FEATURES

When Does Care Overreach? The Harms of Overmedicalization in Mental Health

Image Courtesy of Bryan Christie Design

Triscia Afihene '27

Introduction

In 2024, 61.5 million adults in the United States reported a diagnosed mental health disorder, a figure that only continues to grow (National Alliance on Mental Illness [NAMI], 2025). Fortunately, this trend has been accompanied by increasing mental health awareness among not only scholars and clinicians but also the public. In the 1980s and 1990s, programs such as NAMI's destigmatization campaigns and Congress's "Decade of the Brain" initiative began to recognize the importance of mental health research and mainstream education (Walthall, 2020). Since then, they have successfully encouraged Americans to view mental health as a vital aspect of overall well-being. Through public service announcements, celebrity advocacy, and educational curricula, efforts to address stigma have validated individual experiences and connected millions with life-changing treatment, establishing mental illness as a legitimate health concern that warrants attention, compassion, and care (Walthall, 2020; Waqas et al., 2020). While it is difficult to establish a direct causal relationship, many scholars attribute the expansion of mental health diagnoses to the rise in mental health literacy via awareness efforts (Haslam & Tse, 2024).

Simultaneously, however, the growing visibility of mental health has subtly shifted the boundaries of what is considered "pathological." Conditions once considered natural emotional fluctuations, such as low sexual arousal

and even intense grief following the death of a loved one, began to fall within the bounds of psychiatric classification (American Psychiatric Association, n.d.; Eske, 2020). Another example is premenstrual dystrophic disorder (PMDD), which consists of symptoms such as decreased interest in normal activities, breast swelling or tenderness, and mood swings beginning during the week before menstruation (Johns Hopkins Medicine, n.d.). PMDD became a mental health condition in the Fifth Edition of the American Psychological Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5)—but both psychologists and feminist scholars have criticized the addition of PMDD in DSM-5, claiming that it leads to overdiagnosis of normal hormonal changes or the disempowering of women by claiming women are pathologically emotional, reinforcing the "myth of the irrational woman" (Schroll & Lauritsen, 2022; King, 2020).

Thus, while the medicalization of mental health has helped many people better understand and manage their challenges, it also carries risks. The evolution of the DSM from the Third to Fifth Edition has resulted in notable diagnostic inflation: 51 disorders displayed net inflation (Fabiano & Haslam, 2020). The expanding reach of diagnostic criteria may expose individuals to unnecessary medical interventions, pharmaceutical side effects, and a narrowing of how society understands human emotion and behavior. Ultimately, the motivation to identify, name, and treat—though rooted in good intentions—can, when extended beyond clinical significance, distort medicine's healing power into the source of harm itself.

"These findings raise an uneasy paradox: as treatment efforts expand, so too does the population living with long-term. "

Pathologizing Pain: The DSM and the Cost of Medicalization

The modern tendency to medicalize human hardship can be traced back to the evolution of the DSM, which gradually transformed psychiatry from a loosely interpretive, psychoanalytic discipline into one grounded in diagnostic specificity. The publication of the Third Edition of the manual, the DSM-III, in 1980 marked a turning point (Shorter, 2015). Moving away from the individualized diagnoses of psychoanalysis, the DSM-III adopted explicit, consensus-based criteria that imbued psychiatry with a new sense of legitimacy and precision. For many, this shift was long overdue, and allowed many patients to finally receive standardized diagnostic labels and care, validating their experiences.

Yet, the expansion of diagnostic criteria came with a cost. The DSM-III's standardized framework helped clinicians communicate more clearly and enabled researchers to study mental illness systematically, but it also laid the groundwork for a growing, potentially exploitative pharmaceutical market (Nikkel & Whitaker, 2018). Following the publication of the DSM-III, billions of dollars were invested in psychopharmacological research, leading to the development of drugs like Prozac, the first selective serotonin reuptake inhibitor (SSRI; Kawa & Giordano, 2012).

