

CJTV EPISODE DEVELOPMENT

MENTAL ILLNESS IS NOT MENTAL DISEASE

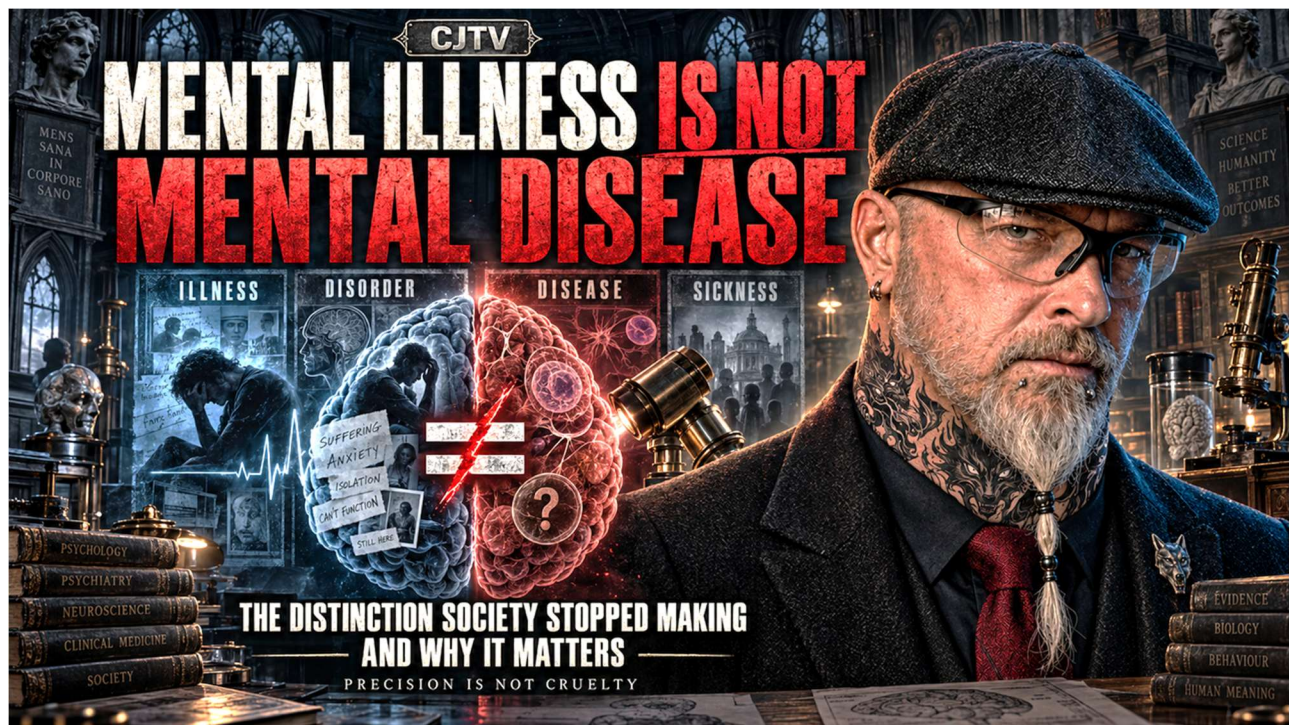
THE DISTINCTION SOCIETY STOPPED MAKING—AND WHY IT MATTERS

Disease • Illness • Disorder • Sickness • Personality • Trauma • Brain Pathology

CJTV — Ideas. Institutions. Behavior.

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Systems Production boundary: This episode distinguishes concepts without diagnosing individuals. “Mental disease” is used as an analytical term for demonstrable pathological processes, not as a separate official DSM-5-TR or ICD-11 diagnostic class. Psychiatric disorders remain real and consequential even when no single laboratory marker confirms them.

Research-based livestream rundown | Psychology | Psychiatry | Neuroscience | Sociology | Mental-Health

Central Question

What is lost when society uses mental health, mental distress, mental illness, mental disorder, mental disease, and neurological disease as though they mean the same thing?

Research Position

Disease, illness, disorder, and sickness identify different levels of a health problem. Disease emphasizes an underlying pathological process. Illness emphasizes the person's lived experience of suffering and dysfunction. Disorder is a clinically useful classification of a significant syndrome. Sickness describes the social status, expectations, and institutional response attached to being recognized as unwell. These categories overlap, but they are not intellectually identical (Ventriglio et al., 2017; Vacca et al., 2025).

