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Essay topic – 'Seeing the whole person beyond the diagnosis'

The Person Behind the Diagnosis

By Sudikshya Parajuli

I remember him before the words claimed him.

Before the diagnosis, he was not a case or a category. He was known by small, ordinary things: the way he lowered his voice so others could speak, the way he always checked up on those around him, the way he remembered birthdays without reminders. His pain was real, but it was not the sum of him. It was a thread woven into a rich tapestry of a full human life, inseparable from his kindness, his loyalty, and his sense of responsibility to others. People spoke about him in terms of who he was, not what was wrong with him.

When the diagnosis arrived, that way of seeing him shifted. It arrived as a tidy clinical certainty, written in notes before anyone had fully asked what he had lived through or what he still carried. Gradually, conversations changed. His anger became a symptom, his silence became pathology, and his gentleness receded into the background. He did not disappear, but he became harder to see beneath the label now placed in front of him.

This experience of a family member revealed to me a central tension in psychiatry: diagnosis is essential, yet dangerous when it replaces the person it is meant to serve. This essay argues that seeing the whole person beyond the diagnosis requires three commitments from psychiatry: recognising the limits of diagnostic categories, attending seriously to context, trauma, and culture, and exercising ethical humility in the use of psychiatric power. Holding these together is what allows psychiatry to remain both scientifically rigorous and genuinely humane.

The Architecture of Reduction

Diagnosis is the cornerstone of modern psychiatry. It provides a shared lexicon for clinicians, guides treatment, enables research, and allows overstretched systems to function with necessary speed and consistency (Craddock & Mynors-Wallis, 2014). For many people, a diagnosis can provide relief by offering a coherent explanation for previously confusing distress, helping to reduce self-blame and uncertainty about one's experience (Schnell et al., 2021). I do not reject the value of diagnosis; in practice, I have witnessed how it can offer relief, structure, and access to care for people who were previously overwhelmed by uncertainty.

However, diagnosis is also an act of reduction. By necessity, it compresses complex human lives which are shaped by history, relationships, culture, trauma, and meaning into criteria and codes (Lane, 2020). In doing so, it risks becoming a form of psychological taxidermy: preserving outward "symptoms" while hollowing out the internal organs of meaning, story, and context. Once spoken, a diagnosis does not merely describe suffering; it begins to shape how a person is interpreted, remembered,

and treated. Literature demonstrates that severe mental health diagnoses are associated with increased stigma, discrimination, and social exclusion, including poorer employment

prospects and strained relationships (Kågström et al., 2025; Kirkbride et al., 2024). In this sense labels do not just describe illness, they change how people are valued in the real world (Mickelberg et al., 2024).

In my family member's case, the label quickly became louder than his story. Conversations shifted toward risk, compliance, and symptom counts rather than who he was or what he had lived through. What happened to him taught me that the danger is not diagnosis itself, but allowing it to become the dominant way we see a person. This dynamic is common in clinical settings. In handover and case discussions, individuals may be framed primarily by their diagnosis before clinicians have the opportunity to know them as people. Once clinicians know a diagnostic label, diagnostic overshadowing can occur, whereby symptoms are attributed to an established diagnosis and other causes are overlooked (Cunningham et al., 2023; Hallyburton, 2022). According to Van der Heijden et al. (2022), confirmatory diagnostic strategies may also occur in clinical practice, whereby clinicians attend more closely to information that supports an initial diagnosis rather than investigating the broader meaning of a person's distress. After all, to fit a human life into criteria and codes, something must be simplified, compressed, or left out. What is lost is not trivial; it is meaning itself. Diagnosis can describe illness, but it cannot explain a life.

Context, Trauma, and Culture

The limits of diagnosis are most visible in the landscape of trauma. Trauma does not respect diagnostic boundaries; it is embodied and enduring, continuing to shape how people experience safety, trust, identity, and connection long after the original harm has passed (D'Andrea et al., 2011). International research suggests that a large proportion of people presenting to mental health services have experienced significant trauma, yet traditional diagnostic frameworks frequently fail to capture its full impact on behaviour and distress (Hennessy et al., 2023; Lu et al., 2022). As a result, behaviours that appear "disordered" in a sterile clinic were often, in their original context, necessary strategies for survival. Hypervigilance may have saved a life; emotional withdrawal may have made unbearable pain tolerable. When psychiatry focuses narrowly on diagnosis, it risks mistaking these adaptive shields for inherent pathology.