However, while these developments dramatically improved the lives of many by providing effective treatment options, they also reinforced the idea that emotional suffering could be treated simply through biochemical correction (Shpancer, 2022). Furthermore, psychiatric medications such as antidepressants carry risks and limitations. Studies and several analyses suggest that some medications may offer short-term improvement compared to a placebo, but can also increase the likelihood of relapse or chronic symptoms over time by 36.4% (Nikkel & Whitaker, 2018; Kirsh, 2019; Batelaan et al., 2017). These findings raise an uneasy paradox: as treatment efforts expand, so too does the population living with long-term iatrogenic mental health challenges—conditions that arise from unintended consequences of medical treatment itself (Moynihan, 2012). Despite the DSM-III's success in legitimizing care, its legacy invites reflection on how a system built to heal can expose individuals to unnecessary medicalization and potential harm.

The Hidden Harms of Overdiagnosis

As diagnostic categories multiplied and pharmaceutical solutions expanded, the threshold for what qualified as a disorder also became increasingly expansive, with criteria for some disorders becoming relaxed (Fabiano & Haslam, 2020). In a study done on a Baltimore population, it was found that of current antidepressant users 38% did not meet the requirements for OCD, major depressive disorder (MDD), or panic disorder, and 69% did not meet the requirements for MDD specifically (Takayanagi et al, 2015). Conversely, research has shown that antidepressants achieve almost no benefit compared to a placebo in mild and moderate depression (Mayor,

2008). What began as a movement toward inclusion and understanding slowly revealed another face, one where overdiagnosis and overmedication exposed individuals to risks that the system was never designed to anticipate.

Since the 1970s, several scholars—including philosopher Ivan Illich and, more recently, influential psychiatrist Allen Frances, who served as Chair of the DSM-IV Task Force—have argued that medicine's good intentions can inadvertently cause harm to patients by transforming a broad range of experiences into diagnosable problems that require treatment. As medicine extended its reach, many pharmaceutical interventions once reserved for severe illness are now used for mild or transient distress, resulting in often quite significant chronic iatrogenic illness (Moynihan et al., 2002). An example can be seen in the expanded use of Olanzapine (Zyprexa), an antipsychotic traditionally prescribed to treat schizophrenia and bipolar disorder, for insomnia (Khaledi-Paveh et al., 2021). Psychiatric medications, such as antidepressants, while life-saving for many, can lead to significant side effects such as the inability to concentrate, facial rigidity, a distorted sense of self, and withdrawal-like symptoms that linger even after the treatments stop. Some patients on psychiatric medications have described feeling "numb" or like a "zombie" to illustrate the handicap that they become over time (Rodriguez Del Barrio et al., 2014). Antidepressant discontinuation syndrome, for example, is a growing issue, with studies showing that approximately 20% of patients experience withdrawal symptoms after discontinuing antidepressant medications after at least six weeks encouraging them to go back on antidepressant (Warner et al., 2006).

"When care becomes synonymous with medication, we risk treating discomfort as disease and exposure to treatment as healing, even when it quietly deepens suffering."

Nevertheless, it is important to acknowledge that overdiagnosis often stems from compassion rather than negligence. Physicians are trained to quickly identify straightforward causes of and treatments for pain; in a healthcare environment where time is often limited, prescribing medication can appear to be the most efficient route to care (Kale & Korenstein, 2018; Wakefield, 2015). Patients, too, often seek explanations for distress that feels unmanageable, turning to medicine for clarity and a way to validate their experience. Yet this shared "risk aversion" creates a loop where the fear of under-treating illness outweighs the caution against unnecessary, and potentially harmful intervention (Hofmann, 2016). Structural forces surrounding psychiatry reinforce this pattern: for instance, pharmaceutical companies, driven by profit and enabled by expanding diagnostic criteria, market new medications directly to both physicians and the public, framing natural variations in mood and behavior as treatable disorders. An example can be seen in biopharmaceutical giant GSK's marketing for the antidepressant Paxil, a drug targeting social anxiety disorder (Wolinski, 2005). These tactics foster a medical culture where care equates to pharmacological treatment, and the side effects that promote long-term use make the maintenance of the disorder more unbearable than the illness (Rodriguez Del Barrio et al., 2014). When care becomes synonymous with medication, we risk treating discomfort as disease and exposure to treatment as healing, even when it quietly deepens suffering. A shift towards cognitive therapies—grounded in self-reflection and behavioral change rather than biochemical correction—offers a path to healing that offers relief without the risks of medication (DeRubeis et al., 2009).

