

The Flood or the Faucet: Overdiagnosis, Underrecognition, and the Rising Tide of Mental Health Diagnoses in High-Income Countries

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ABSTRACT

Over recent decades, diagnostic rates for conditions including depression, attention-deficit/hyperactivity disorder (ADHD), and autism have risen sharply across high-income countries, prompting debate over whether the increase represents overdiagnosis (the pathologizing of normal distress) or the overdue recognition of suffering that earlier systems failed to detect. This narrative review synthesizes epidemiological, clinical, and public-health literature across three thematic axes to weigh the competing explanations. Because rising diagnoses have been indexed by heterogeneous measures, the review defines its primary outcome as the change in diagnostic rates and distinguishes it from related constructs (symptom prevalence, treatment access, severity, and population burden), specifying how each evidence type bears on the question. First, it examines evidence that diagnostic instruments historically calibrated on narrow demographics rendered large populations (women with autism, racial and ethnic minorities, and the stigma-deterred) invisible to clinicians, producing decades of underrecognition now being corrected. Second, it considers data indicating that the psychological environment has measurably deteriorated, drawing on rising suicide mortality, converging adolescent indicators after 2010, the erosion of protective social infrastructure, and the pandemic-associated surge in depression and anxiety. Third, it identifies the specific domains in which overdiagnosis is genuine, most notably the relative-age effect in ADHD and pharmaceutical demand effects, while weighing meta-analytic evidence that diagnostic criteria have not, on average, broadened across editions of the Diagnostic and Statistical Manual. Taken together, the reviewed evidence indicates that although overdiagnosis is real in identifiable corners of the system, corrected underrecognition and genuine environmental deterioration appear to account for a larger share of the observed increase. Rising rates are thus more consistent with a system beginning to detect previously unmet need than with widespread diagnostic excess, although the two processes are not mutually exclusive.

Keywords: overdiagnosis; underrecognition; mental health epidemiology; diagnostic criteria; stigma; ADHD; autism

INTRODUCTION

Every society draws a line between suffering that is normal and suffering that requires intervention. Where that line falls depends not only on biology but on culture, access, and the diagnostic tools available to measure distress. When those tools improve, or when

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the conditions producing distress change, more people inevitably cross the threshold, and the question becomes whether the increase reflects a shift in well-being or merely a shift in measurement. Over the past several decades, diagnostic rates for conditions ranging from depression to attention-deficit/hyperactivity disorder (ADHD) to autism have risen sharply across high-income countries, igniting precisely this debate.

The stakes of attributing this increase to one cause or another are not academic. Overdiagnosis (the application of a clinical label to distress that would resolve without intervention) exposes otherwise healthy individuals to unnecessary medication, stigma, and the iatrogenic harms of treatment. Underdiagnosis leaves genuinely ill people to suffer without support, often until their conditions escalate into crisis. Each error carries a moral and economic cost, and the two are not symmetrical: a system can simultaneously overdiagnose some populations and underdiagnose others, which is precisely what the evidence reviewed here suggests.

Because rising mental-health diagnoses have been indexed by heterogeneous and non-interchangeable measures, this review specifies its primary outcome explicitly. The primary outcome of interest is the secular change in diagnostic rates, that is, the incidence with which clinicians assign mental-disorder diagnoses in a population over time; the interpretive question is whether the observed rise reflects overdiagnosis or the correction of prior underrecognition.

Several related but distinct constructs bear on that outcome only indirectly, and the review treats each accordingly. Symptom prevalence, typically self-reported, indexes underlying morbidity and can diverge from clinician-assigned diagnosis and is therefore central to debates over whether greater awareness inflates self-reported rates. Treatment utilization and unmet need index access to care, an upstream gate to diagnosis, so that a failure to receive treatment does not by itself establish a failure to be diagnosed. Suicide mortality indexes severity at the fatal extreme, so that rising mortality constrains rather than directly measures the diagnostic trend. Disability-adjusted life-years index population burden, and a rising burden does not by itself demonstrate that higher diagnostic rates reflect improved recognition. Social isolation indexes an environmental risk factor upstream of illness rather than a diagnosis. Each class of evidence is accordingly interpreted as bearing specifically on diagnosis, prevalence, severity, access to care, or population burden, rather than as an interchangeable proxy for the diagnostic rate.

