

When Recognition Becomes A Label

Introduction

When I was in eighth grade, I took a year off from school due to prolonged distress following major academic setbacks. My suffering was real, but I was never formally diagnosed with mental disorder. I eventually recovered not because of medical diagnosis or psychiatric treatment, but because I regained purpose, self-worth, and motivation, with support of family and school. Even today, I'm still unsure whether what I experienced would be better understood as a clinical condition or an intense adolescent crisis. I wonder if anything would've been different if I were viewed as a patient, rather than just a confused adolescent.

This uncertainty is closely related to the debate about mental-health diagnosis today. If I had received a diagnosis, perhaps I could have understood my problems earlier and received more professional support. Yet it is also possible that I would've begun to see myself mainly as a patient, and interpreted a difficult period of growth as a permanent medical condition. The difficult question is therefore not whether psychological suffering is real, but when such suffering should be classified as illness.

This essay focuses on conditions where debates between better recognition and overdiagnosis are most likely to arise. Severe psychiatric disorders such as schizophrenia and psychotic disorders often involve severe impairments in neurological and cognitive functioning, making their status as mental disorders less contested. In contrast, diagnosis of conditions such as ADHD, anxiety, depression, and PTSD depends heavily on reported symptoms, clinical interviews, and sociocultural context. These conditions exist on a spectrum between ordinary emotions and prolonged suffering, providing excellent cases for evaluating whether mental illness today is being overdiagnosed or better recognized.

Why Overdiagnosis Occurs

People have been increasingly concerned about whether mental illness is being overdiagnosed and one important reason is that nowadays societies are increasingly prone to understand human struggles through the frameworks of psychiatry. Issues previously handled by family, school and community have now been increasingly understood and dealt with through diagnosis, treatment and clinical intervention. These changes doubtlessly brought many positive influences: psychological interpretations often reduce stigma and encourage people to actively seek support. But they also raise the question of whether we are pathologizing ordinary life struggles.

A key psychological mechanism behind these processes is attribution. Attribution theory suggests that human beings are always searching for explanations for their previous successes and failures. In the past, poor performance in academics, setbacks in socialization or inability to concentrate are often attributed to character traits,

diligence or environmental factors. But now these experiences are increasingly interpreted through the lens of mental disorders. This change could reduce shame and self-blame and help people understand their struggles might not necessarily suggest moral defects or personality failures.

Some adults diagnosed with ADHD describe the diagnosis as removing years of guilt for problems they had previously understood as moral failure (Goulder, 2024). Singh's interviews with mothers of children taking Ritalin similarly found that biological explanations could reduce the feeling that poor parenting had caused the child's behaviour, although parents also gained new responsibilities for managing treatment (Singh, 2004). In these cases, diagnosis does not necessarily remove responsibility; it changes where responsibility is placed.

However, this shift can go too far. When every difficulty is treated as the unavoidable expression of a disorder, explanation may become an excuse that prevents further investigation. Parents may stop examining sleep, family routines, or school environment. Teachers may lower expectations instead of providing more effective support. Patients themselves may begin to believe that effort, adaptation, or personal growth are somehow incompatible with accepting the reality of their condition. The problem is not that mental illness is unreal, but that a diagnosis may become too complete an explanation.

The relative-age effect in ADHD diagnosis illustrates this danger. In British Columbia, children born in the final month of the school-entry year were 30 per cent more likely to receive an ADHD diagnosis and 41 per cent more likely to receive medication than children born in the first month (Morrow et al., 2012). An administrative school cut-off is unlikely to produce a sudden difference in the true prevalence of a neurodevelopmental disorder. The study does not prove that younger children were wrongly diagnosed, but it suggests that ordinary developmental immaturity may sometimes be interpreted as pathology when children are compared with older classmates rather than with age-appropriate expectations.

Social media may amplify this process; platforms like TikTok play an important role in facilitating the destigmatization of mental health issues. Yet they also expose users to an unprecedented amount of psychiatric language. Research shows that TikTok users who frequently view ADHD-related content substantially overestimate the prevalence of ADHD symptoms and are more likely to identify themselves with the disorder (Karasavva et al., 2025).

Similar dynamics can be observed beyond Western social media platforms. Seko and Kikuchi (2022) describe the Japanese "Menhera" phenomenon, a subculture in which psychiatric language became closely associated with a recognizable social identity. Originally referring to users of an online mental health forum, "Menhera" gradually developed into a larger label associated with mental instability, self-harm, or psychological struggles, becoming a subculture with social meaning that transcends

clinical diagnosis, not just a medical description but also how individuals understand themselves and construct their personal identity.

This could be explained with what philosopher Ian Hacking describes as the “looping effect.” (Hacking, 2006) Once a psychiatric label becomes widely recognized, individuals learn which kinds of emotions, behaviors, and narratives society accepts as legitimate expressions of suffering. As a consequence, they describe their complex feelings and experiences through increasingly familiar terms of mental illnesses, even when other situational explanations might also apply. Available diagnostic language shapes which aspects of their experiences they notice, emphasize, and communicate to others, allowing clinicians and researchers to further strengthen the public visibility of these symptoms. Through this cycle of classification and self-expression reinforcing one another, diagnoses not only identify conditions but also teach people how to express themselves, potentially contributing to a gradual increase in overdiagnosis.

