Vol. 39 (2026): Proceedings of 2026 International Conference on Life Sciences and Health Engineering
—— Session 3: Health for All Populations: Forum on Public Health and Clinical Health Sciences
(PHCHS-LSHE 2026)
E-ISSN: 3105-0522 P-ISSN: 3105-0514
DOI: https://doi.org/10.70267/PHCHS-LSHE-2026.2026.39.3943

Mental Illness Diagnosis and the Cultural Meaning of Recovery

Zitong Zhou*

Jinling High School Hexi Campus, 60 Mengdu Street, Jianye District, Nanjing, China

**Corresponding author: Zitong Zhou.*

Abstract

This article examines whether current increases in diagnosis reflect overdiagnosis, better recognition, or conflict over the meaning of recovery. It uses psychological and cultural analysis of diagnostic baselines, medicalization, recognition, clinical categories, and social conditions to distinguish the benefits of the relevant institutions from the costs created by their design and distribution. The article shows that diagnosis can provide recognition and access to care while also narrowing interpretation when social or cultural causes are translated into individual pathology. Rather than treating the prompt as a binary choice, the discussion identifies the mechanisms through which advantages and burdens are allocated, the assumptions that make those mechanisms appear neutral, and the circumstances in which the initial judgment should be qualified. The central finding is that the opposition between overdiagnosis and better recognition is incomplete because diagnostic systems also define which forms of distress count and which model of recovery institutions will support. The article therefore argues for an assessment based on institutional conditions, affected groups, and realistic alternatives rather than on intention, symbolism, or aggregate outcomes alone. This approach preserves the strongest evidence on each side while making the normative conclusion explicit. It also clarifies which conclusions follow from the cited evidence and which remain interpretive judgments. The result is a conditional answer that can guide further debate without presenting historical contingency or contested values as settled fact.

Keywords

mental illness, diagnosis, medicalization, recovery, cultural psychology

1. Introduction

In the emperor's new clothes [1], the catastrophe is not that no one can see. It is that everyone has agreed, in advance, on what seeing correctly looks like, such that the person who sees differently becomes the one whose perception requires explanation. In any sufficiently medicalised society, that child would have been the first referred for assessment, his insistence on a reality the adults around him had collectively agreed to discard reframed not as accuracy but as a symptom worth documenting [11]. The assumption that mental illness names a stable object existing prior to the diagnostic act that names it is not a finding the field arrived at through inquiry. It is the condition under which inquiry was permitted to begin, encoded into frameworks whose cultural and economic genealogy has been extensively documented but rarely allowed to destabilise the

Copyright © 2026 The Authors. All individual papers remain the copyright of their respective author(s) · Published by Zeus Academic Research Publishing Group

frameworks themselves [3, 4]. Who decided what recognition looks like, and what that decision was designed to leave undisturbed, is the question that follows.

2. The Contaminated Baseline

Every methodology has a theory of contamination buried inside it, and psychology's is more revealing than most. When a data point strays far enough from the mean, the standard move is not interrogation but exclusion, the outlier disappearing from the analysis not because it failed to happen, but because its presence makes the model look unstable. The history of psychiatric classification follows this same logic at institutional scale, each revision of the DSM expanding the perimeter of the abnormal while presenting that expansion as refinement rather than redefinition [4]. Recovery assumes a before. That assumption is doing more work than any diagnostic criterion ever written.

A system that classified 106 forms of mental disorder in 1952 and classifies more than 300 today has not deepened its understanding of human suffering in proportion to that expansion. What it has done is progressively narrow the bandwidth of tolerable human variation, such that experiences once absorbed by ordinary social life, among them grief extending beyond two weeks, children unable to sustain attention in classrooms not designed for them, adolescents withdrawing under pressures their nervous systems were not built to endure, become legible to institutions only after they acquire a diagnostic code. Medicalisation has not slowed with greater clinical sophistication; it has accelerated, now carrying the authority of neuroimaging and genetic risk scores to legitimate what is, at its structural core, a narrowing of the tolerable [3]. The outlier is no longer excluded. It is absorbed, reclassified, and returned to the dataset as evidence of the model's improving sensitivity. This is not recognition. It is annexation.

What the expanding diagnostic apparatus inherits, without examination, is a baseline that presents itself as biological fact while encoding a historically specific theory of what a functioning person looks like. Built predominantly in Western clinical contexts, calibrated against populations with the resources to navigate diagnostic interviews, and refined through a publication ecology in which industry-funded trials circulate freely while null results decay in file drawers, it has produced a standard whose cultural partiality has been extensively documented without ever being allowed to destabilise the standard itself [7, 9]. The baseline does not describe human health. It describes the health of a particular kind of human, in a particular kind of society, under a particular kind of pressure, and then names that description universal.

