we are just now making serious scientific headway in understanding the neurochemistry, neurophysiology, and genetics of happiness. Yet, even at this early stage, this much seems clear: there are significant neurochemical differences between people who are chronically happy and people who are chronically unhappy. Some of these differences are to be explained in terms of neurochemicals such as serotonin: happier people tend to have more serotonin than those who are unhappy.[2] This is by no means the only difference, and, again, science is still in its infancy in this department, but serotonin appears to be important. A point that will loom large in our subsequent discussion is that not simply are there such neurophysiological differences, but these differences are due, to a significant degree, to individual genetic differences. As we shall see, this has disturbing consequences for the view that we are responsible for our own happiness. After all, we are not responsible for our genes, so to the extent that our happiness is rooted in our genes, we are not responsible for this large influence on our happiness.

Let me hasten to point out that I am not advocating some sort of genetic determinism, specifically, that our individual levels of happiness are due entirely to our genes. To say that genes have a significant influence is not to say that our happiness is solely caused by our genes, any more than saying that since there are genetic influences that determine our height is to claim that genes are solely responsible for our height. Non-genetic influences on height are evident in cases of malnutrition or serious childhood diseases that may inhibit a child's growth. But even while acknowledging non-genetic influences, genetic influences on an individual's height are undeniable: in Western nations where most children grow up under favorable environmental conditions, their height compared to the societal norm is determined to a large extent by genes. Similarly, how happy we are compared with others in society is determined to a large extent by the genes we inherit from our parents. The idea that there is a genetic component to happiness is generally acknowledged, at least with respect to those diagnosed with depression. Again, this is not to say that a

person's environment has nothing to do with whether they are depressed or not, but it is to say that some of the explanation for susceptibility to depression is genetically based. However, the fact that genetics affect the happiness of those in the normal range is not widely appreciated beyond specialist circles.

The analogy with height is instructive: it is generally accepted that some forms of dwarfism have a genetic component. But of course genes influence the whole range of observed human heights. Similarly, genes do not simply influence those who are clinically depressed, but also contribute to a range of happiness in the so-called 'normally happy' population as well.

Consider Figure 1.1. This graph tells us what we all know: there are very few extremely short people and very few extremely tall people. Most of us fall somewhere in the middle, so human height fits the classic bell curve model. In North America, for example, the average height of adults is approximately 5ft 7in,[†] with very few people under 4 feet or over 7 feet. The same bell graph can be used to describe human happiness (Figure 1.2).

One point of the graphs is to break the tendency to think of human mood propensity as falling into just two categories: those who are depressed, and those who are not depressed. Of course these two categories are perfectly legitimate, just as we can divide human stature into two categories: dwarves and not dwarves. But in both cases there are further distinctions of interest. The 'not dwarves' category includes persons of average height and

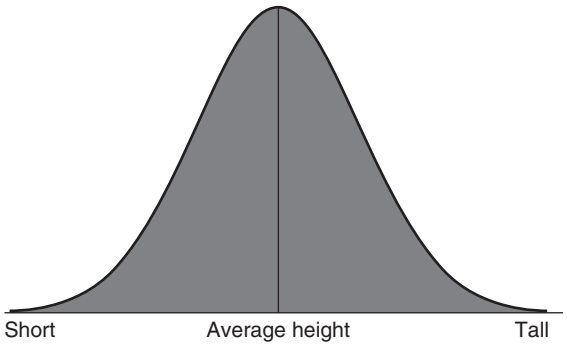

Figure 1.1 Human stature.

[†] There are of course differences in average height when other factors are considered: sex, ethnic background, year of birth, and so on. None of this affects the main point here: human height falls on a normal curve.

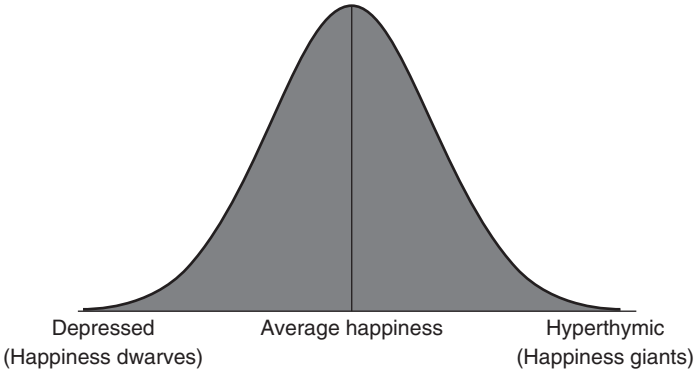

Figure 1.2 Human happiness "stature."

