The Thermometer That Changes the Weather

There are two tales about modern psychiatry, both widely shared and both apparently true. In the first, we have grown complacent: every raucous kid is now a case of ADHD, every bad fortnight a depression, every introvert somewhere on a spectrum, a drug industry and a culture quick to medicalise ordinary distress casting wider nets. In the second, we are at last competent: suffering denied for generations, the masked autistic girl, the adult whose ADHD was called a character flaw, the depressed man told that men do not get depressed, is finally being seen and helped. The question I have been set asks me to choose: are mental illnesses over-diagnosed today, or simply better recognised?

The question is poorly formulated, but instructively so. Taken at face value, the best evidence supports a measured "both": some of the rise is genuine recognition of cases once missed, some is inflation at the margins, a mixture I defend below. But settling the proportions would not settle the dispute, because both answers share a hidden premise: that a diagnosis is a "reading," taken off the patient the way a temperature is taken with a thermometer, a fact already there, waiting to be noticed or missed. On that model, "over-diagnosis" means the instrument has been made too sensitive, and "better recognition" means it has at last been calibrated, but either way it only describes a state that predates it. The premise is not true. A diagnosis does not just describe the person, it acts on them. It is more like a verdict, or a christening, than a reading. The real axis was never detection-accuracy. It is consequence: what the label, as an intervention, does to the life it lands on.

It's a true recognition story, and we should say so

The optimist reading, in its strong form, is right, and the cynic does it a disservice. For most of the twentieth century real disorders went uncounted because the template was too narrow. Autism was modelled on boys, and the girls who masked their traits well enough to pass slipped through. Adult ADHD was barely a category, on the premise that hyperactivity vanished at adulthood; the evidence shows the opposite, with adult diagnoses climbing steeply once clinicians began to look.[1] Depression in men hid behind scripts that recast it as irritability or drink. As criteria broadened and screening spread through schools and primary care, a great deal of real, previously invisible suffering finally registered. To dismiss this as fashionable over-

labelling is to confuse removing a blindfold with inventing the thing newly seen. Recognition is real, and conceding it is what makes the harder point land.

Why "both at once" is compelled, and still not enough

A diagnostic criterion is a line drawn across a continuous distribution. Traits such as inattention, low mood and social difficulty are not bimodal; there is no natural divide between the disordered and the well, only a gradient with most people massed in the middle. Diagnosis sets a threshold along that continuum and calls everything past it a case. Scrape the line down, for perfectly valid reasons, and you sweep in, in one motion, both the genuinely impaired who were wrongly left out and the mild boundary cases for whom the label is a stretch. You cannot do the one without the other. "Better recognition" and "over-diagnosis" are therefore not two processes that better data could prise apart; they are one adjustment seen from opposite ends. So it is indeed both. But this is still inside the measurement world, still asking where to put the line so the reading comes out correct, and accuracy was never what made a diagnosis helpful.

ADHD, where the numbers incriminate the question

ADHD offers something close to a natural experiment. In UK primary care, new ADHD diagnoses over 2000–2018 rose most steeply among adults, roughly twenty-fold among men aged 18 to 29, with prescriptions for that group up nearly fifty-fold.[2] In the United States, adult diagnoses roughly doubled in a single decade.[3] Read those curves as a thermometer and you would conclude the disorder had detonated across the population.

It did not. Reviews that track true prevalence rather than diagnosis find it stable in adults and children alike, even as diagnosis climbs.[4] The most rigorous isolates the cause: when the same protocol is applied across decades, there is no evidence the underlying rate rose, and the variation between studies reflects not the calendar year but methodology, which criteria were used, who supplied the information, and whether impairment was required for a case to count.[5] Diagnosis rose exponentially while the condition held flat, and what moved the numbers was a set of choices about where to draw the line. The reading climbed while the temperature stayed put, the one thing a thermometer cannot do, and exactly what a decision can. The quantity the whole debate fights over is not a measurement, but an artefact of where we chose to stand.