Medicalization Today: Gen Z and the Normalization of Diagnosis

The expansion of psychiatric care did not remain confined to clinics or hospitals—it gradually entered society itself. The push to encourage acceptance and bring validity to mental health and disorders fostered a powerful relationship between pathologization and the media. The efforts of NAMI to bridge psychiatry and the public marked a critical turning point: mental health was no longer a private issue but a collective concern discussed openly. As understanding deepened and awareness spread, the language of mental health became increasingly familiar.

Campaigns like the 2017 World Health Organization's (WHO) "Depression: Let's Talk" encouraged individuals to notice and name negative psychological states, an important step toward help-seeking, but one that may also lead some to equate psychological states such as temporary sadness with clinical depression (Foulkes & Andrews, 2023). Individuals, often because they believe that the experiences they are having are not synonymous with those of a small group of peers, become convinced that their "symptoms" are indicative of a mental disorder,

even when they are common experiences among the general public (Suhr & Johnson, 2022).

The COVID-19 pandemic further intensified this dynamic with increased use of social media. With isolation confining many, particularly Gen Z, to digital spaces, social media became both a source of community and a new space for mental health discourse (Foulkes & Andrews, 2023). In fact, 25% of young people have used social media to self-diagnose, with Gen Z constituting a large proportion (Redshaw, 2023). According to the WHO (2022), during the pandemic, there was a 25% increase in reports of anxiety and depression; in the absence of accessible healthcare, digital spaces often fill the gap, encouraging self-diagnosis and self-treatment. Research has shown that during and after the pandemic, rates of psychotropic medication prescribing increased among patients with depressive disorders (Luo et al., 2024). While this openness has helped normalize conversations around mental health, it also perpetuates a culture in which emotional struggles are immediately medicalized—where understanding the self increasingly begins with searching for symptoms.

Conclusion

The expansion of clinical psychiatry has sought to bring understanding and compassion to those experiencing mental illness, a mission that has given voice to countless forms of suffering once silenced or dismissed. Yet the same expansion that made care accessible has also fueled the temptation to view all forms of distress through a medical lens. When every discomfort becomes a symptom to treat, medicine risks drifting away from its original purpose: to heal where healing is needed and to help people live meaningfully with what cannot be cured. The problem is not medicine's desire to alleviate pain and suffering, but that it risks turning care into exposure, introducing individuals to medications and side effects that they could have gone without (Cassel, 1982). In a study done on a Baltimore population, it was found that of current antidepressant users 38% did not meet the requirements for OCD, major depressive disorder (MDD), or panic disorder, and 69% did not meet the requirements for MDD specifically (Takayanagi et al., 2016). Conversely, research has shown that antidepressants achieve almost no benefit compared to a placebo in mild and moderate depression (Mayor, 2008). In the effort to ensure that no illness goes untreated, medicine sometimes forgets that restraint is also a form of care. Prescribing a drug is an act of trust, and when used without necessity, can harm the very body it was meant to heal and protect (Kale & Korenstein, 2018). The consequences invite a difficult question: how can medicine balance its desire to help with its Hippocratic obligation to "do no harm"?

References

American Psychiatric Association. (n.d.). *Prolonged grief disorder*. Retrieved November 22, 2025, from https://www.psychiatry.org:443/patients-families/prolonged-grief-disorder

Ballard, K., & Elston, M. A. (2005). Medicalisation: A multi-dimensional concept. *Social Theory & Health*, *3*(3), 228–241. https://doi.org/10.1057/palgrave.sth.8700053

Batelaan, N. M., Bosman, R. C., Muntingh, A., Scholten, W. D., Huijbregts, K. M., & van Balkom, A. J. L. M. (2017). Risk of relapse after antidepressant discontinuation in anxiety disorders, obsessive-compulsive disorder, and post-traumatic stress disorder: Systematic review and meta-analysis of relapse prevention trials. *The BMJ*, *358*, j3927. https://doi.org/10.1136/bmj.j3927

Cassel, E. J. (1982). The nature of suffering and the goals of medicine. *New England Journal of Medicine*, *306*(11), 639–645. https://doi.org/10.1056/NEJM198203183061104

Davidson, M., & Gabos-Grecu, C. (2020). Do DSM classifications help or hinder drug development? *Dialogues in Clinical Neuroscience, 22*(1), 73–79. https://doi.org/10.31887/DCNS.2020.22.1/mdavidson

