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Is Mental Illness Over-Diagnosed Now, Or Just Better Recognized ?

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Abstract

The rising prevalence of psychiatric diagnoses is mainly attributed to defensive psychiatry prioritizing prevention of risks over diagnostic decisions rather than improved recognition on mental diseases. Driven by legal and mental health of doctors, self-protection, lowered diagnostic thresholds of revised DSM scales, performance assessment incentives, and symptom exaggeration by patients due to the existence of insurance reimbursement policies, overdiagnosis occurs. It pathologizes normal human emotional experiences, representing both a medical shift and a broader social transformation. Furthermore, defensive medical practice expands boundaries of diagnosis under institutional and legal pressures. As a consequence, the vulnerability and emotional confusion of common individuals are wrongly categorized as mental disorders.

Keywords

Mental Illness; Over-Diagnosis; Style; Styling; Insert

1. Introduction

During the past decades, the probability of being diagnosed with mental illness all over the world has significantly increased. Among international students from 2015 to 2024 in the US, the prevalence of anxiety disorders, depression, and suicidal ideation nearly doubled (Zhai, Xiong & Almaawali et al, 2025). In China, the prevalence rate of mental disorders has risen from a relatively low level in the early period to 23.3% during 2015‑2024. Defensive medical treatment tries to eliminate the potential clinical anxiety from misdiagnosing one kind of illness beforehand, rather than diagnosing patients according to the real probability of having a specific disease, which therefore leads to a series of inefficient tests. These tests inevitably result in some abnormal symptoms at the borderlines. Even though these abnormalities match some of the formal pathological standards, they lack the potential to harm the mental health of patients. Through classifying these nonsensical findings as illnesses, defensive medicine systematically turns mentally healthy people into patients, which causes overdiagnosis. The rise in psychiatric

diagnoses is not primarily the result of improved recognition, but the consequence of a defensive psychiatric system that increasingly prioritizes risk avoidance over diagnostic precision. Under legal, institutional, and cultural pressures, psychiatry has gradually expanded diagnostic boundaries in order to minimize uncertainty and prevent the consequences of underdiagnosis.

2. Psychiatrists' self-protection for legal and mental-health reasons

2.1. Selecting a Template

Psychiatrists often choose to use defensive treatment, which exaggerates the diagnosis, for self-protection both legally and mentally. To begin with, psychiatrists want to avoid legal issues caused by missed diagnoses and make patients aware of their mental health. After severe medical mistakes causing death or serious injury, the court will require doctors to pay a large amount of financial compensation, which usually includes compensatory and punitive damages, report the fault to the national practitioners database, and give out penalties such as revocation or suspension of the medical license. Based on research on 254 psychiatrists in Italy, 60.2% of the psychiatrists practiced defensive medical treatments (Morena, 2023). An article points out that misdiagnosis causing patients' death or severe injury would be identified as medical fault that might involve doctors in civil compensation disputes (Quevedo-Blasco, Pérez & Guillen-Riquelme et al., 2023). Under this sort of panic over being prosecuted, psychiatrists tend to be more conservative with specific groups of patients, which makes them more likely to provide a more definite diagnosis. As diagnoses have been overstated these days, the number of patients being diagnosed with mental illnesses has been elevated during the above process. Thus, the diagnosing rate of psychiatric disorders increased. Furthermore, to protect their own mental health, psychiatrists might decide to use defensive medication. After medical mistakes and accidents, the second victim phenomenon can happen to psychiatrists. Second victim phenomenon refers to 'Any health care worker, directly or indirectly involved in an unanticipated adverse patient event, unintentional healthcare error, or patient injury and who becomes victimized in the sense that they are also negatively impacted.' (Vanhaecht, Seys & Russotto et al., 2022). Another study found that the most common symptoms of the second victim effect are guilt, anxiety, self-blame and decreased self-confidence. At the same time, sleep disorders and post-traumatic stress disorder symptoms are also prevalent. The study clearly points out that the syndrome can induce suicidal thoughts, and more than one-third of the second victims cannot return to normal within three years (Naya, Aikawa & Ouchi et al., 2023). The trauma caused by this phenomenon is no less severe than the trauma inflicted on patients. Therefore, for the sake of preventing themselves from becoming second victims, doctors have to lower the possibility of making medical mistakes and causing accidents, thus defensive

treatment occurs and causes overdiagnosis.

3. Revision of diagnostic scales and lowered diagnostic thresholds

The change in mental scales involves lowering diagnostic thresholds to avoid uncertainty. One of the most important scales used in mental illness diagnosis is the Diagnostic and Statistical Manual of Mental Disorders, which is also known as DSM. During the past few decades, the DSM scale has been revised on a large scale for 4 times. For instance, the edition of the latest DSM-5 has brought lots of new controversial content. To begin with, abolishing the Bereavement Exclusion clause has given psychiatrists more controversial criteria for diagnosing mental illness, which can lead to more diagnosed cases of specific psychiatric disorders. As the diagnostic criteria have been loosened, doctors formulate systematic defensive mechanisms, which prefer overdiagnosis rather than leaving any mental disorders out. For instance, it should be normal for people facing the sadness of bereavement to be depressed, spirit broken, and unmotivated to do anything. However, it is undeniable that a series of safety issues might occur during this period of time, while there is still research revealing that the duration of a sad state is not fixed (Wakefield & Horwitz, 2015). Hence, due to the defensive logic of medication, in the field of psychiatry, when the diagnosis begins approaching in a sensitive direction, the tool itself would be more likely to be set to provide defensive treatment. An article argues that this change, along with the additional multiple new diagnostic categories of the DSM-5, has contributed to a systematic expansion of the diagnostic scope of depressive disorders, misclassifying a significant number of behaviors and symptoms resulting from normal, overly intense sadness triggered by specific circumstances as mental disorders, which leads to negative consequences, such as unnecessary doses of prescription, ineffective scientific research, and over-refined policies on psychological health (Wakefield & Horwitz, 2015). Furthermore, as DSM has moved Asperger's syndrome into the ASD category, the result of diagnosis relies heavily on the subjective assumptions of doctors. As psychiatrists all have their own interpretations towards diagnostic criteria with a broad range, the diagnosing results would be very likely to deviate from the normal course, which reduces the overall accuracy of diagnosis significantly. Research reveals a young male patient, who was misdiagnosed multiple times, initially not diagnosed, then with obsessive-compulsive disorder, but finally revised to autism spectrum disorder. This article suggests that after the DSM-5 combined subtypes such as Asperger's syndrome into a single ASD diagnosis, the unified diagnostic label masks the unique clinical characteristics of these individuals, along with cognitive rigidity being mistaken for delusions in psychotic disorders, unusual behaviors mistaken for disordered behaviors in psychotic disorders, and restrictive interests and repetitive behaviors mistaken for obsessive thoughts and compulsive behaviors in obsessive-compulsive disorder

