Rising Mental Health Diagnoses and the Boundary Between Recognition and Overdiagnosis

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Abstract. Recorded diagnoses of autism spectrum disorder, attention deficit hyperactivity disorder, and other mental health conditions have risen sharply, prompting disagreement over whether clinicians are recognising previously missed needs or medicalising ordinary variation. This paper argues that these explanations are not mutually exclusive. It first separates overdiagnosis from misdiagnosis and underdiagnosis, then distinguishes two pathways to overdiagnosis: overdefinition, in which diagnostic boundaries extend to people unlikely to benefit from a disorder label, and overdetection, in which screening identifies mild or transient abnormalities that would not cause sustained harm. Evidence on women, adults, and culturally diverse populations shows that broader knowledge and access can correct longstanding recognition gaps. At the same time, ambiguous impairment thresholds, unstable early childhood presentations, cognitive and attributional biases, social media misinformation, and institutional incentives can increase false positive or low benefit diagnoses. ADHD provides the clearest integrative example because recognition gaps coexist with relative age effects, changing symptom thresholds, and uncertainty at the boundary between development and disorder. The paper concludes that diagnosis counts cannot establish either progress or excess. A defensible judgement should instead consider symptom persistence, functional impairment, agreement across informants and settings, likely benefit from intervention, and plausible developmental, cultural, or social explanations. Services should offer needs based support without making a diagnostic label the sole gateway to help.

Keywords: Overdiagnosis, recognition, ADHD, autism, mental health literacy, medicalisation.

1. Introduction

1.1 Rising Diagnoses and Public Controversy

Recorded rates of autism spectrum disorder, attention deficit hyperactivity disorder, and several common mental health conditions have increased over recent decades. In autism surveillance, for example, reported prevalence has risen while the age and sex distribution of diagnosis has also changed (Fyfe et al., 2026). ADHD diagnoses have likewise become more common in many settings, alongside greater public attention and changing clinical criteria (Abdelnour et al., 2022). These shifts are often presented as evidence of one of two incompatible stories. One story describes overdue recognition: people whose needs were previously dismissed can now name their difficulties and seek appropriate support. The other describes excess: ordinary variation and situational distress are increasingly converted into disorders.

Neither story can be assessed from diagnostic growth alone. A rise in recorded cases can reflect a change in the underlying prevalence of a condition, improved recognition of previously missed cases, broader access to assessment, altered criteria, increased false positives, or several processes operating at the same time. Public discussion often moves too quickly from a higher count to a moral conclusion. Critics may treat any increase as proof of medicalisation, while defenders may assume that every additional diagnosis represents a corrected injustice. Both inferences exceed the available evidence.

The stakes are practical as well as conceptual. Underdiagnosis can delay treatment, education support, and self understanding. Overdiagnosis can expose people to unnecessary intervention, stigma, adverse expectations, or a fixed illness identity that does not fit the course of their difficulties. It can also direct scarce specialist time toward people with mild or transient problems while those with

severe and persistent impairment wait for care. A balanced analysis therefore needs to protect access without treating diagnostic expansion as automatically beneficial.

1.2 Research Question and Argument

This paper asks: to what extent does the recent growth in mental health and neurodevelopmental diagnoses reflect better recognition, and under what conditions does that growth become overdiagnosis? It offers a conceptual review guided by selected empirical and policy evidence, with ADHD as the main integrative case. The paper does not estimate a single population rate of overdiagnosis because the literature lacks a consistently applied definition and adequate measurement for that task (Thombs et al., 2019). Instead, it identifies the conditions under which a diagnosis is more likely to represent corrected recognition or low benefit classification.

The central argument is that better recognition explains a substantial part of diagnostic growth, especially among women, adults, and people whose symptoms do not match older prototypes. Overdiagnosis remains a credible concern at the boundary of disorder, particularly when diagnostic definitions expand without clear impairment thresholds, screening results are treated as final diagnoses, or cognitive and institutional pressures encourage clinicians and families to interpret transient or contextual problems as fixed pathology. The most useful question is therefore not whether diagnosis has become generally too common. It is whether a particular diagnostic pathway identifies persistent impairment and leads to a net benefit that could not be achieved as well through lower intensity or nonmedical support.

