Ordinary Madness: Sub-Clinical Symptoms and the Moral Dilemma for Diagnosis and Treatment of Mental Disorder

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Abstract

Philosophers of psychiatry and mental illness tend to follow the lead of medical science in concerning themselves almost exclusively with clinical forms of cognitive impairment—mental disorders in their most extreme instances. However, we recognize that there are both common and clinical forms of the associated mental states. Grief is common whereas depression is clinical, and fear of death is common whereas generalized anxiety is clinical. Here I argue for the moral imperative of understanding sub-clinical symptoms of mental disorder – or more colloquially, experiences of ordinary madness. These kinds of experiences belong to the category of mental disorder, but do not present as pathological. The absence of this sub-clinical nuance creates moral dilemmas for philosophers and clinicians concerned with understanding and treating mental illness. If no sub-clinical threshold exists for identifying sub-clinical symptoms, clinicians risk conflating them with clinical cases, and recommending medical interventions which may be unhelpful or harmful. While sub-clinical symptoms may not require clinical care, other interventions may be called for to prevent the development of pathology. Moreover, the model I propose provides tools to combat the stigma surrounding mental illness. Appealing to philosophical models of delusion, I first assert the existence of sub-clinical symptoms, and then review some of the clinical literature in order to highlight the need for more research. I then point to the moral benefits of identifying a sub-clinical threshold and suggest some options for this research to pursue despite the present challenges.

1. Introduction: Experiences of Ordinary Madness

First I must clarify some key terms, and identify the moral risks that motivate my argument. I define sub-clinical symptoms as experiences associated with a mental disorder, but which present in a benign manner, i.e.: infrequently or of mild-to-moderate severity, such that they do not develop into pathology. Pathology here refers to clinical cases of mental disorder, defined by a significantly

diminished quality of life. For example, a clinical anxiety disorder will produce frequent and moderate-to-severe symptoms such that the subject's quality of life is significantly diminished, whereas sub-clinical symptoms of anxiety will produce infrequent, benign, mild-to-moderate instances of the same symptoms, and no appreciable difference in the subject's quality of life. I call these experiences of ordinary madness, as distinct from experiences of pathology.

This distinction helps explain why there are risks associated with conflating sub-clinical and clinical symptoms. Standard DSM-based diagnoses can often lead to invasive and risky forms of treatment that are best suited to cases where quality of life is significantly diminished, and where medical intervention offers a reasonable chance of improvement, which is not always true of sub-clinical cases. This is admittedly a controversial claim that I take for granted until section three, where I offer additional support. There is also the risk that, by failing to divert sub-clinical cases away from standard clinical care, scarce mental health resources are not being appropriately distributed to those with the greatest need. Finally, sub-clinical subjects who are hesitant to accept clinical treatment may cease seeking help altogether, and miss opportunities for early detection of risk factors associated with subsequent development of mental illness. For these reasons, identifying a sub-clinical threshold is crucial.

2. Sub-clinical Symptoms and Rationality

Explanatory models of mental illness sometimes acknowledge that the mental states of a given pathology can represent aberrant instances of an otherwise normal process. Patients therefore represent extreme or deficient instances of common mental states, which become pathological to the extent that they interfere with quality of life. However, assessing the severity of a given mental state to predict subsequent consequences for the subject remains challenging. A particular difficulty for explanatory models of delusions is the rationality constraint, the question of whether or not subjects can be described as rational given the irrational content of delusions. If philosophers want to describe what

meaning a delusion has, we will want to describe it in rational terms, yet the experience seems to evade all rational explanation, making it impossible to characterize the content of a delusion.[1]