Any assessment must begin with the scale of unmet need. Even within high-income countries, only one in three people with depression receive formal care, while worldwide an estimated seventy-one percent of people with psychosis receive no mental health services at all, a figure cited here only as global background for scale (1). Treatment access and diagnosis are not identical (a person may be diagnosed yet untreated, or distressed yet never assessed), so utilization data bear on access to care rather than directly on recognition; even so, gaps of this magnitude indicate that mental-health systems have historically failed to recognize far more suffering than they could plausibly have invented.

The scale of that unmet need is matched by the scale of the underlying burden. Globally, the Global Burden of Disease 2019 study found that disability-adjusted life-years (DALYs) attributable to mental disorders rose from 80.8 million in 1990 to 125.3 million in 2019, with mental disorders' share of total global burden climbing from 3.1 percent to 4.9 percent and showing no measurable decline across three decades (2). These burden estimates are global and are cited here only as background; they index population burden rather than diagnostic behavior. They nonetheless frame the central question, since a burden that is large, rising, and substantially unrecognized is not, on its face, a plausible candidate for a phenomenon driven primarily by overdiagnosis.

This review synthesizes epidemiological, clinical, and public-health literature to weigh the overdiagnosis hypothesis against the alternative explanation of corrected underrecognition. In scope, this review concerns high-income countries, where the diagnostic increase and the debate over its interpretation are best documented and where evidence from the United States predominates; global and low- and middle-income data are cited only as background context and are flagged as such. Rather than conducting an exhaustive systematic search, it organizes the most methodologically informative evidence around three themes: the historical invisibility of populations outside the demographic on which diagnostic tools were calibrated; the measurable deterioration of the psychological environment; and the specific, documented domains in which overdiagnosis is genuine. The central argument that emerges is that while overdiagnosis exists in identifiable pockets, the weight of evidence shows that rising diagnostic rates largely reflect a long-overdue correction of historical neglect, compounded by environmental conditions that have made modern life genuinely harder on the human psyche.

THE SCALE OF HISTORICAL UNDERRECOGNITION

A central argument against the overdiagnosis narrative concerns the number of people who were missed for decades, not because their conditions were absent, but because the instruments designed to detect them were built too narrowly. Consider autism in women. The historical male-to-female diagnostic ratio of four-to-one was long treated as a biological fact, yet a systematic review and meta-analysis by Loomes, Hull, and Mandy found that methodologically rigorous studies (those using active case-finding rather than relying on existing clinical records) yield a ratio closer to three-to-one (3). The discrepancy implies that a substantial population of autistic women was effectively invisible to clinicians whose diagnostic criteria had been calibrated almost entirely on male presentations. When these women are accurately diagnosed in adulthood, frequently after years of being mislabeled with anxiety, eating disorders, or borderline personality disorder, the new diagnosis does not manufacture a disorder; it identifies one that was genuinely present but previously undetected: an instance of corrected underrecognition rather than overdiagnosis.

The mechanism behind this invisibility has itself been documented. In a qualitative study of late-diagnosed autistic women, Bargiela, Steward, and Mandy described systematic “camouflaging” (consciously masking autistic traits by mimicking peers, scripting social interactions, and adopting a studied persona of normality), which, compounded by clinicians’ gendered expectations of how autism presents, repeatedly led professionals to miss the diagnosis well into adulthood (4). Camouflaging is not the absence of autism but its concealment, and when these women are finally recognized, the diagnosis corrects a decades-long failure of detection rather than inventing a disorder. The female autism phenotype thus illustrates the general principle in miniature: a population systematically filtered out by instruments and expectations calibrated on someone else.