2. Clarifying the Debate

2.1 Overdiagnosis Misdiagnosis and Underdiagnosis

The term overdiagnosis is frequently used to describe different problems. In a meta research review of 164 mental health articles, Thombs et al. (2019) identified 193 explicit or implicit uses of the term, but only 11.4 percent were consistent with accepted definitions based on overdefinition or overdetection. Most uses instead concerned misdiagnosis. This inconsistency matters because each problem has a different cause and requires a different remedy.

Misdiagnosis occurs when a person has a clinically significant problem but is placed in the wrong diagnostic category. The appropriate response is better differential assessment. Underdiagnosis occurs when a person who meets relevant criteria and could benefit from recognition is not identified. The appropriate response is improved access, awareness, and clinical sensitivity. Overdiagnosis is different. A person may meet the rules used in practice, yet the detected abnormality may be too mild, transient, or uncertain to cause sustained harm, or the category may have expanded to include people for whom diagnosis and treatment are unlikely to produce net benefit (Brodersen et al., 2018).

The distinction also prevents one group from being used to cancel another. Evidence that some women with ADHD were historically overlooked does not show that every contemporary ADHD diagnosis is accurate. Evidence that some preschool symptoms remit does not show that ADHD is unreal or that early support is unnecessary. Underdiagnosis and overdiagnosis can coexist because they may affect different people, settings, and points along a diagnostic continuum.

2.2 Overdefinition and Overdetection

Brodersen et al. (2018) identify two principal pathways to overdiagnosis. Overdefinition changes the boundary of disease. It can occur when symptom thresholds are lowered, categories are broadened, or functional impairment is described so vaguely that common experiences qualify as disorder. Overdetection concerns what is found rather than how the category is written. Screening may identify a real feature, but that feature may never persist, cause meaningful harm, or require medical intervention.

These pathways can overlap. A broad definition increases the number of mild cases that a sensitive screening process can detect. Conversely, frequent screening can create pressure to interpret

borderline findings as clinically meaningful. Yet neither pathway is identical to a false positive on a single test. Overdiagnosis is ultimately about the relationship between a label, the future course of the condition, and the balance of benefit and harm.

Table 1. Conceptual Distinctions in the Diagnostic Debate

Concept	Core question	Typical evidence	Main risk	Appropriate response
Underdiagnosis	Is a person with persistent impairment being missed	Unmet need, delayed diagnosis, barriers to assessment, group disparities	Continued impairment without support	Improve access, recognition, and culturally responsive assessment
Misdiagnosis	Has a clinically significant problem been assigned to the wrong category	Differential diagnosis, longitudinal reassessment, inconsistent symptom pattern	Incorrect treatment and misunderstanding of need	Reassess alternatives and comorbidity
Overdefinition	Does the diagnostic boundary include mild or ambiguous cases unlikely to benefit	Threshold changes, weak impairment criteria, low agreement at the boundary	Low benefit labels and unnecessary intervention	Clarify impairment and net benefit thresholds
Overdetection	Has screening found a real but transient or harmless abnormality	Longitudinal follow up, spontaneous remission, low predictive value	Premature labelling and overtreatment	Monitor over time before confirming diagnosis

2.3 Why the Distinction Matters

At the individual level, an inaccurate or low benefit diagnosis can alter self interpretation, family expectations, and social relationships. Treatment can create adverse effects, and expectations can contribute to nocebo responses, although evidence about nocebo effects in psychotherapy should not be treated as proof that diagnosis itself necessarily causes harm (Locher et al., 2019). At the service level, rising referrals can lengthen waiting lists and increase pressure on clinicians. The 2025 NHS England ADHD Taskforce described serious gaps in timely assessment and support while also recommending that services monitor both underdiagnosis and overdiagnosis (NHS England, 2025).

The proper response is not diagnostic restriction for its own sake. A system designed only to reduce case numbers may recreate the exclusion that better recognition has begun to correct. The aim should be diagnostic precision combined with support that does not depend entirely on a formal label. This principle becomes clearer when the evidence for improved recognition is considered first.