"giants" – extremely tall individuals. A similar point holds with happiness: there are subdivisions within the 'not depressed' range. Some people are just above the cut-off from depression. At the far end are the hyperthymic. The hyperthymic are the "giants" among the normally happy: the happiest 5 to 10 percent. If we could convert their happiness into stature, they would be over about 6ft 1.[3]

A word about the term 'hyperthymia' is perhaps in order. Although it does not have any agreed-upon clinical definition, sometimes the term is used to indicate a pathology, in particular, sometimes it is associated with 'manic'-type personalities and with other characteristics such as risky behaviors, pathological rashness, and insomnia. I'm using 'hyperthymic' in a non-pathological sense to identify the happiest part of the population. Most of us know people who we might describe as 'unusually happy' who don't exhibit pathologies. It is these individuals of whom we shall use the term 'hyperthymia.' It is true that amongst the top 5 to 10 percent of the happiest people we should expect to find some who exhibit pathologies. Of course there is no suggestion that their pathologies are desirable or part of the happy-people-pills-for-all project. Again the analogy with height is instructive: amongst the tallest 5 to 10 percent of the population we will find those with physical maladies such as tumors on the pituitary gland. We would not look to those so afflicted as a model for increasing human height.

The same point about a variety of gradations within the normal range can be made using the grade point idiom (Table 1.1). To convert the happiness of the hyperthymic to a letter grade, they are as rare as the A+ student.

Table 1.1 Happiness grades

Binary classification	*Depressed*	*Normal or healthy range of happiness*			
Preponderance of positive moods	Very low	Below average	Average	Above average	Highest (the hyperthymic)
Percentage of the total population	10	20	40	20	10
Happiness "grade"	F–D	C	B	A	A+

Most non-clinically depressed persons will fall into the C and B range of happiness.

As with most analogies, it is possible to misconstrue this one: it makes it sound as if more happiness is always better in the way that one might think a higher grade is always better. We will give a reasonable amount of attention to the idea that it is possible to be "too happy" in Chapter 6. It is worth noting too that it is not obvious that an A+ is always better, all considered. An A+ student who achieves his remarkable grade point average at the expense of alienating his friends and family may not be better off, all considered.

It is the happy giants that are of particular interest to us. As a group, they have not been extensively studied. Indeed, the existence of the hyperthymic surprises even mental health care professionals: Dr. Friedman, a psychiatrist, relates the case of a woman that came to him seeking advice in connection with the loss of her husband. Within the last year the woman's husband had died of cancer and she had lost her job. Despite the terrible circumstances, the woman had not sought out Friedman as a patient herself but for advice about her son who was having a difficult time coping with the loss of his father. Friedman says that he was intrigued by the woman's ability to cope with her circumstances:

> Despite crushing loss and stress, she was not at all depressed – sad, yes, but still upbeat. I found myself stunned by her resilience. What accounted for her ability to weather such sorrow with buoyant optimism? So I asked her directly.
>
> "All my life . . . I've been happy for no good reason. It's just my nature, I guess." But it was more than that. She was a happy extrovert, full of energy and enthusiasm who was indefatigably sociable. And she could get by with five or six hours of sleep each night.[4]

The bottom line for us: there are winners and losers in the genetic lottery for happiness. The woman who piqued Dr. Friedman's curiosity had won the genetic lottery for happiness: it is, as she says, just her nature to be happy.

It will be helpful at this point to draw a distinction between 'happy pills' and 'happy-people-pills.' The former is a slang term for a variety of pharmacological agents, such as Valium, presently on the market. 'Happy-people-pills' refers exclusively to pharmacological agents that will re-create for the rest of us what the hyperthymic have through the stochastic or random process of natural selection. That is, the hope is to put in pill form what the happiest amongst us have received genetically: a pill to allow the rest of us to become happy giants.