Recovery assumes a before. For the person whose psychological architecture was assembled entirely within conditions of conditional belonging, where worth was legible only through performance and rest carried the texture of failure, there is no prior state to recover. What presents as illness is not a deviation from their baseline but a faithful record of what their baseline required them to become. Core self-schemas are encoded through relational experience in pre-verbal developmental windows, stored in procedural memory systems that precede deliberate reasoning and resist the propositional revision that cognitive restructuring assumes is possible [12]. To diagnose that record and treat it back toward function is not recognition. It is the system noticing, with considerable institutional delay, the damage it helped produce, and offering as remedy a more efficient return to the site of that damage.

3. Two Systems, One Refusal

In 2021, two governments issued flagship responses to rising adolescent mental health crises, one in Beijing, one encoded across British higher education's expanding welfare infrastructure. Both were documented, funded, and presented as evidence of institutional seriousness. Neither asked what produced the crises they were managing. Whether systems this politically divergent converge on the same structural outcome is not a theoretical question, and the convergence, when examined, is not reassuring [3].

When rising suicide rates and chronic sleep deprivation among Chinese adolescents spending upwards of 9.8 hours daily on campus became impossible to ignore, the state responded with the Double Reduction Policy, prohibiting for-profit tutoring and reducing homework loads [16]. Depression and anxiety scores fell measurably in the short term [15]. Within months, parents were sourcing underground tutoring networks at greater cost, because the gaokao system generating the original pressure had not been touched [2]. The

Copyright © 2026 The Authors. All individual papers remain the copyright of their respective author(s) · Published by Zeus Academic Research Publishing Group

structure producing the symptom continued operating, now carrying the additional legitimacy of having been seen to act.

British universities allocated £15 million in strategic mental health funding and £41 million in disabled students premium funding in 2022 to 2023 alone, building counselling services, mitigating circumstances frameworks, and interruption of study pathways [10]. A student who accesses this infrastructure and eventually graduates has been served by a system that worked exactly as intended. She has also been returned, stabilised and certified, to a degree structure whose assessment logic and credentialist architecture she never had the institutional space to interrogate.

Denial and management are not opposites. They are the same refusal operating at different levels of sophistication, a distinction the psychological literature on defence mechanisms has long recognised without applying to institutional behaviour [13]. One system refuses to name the wound. The other names it, treats it, and returns the person to the knife. The asymmetry in compassion is real. The symmetry in structural preservation is total. Both systems have discovered, through entirely different routes, that the most efficient way to protect a pathogenic structure is to become very good at repairing the people it damages.

4. The Prior Conditions No Protocol Reaches

If both systems repair individuals and return them to pathogenic conditions, the implicit theory of change they share is that functional restoration is equivalent to recovery. That equivalence only holds if the person being restored once possessed a self stable enough to be worth restoring, a condition the evidence suggests is far less universal than the clinical apparatus assumes.

The common factors literature has demonstrated that therapeutic alliance accounts for more outcome variance than any specific intervention technique, a finding that has survived repeated meta-analytic scrutiny across modalities and populations [14]. CBT's institutional dominance did not emerge because it outperformed relational approaches on the variables that matter most to patients. It emerged because it was scalable, manualisable, and legible to funding architectures that needed treatment deliverable in fixed, auditable units, optimising for efficiency rather than effectiveness, and sacrificing in that optimisation precisely the relational process the evidence identifies as primary.

Core self-schemas are encoded through early attachment relationships in pre-verbal developmental windows, stored in procedural memory systems that precede and operate beneath deliberate reasoning [12]. A person who internalised, before they had language for it, that their existence required continuous justification through performance cannot revise that encoding by learning to identify cognitive distortions. The schema is not a thought. It is a structure, and structures do not yield to tools designed for thoughts.

The evidence converges on a sequential dependency that existing clinical frameworks have not formalised. Recognition, being seen as a subject rather than a case, is not a therapeutic bonus that improves the working alliance [5]. It is the prior condition that determines whether any alliance can reach the depth at which schema-level change becomes possible. Below recognition sits something less clinical still, the sustained experience of being accompanied without condition, transmitted not through language but through relational time. The sequential dependency these conditions exhibit can be represented as follows (see Figure 1). A cousin of mine spent fourteen months in irregular contact with a woman who would become her godmother, walking and eating alongside her without agenda. Formal therapy ran in parallel and produced measurable symptom reduction. The schema did not begin to shift until the accompaniment had constituted, for the first time, evidence that her existence did not require a reason.

5. The Verb the Clinic Does Not Have

The person who arrives at a clinic having never been witnessed without condition, having never accumulated enough relational evidence that their presence required no justification, does not need a more accurate diagnosis. She needs a different verb entirely. The clinical vocabulary contains restore, stabilise, manage, and recover. It does not contain begin.

Every system examined here intervenes exclusively at Layer 2 of the sequence illustrated in Figure 1, while treating Layers 0 and 1, and the foundational condition beneath them, as background variables rather than

Copyright © 2026 The Authors. All individual papers remain the copyright of their respective author(s) · Published by Zeus Academic Research Publishing Group

primary mechanisms. The Threshold Model is not a clinical innovation. It is a description of what the evidence has always indicated and the institution has always found inconvenient to operationalise: that durable change requires prior conditions no protocol addresses, transmitted through relational time rather than therapeutic technique [12, 14].