Modern psychiatric classification favors “mental disorder” because many conditions are identified through clinically significant patterns of cognition, emotion, behavior, duration, distress, and impairment rather than one definitive blood test, scan, lesion, or genetic variant. The absence of a diagnostic biomarker does not make the condition unreal; it limits what can be claimed about mechanism and individual diagnosis (Abi-Dargham et al., 2023).

The mental-health system's broad umbrella language serves real purposes: communication, service eligibility, research, insurance coding, epidemiology, and anti-stigma advocacy. Yet simplification can collapse ordinary distress into illness, traits into symptoms, syndromes into diseases, and psychiatric conditions into neurological pathology.

CJTV's governing position is therefore: conceptual precision protects patients. The language used should match the evidence available—lived experience, clinical syndrome, measurable dysfunction, or demonstrable pathology—without treating any one level as the whole person.

What You'll Learn Tonight

- The difference between mental health, distress, illness, disorder, disease, and sickness.
- Why DSM-5-TR and ICD-11 formally classify mental disorders rather than a separate class called mental diseases.
- Why a syndrome can be real and disabling without one definitive laboratory test.
- What a biomarker is and why candidate biomarkers rarely become clinical diagnostic tests.
- Why Alzheimer's disease, brain tumors, infections, epilepsy, and traumatic brain injury provide clearer examples of demonstrable pathology.
- Why schizophrenia and bipolar disorder have strong biological evidence but are still diagnosed clinically.
- Why depression, anxiety, and PTSD cannot be dismissed as merely subjective or imaginary.
- How the Big Five describes personality variation without diagnosing disease.
- Why neuroticism is a vulnerability dimension rather than depression, anxiety, or psychosis.
- How trauma can create symptoms, adaptations, or disorders without producing one inevitable "trauma personality."
- How insurance, institutions, and public-health systems reward broad standardized categories.
- How social media converts ordinary emotion into symptoms and symptoms into identities.
- Why biological explanations may reduce blame while increasing fatalism or perceived dangerousness.
- Why does mental disorder not equal violence.
- How to use precise language without minimizing suffering or reinforcing stigma.

Evidence Standards Used in This Rundown

Conceptual evidence

Definitions must identify whether a claim concerns pathology, experience, clinical classification, or social recognition.

Clinical evidence

Diagnosis requires a defined syndrome, duration, severity, impairment, exclusions, and professional assessment.

Biological evidence

Genetic, imaging, inflammatory, and neurochemical associations are not treated as diagnostic tests unless validated for individual clinical use.

Causal evidence

Association does not establish that a trait, biomarker, trauma, or platform caused a condition.

Personality evidence

Big Five traits describe continuous variation and may correlate with disorders; they are not disorders themselves.

Social evidence

Institutional terminology is examined through clinical utility, coding, access, advocacy, stigma, and public communication.

Current-events evidence

Contemporary examples illustrate public language and platform behavior; they do not replace peer-reviewed findings.

Ethical evidence

Precision must not be used to deny care, invalidate suffering, or portray people with mental disorders as inherently dangerous.

Introduction: One Word Cannot Carry Every Meaning

The phrase “mental health” now appears everywhere: hospitals, schools, workplaces, courts, advertisements, social media, and political debate. Its accessibility is useful, but the phrase is regularly asked to describe positive well-being, temporary distress, diagnosable psychiatric syndromes, severe disability, neurodevelopmental differences, addiction, dementia, neurological injury, and social crisis. One umbrella has been stretched across fundamentally different questions.

This matters because words guide action. If sadness becomes disease, ordinary suffering may be medicalized. If a disabling psychiatric disorder is described as merely an unpleasant experience, treatment need may be minimized. If a neurological disease is treated as a personality problem, pathology may be missed. If a personality trait is treated as a diagnosis, normal variation becomes stigma.

The central distinction is not mind versus body. Mental disorders involve embodied human beings, and neurological diseases affect emotion, cognition, identity, and behavior. The issue is epistemic precision: What kind of evidence supports the claim? Are clinicians observing a syndrome, documenting lived impairment, measuring a biological process, or assigning a social status?