Recognizing Previously Unseen Suffering

Yet the growth in mental illness diagnosis cannot be fully explained through overdiagnosis alone. The improvement in recognition of mental health issues allows people to better recognize conditions that were previously overlooked or misunderstood. Better mental-health literacy can improve people’s knowledge of symptoms and available treatments, and therefore increase appropriate help-seeking (Jorm, 2000). This is especially important when suffering is not easily visible. A student may compensate for attention difficulties with additional work until academic demands become too great. A depressed worker may continue to appear functional while privately experiencing hopelessness. A new mother may hide her emotional struggles because they conflict with social expectations surrounding motherhood. In these cases, lack of diagnosis does not foster resilience, but creates prolonged, exacerbating suffering.

The history of PTSD provides a classic example. People who have experienced prolonged psychological pain after wars, violence, or major disasters were often viewed as weak or lacking resilience. It was only after decades of research, especially after public awareness of Vietnam veterans’ experiences, that PTSD was admitted into the DSM-III in 1980. In this case, the diagnosis did not create a new disease. Rather, a long-existing pain has finally become better understood.

Perhaps the strongest rebuttal to the claim that “rising rates of mental illness merely reflect overdiagnosis” comes from trends in more severe indicators of psychological distress. In America, the proportion of high school students reporting persistent feelings of sadness or hopelessness increased from 26% in 2009 to 40% in 2023, while the suicide rate among individuals aged 10-24 rose from 6.8 to 10.7 per 100,000 between 2007 and 2023 (CDC, 2025). Unlike diagnostic labels, these outcomes cannot easily be explained by changing terminology or fashionable self-identification

alone. While rising rates of mental illness may be influenced by complex factors such as social media, anxiety, and economic insecurity, better recognition of these conditions may help prevent psychological distress from escalating into more severe forms of harm like suicide.

Therefore, better recognition should not be defined as simply giving more people diagnoses. It means correcting forms of systematic blindness. Some groups may be diagnosed more frequently because clinicians have become better at recognizing symptoms that were previously ignored, expressed differently, or hidden behind outward competence. In these cases, an increase in diagnosis may reflect genuine progress.

Where Should We Draw the Boundary?

People usually see the debate between overdiagnosis and better recognition as one primarily about scientific evidence. Yet it is also a disagreement about values. Most would agree that the ultimate goal of mental health services isn't to label people through diagnosis but to help individuals return to a functional and meaningful life. So the core issue isn't whether struggles amount to illness but how society responds to these struggles. And the "socialized" versus "medicalized" way of dealing with struggles depends on societal belief about the roles that individual responsibility, resilience, and medical intervention play in mental life.

The intergenerational debate surrounding "resilience" perfectly illustrates this difference in values. The older generation often believes today's young people lack resilience and are prone to interpret ordinary life challenges as mental health issues. Yet psychological research on the "Kids These Days Effect" shows that adults have repeatedly perceived younger generations as less capable or resilient than their own (Protzko & Schooler, 2019). Meanwhile, another plausible explanation is that people nowadays are more willing to express their pain. People who used to resort to excessive drinking to relieve pain could now more openly say, "I'm depressed," and proactively seek help. So the rising diagnosis rates might not just reflect worsening overall mental health, but also changes in how people understand and express pain.

Ultimately, overdiagnosis and better recognition could both be taking place. Ordinary emotional challenges could become increasingly interpreted through psychiatric frameworks. Meanwhile, real pain that was previously overlooked or dismissed, especially among marginalized groups, now becomes better supported and treated. The boundary between mental illness and ordinary distress cannot be determined by pain alone, because emotions like grief, humiliation, and anxiety can all be severe without necessarily becoming disorders. Yet, the existence of an understandable external cause does not negate the possibility of illness. Family losses, bullying, or academic failure may explain distress, but even if these causes are addressed, the resulting symptoms may still become persistent and functionally impairing. A person may deserve support even when their condition does not meet the threshold of a

psychiatric diagnosis. When schools, families, and institutions offer compassion or accommodation only after a diagnosis is obtained, they create pressure to medicalize distress. The challenge, therefore, is not to decide who is ill, but to ensure that access to care is not contingent on becoming a patient.

Conclusion

I'm still unsure whether my suffering at fourteen represented a mental disorder or a difficult coming-of-age experience, or whether I should've proactively sought psychiatric treatment. When volunteering at my city's youth mental health center, I encountered similar cases from opposite directions. There were adolescents using their mild ADHD diagnoses to explain away every misbehavior and shed self-discipline and personal responsibility. There were also adolescents displaying severe symptoms of depression while their parents still insisted they were simply lazy and faking illness to skip studying. These personal experiences made me realize that it was never a blanket choice between overdiagnosis and better (or under-) recognition.

Mental illness is therefore both over-diagnosed and better recognized. The same social change contributes to both: people are now more willing to treat psychological pain seriously, allowing previously hidden illness to be recognized. Yet, it can also create the belief that suffering becomes legitimate only when it receives a medical name.

The question is neither about reducing nor expanding diagnosis, but to clarify its purpose. Diagnosis should be proportionate to the practical value of the label, broad enough to provide support to those in need, and precise enough to avoid undermining personal agency and community support. A diagnosis should help explain a person's suffering without becoming the final explanation of who that person is.

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