A diagnosis is a thing you do to a person

This is the point J. L. Austin made about the word "real" itself: it is incomplete until you supply a noun and an alternative, a real *what*, as opposed to *what*?[6] "Over-diagnosed or better recognised" inherits the same defect; it asks for a verdict on a quantity without specifying what would count as the wrong one. Ian Hacking, writing on exactly this terrain, drew the conclusion the present debate keeps missing: that a classification of people can be perfectly real and still be historically and socially constituted, because naming a kind of person changes the people so named.[7] His "looping effect" describes how a diagnostic label feeds back on its bearers, who begin to experience and conduct themselves through it, so that category and person remould each other over time.[8] My argument takes this one turn further: looping is what makes the counting debate not merely hard but ill-posed, because if the label alters the life it lands on, asking how many "really" have the condition treats as fixed a target the diagnosis is busy moving.

So if diagnosis is an act rather than a reading, the question about any given diagnosis is not whether it is correct but what it does, and the same diagnosis, applied to two people who both fully meet criteria, can be a key for one and a cage for the other.

For the first, the label is liberation. It makes a bewildering inner life legible, unlocks treatment that works, secures accommodation, and dissolves years of self-blame by moving the problem from character to neurology. *You were not lazy, not weak, not broken: you had an untreated condition* is, for that person, among the most freeing sentences medicine can offer. For the second, the identical words foreclose. Suppose she too meets every criterion: the symptom count, the duration, the impairment that crosses the threshold of clinical significance. Nothing turns on her being a misdiagnosis. Yet the impairment that qualifies her is entangled with a punishing job, an unprocessed grief, an overcrowded classroom, and the manual's demand that symptoms be "clinically significant" is not a measurement but a judgment, made at the same normative margin as the threshold itself. For her the label medicalises a life that was hard for reasons no diagnosis can touch; agency shrinks, expectations lower to fit the category, and she begins to live inside a name never sound enough to hold a whole life. Same accuracy, opposite effects, and the difference is not settled by whether either diagnosis was "correct."

That's why counting can never put an end to the debate. Two textbook-correct diagnoses can differ entirely in their value to a life. Prevalence figures can tell us how many people cross

the threshold; they cannot tell us, for any one of them, whether crossing it helped. The dispute only looked empirical; the question underneath it was always one of value.

The line always gets lower, whether it helps or not

If diagnosis is an act, someone performs it, under pressures that all push the threshold the same way, none required to ask whether the marginal diagnosis improves the marginal life. Not a conspiracy, a structural drift. Clinicians themselves report inconsistent adherence to criteria, rushed evaluations, reliance on shortcuts in place of a proper interview, and an increasingly colloquial use of clinical language that patients carry in from social media.[9] Around them sit incentives, all pointing one way. Pharmaceutical income scales with broad definitions. Schools and universities require a formal diagnosis before granting accommodation, so a student needs the label whether or not it fits. Insurers reimburse only against a coded condition, making the diagnosis the ticket to care. And screening tools are built to be sensitive: applied to the general population, the most widely used adult ADHD screener over-identifies the condition seven- to ten-fold, with a positive predictive value near eleven percent, the false positives left for a fifteen-minute appointment that never corrects them.[10] Each force pushes the line down. None is geared to the only question that counts: will this diagnosis, for this person, leave them better off?

Two objections, and what they concede

Two objections are worth meeting head-on, for a careful reader will raise them both.

The first defends the measurement model on its own ground. Some conditions surely are thermometer-like: discrete, biologically anchored, present or absent wherever the threshold sits. Grant it, and bound it. The measurement picture holds for a few severe, categorical disorders, and there the original question could almost be answered by counting. But the over-diagnosis debate is never about those. It is about the high-prevalence, continuously distributed conditions where the threshold does the defining: ADHD, anxiety, mild depression, the broad edges of the autism spectrum. The model survives only for the cases nobody argues about, and collapses for every case the argument concerns.

The second objection is not that the argument is false but that it is irresponsible. If the only honest verdict is case-by-case, in the consulting room, we seem to surrender the population-level claims advocacy depends on: this many people have this condition, and they are owed this

much care. The worry is fair, but it mistakes what is given up. I am not denying that conditions are real, that they occur at measurable rates, or that under-treatment is a serious harm; indeed the flat true-prevalence finding cuts against the alarmists as sharply as the celebrators, since the real caseload never ballooned into the epidemic the sceptics feared. What I deny is narrower: that an aggregate count, by itself, tells you whether the labelling did good. Advocacy can rest on the first claim. It cannot rest on the second, and when a rising line is waved as self-evidently good or bad news, it invites the very backlash it fears.

