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IS MENTAL ILLNESS OVER-DIAGNOS ED NOW, OR JUST BETTER RECOGNISED?

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Abstract

This essay will examine the cause of the considerable rise in mental illness, whether it be due to over-diagnosis or recognition of previously neglected conditions. By utilising diagnostic trends and research, it argues that both processes can be true. The identification of genuine disorders has increased due to the increase in public awareness and reduced stigma around mental illness. However, the rise of diagnoses can stem from pharmaceutical business' financial incentives, and can encourage the medicalisation of normal experiences of stress and emotional difficulty. The essay will evaluate the economic and ethical implications of the increased diagnoses and concludes that the main issue is not the number of diagnoses, but the conditions under which they are applied. Ultimately, this essay insinuates that mental illness is both over-diagnosed and better recognised and requires practical steps from organisations and policymakers to control incentives and strive for genuine patient benefit rather than ticking a financial box.

Keywords: *mental illness, over-diagnosis, mental health recognition, DSM, pharmaceutical industry, organisational behaviour, workplace wellbeing*

Introduction

In recent years, it has become near impossible to deny the prevalence and attention over mental health illnesses. Companies and businesses have skyrocketed awareness campaigns from Spotify's 'Take a Beat' to the introduction of the meditation app CALM (Roger Horberry. 2025). However, through this sudden growth of acknowledging these illnesses, there is a growingly blurred line between whether this is a real, growing epidemic of mental illness, or whether society has been better at naming a long-neglected set of problems.

To clarify the concept of the prompt, we must first define and distinguish the two juxtaposing sides. Better recognition (The University of Greater Manchester. 2022) alludes to recognising and addressing real mental conditions that were previously shunned or called 'personal weaknesses', whilst over-diagnosis refers to the point at which mild,

context-driven stress is treated as a mental disorder. Or when corporations place over-importance on so-called 'awareness' and 'diagnoses' in order to check off a box, rather than actually catering to patient needs.

In this essay, I argue that mental illness in now both better recognised and, in some contexts, over-diagnosed. The balance between the two depends heavily on how institutions are structured and incentivised – as where diagnosis is evidence-backed and authentic, increased diagnosis shows moral and economic progress. Whereas, where diagnosis is driven purely by profit and convenience, it comes with the risk of becoming an exploited tool that does more harm than good.

What has actually changed?

In order to understand if mental illness really is over-diagnosed, we must address whether there is, in reality, more of it. From what we see now on the media and within our day-to-day lives, it is easy to conclude that we are facing a sort of mental illness epidemic. News anchors report skyrocketing numbers of people suffering from mental illnesses, like depression, anxiety and ADHD (World Health Organisation (WHO). (2025) while schools admit more and more students for special educational needs (BBC News. June 2026). Diagnostic terms seem to be everywhere within colloquial settings, through which we paint the picture that there is a huge increase in mental issues. However, through multiple systematic reviews of population surveys, it has been shown that there has been only a slight increase in the ubiquity of common mental disorders in recent decades, with much of the supposed growth coming from changes in awareness and willingness to disclose, rather than a sudden explosion.

Additionally, the boundaries and definitions of 'mental illness' have definitely been adjusted over time, evident through the constantly revised Diagnostic and Statistical Manual of Mental Disorders (DSM). Diagnoses have been broadened, narrowed and new ones have been introduced. But critics have argued that there is a high risk of certain DSM categories medicalising normal mood variations, like grief or irritability as a child. Yet the structure is still complex as, according to detailed meta-analyses, not every disorder has been magnified – some have actually become tightened. Therefore, this challenges any generalised notion that psychiatry has loosened all its standards.

An important factor to consider with this question is that now, with the changing of the times, we have more data and less stigma. Groups that preciously would have hidden their symptoms, like women, ethnic minorities, low-income groups, are now more likely to receive a diagnosis. Naturally, this would increase the number of recorded cases without necessarily 'proving' that actual mental illness is increasing. Meaning that when we now compare diagnoses from thirty years ago with today, we can see the real suffering that was previously ignored, highlighting the changing social attitudes, another topic within itself, seen as, over time, 'Pro-social reactions like the desire to help increased for depression' (National Library of Medicine. (2022).

Economic and organisational incentives for Over-diagnosis

Alternatively, from a business angle, mental illness has now become a market and a metric, which can be dangerous in terms of over-diagnosis as it caters to a whole sector through which businesses can utilise.

Firstly, the pharmaceutical industry has a very strong influence on how mental illness is defined and treated. These drug manufacturers benefit more the more people qualify for treatment with their products. This creates a conflict of interest, as the experts who are responsible for setting diagnostic criteria and guidelines also receive payments from certain companies that rely on broader definitions of mental illness to maximise their profit. As a result, diagnostic categories can be widened (National Library of Medicine. 2019) so that normal experiences, like mild concentration problems or short-term sadness are more likely to be labelled as medical disorders, increasing the number of people who are given medication.

Secondly, healthcare financing systems can often reward diagnosis. In many countries, hospitals and clinics are paid based on how many diagnoses they provide. For example, a patient with a recognised disorder can generate higher payments by insurers or justify access to special funding streams. This

then leads to 'up-coding' (National Health Care Anti-Fraud Association (NHCAA). (2025), which is when labels that increase revenue or resources are chosen, which is easier now due to the increasingly fuzzy boundary between normal stress and mental disorder. Most clinicians do not favour over-diagnosis, but they work in systems under financial pressure, where managers use diagnosis numbers to measure performance. This can then lead to labelling more people and 'assigning' disorders.