The problem of the rationality constraint can be generalized beyond clinical delusions. Trying to explain any mental disorder is likely to encounter the problem of rationally explaining the irrational, but perhaps this problem is not so intractable as it may appear. Lisa Bortolotti takes the case of delusions to argue against the rationality constraint and offer an alternative explanatory model. She proposes that delusions are functionally irrational beliefs; they play the same role as beliefs in informing judgement, character, and behaviour, but are not supported by reason or vulnerable to counter-arguments. When it comes to the formation of delusions, Bortolotti endorses a 'sub-personal' account: the belief-like delusion is integrated into the broader system of the subject's beliefs, without the subject being personally aware of the misguided reasons that support the delusion.[2] The subject does not perceive the delusion as irrational, but instead correctly assesses themselves as a generally rational agent, holding mostly rational beliefs, and supports the delusion for this reason. The delusion can be identified only insofar as it has no independent rational support in comparison with other beliefs. In a sense then, the delusion is a belief which is pathological to the extent that its extreme departure from reason diminishes quality of life for the subject.

Here we have a plausible explanation of a fundamentally irrational mental state, which seems to provide a satisfying response to the explanatory dilemma implicit in the rationality constraint. If we accept that the content of a subject's delusions are functionally irrational beliefs, we can describe the severity of a delusion in terms of its departure from reason. One upshot here is that we can also talk about sub-clinical delusions. By situating delusions on a spectrum of rationality, we can characterize clinical symptoms as those which exhibit an extreme deviance from rational norms, resulting in severe

1 John Campbell, “Rationality, Meaning, and the Analysis of Delusion”, *Philosophy, Psychiatry, and Psychology* 8 (2-3): 89-100.

2 Lisa Bortolotti, “Delusions and the Background of Rationality”, *Mind & Language*, Vol. 20 No. 2 April 2005, pp. 189–208.

changes in quality of life, and sub-clinical symptoms as those which exhibit a comparatively moderate and benign deviance but which are still experienced by the subject.

It may seem counter-intuitive at first to consider symptoms of mental illness as existing on a spectrum. Common thinking is that symptoms are either present or absent. However, when dealing with mental states, this dichotomy is not obviously correct or useful. We should not take for granted that healthy people are rational, and we should also be careful to discriminate between different kinds of rationality. What is considered rational behaviour or thought can be relative to a particular culture, society, individual, or situation, and in the case of mental disorder, it is important that we avoid the easy answer of equating pathology with irrationality, and instead take a careful look at what rational faculties are compromised and in what way in each case. I draw some additional support here from Gold and Hohwy, who take delusions of shizophrenia patients as demonstrative of experiential irrationality—the irrationality of an experience, in this case caused by a breakdown in egocentricity, the ability of the subject to identify their thoughts as internally generated—as opposed to procedural or content irrationality. This schema is also adaptable to a spectrum framework, i.e.: delusions can be situated on a spectrum wherein their severity correlates with the degree to which egocentricity, and therefore experiential rationality, is compromised, resulting in a diminished quality of life.

The authors point out that, aside from the schizophrenic subject's strange experiences, there may be a surprisingly intact rational faculty at work. More importantly, the subject may endorse the verity of a delusional experience for reasons that appear rational to them, while remaining utterly irrational to outside observers. Most of us would agree that if we had some kind of extremely strange experience, there would be a sense of relief in being able to explain that experience. This could be the case for the schizophrenic subject that has intermittent hallucinations, for example. Outside observers may think the deluded subject should just recognize their experiences as irrational symptoms of pathology and seek treatment, or ignore them, but certainly not endorse them. However, as Gold and Hohwy note, “In

asking the schizophrenic subject to refrain from explaining his experience, we would be asking him to forgo any story about why his experience is so strange, and that seems to be a demand that no agent [...] could meet."[3]

The take away here is that there can be breakdowns in some forms of rationality while others remain intact, and that both healthy and pathological populations may naturally demand a rational explanation for instances of mental aberration. It seems reasonable to suggest that sub-clinical delusion-like symptoms could be supported in much the same way: a strange experience that begs for explanation. If it is true that healthy people are not unequivocally rational, while mentally ill people are sometimes partially rational, and if Bortolloti's description of delusions as non-rational beliefs is correct, the implication is that sub-clinical forms of benign delusional thinking and behaviour can obtain in healthy subjects. In a way, all of us will experience delusional thinking or behaviour at some point in our lives, supported by lapses of reason, but most of us will not experience a diminished quality of life as a result that would constitute a clinical condition. Therefore, assessing a mental state's rationality alone is insufficient for identifying pathology.