The broader pattern, diagnostic tools calibrated on a narrow demographic and then failing everyone outside it, extends well beyond autism. The Kaiser Family Foundation reports that thirty-nine percent of Black adults and thirty-six percent of Hispanic adults reporting fair or poor mental health received any mental health services in the past three years, compared with fifty percent of White adults (5). These gaps reflect multiple intersecting factors, from insurance barriers to cultural preferences for non-clinical coping, and should not be

attributed solely to diagnostic failure. Yet they indicate that entire communities face structural obstacles to even entering the clinical system, the threshold at which recognition becomes possible at all.

Critics who argue that previous generations endured greater hardship without psychiatric labels often confuse silence with resilience. In a systematic review of quantitative and qualitative studies, Clement and colleagues found that stigma is a significant barrier to help-seeking, with men, youth, and ethnic minorities disproportionately deterred from pursuing clinical evaluation (6). Help-seeking barriers are admittedly distinct from diagnostic failures: a person who never enters the system because of stigma has not been misjudged by a clinician who never saw them. But this distinction reinforces rather than undermines the central point: the system cannot diagnose what it is never given the opportunity to see.

The most direct evidence that stigma, rather than the absence of illness, suppressed historical rates comes from a natural experiment in public disclosure. When several South Korean celebrities publicly disclosed their own panic disorder, diagnoses of panic disorder rose 775.6 percent above the projected baseline, while diagnoses of obsessive-compulsive disorder showed no comparable increase over the same period (7). The OCD comparison is analytically informative: if a cultural appetite for self-diagnosis or fashionable labeling were driving the surge, it should have inflated unrelated diagnoses as well. Instead, because licensed physicians diagnosed every patient in the study, the most parsimonious explanation is that disclosure reduced stigma and allowed an already-existing population of sufferers to seek and receive care. This interpretation aligns with longitudinal attitude data showing that, as mental health treatment seeking became more acceptable in and after the 2000s and the perceived stigma associated with it declined (8), the barrier that stigma posed to millions eroded, making an influx of diagnoses the predictable result rather than a sign of inflation. Together, these findings suggest that earlier generations’ lower diagnostic rates reflected the suppression of recognition, not the absence of illness.

A PSYCHOLOGICALLY HOSTILE ENVIRONMENT

Nor can rising diagnoses be dismissed as pure diagnostic drift when the environment itself has measurably worsened. Suicide rates in the United States climbed roughly thirty percent between 2002 and 2018

and reached nearly 49,500 deaths in 2022 (9). Suicide mortality speaks to the most severe end of the illness spectrum and does not directly resolve the boundary debate about milder presentations. However, it establishes a floor: a meaningful portion of the documented increase corresponds to genuine, fatal deterioration, which constrains how much of the overall rise can plausibly be attributed to diagnostic inflation alone. Fatal outcomes are not plausibly attributable to relabeled normality.

Among adolescents, Twenge and colleagues documented sharp increases in depressive symptoms, suicide-related outcomes, and completed suicides beginning after 2010, coinciding with the rapid diffusion of smartphones and new-media screen time (10). The evidentiary force of their analysis lies in convergence: depressive symptoms drawn from two nationally representative surveys, suicide-related outcomes from a separate surveillance system, and completed suicides from CDC mortality records all rose in tandem. Reporting biases or loosened clinical standards might inflate any single instrument, but they cannot independently produce matching spikes across methodologically distinct data sources at the same historical moment. Genuine deterioration is the most coherent explanation, and it undercuts the claim that rising adolescent diagnoses are mere artifacts of diagnostic fashion.