To see the whole person is to accept a radical truth: distress often makes sense; not in spite of its intensity, but because of it. A trauma-informed approach shifts care from control to understanding, reframing behaviour as meaningful rather than simply symptomatic (Sweeney et al., 2018). This shift is particularly important in Aotearoa New Zealand, where Māori and Pasifika perspectives conceptualise mental health as a relational ecosystem, inseparable from whānau, culture, spirituality, and whenua (Suaalii-Sauni et al., 2009; Wilson et al., 2021). Te Whare Tapa Whā reminds us that if the walls of the whare are shaking, we do not only inspect the individual timber; we look to taha whānau, taha wairua, and connection to land (Durie, 1998; Purdy, 2020).

Despite this, western diagnostic systems remain rooted in individualism, often locating the problem exclusively within the individual rather than within systems, relationships, or historical context (Kirmayer, 2012). In Aotearoa, Māori experience disproportionately higher psychological distress and poorer access to culturally appropriate services compared with non-Māori populations (Russell, 2018; Williams et al., 2018). When diagnostic frameworks are applied without an understanding of culture and history, they

risk obscuring the legacies of colonisation, intergenerational trauma, and structural inequity, locating distress within the individual rather than recognising its roots in systemic injustice (Bredstrom, 2019; Wahine, 2015;

Wilson et al., 2021). When we pathologise a person without acknowledging the history of their land and lineage, we are not healing them; we are silencing the context of their pain.

Ethics, Power, and Recovery

Diagnosis carries significant authority. It does not merely describe; it also prescribes. It shapes how behaviour is interpreted, how expectations are calibrated, and how relationships unfold within clinical settings (Timimi, 2011). In some circumstances, a diagnosis can justify coercive treatment or involuntary care, making it one of the most powerful tools in medicine (Silva et al., 2023). When diagnostic certainty is privileged over lived experience, care risks becoming something done to people rather than with them, reducing individuals to passive recipients of management rather than active partners in healing.

Seeing the whole person therefore requires clinical humility; the recognition that the person in question is the world's leading expert on what it is like to be them. This does not mean rejecting clinical expertise; it means balancing it with lived experience through genuine shared decision-making. Evidence consistently shows that collaborative decision-making improves therapeutic alliance, treatment adherence, and satisfaction with care (Hoque, 2024; Opland & Torrico, 2024). It also reduces power imbalances that can otherwise alienate patients from services (Trinh et al., 2020).

Importantly, seeing beyond diagnosis does not reject evidence-based care. Rather, it situates diagnosis within relationship, context, and meaning. Recovery-oriented models which prioritise hope, agency, and lived experience have shown to be associated with better engagement with services, greater sense of control, and improved quality of life, even when symptoms persist (Frost et al., 2017; Martinelli et al., 2019). In community settings, recovery-oriented practice has been linked to reduced hospital admissions and better long-term functioning (Mousavizadeh et al., 2023).

Recovery must therefore be understood more broadly than symptom reduction. Recovery is not merely the absence of a p-value or a checklist item; it is the presence of agency and self-authorship. For one person, recovery may mean returning to work. For another, it may mean the restoration of their mana or reconnection with their pepeha. For many, it simply means being recognised again as fully human rather than as a diagnosis walking into a room. Even within stretched, underfunded systems, how clinicians choose to see people remains a moral decision. When care is relational rather than purely technical, people are more likely to stay engaged, trust services, and experience dignity within treatment (Wampold & Flückiger, 2023).

Conclusion

For the family member I began this essay with, the greatest loss was not only his illness; it was how quickly language reshaped him in the eyes of others. I learned to look past the diagnosis, to remember his quiet kindness, his care for others, and the experiences

that shaped his distress. I began to understand that his pain was not his identity, but part of his story.

Psychiatry does not fail when it names suffering. It fails when the name becomes the destination. To see the whole person beyond the diagnosis is not a sentimental ideal; it is an ethical obligation. When psychiatry holds together scientific rigour, cultural humility, trauma-informed care, and respect for lived experience, it does more than treat illness. It restores dignity. When we look past the diagnosis to the person, their history, and their strength, we deepen care and uphold the ethical integrity of psychiatry itself.

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