



# The Thin Line Between Illness and Flaw: A Critical Examination of Psychiatric Diagnosis and Personality Assessment

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**ABSTRACT:** This article explores the difficulties psychiatrists encounter in differentiating between mental illness and character flaws given the evolving diagnostic criteria and cultural norms. It evaluates the basic theories of psychiatric classification and the impact of social expectations on the description of mental diseases from a historical viewpoint. The sophisticated web of influences that lead to the development of mental disease and personality structure is highlighted by an analysis of the interactions between genetic and environmental factors. This research also examines the role decision-making skill plays in differentiating personality features from mental disease. Finally, it emphasizes the need for more investigation and comparison in the neural activation patterns of psychiatric patients and non-patients through computational models to enhance diagnostic precision.

**KEYWORDS:** Psychiatry, DSM-5, Mental Illness, Personality flaw, Cultural Norms, Decision-making, Neuroplasticity.

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## I. INTRODUCTION

In a society that seeks definitive explanations for complicated phenomena, scientists have attempted to make clear distinctions between an illness and a flaw despite their similar origins. Specifically, in the field of psychiatry, psychologists have proposed internationally-agreed-upon classifications of mental disorders in the DSM-5, to ensure standardized definitions and assessments of different mental states [1]; however, scientists have regularly adjusted the diagnostic criteria to align with cultural norms and have changed the titles of specific disorders to avoid over-diagnosis or misdiagnosis. This changing nature has sparked disputes over the reliability and significance of such standardization, highlighting the challenge of truly differentiating between a psychiatric illness and a character flaw because their respective definitions vary depending on the quantitative and qualitative evaluation measures used, such as social expectations [2]. Moreover, investigations in psychiatry and neuroscience suggested that the modern DSM system is becoming an epistemic blinder, impeding innovative progress towards valid diagnosis [3].

This paper explores the boundary between psychiatric illnesses and character flaws through presenting definitions and historical overview, examining the role of genetics and environmental factors, comparing physiological evidence, and evaluating whether there is a difference in decision-making ability.

## II. BACKGROUND AND HISTORICAL OVERVIEW

Psychiatric illness is defined as “an **ongoing dysfunctional** pattern of thought, emotion, and behavior that causes **significant** distress, and that is considered **deviant** in that person's culture or society” [4]. A character flaw, on the other hand, is described as an **undesirable** quality of someone's character [5].

The key words in both definitions are qualitative adjectives, rather than quantitative measures or data. The severity of a psychiatric illness seems to be higher than that of a character flaw according to the definitions: For example, *dysfunctional*, *significant distress*, and *deviant* are much more severe adjectives than *undesirable*. Three major theories are used to determine psychiatric illnesses: realism, pragmatism, and constructivism. Realism hypothesizes independent of human discovery or human definition; illnesses and flaws exist as two separate entities. Pragmatism focuses on illustrating a certain need for clarity — to be diagnosed with a particular disorder. This desire for clarity is one of the incentives leading to the establishment of diagnostic manuals. Constructivism posits that humans have the internal drive to seek meanings in their constructed reality [6]. These

three fundamental theories about the nature of psychological disorders conveyed the creation of Psychiatry, as a subject, to make sense of the mental abnormalities. Other basic way of differentiation includes the identification and duration of symptoms. Diagnosed mental illness is accompanied by more persistent symptoms, while personality flaws cause fleeting symptoms [1].

### **III. THE INDISTINCT BOUNDARY**

Despite having a list of psychiatric illnesses in the globally recognized DSM-5 document, individual psychiatrists find challenging to determine the exact differences between psychiatric illnesses and character flaws. Moreover, there is no explicit definition of *mental disorder* that is universally agreed upon by scientists. Furthermore, the adjectives used to describe mental illnesses are often biased and based on the constantly changing social values [7]. When the definition itself sparks disputes in the mental health field, one should not expect a distinct boundary between these two concepts. For example, no scientific measure or research can clearly differentiate between a bad temper and mania or between energetic and hyperactive qualities, except for the personal viewpoints of psychiatrists.