A sub-clinical threshold should identify symptoms which are not severe enough to warrant clinical diagnosis, but which nonetheless produce mild-to-moderate distress in the subject. I have argued that philosophical models of clinical delusion tend to admit the possibility that symptoms of mental disorder present on a spectrum that includes clinical and sub-clinical forms, and as we will see this principle is applicable to other mental disorders beyond delusion. In addition, I have argued that all people suffer from lapses in reason, and are therefore vulnerable to experience sub-clinical symptoms of mental disorder. When these symptoms are severe enough to present a significant obstacle to the subject's quality of life, they cross the clinical threshold, but there remains a grey area that remains to be defined: the sub-clinical threshold. Below I will consider some of the scientific scholarship on sub-

3 Ian Gold and Jakob Hohwy, "Rationality and Schizophrenic Delusion," *Mind & Language*, 15(1), 2000: 146-167.

clinical symptoms, and argue for the ethical value of expanding this research in both philosophical and clinical contexts.

2.1. Subclinical Symptoms in the General Population

Some clinical research on delusion supports the idea that symptoms of mental disorder exist on a spectrum. For example, Zawadzki et al's study uses the Peters et al. Delusions Inventory (PDI)[4] scale to investigate the relationship between cognitive biases and delusional ideation in the general population, and suggests that common cognitive biases exist at different degrees in clinical, sub-clinical, and healthy populations.[5] The important clinical implication of the PDI scale and Zawadzki et al.'s measures of a specific bias—the bias against discomfirmatory evidence (BADE) associated with delusions—is that there are psychometric tests that separate clinical from sub-clinical cases, and if we can make this distinction with delusions, a similar psychometric test for identifying a sub-clinical threshold for other conditions may also be useful. The implication for philosophers, however, is different.

The clinical value of a study like Zawadzki's may be diminished by the study's weaknesses: the sample of 121 healthy test subjects is relatively small, may not reflect sub-clinical populations, and moreover it is difficult to draw conclusions from self-reported data. However, philosophers can benefit from the premise implicit in such a study, namely that symptoms of mental disorder are far more widespread, and often benign, than medical models suggest. While it is natural to develop a concept of mental illness that, informed by the clinical research, appears beyond familiarity to healthy subjects, this concept becomes threatened once we investigate mental aberrations in the general population. The study's authors write, “a growing body of evidence [...] indicates that delusion-like-beliefs exist as a continuum within both clinical and non-clinical populations. For example, one study comparing 359

4 Emmanuelle Peters et al., “Measuring Delusional Ideation: The 21-Item Peters et al. Delusions Inventory (PDI),” *Schizophrenia Bulletin*, 30(4), 2004: 1005-1022.

5 John Anthony Zawadzki et al., “Cognitive factors associated with subclinical delusional ideation in the general population”, *Psychiatry Research,* (197), 2012: 345-349.

members of the general population with 53 schizophrenia patients found that if the number of 'delusional' beliefs were the primary diagnostic criterion, 24% of the population would be diagnosed with schizophrenia."[6] In other words, studies like these give precedent to philosophical investigations of ordinary madness, insofar as these experiences are a common part of the human condition, and for that reason alone are worthy of attention.