Tonight, CJTV will investigate what society gains from broad language—and what it loses when convenience becomes conceptual collapse.

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MAIN TOPIC ONE

THE CATEGORIES SOCIETY COLLAPSED

Primary scholarly foundation: Vacca, M., et al. (2025). Definitions of “mental disorder” from DSM-III to DSM-5. *Behavioral Sciences*, 15(6), 830. <https://doi.org/10.3390/bs15060830>

Introductory discussion points

- Mental health is a positive capacity for functioning and well-being; it is not simply another name for mental illness. A person can have a diagnosis and experience meaningful well-being or have no diagnosis while functioning poorly.
- Illness emphasizes subjective suffering and impairment. Disease emphasizes an underlying pathological process. Disorder identifies a clinically significant syndrome even when its complete cause is unknown.
- Sickness is the social dimension: whether families, employers, courts, insurers, and communities recognize a condition and what rights, duties, accommodations, or stigma follow.
- DSM-5-TR and ICD-11 use “mental disorder” as the operative category. “Mental disease” can support conceptual analysis, but it is not a parallel official diagnostic division (World Health Organization, 2024; Vacca et al., 2025).

1.1 — Mental Health Is Not the Absence of Diagnosis**Explain**

Mental health means the capacity to cope, function, relate, learn, work, and participate in community life.

Detail

Well-being and disorder are related but not exact opposites. Symptoms, functioning, meaning, support, and recovery can move differently over time.

Application

Application: Ask whether a person with a well-managed disorder but strong relationships and purpose have “no mental health.” The answer exposes the weakness of a single continuum.

Livestream emphasis

Livestream emphasis: “MENTAL HEALTH IS SOMETHING EVERYONE HAS. MENTAL DISORDER IS NOT SOMETHING EVERYONE HAS.”

1.2 — Illness: The Lived Experience

Explain

Illness refers to how suffering is experienced: fear, despair, confusion, exhaustion, loss of control, or inability to function.

Detail

Lived experience is evidence about pain and impairment, but it does not by itself identify one biological mechanism or diagnostic category.

Application

Application: Listen seriously to the experience while still asking about duration, context, medical conditions, substance effects, sleep, trauma, and alternative explanations.

Livestream emphasis

Livestream emphasis: “SUFFERING IS REAL, BUT SUFFERING ALONE DOES NOT NAME ITS CAUSE.”

1.3 — Disease: Demonstrable Pathology

Explain

Disease emphasizes a pathological process supported by findings such as degeneration, lesion, infection, seizure activity, toxic exposure, or another measurable abnormality.

Detail

Even disease is not always visible through one test, and biological findings can be probabilistic. The distinction is about the evidentiary target, not absolute certainty.

Application

Application: Contrast a mood syndrome with behavioral change caused by a frontal brain tumor: similar outward behavior can require radically different investigation and treatment.

Livestream emphasis

Livestream emphasis: “SAME BEHAVIOR. DIFFERENT PATHOLOGY. DIFFERENT RESPONSIBILITY TO INVESTIGATE.”

1.4 — Disorder and Sickness: Clinical and Social Categories

Explain

A disorder is a clinically significant pattern; sickness is the social role assigned to someone recognized as unwell.

Detail

Classification permits communication and access but also determines who is believed, treated, insured, accommodated, supervised, or stigmatized.

Application

Application: Ask who benefits and who is excluded when a system requires a diagnostic label before providing help.

Livestream emphasis

Livestream emphasis: “THE LABEL OPENS DOORS AND SOMETIMES BECOMES A CAGE.”

MAIN TOPIC TWO

WHAT BIOLOGY CAN—AND CANNOT—PROVE

Primary scholarly foundation: Abi-Dargham, A., et al. (2023). Candidate biomarkers in psychiatric disorders: State of the field. World Psychiatry, 22(2), 236–262. <https://doi.org/10.1002/wps.21078>

Introductory discussion points

- Psychiatric disorders have biological dimensions, but biological involvement is not the same as a validated diagnostic biomarker.
- A biomarker is an objectively measured characteristic indicating a biological process, disease process, or response to intervention. It must work reliably in the individual clinical setting for its claimed purpose.
- Brain imaging and genetic studies usually identify average group differences with substantial overlap; they do not ordinarily diagnose one patient.
- Neurology and psychiatry overlap. The useful distinction is not “real brain disease” versus “imaginary mental illness,” but the type and strength of evidence supporting pathology, syndrome, and mechanism.