(Ying, JiangbJian, et al. 2023). Refinement of scales enlarges the group of people being diagnosed, lowering the diagnostic threshold, which involves any groups of patients with potential risks into the overall number of diagnosed patients. This method of defensive medical treatment significantly reduces the possibility of risks emerging in vulnerable groups of people, which thereby leads to overdiagnosis.

4. Performance Assessment Driving Defensive Diagnosis Behaviour

Under lots of circumstances, performance assessments are more likely to encourage "diagnosable" pain, which makes psychiatrists diagnose more defensively and eventually leads to excessive diagnosis. Performance assessment refers to regular and systematic quantitative assessment and value judgment conducted in terms of medical service quality, operational efficiency, and satisfaction levels, including the number of patients a doctor diagnosed, the ratings from patients and the variety of illness diagnosed. Performance assessment directly decides how much salary a doctor can earn. If a psychiatrist diagnoses a large number of cases in a year, including a wide variety of illnesses, this doctor will be evaluated as an outstanding therapist and earn more money during the year than those with a medium or low number of cases (Tait & Shah, 2007). An article sharply criticizes the mechanism of payment by results in psychiatry, pointing out that this system is essentially payment by volume, as it measures outcomes based on the quantity of services provided rather than actual clinical results. What's more important, it systematically encourages clinicians to code diagnosis as more severe or acute than they actually are (Tait & Shah, 2007). Therefore, for the sake of gaining a better performance assessment, psychiatrists might prefer to exaggerate the diagnosis to a level of severity that inevitably requires treatment.

5. Medical-insurance reimbursement incentives and patient symptom exaggeration

A common understanding in favor of the increased mental disorder diagnosis rate is that it reflects better public knowledge of mental diseases. Indeed, during the past few decades, the recognition rate of mental diseases has been elevated significantly. In Singapore, according to two rounds of nationally representative surveys in 2015 and 2023, respectively, the overall recognition rate of five mental disorders has significantly increased from 43.7% to 59.3%, among which the recognition rate of obsessive-compulsive disorder has soared by 33.6% to 62.3% (Shahwan, Tan & Tan et al., 2026). Nevertheless, the statistical rises may have been bringing more people into the consulting room, but it does not mean that patients have been correctly diagnosed. Prior authorization requirements for health insurance plans have become a major barrier to healthcare access in the United States. A systematic review of 25 studies found that PA requirements not only lead to delayed treatment,

reduced clinical effectiveness, and impaired patient outcomes, but are also significantly associated with disease progression, preventable hospitalizations, prolonged hospital stays, and lower disease-free survival rates (Murphy, 2025). Insurance reimbursement structures can unintentionally encourage defensive psychiatric practices by rewarding severe and medically codified diagnoses over mild or ambiguous distress. Under such reimbursement structures, patients may feel pressured to present their distress in more severe or clinically recognizable terms in order to qualify for financial support. Hospitalization treatment and severe disease have become the only two ways eligible for reimbursement after years of laws altering the rules of medical insurance. To increase the fund's efficiency, policy creators usually only retain hospitalization, emergency rescue, and some critical outpatient services in the reimbursement pool. Even under the circumstances where the outpatient department is retained in reimbursement, usually a high deductible, a low cap, and a low reimbursement ratio are set, which results in patients still feeling unable to get reimbursed (Duffy, Ly & Trish, 2026). This medical insurance policy shapes the institutional perception that "only inpatient treatment can receive true reimbursement", which contrasts sharply with the low perceived benefit for outpatient services (Duffy, Ly & Trish, 2026). Thereby, patients will try their best to exaggerate the descriptions of their symptoms, to make their illness severe enough for reimbursement. For instance, a patient who has felt depressed for a week might tell the doctor that they have been depressed for a whole month. The occurrence of over-exaggerated self-description compromises the accuracy of diagnosis, which leads to severe overdiagnosis and an increased number of diagnosed patients.

6. Outro

From individual, organizational, and legal perspectives, doctors and patients, pursuing their own goals, layer complex interlinked factors, leading to defensive treatment and overdiagnosis. Whether driven by doctors' self-protection, updated scales, or patients exaggerating for reimbursement, it reflects a defensive psychiatric system shaped by growing social fear of uncertainty and risk. Thus, psychiatry places prevention of harm over diagnostic precision, gradually expanding diagnostic thresholds. This growth in psychiatric diagnosis is not just a medical alteration but a broader social transformation in how modern societies understand emotional confusion, vulnerability, and uncertainty. As the fear of missing illness exceeds the fear of excessive diagnosis, common human experiences risk being pathologized.

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