DeRubeis, R. J., Siegle, G. J., & Hollon, S. D. (2008). Cognitive therapy vs. medications form depression: Treatment outcomes and neural mechanisms. *Nature Reviews Neuroscience*, *9*(10), 788–796. https://doi.org/10.1038/nrn2345

Eske, J. (2020, November 26). *What is female arousal disorder? Symptoms and treatment*. Medical News Today. https://www.medicalnewstoday.com/articles/female-arousal-disorder

Fabiano, F., & Haslam, N. (2020). Diagnostic inflation in the DSM: A meta-analysis of changes in the stringency of psychiatric diagnosis from DSM-III to DSM-5. *Clinical Psychology Review*, *80*, 101889. https://doi.org/10.1016/j.cpr.2020.101889

Foulkes, L., & Andrews, J. L. (2023). Are mental health awareness efforts contributing to the rise in reported mental health problems? A call to test the prevalence inflation hypothesis. *New Ideas in Psychology*, *69*, 101010. https://doi.org/10.1016/j.newideapsych.2023.101010

Haslam, N., & Tse, J. S. (2025). Public awareness of mental illness: Mental health literacy or concept creep? *Australasian Psychiatry*, *33*(1), 18–20. https://doi.org/10.1177/10398562241292202

Hofmann, B. (2016). Medicalization and overdiagnosis: Different but alike. *Medicine, Health Care and Philosophy*, *19*(2), 253–264. https://doi.org/10.1007/s11019-016-9693-6

Hofmann, S. G., Asnaani, A., Vonk, I. J. J., Sawyer, A. T., & Fang, A. (2012). The efficacy of cognitive behavioral therapy: A review of meta-analyses. *Cognitive Therapy and Research*, *36*(5), 427–440. https://doi.org/10.1007/s10608-012-9476-1

John Hopkins Medicine. (n.d.). *Premenstrual dysphoric disorder (PMDD)*. https://www.hopkinsmedicine.org/health/conditions-and-diseases/premenstrual-dysphoric-disorder-pmdd

Kale, M. S., & Korenstein, D. (2018). Overdiagnosis in primary care: Framing the problem and finding solutions. *BMJ*, k2820. https://doi.org/10.1136/bmj.k2820

Kawa, S., & Giordano, J. (2012). A brief historicity of the Diagnostic and Statistical Manual of Mental Disorders: Issues and implications for the future of psychiatric

canon and practice. *Philosophy, Ethics, and Humanities in Medicine*, *7*(1), 2. https://doi.org/10.1186/1747-5341-7-2

Khaledi-Paveh, B., Maazinezhad, S., Rezaie, L., & Khazaie, H. (2021). Treatment of chronic insomnia with atypical antipsychotics: Results from a follow-up study. *Sleep Science*, *14*(1), 27–32. https://doi.org/10.5935/1984-0063.20190149

King, S. (2020). Premenstrual syndrome (PMS) and the myth of the irrational female. In C. Bobel, I. T. Winkler, B. Fahs, K. A. Hasson, E. A. Kissling, & T.-A. Roberts (Eds.), *The Palgrave Handbook of Critical Menstruation Studies* (pp. 287–302). Springer Singapore. https://doi.org/10.1007/978-981-15-0614-7_23

Kirsch, I. (2019). Placebo effect in the treatment of depression and anxiety. *Frontiers in Psychiatry*, *10*, 407. https://doi.org/10.3389/fpsyt.2019.00407

Luo, H., Chai, Y., Li, S., Lau, W. C. Y., Torre, C. O., Hayes, J., Lam, I. C. H., Lin, X., Yin, C., Fortin, S., Kern, D. M., Lee, D. Y., Park, R. W., Jang, J.-W., Chui, C. S. L., Li, J., Seager, S., Man, K. K. C., & Wong, I. C. K. (2024). Psychotropic drug prescribing before and during the COVID-19 pandemic among people with depressive and anxiety disorders: A multinational network study. *The Lancet Psychiatry*, *11*(10), 807–817. https://doi.org/10.1016/S2215-0366(24)00245-1

Mayor, S. (2008). Meta-analysis shows difference between antidepressants and placebo is only significant in severe depression. *BMJ*, *336*(7642), 466.1-466. https://doi.org/10.1136/bmj.39503.656852.DB