A further demonstration that the environment shapes diagnostic rates came with the COVID-19 pandemic. Modeling prevalence across 204 countries, Santomauro and colleagues estimated that in 2020 alone the pandemic was associated with a 27.6 percent increase in cases of major depressive disorder (MDD), an additional 53.2 million cases, and a 25.6 percent increase in anxiety disorders, an additional 76.2 million cases, with women and younger people most affected (11). This evidence is global rather than specific to high-income countries and is adduced here for the mechanism it demonstrates, namely that environmental deterioration produces genuine illness, rather than as a measure of the high-income diagnostic trend. An external shock of known timing produced a sudden, worldwide spike in two of the most commonly diagnosed conditions, yet no change in diagnostic criteria occurred in 2020 to manufacture it. The episode thus functions as a large-scale external shock, rather than a natural experiment in the strict sense, indicating that when conditions deteriorate, genuine illness, not merely its labeling, rises in step.

The hostility of the modern environment extends beyond acute shocks to the slow erosion of social life itself. The U.S. Surgeon General has declared

loneliness a public health epidemic, documenting that American participation in civic organizations, religious communities, and informal social gatherings has declined steadily for decades while the average number of close friendships has fallen sharply (12). Loneliness of this kind is a structural shift rather than a clinical one: the erosion of communal institutions, rising geographic mobility, and the migration of social life onto digital platforms have dismantled the social infrastructure that historically buffered individuals against psychological distress. Protective factors do not register in diagnostic manuals, but their disappearance is no less consequential for that. When an environment strips away its protective scaffolding at population scale, an increase in clinically significant suffering is the predictable result, not a measurement artifact. From rising suicide mortality and converging adolescent indicators to a pandemic-driven global surge and the documented collapse of social connection, the evidence indicates that a substantial share of rising diagnoses reflects real environmental deterioration.

WHERE OVERDIAGNOSIS IS GENUINE

Intellectual honesty demands acknowledging the domains in which overdiagnosis is real, even within a broader picture of underrecognition. The most compelling evidence concerns ADHD and what researchers term the relative age effect. A large study published in the *New England Journal of Medicine* found that children born in August (the youngest in their cohort under a September 1 enrollment cutoff) were thirty-four percent more likely to receive an ADHD diagnosis than their classmates born in September (13). In absolute terms, the diagnosis rate was 85.1 per 10,000 children among August births versus 63.6 per 10,000 among September births, and the excess appeared only in states that used the September 1 cutoff, precisely the pattern expected if the calendar, rather than the child, were driving the label. The most plausible interpretation is that within this age-cutoff population, ordinary developmental immaturity is being pathologized, as teachers and clinicians implicitly compare barely-five-year-olds with nearly-six-year-olds and read the difference as disorder. The finding does not indict ADHD as a category, nor the majority of diagnoses, but it exposes a clear pocket in which the system mistakes youth for illness.

Commercial pressures distort the picture further. In a randomized controlled trial published in *JAMA*, standardized patients presenting with adjustment

disorder (a condition that does not ordinarily warrant pharmacotherapy) received a prescription for a brand-name antidepressant fifty-five percent of the time when they specifically requested it, compared with ten percent when they made no request (14). Although the study is now two decades old, the underlying dynamic, in which patient demand shaped by marketing reshapes clinical judgment, has if anything intensified in an era of direct-to-consumer advertising and online health information. These are genuine failures that warrant targeted reform: better age-norming in ADHD screening, stricter regulation of pharmaceutical advertising, and more rigorous clinical training.

Beyond these specific mechanisms, the most substantial theoretical challenge to the underrecognition thesis holds that heightened awareness may itself generate apparent illness. The prevalence inflation hypothesis, articulated by Foulkes and Andrews, proposes that mental-health awareness efforts, while reducing stigma and improving recognition, may also lead some individuals to reinterpret transient or mild distress as symptoms of a disorder and to report it as such, inflating measured prevalence without a corresponding change in underlying pathology (15). A related account, Haslam's concept of "concept creep," documents how the semantic boundaries of harm-related concepts such as trauma, abuse, and mental disorder have gradually expanded to encompass milder phenomena, potentially lowering the implicit threshold at which ordinary experience is labeled pathological (16). These mechanisms are conceptually distinct from the diagnostic-criteria question: they operate through self-labeling and cultural framing rather than through formal revisions to the DSM, and they would be largely invisible to a meta-analysis of criterion stringency. They represent the most serious version of the overdiagnosis argument precisely because they could, in principle, drive rising self-reported rates even if clinician-applied criteria remained unchanged.