Replace the question

To answer the question as posed would accept its false premise. "Over-diagnosed, or better recognised?" demands one measurement verdict on something that is not a measurement, a single ruling on millions of individual acts, each with its own effect. Swap it out. For each diagnosis we now make that we once would not have, ask the one thing that tracks what a diagnosis actually is: does the label, working as an intervention in this particular life, leave this particular person better off? Where yes, call it recognition and be glad of it. Where no, call it over-reach and pull the line back. That judgement is irreducibly case-by-case, made at the margin where the threshold is set, and no graph, however steep or reassuring, can stand in for it.

The debate surrounding modern psychiatry has largely been a discussion of the crest of the wave: is it rising because we are at last measuring it honestly, or because we keep moving the gauge further down the beach? It was the wrong thing to watch. It was never about how high the water has climbed. It was about what the water is doing to the people standing in it.

Endnotes

[1] W. Chung et al., "Trends in the Prevalence and Incidence of Attention-Deficit/Hyperactivity Disorder Among Adults and Children of Different Racial and Ethnic Groups," *JAMA Network Open* 2, no. 11 (2019): e1914344.

[2] D. G. J. McKechnie, E. O'Nions, S. Dunsmuir, and I. Petersen, "Attention-Deficit Hyperactivity Disorder Diagnoses and Prescriptions in UK Primary Care, 2000–2018: Population-Based Cohort Study," *BJPsych Open* 9, no. 4 (2023): e121. The largest relative increases were among adults; the figures cited are for men aged 18–29.

[3] Chung et al., "Trends," e1914344.

[4] Alex F. Martin, G. James Rubin, M. Brooke Rogers, Simon Wessely, Neil Greenberg, Charlotte E. Hall, Angie Pitt, Poppy Ellis Logan, Rebecca Lucas, and Samantha K. Brooks, "The Changing Prevalence of ADHD? A Systematic Review," *Journal of Affective Disorders* 388 (2025): 119427. A review of forty studies across seventeen countries found no significant rise in ADHD prevalence in adults or children since 2020.

[5] G. V. Polanczyk, E. G. Willcutt, G. A. Salum, C. Kieling, and L. A. Rohde, "ADHD Prevalence Estimates Across Three Decades: An Updated Systematic Review and Meta-Regression Analysis," *International Journal of Epidemiology* 43, no. 2 (2014): 434–442. The authors conclude that variability in prevalence estimates is explained by methodological factors, and that there is no evidence of an increase in the number of children meeting criteria when standardised procedures are followed.

[6] J. L. Austin, *Sense and Sensibilia*, ed. G. J. Warnock (Oxford: Oxford University Press, 1962), 62–77, on the incompleteness of "real" absent a noun and a contrast; discussed in this connection by Ian Hacking, *Rewriting the Soul: Multiple Personality and the Sciences of Memory* (Princeton: Princeton University Press, 1995), 10–11.

[7] Hacking, *Rewriting the Soul*, 11–17, arguing that a disorder may be historically and socially constituted without thereby being unreal.

[8] Ian Hacking, "Making Up People," in *Reconstructing Individualism*, ed. T. Heller, M. Sosna, and D. Wellbery (Stanford: Stanford University Press, 1986), 222–236; and "The Looping Effects of Human Kinds," in *Causal Cognition: A Multidisciplinary Debate*, ed. D. Sperber, D. Premack, and A. J. Premack (Oxford: Clarendon Press, 1995), 351–383.

[9] S. R. Weber, "Commentary on Sources of Attention-Deficit/Hyperactivity Overdiagnosis Among U.S. Adults," *Healthcare* 13, no. 18 (2025): 2367. Weber lists non-adherence to DSM-5-TR criteria, poor diagnostic practice, electronic distraction, and shifting cultural use of the term among the contributing sources.

[10] S. R. Chamberlain, S. Cortese, and J. E. Grant, "Screening for Adult ADHD Using Brief Rating Tools: What Can We Conclude from a Positive Screen? Some Caveats," *Comprehensive Psychiatry* 108 (2021): 152224. In two general-population samples the ASRS indicated probable ADHD in 26.0% and 17.3% against an expected prevalence of about 2.5%, a positive predictive value of roughly 11.5%, implying seven- to ten-fold over-identification.