Moynihan, R. (2012). *Disease-mongering: Widening the boundaries that define medical illness*. Health Action International. https://haiweb.org/encyclopaedia/disease-mongering/

National Alliance on Mental Illness. (n.d.). *Mental health by the numbers*. Retrieved November 22, 2025, from https://www.nami.org/about-mental-illness/mental-health-by-the-numbers/

Nikkel, R., & Whitaker, R. (2018, October 22). Flooding the world with psychiatric drugs could boost the burden of mental disorders. *STAT*. https://www.statnews.com/2018/10/22/flooding-world-psychiatric-drugs-boost-burden-mental-disorders/

Redshaw, L. (2023, August 2). Is self-diagnosis on social media helping or hurting people's health? *Tebra*. https://www.tebra.com/theintake/medical-deep-dives/tips-and-trends/is-self-diagnosis-on-social-media-helping-or-hurting-peoples-health

Robinson, J. (2022, August 31). The serotonin theory of depression: How the media got it all wrong. *The Pharmaceutical Journal*. https://pharmaceutical-journal.com/article/feature/the-serotonin-theory-of-depression-how-the-media-got-it-all-wrong

Rodriguez Del Barrio, L., Onocko Campos, R., Stefanello, S., Vianna Dantas Dos Santos, D., Cyr, C., Benisty, L., & De Carvalho Otanari, T. (2014). Human rights and the use of psychiatric medication. *Journal of Public Mental Health*, *13*(4), 179–188. https://doi.org/10.1108/JPMH-06-2013-0039

Schroll, J. B., & Lauritsen, M. P. (2022). Premenstrual dysphoric disorder: A controversial new diagnosis. *Acta Obstetricia et Gynecologica Scandinavica*, *101*(5), 482–483. https://doi.org/10.1111/aogs.14360

Shorter, E. (2015). The history of nosology and the rise of the Diagnostic and Statistical Manual of Mental Disorders. *Dialogues in Clinical Neuroscience*, *17*(1), 59–67. https://doi.org/10.31887/DCNS.2015.17.1/eshorter

Shpancer, N. (2022, July 24). Depression is not caused by chemical imbalance in the brain. *Psychology Today*. https://www.psychologytoday.com/us/blog/insight-therapy/202207/depression-is-not-caused-chemical-imbalance-in-the-brain

Suhr, J. A., & Johnson, E. E. H. (2022). First do no harm: Ethical issues in pathologizing normal variations in behavior and functioning. *Psychological Injury and Law*, *15*(3), 253–267. https://doi.org/10.1007/s12207-022-09455-z

Takayanagi, Y., Spira, A. P., Bienvenu, O. J., Hock, R. S., Carras, M. C., Eaton, W. W., & Mojtabai, R. (2015). Antidepressant use and lifetime history of mental disorders in a community sample: Results from the Baltimore Epidemiologic Catchment Area Study. *The Journal of Clinical Psychiatry*, *76*(01), 40–44. https://doi.org/10.4088/JCP.13m08824

Walthall, J. (2020, June 1). The evolution of the mental health movement. *National Alliance on Mental Illness*. https://www.nami.org/Blogs/NAMI-Blog/June-2020/The-Evolution-of-the-Mental-Health-Movement

Warner, C. H., Bobo, W., Warner, C., Reid, S., & Rachal, J. (2006). Antidepressant discontinuation syndrome. *American Family Physician*, *74*(3), 449–456.

Waqas, A., Malik, S., Fida, A., Abbas, N., Mian, N., Miryala, S., Amray, A. N., Shah, Z., & Naveed, S. (2020). Interventions to reduce stigma related to mental illnesses in educational institutes: A systematic review. *The Psychiatric Quarterly*, *91*(3), 887–903. https://doi.org/10.1007/s11126-020-09751-4

Wolinsky, H. (2005). Disease mongering and drug marketing. *EMBO Reports*, *6*(7), 612–614. https://doi.org/10.1038/sj.embor.7400476

World Health Organization. (2022, March 2). *COVID-19 pandemic triggers 25% increase in prevalence of anxiety and depression worldwide*. https://www.who.int/news/item/02-03-2022-covid-19-pandemic-triggers-25-increase-in-prevalence-of-anxiety-and-depression-worldwide