3. The Case for Better Recognition

3.1 Awareness Help Seeking and Access

Greater awareness can increase diagnoses without increasing the underlying frequency of a condition. Public campaigns, school information, popular culture, and online communities give people concepts with which to interpret persistent difficulties. They can also reduce shame and make professional help more acceptable. Abdelnour et al. (2022) describe increased public interest in ADHD alongside changing diagnostic practice. Search trends and social media attention cannot establish true prevalence, but they can indicate that more people recognise the term and consider seeking assessment.

Access also shapes what is recorded. Diagnostic numbers rise when more clinicians are trained, referral routes become clearer, and adults are able to seek assessment for problems that began earlier

in life. The NHS England ADHD Taskforce attributes increased demand to several factors, including greater awareness, prior missed diagnosis, recognition of ADHD across the life course, and the practical role that diagnosis can play in obtaining support (NHS England, 2025). In this context, more referrals may reveal needs that already existed rather than create them.

Awareness is nevertheless an entry point, not a validation procedure. A person may correctly recognise a pattern, partially recognise it, or adopt a label that feels explanatory but does not survive clinical assessment. Better recognition therefore depends on access to careful evaluation rather than on publicity alone.

3.2 Broader Criteria as Corrective Recognition

Broader diagnostic criteria are sometimes treated as direct evidence of overdefinition. That conclusion is too simple. Earlier categories may have been based on narrow prototypes and may have excluded people with substantial impairment. DSM-5 lowered the ADHD symptom threshold to five for people aged 17 years and older, raised the required age of onset from before 7 to before 12, and permitted ADHD and autism spectrum disorder to be diagnosed together (Abdelnour et al., 2022). These changes broadened diagnostic recognition across age and co-occurring conditions. Broader criteria can therefore improve validity when they capture persistent impairment that older rules missed.

The same change can also create risk at the boundary. If a category accommodates more varied presentations but does not specify how much impairment is clinically meaningful, clinicians may agree on core cases while disagreeing on mild ones. Expansion is corrective when it improves identification of people who experience sustained difficulties and benefit from support. It becomes overdefinition when inclusion is driven mainly by common symptoms, uncertain impairment, or access rules that make diagnosis the only route to assistance.

3.3 Historical and Cultural Under Recognition

Sex and age patterns show why diagnostic growth can represent correction. Reviews of adult ADHD report different prevalence and clinical effects by sex, while database evidence indicates that depression and anxiety can complicate the timing and subtype of ADHD diagnosis in women (Faheem et al., 2022; Siddiqui et al., 2024). The NHS England Taskforce also identifies females as a group affected by previous missed or misdiagnosis (NHS England, 2025). These findings are consistent with the possibility that more visible hyperactivity shaped older prototypes, leaving quieter inattentive or internalising presentations less likely to be recognised.

Autism offers a related example. Population based data show that the male to female ratio in autism diagnosis changes across age and birth cohorts (Fyfe et al., 2026). Such trends do not prove that every later diagnosis is correct, but they weaken the assumption that older diagnostic ratios represented an unbiased biological constant. Diagnostic systems learn from the populations they have previously seen. If those populations are unrepresentative, greater inclusion can improve recognition rather than merely inflate prevalence.

Culture adds another layer. Symptoms are not reported in a social vacuum, and clinicians interpret the form in which distress is expressed. Ryder et al. (2008) compared Chinese and Euro Canadian outpatients with depression using spontaneous reports, interviews, and questionnaires. Chinese patients reported more somatic symptoms in spontaneous reports and interviews, while Euro Canadian patients reported more psychological symptoms across the measures. The study cautions against a crude stereotype that one culture simply somatises and another does not. Its broader implication is that a diagnostic interview centred on one culturally familiar vocabulary may miss distress expressed through another.

Culturally responsive assessment should therefore ask how distress is described, what meanings a family attaches to symptoms, and which forms of impairment are visible in the person's setting. This approach can reduce under recognition without lowering standards. Cultural sensitivity is not an instruction to assume pathology whenever someone uses a different idiom of distress. It is a reason

to examine symptoms, context, and function before deciding whether a psychiatric category is the best explanation.