The classification of illnesses is highly dependent on the cultural contexts, as indicated by the regular revision of DSM-5. Both the diagnosis of psychiatric illnesses and the judgment of character flaws are relative to societal norms. To examine an individual's personality, psychologists typically start by measuring their deviance from the "Standard Normal Person", a hypothetical personality that behaves in accordance with the average person of the society [8]. Not only would the model vary from culture to culture, but it would also be expected to vary largely over time. Moreover, apart from the popular modification of disorders related to LGBTQ groups, Kurt Schneider, a German psychiatrist who contributed to the diagnosis of schizophrenia [9], created a category of "fanatic psychopath" in his book on personality disorders. This category was initially regarded as credible but was later rejected as societal norm shifted [10].

Another issue complicating the diagnosis process is the inherent power dynamic involved. Subjects themselves cannot justify their own rationality or health once others suspect them as "insane." For example, people may be deemed psychologically ill by their peers if they don't adhere to the established social rules [11]. Despite the DSM-5's attempt in incorporating cultural considerations into the process of diagnosis, the burden-of-proof dilemma remains.

### **IV. INTERPLAY OF COMPLEXITIES**

Psychiatric illnesses are often caused by the interplay of multiple factors, including genetic, environmental, biological, and psychological elements. Similarly, personalities are also products of combined factors.

#### **4.2 Genetic Factors**

Psychiatric problems can be hereditary like other illnesses, but genetic factors do not directly lead to the development of mental illnesses as they merely increase the risk [12]. For example, there is a widely known link between disinhibited personality traits and antisocial behavior [13]. It is also true that sensitive people are more likely to be diagnosed with depression due to their detailed observation of pain.

#### **4.3 Environmental Factors**

Factors such as poverty, parenting styles, education, and social networks can impact a person's mental development as well as the development of their personality. Personality, a set of traits and disposition exhibited by an individual, sets them apart from other people. According to Erikson's stages of development, children at age of ten are in the industry vs. inferiority stage, where they seek approval from friends and social groups, whereas 20-year-olds are in the intimacy vs. isolation stage, where they explore romantic relationships and connections with peers [14]. These changes in social dynamics can impact an individual's psychological states, promoting personality changes. Mental illnesses often develop as a result of biological or personality weaknesses, suggesting that negative environmental factors can further exacerbate the development of disorders.

Because both conditions can be the products of the same root cause, the only way to differentiate an illness from a simple flaw is by asking, "To what extent is the mental problem troubling", which again varies from individual to individual. A potential solution could be to compare the subject's past health records with their current display of behaviors. However, being certain that the individual was previously healthy could be another demanding task.

## **V. AMBIGUOUS PHYSIOLOGICAL EVIDENCE**

Most people are inclined to believe that those diagnosed with psychiatric disorders have damaged brains; however, evidence of physiological changes is ambiguous because both physiological illnesses and personality flaws can lead to modifications of neuron pathways. Neuroplasticity occurs under a diversity of conditions, not limited to physical damage. Sensory stimulation, repetitive practice, and hormonal fluctuations can all lead to changes of one's brain structure [15].

Environmental factors can have a profound impact on individual mental development: for example, poverty can significantly affect a child's brain structure. In a 10-year longitudinal study conducted by Luby et al., with a sample of 145 children age from six to twelve, scientists found a positive correlation between low Social-economic-status (SES) and low hippocampal volume [16]. Since poverty triggers stress, and stress leads to fear, children experiencing low SES regularly emit high amounts of cortisol, decreasing their hippocampus volume and leading to poor memory. Even though poverty is associated with higher rates of anxiety, depression, and PTSD, most participants were not diagnosed with psychiatric disorders later in life because association is not causation [17]. However, these individuals could be labeled with the adjectives: "forgettable," "inattentive," and "unreliable," illustrating how even brain structure changes cannot accurately reflect the outcome of an individual's mental state.