What I will propose in Chapter 7 is that we "reverse-engineer" the happy giants: look to see what it is about the biology of the hyperthymic that makes them so happy and put this in pill form for the rest of us. I provide reasons in this same chapter for thinking that the process of reverse-engineering the hyperthymic could take approximately ten years and ten billion dollars. We may not have to wait that long for a pharmacological boost: I will also argue that there is reason to hope that at least some may benefit from experimenting with our current stable of antidepressants. But, and this is an important qualification, there are well-known deficiencies with our current stable of antidepressants, so using them would only be a stopgap measure.

1.4 Therapy versus Enhancement

Happy-people-pills for all seeks to boost the happiness of all – at least those who desire to boost their happiness. As noted, this includes those in the lowest range of happiness – the clinically depressed – and persons in the "normal range" of happiness. I have indicated too that genes play a causal role in the moods of all of us, not just the depressed. This suggests (but hardly necessitates) that there is no significant technical or scientific challenge to boosting the happiness of those in the normal range as compared with the challenge of boosting the depressed into the normal range with pharmacological agents. It should be obvious that the fact that the scientific and technological challenges are similar is in itself no reason for pursuing the use of happy-people-pills for those in the normal range. After all, this would ignore the question of whether there are other non-scientific and non-technological dissimilarities.

One often cited difference is that there is a clear moral difference between therapeutic and enhancement uses of happy-people-pills. Certainly public perception acknowledges a large difference: most citizens in Western democracies agree that, at least in some cases, pharmacology is an appropriate means to treat depression, but often recoil in horror at the prospect of the normally happy availing themselves of happy-people-pills. Thus, the therapy versus enhancement distinction is important because it is often cited as justification for using pharmacology for the depressed, but not for the normally happy. For instance, even Leon Kass, one of the most prominent critics of pharmacological enhancement of happiness, thinks that it is appropriate, at least in some cases, to use the family of antidepressants known collectively as SSRIs (selective serotonin reuptake inhibitors) to treat some forms of depression.[5] At least part of his reasoning seems to be that treating depression is a matter of therapy, rather than enhancement. Therapy here is understood as restoring "normal functioning," but Kass will have no truck with the idea that we should use pharmacology for enhancement purposes, to boost within the normal range, or, more radically, beyond what is possible given human nature. In contrast, happy-people-pills for all says that everyone – every consenting adult, that is – should have access to happy-people-pills. And while Kass and I are at loggerheads, there is also a third possibility: pharmacology should not be available to anyone, including the depressed. To keep these straight, it will help to provide some names to these positions.

'Bioconservatives' endorse the view that the use of pharmacology for therapeutic purposes is permissible, but the use of pharmacology for enhancement purposes is not permissible. Thus, Kass is a 'bioconservative.' We will consider some of his criticisms below, most of which revolve around the idea that happy-people-pills are "dehumanizing." In any event, bioconservatives can consistently maintain that pharmacology is underutilized presently, that is, we should be doing more to deploy happy-people-pills in therapeutic cases.[‡] For example, the World Health Organization predicts that depression will become the second leading cause of death by the year 2020, so one can easily imagine bioconservatives calling for increased use of pharmacology as a means to combat depression.[6] On the other hand, we may think of 'bioabolitionists' as those who believe that

[‡] Kass thinks that antidepressants are overprescribed. I am simply making a theoretical point that it would not be inconsistent for a bioconservative to call for greater therapeutic use of pharmacology.

pharmacology is always inappropriate, even as a therapeutic intervention. Amongst mainstream mental health care professionals there is pretty near consensus that bioabolitionism is wrong: at least some pharmacological interventions are appropriate at least some of the time. Naturally, this still leaves lots of room for disagreement in the quest to answer the questions: which pharmacological agents should be used on which patients and for how long?

'Bioprogressivism,' the view advocated here, stands in agreement with bioconservatives in endorsing the therapeutic uses of pharmacology. So, bioconservatives and bioprogressives are united against abolitionists on this point. Where bioprogressives and bioconservatives part company is on the question of whether happy-people-pills should be used for enhancement purposes, to make people feel "better than well," to invoke Peter Kramer's famous phrase.[7] Our primary focus is on the dispute between happy-people-pills progressives and conservatives: the prospect of enhancing the happiness of "normally happy" people. This is not to say that the happiness of those diagnosed with depression is irrelevant or merely a 'side-issue.' Rather, the argument is that if we accept happy-people-pills for the enhancement of happiness of persons in the normal range of happiness, then it seems we have at least as strong a reason to accept it for therapeutic treatment of the depressed.