This challenge has empirical grounding in at least one contemporary domain. The rapid emergence of self-diagnosis facilitated by social media (illustrated by clusters of functional tic-like behaviors reported among adolescents who were heavy consumers of tic-related content during the pandemic) demonstrates that cultural transmission can shape symptom presentation and help-seeking in ways unrelated to any underlying neurodevelopmental disorder (17). The prevalence-inflation and concept-creep accounts are nonetheless bounded in important respects. They apply most forcefully to self-reported symptoms and to the mildest

presentations, rather than to the clinician-confirmed diagnoses, hospitalizations, and deaths that anchor much of the evidence reviewed above: the South Korean disclosure study counted only physician-assigned diagnoses, and suicide mortality is not susceptible to relabeling. Awareness may therefore inflate the mildest end of the distribution while leaving the moderate-to-severe end (where the largest treatment gaps persist) largely governed by genuine need. On this reading, overdiagnosis and underrecognition act predominantly on different segments of the severity spectrum rather than competing to explain the same cases, and a full account of rising rates must weigh both.

Yet documented pockets do not substantiate the sweeping claim that mental illness is, on the whole, overdiagnosed. The most direct test of that claim is whether diagnostic criteria themselves have systematically loosened over time. A 2020 meta-analysis by Fabiano and Haslam, reviewing 123 studies across consecutive editions of the Diagnostic and Statistical Manual, found an average diagnostic risk ratio of 1.00, meaning that, on average, revisions to existing criteria have not broadened the threshold for diagnosis (18). Across roughly forty years, the statistical probability of qualifying for a diagnosis remained essentially unchanged from one DSM edition to the next, with the well-known exceptions of conditions such as autism and ADHD. The data directly contradict the popular intuition that each new manual opens the floodgates. Overdiagnosis is a real phenomenon in identifiable corners of the system, but the evidence confines it to those corners rather than placing it at the center of the secular rise in diagnostic rates (Table 1).

SYNTHESIS AND LIMITATIONS

Synthesized across these three axes, the literature points in a consistent direction. The populations historically rendered invisible by narrowly calibrated instruments, the disclosure-based natural experiment in which reduced stigma unmasked pre-existing illness, and the converging indicators of genuine environmental deterioration together account for far more of the rising trend than the documented but bounded instances of overdiagnosis. The overdiagnosis and underrecognition hypotheses are not mutually exclusive; the most defensible reading of the evidence is that both operate simultaneously, but on vastly different scales.

These conclusions carry practical weight. If the dominant error is underrecognition rather than

Table 1. Summary of the key studies synthesized in this narrative review. For each study, the table reports the first author and year, the study design, the principal quantitative or qualitative finding, the finding's relevance to the overdiagnosis–underrecognition debate, and a brief note on the study's main methodological strength or limitation. Studies are listed in the order in which they are discussed in the text and span the three thematic axes of the review: historical underrecognition, environmental deterioration, and genuine overdiagnosis. Abbreviations are defined in the note beneath the table.