The person this analysis has in mind is not a clinical edge case. Among Chinese adolescents, suicidal ideation reached a prevalence of 15.4% in recent meta-analytic estimates, with non-suicidal self-harm rates in middle school students at 27.4% against a global average of 19.5% [8]. In British universities, female students report mental health difficulties at twice the rate of male students, with over 50% of non-binary students reporting difficulties in 2024, figures rising despite substantial infrastructure investment [6]. These are not numbers describing a population lacking adequate technique. They describe a population for whom the prior conditions of genuine change are structurally unavailable, and for whom the systems designed to help have become, through their very effectiveness at surface-level repair, a mechanism for deferring that recognition indefinitely.

She stopped asking whether she was trying hard enough. She started asking what she was trying for. That was not a symptom resolving. That was a self beginning. The clinical apparatus has one verb. It has no syntax for what happens when a self comes into existence for the first time, and that absence is not a technical oversight requiring a better manual. It is a theoretical failure requiring a different account of what a person is before they become a patient, one that begins not with disorder but with the conditions under which a self capable of disorder, and of recovery, and of genuine change, becomes possible at all.

6. Conclusion

Recovery is not a neutral verb. It presupposes a self that once existed intact, a damage that arrived from outside, and a clinical task of restoration, and in doing so writes out of existence the person for whom the damage and the self were constructed simultaneously, for whom Layer -1 was never available, for whom there is no prior wholeness to recover because wholeness was never the condition on offer. That person is not an edge case the system has failed to reach. She is the evidence that the system's foundational grammar was written for someone else. More funding, better training, expanded diagnostic categories, reduced stigma, none of these may touch the prior question. That question has no clinical answer. It has only a social one, and the most dangerous thing the clinical apparatus has ever done is make that easy to forget.

References

[1] Andersen, H. C. (1837). The emperor's new clothes. C. A. Reitzel.

[2] Chen, L., and Lin, S. (2024). Examining China's "double reduction" policy. ECNU Review of Education, 7(3), 1–24.

[3] Conrad, P. (2007). The medicalisation of society. Johns Hopkins University Press.

[4] Hacking, I. (1999). The social construction of what? Harvard University Press.

[5] Honneth, A. (1995). The struggle for recognition. Polity Press.

[6] House of Commons Library. (2024). Student mental health in England: Statistics, policy, and guidance. UK Parliament.

[7] Kirmayer, L. J. (2015). Re-visioning psychiatry. In L. J. Kirmayer, R. Lemelson, and C. A. Cummings (Eds.), Re-visioning psychiatry (pp. 622–660). Cambridge University Press.

[8] Lancet Public Health. (2020). Adolescent mental health in China requires more attention. The Lancet Public Health, 5(12), e632.

[9] Moncrieff, J. (2008). The myth of the chemical cure. Palgrave Macmillan.

[10] Office for Students. (2023). Meeting the mental health needs of students. Office for Students.

[11] Rosenhan, D. L. (1973). On being sane in insane places. Science, 179(4070), 250–258.

[12] Siegel, D. J. (2012). The developing mind (2nd ed.). Guilford Press.

Copyright © 2026 The Authors. All individual papers remain the copyright of their respective author(s) · Published by Zeus Academic Research Publishing Group

[13] Vaillant, G. E. (1992). Ego mechanisms of defense. American Psychiatric Press.

[14] Wampold, B. E., and Imel, Z. E. (2015). The great psychotherapy debate (2nd ed.). Routledge.

[15] Wang, D., Chen, X., Ma, Z., Liu, X., and Fan, F. (2022). Has the "double reduction" policy relieved stress? Child and Adolescent Psychiatry and Mental Health, 16(1), 1–12.

[16] Yang, Y. (2024). Research on China's adolescent mental health policies. Frontiers in Public Health, 12, 1408991.

Funding

This research received no external funding.

Conflicts of Interest

The authors declare no conflict of interest.

Acknowledgment

This paper is an output of the science project.

Open Access

This chapter is licensed under the terms of the Creative Commons Attribution-NonCommercial 4.0 International License (http://creativecommons.org/licenses/by-nc/4.0/), which permits any noncommercial use, sharing, adaptation, distribution and reproduction in any medium or format, as long as you give appropriate credit to the original author(s) and the source, provide a link to the Creative Commons license and indicate if changes were made.
The images or other third party material in this chapter are included in the chapter's Creative Commons license, unless indicated otherwise in a credit line to the material. If material is not included in the chapter's Creative Commons license and your intended use is not permitted by statutory regulation or exceeds the permitted use, you will need to obtain permission directly from the copyright holder.



Copyright © 2026 The Authors. All individual papers remain the copyright of their respective author(s) · Published by Zeus Academic Research Publishing Group