Our distinction between happy-people-pills conservatives and happy-people-pills progressives is made in terms of a therapy/enhancement distinction which itself has come under extensive scrutiny and criticism. One reason for skepticism is the fact that there looks to be no sharp demarcation between those who are classified as depressed and those in the normal or healthy range. To make the point, let us think again about human height. Figure 1.3 indicates what we all know: people come in a wide range of heights.

Using these data we might define, for example, three categories: 162cm to 194cm in height is 'normal height,' while 'short' refers to persons under 162cm and 'tall' to persons over 194cm. But we can see that there is a real worry that these categories are somewhat arbitrary. After all, it is not as if we find some natural break in human height that separates people into three height categories: under 150cm, 170–80cm, and over 200cm. If people fell naturally into one of these three height categories with no overlap, then we would have some reason to think that our definitions of 'short,' 'normal,' and 'tall' cut nature at its joints, for in this hypothetical scenario there are no persons in the in-between areas, that is, in the 151–179cm range and in the

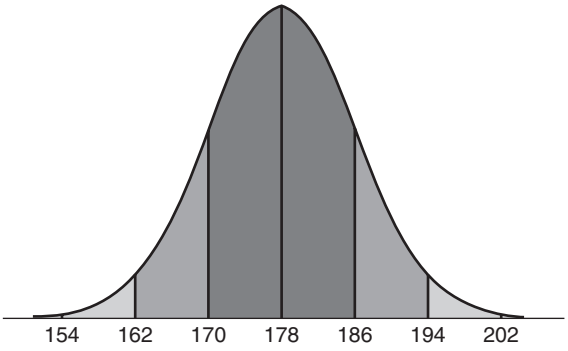

Figure 1.3 Population versus height in cm.

181–199cm range. Given that human height is better represented by our graph with a continuous normal curve, we can see the arbitrary nature of our definitions. It seems we could just as easily have defined 'short' as being under 150cm in height or under 130cm in height, or under 138.3cm in height. In other words, we could take any particular height as a possible cut-off point for one of these categories. The fact that the curve is continuous means that there will be some people who lie just on one side of the distinction or the other. So, for each proposed cut-off point it seems we can ask: why not just a little bit one way or the other on the normal curve? The point here is not that we cannot rigorously define any particular cut-off point: we might say that 'short' means one standard deviation from the mean, and have a well-defined measure of one standard deviation. But this does not solve the problem of *justifying* the cut-off point of one standard deviation: why not one and a half or two standard deviations as the cut-off point for 'short'?

A similar point seems to apply to our happiness curve (Figure 1.3). Just as there are no discontinuities in the populations that might underwrite the categories of short, normal, and tall persons, so too it is the case that there are non-continuous populations of 'depressed,' 'normal,' and 'hyperthymic' persons. Anywhere we happen to draw a line between short and normal, and between depressed and normal, it seems we will have some element of arbitrariness.

At least some bioconservatives are happy to admit that there is some arbitrariness to the line drawing in such cases. Francis Fukuyama, for example, notes that as a matter of policy we must sometimes stipulate rigid divisions where it is implausible to think that such rigid divisions cut nature at its joints.[8] Consider that in some jurisdictions 18 is the

legal drinking age. Are we really to believe that persons who are 17 years, 11 months, and 29 days old lack the intellectual and moral development of someone a day older that justifies permitting the latter but not the former to partake of alcohol? Obviously there are many people younger than 18 who are more responsible than many people over 18, but our policy does not recognize this. Policy is a blunt instrument. Still, we seem to have little choice here. We could hardly leave it to the individuals in question to decide. Most 13-year-olds will attest to their nearly infinite maturity. Nor would we want to leave the drinking age to the discretion of sales clerks at liquor stores.