2.2. Sub-clinical Symptoms in Adolescents

Another study with similar insights focuses on adolescent subjects, and highlights the potential risks when clinicians fail to discriminate between clinical and subclinical experiences. Heather Altman et al. recruited thirty-eight adolescents from two treatment facilities to measure the rate at which non-psychotic adolescents experience sub-clinical symptoms generally associated with psychotic disorder. They describe these symptoms as "usually identified as being part of a psychotic disorder, [but] not frequent or severe enough to warrant a clinical diagnosis."[7] Given this description, it is all too easy to imagine clinicians who may have less familiarity with mental illness making hasty diagnoses without stopping to consider whether the reported symptoms meet the threshold that warrants clinical intervention. Here we begin to see the ethical importance of identifying a sub-clinical threshold, and developing a new program of interventions, in order to avoid the risks that come with clinical treatment of mental disorder.

The authors assessed participants through interviews and a battery of self-report questionnaires designed to estimate IQ and measure psychological symptoms of shizotypal disorder, schizophrenia, depression, dissociation, hallucinations, and delusions. The participants' medical records were also assessed in order to rule out any clinical diagnoses. Based on their analysis, the authors suggest that sub-clinical hallucination is associated with dissociative symptoms indicative of post-traumatic stress

6 Zawadzki et al., "Cognitive factors associated with subclinical delusional ideation in the general population," 345.
7 Heather Altman et al., "Subclinical Hallucinations and Delusions in Nonpsychotic Adolescents", *Journal of Child Psychology and Psychiatry*, 38(4) 1997: 413.

disorder (PTSD), while sub-clinical delusion is associated with schizotypal traits. These conclusions point to sub-clinical symptoms as reliable risk-indicators for mental disorders. This result can only be tentative, however, given the limitations of the study: It is difficult to draw statistically significant conclusions from a small sample, and the study lacked a control group of adolescents with clinical diagnoses with which to compare. However the authors point out relatively little research has been done directly on sub-clinical symptoms, and studies like this may suggest paths for future research.[8]

Despite the study's limitations, one could infer that mental disorders generally involve symptoms that can present as sub-clinical. If this is the case, it is crucial that we understand the distinction between clinical and sub-clinical instances of these symptoms, in order to avoid the potential harms of misdiagnosis, which I will expand on in another section. My aim here is to emphasize that the mere existence of sub-clinical symptoms, in the absence of any rigorous philosophical model which explains their relation to mental pathology, creates a situation where avoidable instances of misdiagnosis are commonplace. Both studies referenced above make a good case, from a clinical standpoint, for taking sub-clinical symptoms seriously.

2.3. The Zurich Study: Subclinical Symptoms as Predictors of Mental Disorder

I have argued that clinicians, if well equipped to identify and diagnose sub-clinical symptoms, may be able to construct unique treatment and prevention plans for these patients which avoid the risks of clinical intervention, and may prevent the development of full-blown mental disorder. W. Rossler et al's thirty-year Zurich study supports the latter claim, following subjects with sub-clinical symptoms of psychosis to determine the rate of subsequent development of mental disorder. The study is limited by the reduction of the sample size over time, infrequent assessments, and the ambiguity of data derived from self-reporting. However, among the studies reviewed for this paper, only the Zurich study followed a significant sample size (591 at onset, reduced to 335 by the end of the trial) over an

8 Altman et al., “Subclinical Hallucinations and Delusions,” 413-420.

extended period of time. Participants were interviewed seven times during the trial period, and the study used a modified psychometric scale to assess symptoms of psychosis, schizotypal syndrome, and schizophrenia. The authors point out that while research has advanced in assessing sub-clinical symptoms of mental disorder, the issue is controversial for its implications: "Psychotic symptoms are actually widespread in the general population and, in particular, among young adults [...] sub-clinical symptoms may not only indicate a specific risk for psychosis but also point to a more general underlying psychopathology that predisposes one to a variety of common mental disorders, e.g., depressive and anxiety disorders, or substance-use disorders."[9]

Here we see one unusual obstacle to researching sub-clinical symptoms: Their prevalence and their role in the development of full-blown mental disorder suggests that the experiences of mentally ill subjects, and the vulnerability of healthy people to those experiences, are more common than one might expect. This is a disturbing proposition to consider. It seems uncontroversial to claim that most people would ideally view themselves as rational, healthy, and therefore well guarded against mental illness. As obvious as it may be under scrutiny, it is not easy to accept that our rational faculties, even if we are perfectly healthy, are always vulnerable. Researching sub-clinical symptoms, whether from a clinical or philosophical standpoint, forces the investigator to reflexively consider their own mental states, to question their own beliefs and the reasoning that supports them. While such reflection may never reveal the presence of symptoms that are characteristic of mental disorder, the possibility is nonetheless discomfiting.