3.4 Interim Judgement

The evidence for recognition gaps makes one conclusion unavoidable: rising diagnoses cannot be treated as a single block of overdiagnosis. Some increase reflects people reaching services after years of unmet need, and some reflects diagnostic models becoming less dependent on a narrow childhood, male, or culturally specific prototype. Yet inclusion remains valuable only when it predicts sustained impairment and guides useful support. The analysis must therefore move from the size of a category to the mechanisms that can produce low benefit diagnoses within it.

4. Mechanisms of Overdiagnosis

4.1 Diagnostic Subjectivity and Overdefinition

Mental health diagnosis generally relies on patterns of reported and observed experience rather than on a single definitive laboratory test. This does not make diagnosis invalid, but it places greater weight on symptom description, functional impairment, context, and clinical judgement. Gascon et al. (2022) conclude that the current formulation of ADHD diagnostic criteria, clinical practices, and an inordinate focus on performance may contribute to inflated prevalence rates. Clinical flexibility may be necessary because impairment differs across settings, but it can weaken reliability at the boundary.

Common symptoms make the boundary particularly difficult. Inattention, restlessness, low mood, and anxiety occur in clinical and nonclinical populations. The diagnostic task is not simply to detect their presence. It is to establish their pattern, duration, developmental appropriateness, cross situational consistency, and effect on functioning. When these dimensions are compressed into a symptom checklist, a broad definition may classify people whose difficulties are mild, temporary, or better explained by sleep, stress, learning needs, family conditions, or another disorder.

Evidence from Australian birth cohorts illustrates the need to separate symptoms from labels. Kazda et al. (2023) found that cumulative incident ADHD diagnoses increased from 4.6 percent in an earlier cohort to 5.6 percent in a later cohort while parent reported hyperactive and inattentive behaviour scores remained stable. Among diagnosed children, 26.5 percent had prediagnosis behaviour scores in the normal range. These findings do not identify each case as overdiagnosed because rating scales cannot replace full assessment. They do show that growth in diagnostic practice can occur without parallel growth in the measured behaviours and that the threshold between ordinary and clinical variation deserves direct study.

4.2 Early Screening and Overdetection

Early screening can be beneficial when it identifies children who need observation, educational adjustment, family support, or specialist assessment. Its value is greatest when it functions as an initial signal rather than a final label. Screening measures are designed to be sensitive and therefore accept some false positives. Problems arise when a positive screen is treated as a confirmed disorder or when uncertainty is hidden from families.

Developmental change is central to this risk. Overgaard et al. (2023) followed children from age three to age eight and found limited stability in some preschool ADHD classifications. Of the children classified by parents as having a hyperactive impulsive presentation at age three, 71 percent were no longer classified within any ADHD presentation at age eight. Parent teacher agreement was also low to moderate for symptom counts and very low for classified presentations. The authors therefore recommended caution in communicating concern about preschool hyperactivity and impulsivity.

This evidence supports staged assessment, not the rejection of early help. A child can benefit from support even when a long term diagnosis remains uncertain. Monitoring across time and settings allows clinicians to identify persistence while avoiding a fixed identity based on a transient

developmental phase. The distinction between support and diagnosis is especially important where families or schools believe that no assistance is available without a label.

4.3 Cognitive and Attributional Biases

Diagnostic decisions are influenced by how adults explain behaviour. Parents and teachers may attribute inattention or activity to a disorder, to developmental immaturity, to classroom demands, or to stress. These interpretations affect which children are referred and what information reaches a clinician. Relative age research provides a concrete example. In a large Canadian study, children who were younger than classmates in the same school year were more likely to receive an ADHD diagnosis and medication (Morrow et al., 2012). The association does not prove that the diagnoses were wrong. It shows that behaviour judged against older classmates can be mistaken for behaviour judged against an age appropriate developmental standard.

Once a diagnostic possibility is raised, confirmation bias can shape attention. Adults may notice behaviour that fits the suspected category and discount situations in which the child functions well. A clinician may also anchor on a referral question and give insufficient weight to alternative explanations. These are risks of reasoning, not accusations of bad faith. They are best addressed through structured differential assessment, information from more than one observer, examples from different settings, and deliberate attempts to identify disconfirming evidence.