Study	Design	Key finding	Relevance to the debate	Methodological strength / limitation
GBD 2019 Collaborators (2022) (2)	Global burden systematic analysis	Mental-disorder DALYs rose 80.8M→125.3M (1990–2019)	Large, rising burden (global context)	Comprehensive multi-country modeling; estimates rely on imputation where primary data are sparse, especially in low-income regions
Loomes et al. (2017) (3)	Systematic review & meta-analysis	True autism male:female ratio ~3:1 in rigorous studies	Underrecognition of women	Pooling and active case-finding reduce ascertainment bias; between-study heterogeneity remains
Bargiela et al. (2016) (4)	Qualitative study	Camouflaging in women delays and prevents diagnosis	Mechanism of female underrecognition	Rich mechanistic detail; small, self-selected sample limits generalizability
KFF (2024) (5)	Population survey	39% Black / 36% Hispanic vs 50% White received care	Structural barriers to recognition	Large representative sample; self-reported use and cross-sectional design preclude causal inference
Clement et al. (2015) (6)	Systematic review	Stigma deters help-seeking, especially in men, youth, and minorities	Suppressed recognition	Broad qualitative and quantitative synthesis; included studies vary in design and stigma measures
Kim et al. (2024) (7)	Observational interrupted time-series (natural experiment)	Panic disorder diagnoses +775.6% after celebrity disclosure; OCD unchanged	Stigma reduction, not inflation	OCD control strengthens causal inference; observational and specific to one country
Mojtabai (2007) (8)	Repeated cross-sectional survey	Treatment-seeking more acceptable; stigma fell 1990–2003	Falling barriers to care	Nationally representative; attitudinal rather than diagnostic, and now dated (through 2003)
CDC / Garnett & Curtin (2024) (9)	Vital-statistics report	~49,500 suicide deaths in 2022; +30% (2002–2018)	Severe-end deterioration	Near-complete mortality coverage; captures only the fatal extreme, not milder morbidity or diagnostic behavior
Twenge et al. (2018) (10)	Repeated cross-sectional / surveillance	Adolescent depression and suicide rose after 2010	Genuine deterioration	Convergence across independent datasets; correlational, cannot establish screen-time causation
Santomauro et al. (2021) (11)	Modeling study (204 countries)	+27.6% MDD, +25.6% anxiety in 2020 (COVID-19)	Environment drives genuine illness	Wide geographic scope; modeled estimates depend on pre-pandemic inputs and assumptions
Murthy / U.S. Surgeon General (2023) (12)	Public-health advisory	Loneliness epidemic; social connection eroded	Loss of protective factors	Authoritative synthesis; an advisory rather than a primary study, and loneliness is a risk factor, not a diagnosis

Continued Table 1. Summary of the key studies synthesized in this narrative review. For each study, the table reports the first author and year, the study design, the principal quantitative or qualitative finding, the finding's relevance to the overdiagnosis–underrecognition debate, and a brief note on the study's main methodological strength or limitation. Studies are listed in the order in which they are discussed in the text and span the three thematic axes of the review: historical underrecognition, environmental deterioration, and genuine overdiagnosis. Abbreviations are defined in the note beneath the table.

Study	Design	Key finding	Relevance to the debate	Methodological strength / limitation
Layton et al. (2018) (13)	Cohort study	August-born children 34% more likely to receive an ADHD diagnosis	Genuine overdiagnosis (relative age)	Large administrative cohort with a clean cutoff quasi-experiment; observational and US-specific
Kravitz et al. (2005) (14)	Randomized controlled trial	Brand-name antidepressant prescribed 55% vs 10% on patient request	Commercially driven overdiagnosis	Randomization isolates demand effects; two decades old and based on standardized patients
Foulkes & Andrews (2023) (15)	Hypothesis / narrative review	Awareness efforts may lead some to relabel mild distress as disorder	Awareness-driven overdiagnosis (prevalence inflation)	Articulates a testable mechanism; hypothesis paper awaiting direct empirical confirmation
Haslam (2016) (16)	Theoretical review	Concepts of harm and pathology have expanded to include milder phenomena	Concept creep lowers the labeling threshold	Synthesizes semantic expansion across concepts; conceptual analysis rather than epidemiological measurement
Müller-Vahl et al. (2022) (17)	Clinical case series	Social-media-linked functional tic-like behaviors, distinct from Tourette syndrome	Cultural transmission shapes symptom presentation	Documents a contemporary mechanism; small, clinic-based case series rather than epidemiological measurement
Fabiano & Haslam (2020) (18)	Meta-analysis (123 studies)	Mean diagnostic risk ratio 1.00 across DSM editions	Criteria not broadly loosened	Directly tests criterion broadening; averages may mask condition-specific expansion (e.g., autism, ADHD)