Part of the reason that some bioconservatives do not find it troubling to admit that such distinctions are *somewhat* arbitrary is that clearly it does not follow that the distinction is *entirely* arbitrary. It is not arbitrary to say that five-year-olds are too young to be permitted to drink alcohol and 40-year-olds are old enough. So, some people are clearly too young to drink, and some clearly old enough to drink, and then there is the grey area in between. As a practical matter we cannot always allow grey areas in policy, and so sometimes we are forced to draw precise lines where none exist in nature. By a similar token, the bioconservative can admit that the line between depressed and not-depressed is grey, but as a matter of policy we may have to draw a hard and fast distinction. They might agree that policy will require that some who are at the very low end of the healthy range but not clinically diagnosed with depression may be refused treatment, while those who barely qualify as depressed may be treated.

To illustrate, psychiatrists and other mental health care professionals use the Hamilton Depression Scale as one means to assess a patient's level of depression. The initial version of the test consisted of 17 question items to be put to prospective patients. Questions dealing with suicide, feelings of guilt, depressed moods, etc. are ranked on a 0–4 scale where 0 indicates absence and 4 is the strongest indicator. Other items, such as level of agitation, are ranked on a 0–2 basis, meaning that they will weigh less in the final tally. The highest possible score is 52. Patients who score 30 or above are generally classified as severely depressed while a score of 7 or under is taken to be a sign that the patient is 'normal,' or lacking clinical signs of depression. So, consider Alexandra who scores a 7 on the Hamilton Depression Scale and is barely in the normal range, while Brian scores 8 and so is classified as among the depressed. The bioconservative must say that Alexandra is not a candidate for pharmacological treatment

but Brian is. Critics, then, will ask, How can such a small difference – only one point on the Hamilton scale – justify such radically different responses on our part?

For my part I do not think that bioprogressivists ought to make too much of the fact that a line is drawn somewhere between normal and depressed. Again, the fact that there may not be any sharp, non-arbitrary means to draw a sharp distinction does not show that there is no distinction. Anyone who thinks it does should contemplate the standard philosophical question of how many hairs one must lose before one is bald. It is difficult to say exactly how many hairs must vanish before a person is bald, but surely there is a clear difference between the bald and the hirsute. Anyone looking for a reasoned defense of happy-people-pill bioprogressivism will have to do much better than simply pointing out that the line between therapy and enhancement may be fuzzy.[9]

So we will grant the happy-people-pills conservative the therapy/enhancement distinction.[10] I say 'grant' here because it is clearly necessary for the bioconservative position, but it is not necessary for the bioprogressivist. The bioprogressivist could accept, indeed welcome, an argument that showed that there is no viable distinction between therapy and enhancement, since the bioprogressivist wants to enhance the happiness of all those who want to use happy-people-pills. So, happy-people-pills progressivists may object that I grant too much in accepting a therapy/enhancement distinction, but bioconservatives can hardly complain.

Much of this work is an argument to the effect that there are morally compelling reasons to permit or encourage the use of pharmacology for enhancement purposes. The reasoning, in a nutshell, is that the happiest amongst us have enviable lives. As we shall see, not only are they happier than the rest of the population, they tend to have the most success in their love lives, at work, in making friends, in being prosocial, etc. There is a natural tendency to think: ''well of course those who are successful in their marriages, at work, making friends, being active in their communities, etc. are happy; after all, they have so much success.'' As we shall see, however, while success does cause happiness, happiness also causes success. This means that those born with a genetic tendency to be amongst the happiest are doubly blessed: not only are they likely to be happier, but they are also likely to have more success in their love lives, at work, making friends, and so on. Putting in pill form what they have through the genetic lottery will mean more of us can enjoy greater happiness and success.

1.5 Signposts

It may be helpful to conclude this chapter by briefly summarizing what lies ahead. The next chapter is the obligatory excursion into Huxley's *Brave New World*. I argue that as a technological prophecy *Brave New World* offers very little in the way of philosophical elucidation of the issue of pharmacological enhancement of happiness. In part the problem is that *Brave New World* casts a net so wide that it makes it near impossible to gain a clear focus on the issue at hand. True, *soma*, the great happy pill of the *Brave New World*, features prominently in the work, but so too do many other technologies. For example, there is the use of alcohol to stunt the intellectual capacities of the lower classes, ectogenesis (babies in a bottle), the widespread practice of indoctrination rather than education of its denizens, and so on. Even *soma* itself, as we shall see, introduces elements that are not relevant for the present purposes; specifically, it is not just a mood enhancer, but also a tranquilizer and a hallucinogenic. It is not without merit: *Brave New World* offers a useful foil for integrating the question of the relationship and nature of happiness and the good life.