Social media can intensify this process by supplying highly available symptom narratives. Yeung et al. (2022) examined the 100 most popular English language TikTok videos about ADHD and classified 52 percent as misleading, 27 percent as personal experience, and 21 percent as useful. The study does not show that viewing a video causes a diagnosis. It does show that many people encounter vivid, simplified claims before entering assessment. Broad statements such as identifying with procrastination or distraction can encourage self labelling because the experiences are common and personally recognisable.

Self recognition can be the first step toward legitimate help, particularly for people missed by older stereotypes. The safeguard is not to ridicule self diagnosis. It is to distinguish a hypothesis from a clinical conclusion. A useful assessment asks what evidence would count against the proposed diagnosis, whether impairment is persistent across contexts, and whether another explanation better accounts for the pattern.

4.4 Institutions Medicalisation and Concept Creep

Diagnostic growth also reflects the institutions in which decisions are made. Schools need ways to allocate accommodations. Health systems need categories for referrals and reimbursement. Families may need documentation to secure support. When resources depend on diagnosis, ordinary differences and genuine needs alike are channelled toward medical classification. The NHS England Taskforce responds to this problem by recommending that early support for neurodivergence should be needs led and should not require a clinician provided diagnosis (NHS England, 2025).

Medicalisation and psychiatrization describe a wider shift in which more human difficulties are interpreted through medical language. Beeker et al. (2021) present psychiatrization as a multilevel process involving concepts, institutions, and everyday self understanding. Haslam et al. (2021) connect this process with concept creep, in which psychological categories expand to cover a broader range of experiences. These frameworks help explain why diagnostic language can spread even without a deliberate plan by any single profession or industry.

The shift has benefits. A medical explanation can replace moral blame, validate suffering, and open access to care. It can also narrow attention to individual pathology when classroom design, economic insecurity, discrimination, family stress, or normal developmental variation contributes to the problem. A diagnosis is most useful when it adds explanatory or practical value rather than simply renaming distress.

Table 2. ADHD Evidence Across Recognition and Overdiagnosis Pathways

Pathway	Evidence	What the evidence supports	What it does not establish	Practical safeguard
Corrective recognition	Greater awareness, life course recognition, and previously missed female presentations described in reviews and NHS policy evidence	Some diagnostic growth represents unmet need entering services	Every new referral or diagnosis is valid	Preserve access and assess impairment carefully
Overdefinition	Diagnosis increased across cohorts despite stable behaviour scores, with some diagnosed children scoring in the normal range before diagnosis (Kazda et al., 2023)	Diagnostic thresholds and practice changed independently of measured behaviour trends	A case level estimate of overdiagnosis	Report functional impairment and alternatives, not symptoms alone
Overdetection	Many preschool hyperactive impulsive classifications did not persist to age eight (Overgaard et al., 2023)	Some early presentations are unstable	Early support is unnecessary	Use staged assessment and longitudinal monitoring
Developmental attribution	Younger children within a school year were more likely to be diagnosed and treated (Morrow et al., 2012)	Relative maturity affects referral and diagnosis	All diagnoses in younger pupils are errors	Compare behaviour with age appropriate expectations
Information and confirmation bias	Popular TikTok ADHD content often included misleading generalisations (Yeung et al., 2022)	Preassessment information can be inaccurate and highly salient	Social media directly causes overdiagnosis	Treat self diagnosis as a hypothesis and seek disconfirming evidence

4.5 ADHD as an Integrative Case

ADHD demonstrates why a binary answer fails. Greater recognition has helped women, adults, and people with less stereotypical presentations reach assessment. Broader life course criteria can describe persistent difficulties that childhood centred models ignored. At the same time, symptoms lie on a continuum, preschool presentations may change, relative age affects adult judgements, and public narratives can make common experiences seem diagnostic.

The same person may also encounter several mechanisms in sequence. A social media account may provide a useful vocabulary, a school may encourage referral, a screening scale may produce a high score, and a clinician may then decide whether the pattern is persistent and impairing. None of the first three steps proves either disease or overdiagnosis. The quality of the final judgement depends on whether the assessment integrates developmental history, multiple informants, context, comorbidity, alternative explanations, and likely benefit from intervention.