The Zurich study points out that further research into the role of sub-clinical symptoms in early assessment and treatment of mental disorders is important to medical science, despite the uncomfortable truths this research may uncover, as they may be reliable predictors of the future development of mental disorder. However, as the authors note, research in this field is lacking for an

9 Wulf Rossler et al., "Sub-clinical psychosis symptoms in young adults are risk factors for subsequent common mental disorders", *Schizophrenia Research*, 131 (2011): 18. Accessed online. DOI:10.1016/j.schres.2011.06.019

equally innocent reason: sub-clinical symptoms, by definition, "have not reached the diagnostic threshold."[10] This again highlights the need for identifying a sub-clinical threshold. The authors conclude that sub-clinical psychosis symptoms "co-occur at a high rate with specific mental disorders, even though this has hardly been recognized mainly because sub-clinical psychosis does not fulfill the required criteria for a specific diagnosis. Thus, it is probably worthwhile to include these syndromes in further discussions when revising DSM."[11]

3. The Ethical and Clinical Importance of Understanding Ordinary Madness

I have reviewed some philosophical and clinical literature to assert the existence of sub-clinical symptoms of mental disorder, and the importance of studying these experiences. A better understanding of sub-clinical symptoms may elucidate explanatory models of mental disorder, and also provide better diagnostic and treatment methods for clinicians and other medical professionals. In this section I elaborate on the moral imperative of understanding sub-clinical symptoms, and the challenge facing future avenues of research.

Debate surrounding the moral justifications behind the rise of the psychiatric and pharmaceutical industries is ongoing. Foucault famously argued that the rise of the psychiatric institution was wrapped up in institutions of power, which became less concerned with maintaining mental health and preventing illness, and more concerned with maintaining the efficiency of the patient's contribution to society.[12] While my aim here is not to engage with the scholarship on Foucault and his understanding of mental illness, his influence can hardly be avoided when thinking about the moral and political implications of treating mental disorder, and he provides a useful marker in history, showing that a rigorous critique of medical ethics regarding mental illness has been ongoing since the

10 Rossler et al., "Sub-clinical psychosis symptoms in young adults," 22.
11 *Ibid.*
12 Federico Leoni, "From Madness to Mental Illness: Psychiatry and Biopolitics in Michel Foucault", *The Oxford Handbook of Philosophy and Psychiatry*, ed. K.W.M. Fulford, Martin Davies, G.T. Gipps, George Graham, John Z. Sadler, Giovanni Stanghellini, Tim Thornton. Online version, Sept. 2013. DOI: 10.1093/oxfordhb/9780199579563.013.0008

1960s. Presumably then, there are significant moral dilemmas that remain unsolved in recent decades.

The most current and widely accepted best practices of diagnosis and treatment are codified in the Diagnostic and Statistical Manual of Mental Disorders (DSM), which has a history of controversy over its definitions of what constitutes mental illness. The DSM is emblematic of the purpose of this paper: As a document created and designed for clinicians, it is naturally concerned with pathology in subjects who are already seeking medical help, and effective treatments which may ease suffering. My contention is that in the absence of a similarly comprehensive understanding of sub-clinical conditions, the DSM may encourage medical practitioners to disproportionately misdiagnose sub-clinical cases and recommend treatment where it is inappropriate to do so. In these cases, even the act of misdiagnosis can constitute harm for the patient. In addition, subjects seeking help may abandon their search, for fear of the consequences of clinical treatment, and without any alternative.