2.1 — A Biological Association Is Not a Diagnostic Test**Explain**

A biological association is a statistical relationship between a measured feature and a condition.

Detail

To become a diagnostic test, a marker needs adequate sensitivity, specificity, replication, standardization, and clinical usefulness across relevant populations.

Application

Application: Do not convert “associated with depression” into “a blood test proves depression” or “a scan shows who has schizophrenia.”

Livestream emphasis

Livestream emphasis: “A GROUP DIFFERENCE IS NOT AUTOMATICALLY AN INDIVIDUAL DIAGNOSIS.”

2.2 — Why Psychiatry Uses Syndromes

Explain

A syndrome is a recognizable cluster of symptoms and signs that commonly occur together.

Detail

Psychiatric classification relies heavily on syndromes because causes are heterogeneous: different pathways can produce similar symptoms, and similar pathways can produce different outcomes.

Application

Application: Diagnosis should guide communication and care while remaining open to revision when neurological, medical, substance-related, or contextual evidence changes.

Livestream emphasis

Livestream emphasis: “A DIAGNOSIS ORGANIZES EVIDENCE. IT DOES NOT COMPLETE THE SCIENCE.”

2.3 — Clearer Disease-Level Pathology

Explain

Neurological diseases may present with identifiable degeneration, lesions, seizures, immune processes, infection, vascular injury, or toxic effects.

Detail

Alzheimer’s disease, frontotemporal degeneration, brain tumors, epilepsy, encephalitis, and traumatic brain injury can alter mood, cognition, inhibition, perception, and personality.

Application

Application: New or abrupt behavioral change especially with cognitive or neurological signs requires medical assessment rather than a purely moral or personality explanation.

Livestream emphasis

Livestream emphasis: “WHEN PERSONALITY CHANGES SUDDENLY, DO NOT ASSUME CHARACTER BEFORE EXAMINING THE BRAIN.”

2.4 — Schizophrenia and Bipolar Disorder: Biological but Clinically Diagnosed

Explain

Schizophrenia and bipolar disorder have strong genetic and neurobiological research bases, yet routine diagnosis remains clinical.

Detail

No single gene, scan, neurotransmitter level, or blood marker presently provides a definitive standalone diagnosis for an individual.

Application

Application: Describe these as serious psychiatric disorders with biological contributions, not as either purely subjective illness or fully mapped neurological disease.

Livestream emphasis

Livestream emphasis: “BIOLOGICAL EVIDENCE IS STRONGER THAN BIOLOGICAL CERTAINTY.”

MAIN TOPIC THREE

WHERE PERSONALITY AND TRAUMA FIT

Primary scholarly foundation: Gupta, P., et al. (2024). A genome-wide investigation into the underlying genetic architecture of personality traits and overlap with psychopathology. Nature Human Behaviour, 8, 2235–2250. <https://doi.org/10.1038/s41562-024-01951-3>

Introductory discussion points

- The Big Five describes continuous personality variation: openness, conscientiousness, extraversion, agreeableness, and neuroticism.
- Traits can correlate with symptoms or disorder risk without becoming symptoms, diagnoses, or diseases.
- Neuroticism is a broad vulnerability toward frequent negative emotion; it is not depression, generalized anxiety disorder, bipolar disorder, or psychosis.
- Trauma can influence functioning, coping, threat perception, trust, and trait expression, but no single “trauma personality” follows inevitably.

3.1 — Trait Is Not Symptom**Explain**

A trait is a relatively enduring tendency; a symptom is a clinically relevant experience or behavior that may signal a problem.

Detail

Introversion is not social anxiety. Low conscientiousness is not ADHD. Openness is not psychosis. Low agreeableness is not antisocial personality disorder.

Application

Application: Before labeling behavior, ask whether it is longstanding, cross-situational, distressing, impairing, episodic, medically caused, or context-specific.

Livestream emphasis

Livestream emphasis: “NORMAL PERSONALITY VARIATION IS NOT A DIAGNOSTIC MENU.”

3.2 — Vulnerability Is Not Destiny

Explain

A vulnerability factor changes probability; it does not determine outcome.