Third, schools and workplaces may also use diagnoses to manage risk and accountability. A school that pushes students towards psychiatric testing may be trying to secure extra support but may also be seeking a label that shifts responsibility away from the institution's own environment. Similarly, a company may prefer to frame an employee's breakdown as individual vulnerability fitting into a neat diagnostic box, rather than a response of overworking or bulling. In this context, over-diagnosis becomes a way of avoiding accountability and responsibility as we treat the person instead of changing the system.

Although this correlation does not necessarily 'prove' that mental health is over-diagnosed, it does reveal how behaviour within business models can push the system in that direction. When diagnoses are linked to profit, funding and avoiding blame, it becomes more likely that labels will increase, whether or not they are medically necessary.

The case for better recognition

It would, however, be a mistake to come to the conclusion that more diagnosis is merely a system of commercial excess. There is also a strong ethical and economic case for recognising mental illness more thoroughly, especially from an institutional standpoint.

Mental disorders cause a large amount of economic loss around the world (National Library of Medicine. 2022), particularly recently. Conditions like depression, anxiety and substance-use disorders lead to many years of reduced quality of life, costing trillions of dollars through healthcare spending, welfare support and lost productivity. For businesses, this shows up as staff absences and low performance. Employees with untreated mental health issues are therefore more likely to miss work or leave the organisation altogether. From this point of view, it is rational for employers to take mental health seriously.

Consequently, many companies have began investing in mental health programmes including, Employee Assistance Programmes, counselling hotlines and mindfulness apps. It has been suggested that initiatives like this can improve productivity (World Health Organisation (WHO). (2024), with an estimate of several dollars returned for every dollar invested. From this view, higher diagnosis rates are not purely about over-medicalising normal behaviour, but about identifying people who need help so that support can be provided. Therefore, for example, a manager acknowledging that a significant portion of staff meet criteria for depression is critical information for workforce planning and risk management.

Moreover, better recognition can be seen from a judicial perspective. Historically, entire groups were under-diagnosed – women's suffering being dismissed as 'hysteria', racial minorities whose distress was stereotyped as aggression, people in poor areas having no access to mental healthcare. To treat under-diagnoses as morally neutral while condemning over-diagnosis is to ignore history. If we believe that everyone has the right to relief from avoidable suffering, then identifying genuine mental illness is moral progress.

Therefore, the challenge is to distinguish between the recognition that opens access to help from labelling that serves institutional interests. From a social policy perspective, this means questioning whether diagnosis actually improves outcomes – does it lead to evidence-based treatment and healthier organisational cultures, or does it simply produce more forms and prescriptions?

How should institutions diagnose mental illness?

Although the essay questions seems to demand a yes-or-no response, if taken from a business viewpoint, a more pragmatic conclusion can be deduced: institutions should expand diagnosis where it leads to genuine benefit and limit it when it does not. This may seem like an obvious solution, yet it has demanding implications for how organisations organise incentives and measure success.

Firstly, effective diagnosis must be judged by outcomes over volume. For employers and healthcare providers, the key question is not 'how many' individuals are diagnosed, but whether those individuals are better of as a result. For instance, when an employee is diagnosed with anxiety and therefore receives therapy and proper workplace accommodation, diagnosis has fulfilled its purpose. By contrast, however, if the label merely leads to marginally effective medication while the harmful organisational practices that generated the original stress continue, diagnosis risks serving as institutional convenience rather than genuine care and action.

Secondly, diagnosis should be paired with investment in prevention. While it is often simpler to categorise individuals than to reform whole systems, prevention is, in the long run, far more sustainable, ethical and economically superior. Employers can redesign roles to increase autonomy, ensure reasonable workloads, increase supportive leadership and address harassment. Educational institutions can moderate excessive performance pressures and foster a more supportive environment, which would then increase performance anyway. In contexts like these, genuine mental illness will still exist, but preventable distress would reduce, clarifying when diagnosis is real rather than a response to unreasonable conditions.

Finally, managers and people in power must remain alert to the power of this diagnostic language. When organisations enthusiastically adopt clinical labels, this may unintentionally cause individuals to associate all forms of struggle as mental disorders. While this can reduce stigma, it may also weaken individual agency. An ideal, responsible approach would acknowledge the reality of mental illness while leaving room for non-medical ways of understanding and dealing with difficulty, like relationships, community and social change. Good management should therefore encourage multiple ways of thinking about wellbeing, rather than treating diagnosis as the only explanation.

Conclusion

So, to conclude, is mental illness really over-diagnosed now, or just better recognised? There is no reductive, black-and-white answer to this because, as evidence and incentives suggest, it is both. Rightly, we are more willing to address real mental issues, which has opened doors to treatments and workplace reform that improve individual lives as well as the organisation's performance. Simultaneously, though, the commercial interests of certain pharmaceutical companies, and the managerial convenience of labelling, over-diagnosis has been increasing in certain contexts, where the benefits of a diagnosis are, at worst, harmful.

Again, taking this from an organisational lens, the key question is not the number of diagnoses made, it's about how well institutions structure the conditions in which these diagnoses are applied. Recognition signals progress only when incentives provide support for genuine patient and employee benefit. Diagnosis risks becoming a tool of control when, instead, they reward volume, profit or blame-shifting. The responsibility of organisational leaders and policy makers is to ensure that mental health diagnoses lead to real support, not just financial gain.

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