Serife Tekin has argued that DSM diagnoses are not always providing patients with a 'good narrative' conducive to recovery. She points out that there are potential risks and benefits to diagnosis. One potential benefit is that diagnosis may provide a rational explanation of the strange symptoms the subject experiences, and a reassuring sense of direction toward recovery, giving the subject a feeling of self-empowering agency that aids treatment. The potential risk, on the other hand, is that diagnosis may encourage the subject to perceive their own symptoms as entirely outside of their control, thereby producing a sense of helplessness, diminishing the subject's agency, and curtailing the efficacy of treatment before it begins. Tekin worries that this effect can obtain even when diagnosis is accurate and warranted,[13] and I think it reasonable to add that in subjects who are misdiagnosed, the risk is magnified.

While Tekin's work is somewhat speculative, I find it compelling and without any obvious counter-arguments. For someone who is reasonably healthy, albeit in moderate mental distress owing to

13 Serife Tekin, “Self-concept through the diagnostic looking glass: Narratives and mental disorder”, *Philosophical Psychology*, 24: 3, 357-380

the experience of sub-clinical symptoms, to be diagnosed as clinically ill amounts to an indictment of the patient's character, a condemnation of their inability to comfortably explain or ignore their own strange experiences. To then prescribe medications to return the sub-clinical patient to a state of health which they never left in the first place is to signal that the subject's problems are far greater than might have been perceived, and the solution beyond their own means. The result may be anxiety over the diagnosis, feeling overwhelmed by its grandeur, and disempowered by a sudden dependence on pharmaceuticals. In order to determine whether a diagnosis would provide a good narrative we may have to consider how severe the specific case is, and whether the risks of diagnosis outweigh the benefits. For example, some sub-clinical cases may call for preventative measures rather than invasive measures, like therapy rather than medication, if they are not misdiagnosed as clinical cases. Someone seeking medical attention for anxiety for the first time, through a family physician, for example, may be experiencing an unusually intense instance of anxious symptoms which are generally infrequent and mild. A prescription for anti-anxiety medication may pose more risk to such a subject than a chance to work through their distress in therapy, yet it is far easier to access medication than therapy through common access points.

Before elaborating on the ethics of introducing potentially risky and invasive treatment, I want to take a moment to emphasize that non-invasive approaches appear to be vastly underutilized. Another article by Tekin, “The Missing Self in Scientific Psychiatry”, proposes to make the self an object of empirical investigation, and thereby bring it into the conversation of psychiatric treatment. While I am not convinced that Tekin's proposal makes a successful case for the empirical study of the self, I do in principle agree that including a self-concept in the process of diagnosis and treatment of mental disorders is critical.[14] Tekin writes, “Most mental disorders are expressed in the form of anomalies in such self-related capacities and attitudes as self-control, self-conceptualization, self-respect, and self-

14 Serife Tekin, “The missing self in scientific psychiatry,” *Synthese*, published online Feb. 2017. DOI: 10.1007/s11229-017-1324-0

esteem, and, as such, they cause an individual's relationship with herself and others to deteriorate. In this regard, most mental disorders directly affect the person, or the self." Yet it is not uncommon for philosophers and clinicians alike to describe patients as neurological machines that have broken down. A mechanistic perception from outside observers may encourage a mechanistic self-concept, implying that only neurological solutions are viable. For the person who may find relief in therapy or a change in life circumstances or other psychological remedies, these reductive attitudes are dangerously unhelpful.

Cases can be described as clinical when the patient's quality of life is significantly diminished. In such cases it is far easier to balance benefit against harm when recommending potentially risky treatment. The clinician's aim is to end the patient's suffering, and when suffering is severe, the options are admittedly limited. Talk therapy is not an option in the face of an imminent threat of suicide, but medication is. Sub-clinical cases, however, are just the opposite: Quality of life is not severely compromised, and medical intervention may not only be unwarranted, but dangerous. Therefore the sub-clinical subject should preferably be offered low-risk, non-invasive treatments as a preventative measure to the potential development of more severe mental illness.