5. Discussion and Conclusion

5.1 A Layered Answer

The increase in mental health and neurodevelopmental diagnoses is partly better recognition and partly a product of diagnostic expansion and detection practices. The balance varies by population and setting. Among groups whose difficulties were historically interpreted through narrow male, childhood, or culturally specific prototypes, growth can represent correction. Among mild, short lived, or highly contextual presentations, the risks of overdefinition and overdetection are greater.

Institutional rules influence both patterns by determining who is referred and whether a label is required for support.

This layered account explains why prevalence or diagnosis counts cannot settle the debate. Four questions are more informative. First, are symptoms persistent across time rather than limited to a temporary developmental or stressful period? Second, do they produce meaningful functional impairment across relevant settings? Third, do independent sources of information converge while plausible alternatives have been examined? Fourth, is diagnosis likely to improve outcomes through treatment, accommodation, understanding, or access to support? A diagnosis that meets a checklist but fails these tests may have limited value even if it is technically permissible.

The framework also changes the ethical question. The aim is not to maximise or minimise diagnoses. It is to identify people for whom a clinical formulation will produce more benefit than harm while providing proportionate support to others. This standard respects the reality of mental illness without assuming that every difference requires a medical identity.

5.2 Implications for Research Assessment and Services

Research should use a clear definition of overdiagnosis and separate it from misdiagnosis, false positive screening results, and overtreatment. Studies should report how impairment thresholds were applied, where participants came from, and whether symptoms persisted. Longitudinal designs are especially important because overdiagnosis cannot be inferred reliably from a cross sectional disagreement between a checklist and a clinical label.

Clinical assessment should combine developmental history, information from more than one setting, and explicit differential diagnosis. Borderline cases deserve more, not less, attention to context. Clinicians can reduce confirmation bias by documenting evidence that supports the diagnosis, evidence that conflicts with it, and the reasons alternatives were rejected. Cultural formulation should examine how a person describes distress and how family or community meanings affect help seeking, without turning cultural difference into either pathology or a reason to withhold care.

Screening pathways should preserve the distinction between a positive result and a confirmed diagnosis. When risk is uncertain, follow up and low intensity support may be more appropriate than immediate labelling or medication. Service design should also reduce the pressure to diagnose by making educational and psychological support available on the basis of need. This approach is consistent with the NHS England Taskforce recommendation that support should begin early and should not depend on clinical diagnosis (NHS England, 2025).

5.3 Mental Health Literacy and Education

Young people need mental health literacy that supports action without teaching them to convert every difficult feeling into a disorder. Jorm (2012) defines mental health literacy broadly as knowledge linked to recognition, prevention, help seeking, self help, and support for others. In schools and online environments, this education should explain the difference between ordinary distress, a screening signal, and a clinical diagnosis. It should also make clear that uncertainty does not invalidate suffering and that help can begin before a final label is reached.

For adolescents, the most responsible message combines two commitments. Persistent impairment deserves attention, and asking for help should not require shame. At the same time, a familiar symptom list is not a complete diagnosis, and identities formed around an online description should remain open to revision. Teaching students how to evaluate sources, notice confirmation bias, and consider developmental and cultural context can improve help seeking while reducing unnecessary labelling.

6. Conclusion

Rising diagnosis is neither a simple triumph of awareness nor straightforward proof of medical excess. Better recognition has corrected real exclusions, while overdefinition, overdetection,

cognitive bias, and institutional pressure can still create diagnoses with uncertain benefit. ADHD shows how these processes can operate within the same category and even within the same diagnostic pathway.

The most defensible boundary is based on persistence, functional impairment, converging evidence, and expected net benefit. Medical intervention should be concentrated where these conditions are strongest. People outside that boundary should not be abandoned; they may need educational adjustment, social support, brief psychological help, or time and monitoring. A system that can offer support without forcing every difficulty into a diagnosis is better equipped to recognise serious need and less likely to pathologise ordinary human variation.

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