Detail

Genetic and personality findings are polygenic, probabilistic, and dependent on development and environment. Current predictive power for individuals remains limited.

Application

Application: Use traits to frame possible coping patterns or vulnerabilities, never to announce who will become mentally ill, psychotic, addicted, or violent.

Livestream emphasis

Livestream emphasis: “RISK IS A CHANGE IN ODDS—NOT A SENTENCE ABOUT THE FUTURE.”

3.3 — Trauma, Adaptation, and Disorder

Explain

Trauma exposure is an event history; a trauma response is an adaptation; PTSD is a defined disorder.

Detail

Hypervigilance, avoidance, numbing, irritability, sleep disruption, or mistrust may resemble personality change while reflecting current symptoms or survival learning.

Application

Application: Separate what happened, what the person experiences, how functioning changed, whether criteria are met, and whether change persists across contexts.

Livestream emphasis

Livestream emphasis: “TRAUMA CAN SHAPE BEHAVIOR WITHOUT BECOMING THE WHOLE IDENTITY.”

3.4 — Personality, Disorder, and Disease Can Interact

Explain

A person can simultaneously have a personality profile, a psychiatric syndrome, and an independent neurological or medical disease.

Detail

Traits may affect help-seeking, adherence, coping, social support, and symptom reporting; illness can also alter the behavior through which personality is observed.

Application

Application: Avoid assuming that a low trait score caused a disorder or that treatment should attempt to erase normal personality differences.

Livestream emphasis

Livestream emphasis: “PERSONALITY INFLUENCES THE JOURNEY. IT IS NOT THE DIAGNOSIS.”

MAIN TOPIC FOUR

WHAT THE COLLAPSE COSTS SOCIETY

Primary scholarly foundation: Baek, C. H., et al. (2023). Influence of biogenetic explanations of mental disorders on stigma and help-seeking behavior: A systematic review and meta-analysis. Journal of Korean Medical Science, 38(3), e25. <https://doi.org/10.3346/jkms.2023.38.e25>

Introductory discussion points

- Simplified language can improve access and reduce shame, but it can also hide meaningful differences in cause, evidence, treatment, prognosis, and responsibility.
- Biological explanations may reduce personal blame while increasing beliefs that a person is fundamentally different, permanently impaired, unpredictable, or dangerous.
- Administrative systems require categories for reimbursement and services, creating pressure to translate complex distress into a billable diagnosis.
- Social media intensifies category collapse by rewarding brief identity labels, self-diagnosis, dramatic certainty, and emotionally persuasive personal testimony.

4.1 — Medicalization: When Distress Becomes Diagnosis**Explain**

Medicalization is the process through which human experiences become defined and treated as medical problems.

Detail

Medicalization can validate suffering and unlock care, but overextension can pathologize grief, fear, eccentricity, conflict, and ordinary variation.

Application

Application: Ask whether the label improves understanding and treatment or merely relocates a social problem inside an individual patient.

Livestream emphasis

Livestream emphasis: “NOT EVERY PAINFUL EXPERIENCE IS A DISORDER AND NOT EVERY DISORDER IS JUST ORDINARY PAIN.”

4.2 — Insurance and Institutional Convenience

Explain

Standardized diagnoses allow systems to authorize treatment, measure prevalence, assign services, and communicate across professionals.

Detail

Clinical utility does not prove that each category represents one uniform disease with one cause. Administrative precision and biological precision are different.

Application

Application: Distinguish a code used to obtain care from a claim that science has identified a single pathological entity.

Livestream emphasis

Livestream emphasis: “A BILLING CODE CAN BE NECESSARY WITHOUT BEING A COMPLETE THEORY OF THE MIND.”

4.3 — Social Media and Diagnostic Identity

Explain

Self-diagnosis uses personal interpretation often informed by online content to assign oneself a condition without full professional assessment.

Detail

Online information can create recognition and community, but symptom lists stripped of duration, impairment, context, exclusions, and base rates invite false certainty.

Application

Application: Treat an online label as a reason to seek assessment, not as proof of diagnosis, disease mechanism, or identity.

Livestream emphasis

Livestream emphasis: “THE ALGORITHM CAN INTRODUCE A QUESTION. IT CANNOT COMPLETE THE EVALUATION.”