Some researchers are working to establish evidence-based non-invasive treatments for sub-clinical depression as a preventative to the development of major depression, by providing data on the interventions specifically effective for sub-clinical patients.[15] One similarly motivated meta-analysis assessed the success rate of psychological treatment for sub-clinical depression—defined here as "clinically relevant depressive symptoms but standard diagnostic criteria for a depressive disorder are not met"—and reported that psychological treatments had a "statistically significant effect on subclinical depression, [and] a significant preventive effect on the onset of major depressive disorder at

15 Ebert DD, Buntrock C, Reins JA, et al. "Efficacy and moderators of psychological interventions in treating subclinical symptoms of depression and preventing major depressive disorder onsets: protocol for an individual patient data meta analysis of randomised controlled trials", *BMJ Open*, March 2018. DOI:10.1136/ bmjopen-2017-018582

6 months [...] and possibly at 12 months."[16] Finally, a review of the available literature on the efficacy of anti-depressants by Maria Iglesias-González et al. once again emphasizes that there is a scarcity of literature available, and that further research must be done. The only results were that there is not enough clinically relevant data to make any recommendations for or against the use of anti-depressants as opposed to watchful waiting and psychological treatments in sub-clinical depression.[17] Furthermore, some research suggests that the vast majority of available data on the efficacy of anti-depressants only consider inadequate sample sizes, which yield only tentative conclusions.[18]

If data in support of the treatment of sub-clinical depression with anti-depressants is inadequate, why does this remain a popular response by medical practitioners? If we characterize pharmaceutical intervention as risky and invasive, this would be an unjustifiable treatment option for patients who have not met the clinical threshold. To further elaborate this point, I consider Maslen et al's framework in addressing the ethics of introducing potentially risky and invasive treatment.[19] Maslen's article deals with ethical concerns when administering direct brain stimulation (DBS) as treatment for anorexia nervosa. DBS presents significant moral questions, as it can immediately alter the patient's mental state, and by extension their self-concept. Therefore relief may be significant and immediate, but questions remain whether the resulting personality is authentic to the subject, and whether authenticity is important enough to override the potential benefits DBS offers to the subject's quality of life. The authors suggest that a crucial question here is whether the subject is compelled or coerced into treatment, the distinction being that compulsion ignores concerns of the subject's autonomy or consent in favour of providing necessary treatment, even involuntarily, whereas coercion appeals to the

16 Pim Cuijpers et al., "Psychotherapy for subclinical depression: meta-analysis", *The British Journal of Psychiatry*, 205 (2014): 268-274.

17 Maria Iglesias-González et al., "Comparing watchful waiting with antidepressants for the management of subclinical depression symptoms to mild-moderate depression in primary care: a systematic review", *Family Practice*, 2017 34(6): 639-648.

18 John PA Ioannidis, "Effectiveness of antidepressants: an evidence myth constructed from a thousand randomized trials?", *Philosophy, Ethics, and Humanities in Medicine*, 2008 3(14). DOI: 10.1186/1747-5341-3-14.

19 Hannah Maslen et al., "The Ethics of Deep Brain Stimulation for the Treatment of Anorexia Nervosa", *Neuroethic*, September 2015: 215-230.

autonomy of the patient in order to avoid the more harmful option of forcing treatment on an involuntary patient.[20]

While it may be morally permissible to force or coerce treatment on a patient whose life is at risk, or whose quality of life is so poor that there appears to be no other option, it is far more difficult to justify either compulsory or coercive treatment for sub-clinical cases. For one, the prospective benefit to the sub-clinical subject's quality of life is significantly less given that sub-clinical symptoms themselves represent little detriment in that respect already. Further, common interventions for mental disorder may prove harmfully invasive to sub-clinical subjects. The authors briefly note this broader implication of their research:

> The use of DBS to reduce anxiety prompts relevant comparisons with using antidepressants or anti-anxiety medications. To a large extent, the ethical issues associated with this particular mechanism – especially those associated with authenticity – are not unique to DBS, since these pharmacological agents also amount to direct interventions. For example, philosophers have debated whether taking the drug Prozac to treat depression would promote or diminish the authenticity of the agent's experiences.[21]

If it is important, as the authors suggest, to consider the authenticity of the subject's self-concept, the validity of their consent to treatment, and the risk or invasiveness of the proposed treatment, for patients of severe anorexia nervosa, depression, or anxiety, then it can only be equally important to give the same considerations to those exhibiting sub-clinical symptoms of mental disorder, who have less to gain and more to lose in clinical interventions. If anti-depressants change the authenticity of a subject's experiences, they must be regarded as invasive and risky, and the patient's autonomy must be safeguarded against that risk. Therefore, in sub-clinical cases, medications should be regarded as a last resort, where the potential harm of medication outweighs the potential benefits, and where psychological treatments may be successful.

3.1 Avenues for Future Research

20 Maslen et al., "The Ethics of Deep Brain Stimulation."
21 *Ibid.* 234.

People who experience sub-clinical symptoms have little reason to submit themselves to clinical study, and clinicians have little motivation to direct their resources toward healthy subjects, thus complicating future avenues for research. Therefore it falls on philosophy to fill this gap in understanding, to account for the human condition in a way that explains the experience of sub-clinical symptoms and their position on a spectrum of severity, and to produce the data that will inform clinical practice. In preparing for this paper, I found one extremely compelling example worth mentioning. Hannah Pickard is a philosopher who has worked in a clinical setting with patients experiencing personality disorder and addiction, and has produced some promising data on the philosophical dimension of treating mental disorder. Pickard's work takes seriously the agency of patients in their own recovery, and privileges psychological treatments as a first line of defence. Treating patients as responsible agents capable of self-improvement and good behaviour seems to be an essential part of any medical treatment, and it is refreshing to read Pickard's endorsement of the idea. Her research could be mapped onto other psychiatric conditions like depression, for example, and it is useful insofar as it suggests a practical way for clinicians to take to heart the moral considerations outlined here.

There is insufficient space here to make an exhaustive analysis of Pickard's methods as an example for others, but this topic is worth further attention. There are also ways that progress can be made in a clinical context. One possibility is to use current advocacy and education campaigns directed at ending and reducing stigma to encourage healthy people to volunteer for medical research to help the mentally ill. Similarly, these campaigns could educate people about sub-clinical symptoms and their relation to mental illness. Finally, it is worth pointing out that this research can itself serve to reduce social stigma towards the mentally ill. Associating the experiences of the mentally ill with the experiences of healthy subjects, separated only by a matter of degree, offers an explanatory narrative of mental illness that does not ostracize the ill, and makes healthy people aware that experiences of madness, ordinary or otherwise, are not so uncommon as they might have previously believed.

4. Conclusion

I have argued for the importance of understanding sub-clinical symptoms of mental disorder, in order to avoid misdiagnoses, improve understanding of clinical conditions, improve treatment options, and reduce stigma toward mental illness. However, a major limitation of my argument is the very problem it seeks to alleviate: the dearth of available research on sub-clinical symptoms of mental disorder. This, despite the fact that philosophical models of severe clinical conditions often admit that the mental states involved exist on a spectrum and can present in normal and sub-clinical cases. I have appealed to these models to assert the existence and relevance of sub-clinical symptoms to philosophy of psychiatry, and suggested that it is the job of philosophers to continue their work into this field. In the future, we may discover appropriate criteria for a sub-clinical threshold, which would allow clinicians to prevent avoidable misdiagnoses, and focus medical resources on those who need it most. Along with this tool, we should endeavour to create novel programs of treatment for sub-clinical symptoms, which rely on psychological interventions, and only consider more invasive options as a last resort.

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