Note. Studies are listed in the order in which they are discussed in the text, and reported values are reproduced from the cited sources. *M* denotes million. Abbreviations: ADHD, attention-deficit/hyperactivity disorder; DALYs, disability-adjusted life-years; DSM, Diagnostic and Statistical Manual of Mental Disorders; KFF, Kaiser Family Foundation; MDD, major depressive disorder; OCD, obsessive-compulsive disorder.

overdiagnosis, then policy responses calibrated to the overdiagnosis narrative (raising diagnostic thresholds, restricting access to assessment, or treating rising prevalence as *prima facie* evidence of medicalization) risk compounding the very neglect the data expose. A more defensible posture treats the two errors as distinct problems demanding distinct remedies: targeted safeguards where overdiagnosis is demonstrated, such as age-norming ADHD assessment and constraining direct-to-consumer pharmaceutical influence, paired with sustained investment in access, screening, and culturally responsive care where underrecognition prevails.

Conflating the two (invoking documented pockets of overdiagnosis to justify across-the-board skepticism toward rising rates) mistakes a local problem for a global one and threatens to withdraw recognition from the populations who waited longest to receive it. Because the cost of that error would fall disproportionately on the populations the system has historically been slowest to detect, rising diagnostic rates should not, by default, be treated as evidence of excess.

Several limitations temper these conclusions. As a narrative rather than systematic review, this synthesis selected studies for their methodological strength and

illustrative value rather than through an exhaustive, preregistered search, and it is therefore vulnerable to selection effects that a formal systematic review with explicit inclusion criteria and a PRISMA-style accounting of records would mitigate.

Consistent with its stated scope, this review concerns high-income countries and is not generalizable to low- and middle-income settings, where both the epidemiology of diagnosis and the largest treatment gaps differ; moreover, two datasets cited only as background, the Global Burden of Disease estimates and the COVID-19 prevalence modeling, aggregate across income levels and are used here to establish scale and mechanism rather than to characterize the high-income diagnostic trend.

Several key sources, including the disclosure study and the relative-age analysis, are observational, so causal language should be read with appropriate caution. In addition, because direct, long-run series of diagnostic incidence are unavailable for several of the conditions considered, some inferences necessarily rest on indirect indicators (treatment access, population burden, and mortality) whose bearing on diagnostic rates is, as set out above, only partial.

Finally, the term diagnosis aggregates heterogeneous conditions whose epidemiology differs markedly; autism, ADHD, depression, and panic disorder may each sit at different points on the overdiagnosis–underrecognition continuum. These caveats argue not against the central conclusion but for the systematic, demographically representative research needed to locate the diagnostic line condition by condition.

CONCLUSION

The evidence assembled here supports a differentiated conclusion rather than a single verdict. Overdiagnosis is demonstrable in specific, bounded contexts (the relative-age effect in ADHD and demand-driven prescribing among them), and awareness-related mechanisms such as prevalence inflation and concept creep may add to apparent rates at the mildest end of the severity distribution. Set against these bounded effects, however, are the treatment gaps that persist even in high-income settings, the recovery of populations historically missed by narrowly calibrated instruments, the disclosure-based evidence that stigma once suppressed recognition, and the convergent indicators of environmental deterioration; on the evidence reviewed, these processes account for a greater share of the secular rise than the documented instances of overdiagnosis. Two implications follow. First,

because overdiagnosis and underrecognition operate on different conditions and different segments of the severity spectrum, they call for correspondingly targeted responses rather than a single adjustment to diagnostic thresholds. Second, the appropriate empirical priority is condition-specific, demographically representative research capable of locating the diagnostic threshold separately for autism, ADHD, depression, and anxiety, since aggregate figures obscure the divergent trajectories these conditions follow. Rising diagnostic rates are thus best interpreted not as uniform evidence of excess but as a composite signal whose components warrant distinct clinical, methodological, and policy responses.

CONFLICT OF INTEREST

The author declares that there are no conflicts of interest related to this work.

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