4.4 — Violence, Stigma, and Accountability

Explain

Mental disorder is not synonymous with violence, dangerousness, incompetence, or lack of agency.

Detail

Risk depends on specific symptoms, history, substance use, acute stress, access to means, victimization, social context, and protective factors not diagnosis alone.

Application

Application: Explain behavior without using disease as automatic excuse or illness as automatic evidence of danger. Preserve treatment, rights, accountability, and victim impact together.

Livestream emphasis

Livestream emphasis: “UNDERSTANDING A CONDITION DOES NOT REQUIRE FEARING THE PERSON OR ERASING RESPONSIBILITY.”

CJTV LANGUAGE-TO-EVIDENCE LADDER

Production rule: Present the same behavioral complaint while increasing the strength and type of evidence. Ask when the audience changes its language—and whether the new term is justified.

LEVEL A — Distress without established disorder

A person reports fear, sadness, sleeplessness, and difficulty concentrating after a major loss. Ask: Is this illness, expected distress, a disorder, or not enough information?

LEVEL B — Clinically significant syndrome

Symptoms persist, defined criteria are met, functioning is impaired, and competing explanations have been assessed. Ask: What does “mental disorder” now add?

LEVEL C — Biological association

Research shows group-level genetic, imaging, or inflammatory associations. Ask: Does this establish disease in this individual?

LEVEL D — Demonstrable neurological pathology

Testing identifies degeneration, lesion, seizure activity, infection, or traumatic brain injury associated with the behavioral change. Ask: How should disease language change explanation and treatment?

LEVEL E — Social recognition

An employer, family, court, insurer, or online community accepts or rejects the person’s sick role. Ask: Who controls whether suffering becomes socially legitimate?

Host note: The ladder does not rank suffering. It ranks as the type of evidence supporting different claims.

THE CENTRAL UNCOMFORTABLE QUESTION

Has society expanded “mental health” language because it understands psychological suffering better—or because one convenient vocabulary allows institutions to avoid explaining what they actually know?

Then reverse it:

If we insist on the word disease only when pathology is demonstrable, do we create needed precision—or risk denying the reality and seriousness of disorders whose biomarkers remain incomplete?

The episode succeeds only if viewers can defend precision without invalidation and compassion without conceptual confusion.

EPISODE CONCLUSION

Mental illness, mental disorder, mental disease, and sickness overlap, but each answers a different question. Illness asks what the person experiences. Disorder asks whether a clinically significant syndrome is present. Disease asks what pathological process can be demonstrated. Sickness asks how society recognizes and responds to the condition.

Psychiatry uses syndromic classification because the science of individual mechanisms remains incomplete—not because psychiatric suffering is imaginary. Neuroscience has identified substantial biological involvement across many disorders, but candidate biomarkers have not generally achieved the reliability and specificity required for routine standalone diagnosis.

Personality and trauma add further complexity. Traits shape vulnerability and coping without constituting diagnoses. Trauma can produce suffering, adaptation, or disorder without producing one predetermined personality. Social media and institutional systems can help people name suffering, but they can also transform loose resemblance into diagnostic certainty.

CJTV closing line: “Precision is not cruelty. Compassion is not imprecision. If the words determine the treatment, the rights, and the future, then the distinctions matter.”

Audience Questions With Possible Responses

Question 1

Are mental illness and mental disease official opposite categories?

Possible response: No. The distinction is conceptually useful, but DSM-5-TR and ICD-11 formally classify mental disorders rather than two opposing classes.

Question 2

What does illness emphasize?

Possible response: The person's lived experience of suffering, disruption, and impaired functioning.

Question 3

What does disease emphasize?

Possible response: An underlying pathological process supported by biological or medical evidence.

Question 4

What is a mental disorder?

Possible response: A clinically significant syndrome involving disturbance in cognition, emotion regulation, or behavior, usually with distress or impairment.

Question 5

What is sickness?

Possible response: The social recognition and institutional role assigned to someone considered unwell.

Question 6

Does the absence of a biomarker make a disorder unreal?

Possible response: No. It limits mechanistic and diagnostic certainty; it does not erase symptoms, impairment, or treatment need.

Question 7

Do brain scans diagnose depression or schizophrenia?