## **VI. ABILITY OF DECISION-MAKING**

To diagnose a person with a psychiatric illness, patients will usually undergo psychological testing that assesses their cognitive functioning, emotional states, personality traits, and related symptoms. However, the ability to make clear and beneficial decisions is an important criterion often neglected by most diagnostic tests [18]. Currently, there is no official, scientific method of measuring an individual's decision-making function. Nevertheless, extensive research on this topic could prompt a potential break-through in determining the difference between psychiatric illness and personality flaws because empirical evidence is showing signs of progression.

*Herbert Simon's decision-making model* [19] articulates the process a mentally healthy person would undergo when making a decision: (1) identifies a problem and delineates multiple solutions, (2) determines consequence of each alternative, (3) and arrives at the most efficient alternative.

Mainstream theorists posit that people with severe mental illnesses tend to have poor rational regulation over self-harming actions, such as suicide, as a result of poor decisions. Some psychiatric illnesses, such as schizophrenia, can result in patients having poor cognitive control. Specifically, they do not behave in accordance to either their or the society's desired goal and are unable to understand the consequences of their actions due to the limited information that can be processed [20]. In this case, illnesses could fail patients to make the most optimum decision, potentially attributing to the demonstration of harmful behaviors.

On the other hand, healthy people with avoidant tendencies or impulsive personalities might exhibit the same actions to avoid the complexity of life: the stressful and painful experiences. Suicide might be considered a desired alternative in both those diagnosed with mental illness and healthy individuals [21]. Moreover, individuals of both conditions can be prone to display immoral behavior. Those with psychiatric illness often cannot resist the urge for revenge due to impulsivity [1], but psychologically normal people with poor connections between their amygdala and prefrontal cortex might behave in the same way due to conscious hate or annoyance of the subject at hand. Surprisingly, in some cases, individuals in the diagnostic group retain competent decision-making ability.

Research conducted in the field has not yet been able to explain at which phase of decision-making the difference of processing occurs. Current diagnoses are made based on qualitative analysis of factors across diagnostic boundaries, but quantitative measurable differences between illnesses and character flaws remains undiscovered. Tracking and comparing changes in an individual's decisions-making ability before, during, and after the emergence of psychiatric symptoms in longitudinal studies may shed new insights [22]. Development of standardized decision-making assessment tools could also help in the field of clinical psychiatry.

## **VII. FURTHER INSIGHTS**

As aspects such as physiological evidence and cognitive processing abilities can be ambiguous, along with the interplay of more complex factors, the boundary between psychiatric illness and personality flaw can seem indistinct. Currently, most psychiatrists conduct personalized evaluations of individuals with assistance of the DSM-5. However, research by Regier et al. in 2013 [23] found that out of fifteen diagnoses made referencing the DSM-5, six diagnoses were in questionable range and three were in unacceptable range, suggesting that, due to the lack of quantitative standardization, diagnosis based on the psychiatrist's interpretation, leaving room for misdiagnosis. This is because empirical research has not yet provided a clear boundary between these two concepts because they could lead to similar behaviors or thoughts.

The emergence of "Psychiatry" as a field of study has sparked major disputes among the public over the years. The pro-label group believes that labeling patients with psychiatric illnesses allows the patient to overcome

the illness with appropriate therapies. On the other hand, the anti-labelers think that diagnosis not only makes individuals more vulnerable to preconceptions and negative stereotypes that affect how others treat them [24]. Scientists should collectively focus on revolutionizing the existing system by establishing measurable universal standards while maintaining individualized modifications, depending on cases, to avoid wrong judgments that could have lasting impacts on diagnosed individuals. Specifically, psychologists can adapt research in other fields of study, such as computer science and medicine. Using computational models and neuroimaging, scientists can further investigate the differences in neural activation patterns when healthy individuals and individuals with severe psychiatric disorders engage with cognitive processing, such as decision-making [25].

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