Chapters 3, 4, and 5 examine the question of the good life and engage with millennia-old debates on this subject. The conclusion reached is that the good life comprises happiness and a variety of other goods including knowledge, friendship, and virtue, among others. Chapter 3 attempts to illuminate ordinary-language, social-science, and philosophical uses of the word 'happiness.' As noted above, it is argued there is both a cognitive and an affective component to happiness. Chapter 4 argues, contrary to hedonists and desire satisfactionists, that the best lives contain as many and as much of a long list of goods: positive moods, life satisfaction, friendship, love, autonomy, knowledge, health, virtue, desire satisfaction, and so on. This conclusion, as we shall see, is probably not too far from the ''common sense'' conception of wellbeing. Chapter 5 argues that moral virtue should also be included in the long list of items that make up the good life.

Chapters 6 and 7 deal with the science of happiness. Chapter 6 shows that contemporary social science research supports the view that happiness (understood as positive moods and emotions) promotes achievement: the ''higher'' aspects of humanity including work, love, and virtue. Chapter 7 reviews the idea that there is a considerable genetic component to happiness as well as current happiness technology. The best extant possibilities are antidepressants, but there is a lack of scientific studies of their effects on the

moods of those in the normal range. A stopgap measure to promote happy-people-pills is to test the efficacy of existing antidepressants on normally happy persons. For the longer term, a research program is proposed for ''reverse-engineering'' the hyperthymic to garner insights for creating happy-people-pills.

Chapters 8 to 10 deal with the ethical and policy questions that arise on the assumption that we can create happy-people-pills. Chapter 8 looks at the arguments for using happy-people-pills. The arguments in support turn on the claim that happy-people-pills will promote the good life for those taking happy-people-pills *and* for wider society. In particular, it is argued that happy-people-pills will raise the likelihood of people being happier, more productive at work, better in their personal lives with friends and family, and also more virtuous. Chapter 9 seeks to rebut various criticisms of using happy-people-pills, including the ideas that happy-people-pills will lead to false happiness and emotional inappropriateness. Chapter 10 looks at policy implications. It is argued that, at minimum, governments should permit the development of happy-people-pills. Merely permitting the use of happy-people-pills would probably provide plenty of financial incentive for private companies to develop happy-people-pills. On the other hand, if governments have a moral duty to promote the wellbeing of their citizens, then governments have a moral duty to develop happy-people-pills.

Some readers may wish to take a short-cut through the book: Chapters 3, 4, and 5 are the most philosophically dense, and some may wish to skip them initially and head straight to chapter 6. Chapter 6 begins with a very brief summary of the conclusions of these chapters for those readers who wish to follow this route. These chapters are essential for the main argument of this work, but they may be postponed for those who first want to get a sense of the broad contours of the overall argument.

Notes

1. Healy, *Let Them Eat Prozac*, 182.
2. Peirson and Heuchert, ''Correlations for Serotonin Levels and Measures of Mood in a Nonclinical Sample''; Williams et al., ''Associations Between Whole-Blood Serotonin and Subjective Mood in Healthy Male Volunteers.''
3. I have used the vague ''over about 6ft 1in'' locution because it is surprisingly hard to measure and compare human height. Schilling, Watkins, and Watkins, ''Is Human Height Bimodal?''
4. Friedman, ''Born to Be Happy, Through a Twist of Human Hard Wire.''

5. Kass, "Ageless Bodies, Happy Souls."
6. Patel, "Is Depression a Disease of Poverty?"
7. Kramer, *Listening to Prozac*.
8. Fukuyama, *Our Posthuman Future*.
9. Fukuyama (ibid.) does a nice job of showing that this is not the most promising line of argument for the bioprogressive to take.
10. For more on the therapy/enhancement distinction see Daniels, "Normal Functioning and the Treatment–Enhancement Distinction," and Resnik, "The Moral Significance of the Therapy–Enhancement Distinction in Human Genetics."

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