Possible response: Not as routine standalone tests for individual patients.

Question 8

Are schizophrenia and bipolar disorder biological?

Possible response: They have strong biological and genetic evidence, but no single marker currently provides definitive individual diagnosis.

Question 9

Why call Alzheimer's a disease?

Possible response: It involves demonstrable neurodegenerative pathology, although clinical presentation and testing still require interpretation.

Question 10

Is neuroticism a mental illness?

Possible response: No. It is a normal personality dimension associated with sensitivity to negative emotion and statistical vulnerability.

Question 11

Is introversion social anxiety?

Possible response: No. Introversion is a personality tendency; social anxiety involves distress, fear, avoidance, and impairment.

Question 12

Does trauma automatically cause PTSD?

Possible response: No. Trauma exposure and PTSD diagnosis are separate questions.

Question 13

Why do systems prefer broad labels?

Possible response: Shared categories support communication, coding, treatment access, research, and public education.

Question 14

What is the risk of biological explanations?

Possible response: They may reduce blame but can also increase fatalism, perceived difference, or stereotypes of dangerousness.

Question 15

What is the main takeaway?

Possible response: Use the term that matches the evidence: experience, syndrome, pathology, or social response—and never reduce the person to the label.

STUDY GUIDE APPENDIX — KEY TERMS

Academic Terms

Biomarker: An objectively measured characteristic evaluated as an indicator of a biological process, pathological process, or response to an intervention.

Clinical significance: The degree to which symptoms produce meaningful distress, dysfunction, impairment, or risk.

Comorbidity: The presence of two or more conditions in the same person.

Disease: A health concept emphasizing an underlying pathological process.

Differential diagnosis: Systematic comparison of plausible explanations before selecting a diagnosis.

Disorder: A clinically significant syndrome involving disturbance and impairment; the term does not require one known cause.

Epistemic precision: Matching the strength and type of a claim to the evidence that supports it.

Etiology: The cause or causal pathway of a condition.

Heterogeneity: Meaningful variation among people who share the same diagnosis or category.

Illness: The lived experience of being unwell, including suffering and impaired functioning.

Medicalization: The process through which experiences or social problems become defined and managed as medical conditions.

Mental disorder: A clinically significant disturbance in cognition, emotional regulation, or behavior, usually associated with distress or impairment.

Neurological disease: A disorder of the nervous system involving neurological dysfunction or pathology.

Pathology: The structural, functional, cellular, biochemical, or physiological processes associated with disease.

Personality trait: A relatively enduring dimension of thinking, feeling, and behavior.

Psychiatric syndrome: A clinically recognized cluster of psychological and behavioral symptoms.

Sensitivity: A test's ability to identify people who have the target condition.

Sickness: The social recognition, expectations, and institutional status associated with being considered unwell.

Specificity: A test's ability to identify people who do not have the target condition.

Transdiagnostic: Operating across several diagnostic categories rather than belonging to only one disorder.

General Terms

Brain disease: Everyday phrase for a condition involving demonstrable brain pathology; it should not be used as a blanket synonym for every psychiatric diagnosis.

Diagnosis: A professional classification based on evidence and defined criteria.

Distress: Psychological suffering that may or may not meet criteria for a disorder.

Functioning: A person's ability to manage daily life, relationships, work, learning, and self-care.

Mental health: Psychological well-being and capacity to cope and function.

Mental illness: A broad term emphasizing clinically important psychological suffering or conditions.

Normal variation: Differences among people that do not by themselves constitute disorder.

Pathologize: To interpret ordinary variation or understandable distress as evidence of disease or disorder.

Risk factor: A characteristic associated with a greater probability of an outcome; it does not prove causation.

Self-diagnosis: Assigning oneself a condition without a complete professional assessment.

Social stigma: Negative stereotypes, prejudice, or discrimination attached to a condition or identity.

Symptom: A reported or observed feature that may indicate a condition but is not a diagnosis by itself.

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FINAL SCHOLARLY CAUTION

The disease–illness distinction is an analytical framework, not a license to rank whose suffering is “real.” Psychiatric disorders may involve powerful biological processes even when routine diagnosis remains syndromic. Neurological pathology may coexist with psychological and social causes. The academically defensible position is not separation without overlapping; it is precision about which claim each form of evidence can support.

