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How do we talk about overdiagnosis of mental health conditions without dismissing people's suffering?

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On 16 March the health and social care secretary, Wes Streeting, made headlines by declaring in an interview that there was an "overdiagnosis" of mental health conditions. The comment was made in the context of discussing reforms to the welfare system that would focus on getting sick and disabled people off benefits such as Personal Independence Payments and into work. Streeting acknowledged that there was a spectrum of mental ill health but believed that overdiagnosis was part of the problem, with too many people being "written off."

Overdiagnosis describes a diagnosis that doesn't benefit the person in question and makes people into patients unnecessarily. It can happen when diagnostic thresholds are expanded to include large groups of people with increasingly mild symptoms or when conditions are diagnosed that are unlikely to progress to cause harm.[1]

Concerns about overdiagnosis have been raised in a number of areas of medicine, including ongoing debates about the balance of benefits and harms in strategies for early detection of cancers[2] or for diagnosing and treating hypertension.[3] In a similar vein there have been discussions about the extent to which labelling people with particular mental health diagnoses is helpful, or whether medical framings of these issues may even be actively harmful.[4]

Psychiatric diagnoses can medicalise people's suffering, turning distress into an illness to be treated. But doing so risks obscuring the causes of this distress. For example, patients may feel anxious because of financial insecurity. The "diagnose and treat" model may lead to the diagnosis of an anxiety disorder and prescription of an antidepressant (and perhaps a referral for cognitive behavioural therapy). In this medicalised approach, the cause of the suffering—financial precariousness—is usually left unaddressed. People who have now become patients may feel "written off," in Streeting's terms, or consigned to a hopeless and sick future. This pathologisation may be detrimental to their recovery.[5]

However, discussion of overdiagnosis of mental health conditions has been tainted by victim blaming. Questions about whether medical diagnosis and treatment is the best response to distress have been conflated with questions about the existence or legitimacy of that distress. People criticising the medicalisation of suffering need to be careful to separate these matters. Current discourse often tangles discussion about this medicalisation with speculation about whether people really are in distress or whether they're seeking a diagnosis to get time off work or even to seem "edgy."[6]

This conflation feeds stereotypes about what the previous prime minister, Rishi Sunak, dismissively called "sick note culture" and the idea that people who report mental health difficulties are exaggerating or making things up. Streeting's comments on overdiagnosis also risk undermining people with severe or complex mental health conditions who face a struggle to get appropriate treatment and support.

Difficult rhetoric

In the context of a decade of campaigns encouraging people to talk about their mental health, such rhetoric is particularly difficult to hear. People have responded to these awareness raising campaigns by seeking help in greater numbers—and now they're being told that they've sought help too much, their distress is too mild, and they're a burden on the state. While it might not be helpful to label all distress as a form of mental illness, it doesn't mean that this distress can't be extremely difficult to live with or that the people experiencing it aren't in need of support.

It's possible to simultaneously acknowledge and legitimise this suffering while also questioning the "diagnose and treat" model of mental healthcare. This conversation should focus on discussing different approaches, including conceptual alternatives to psychiatric classification[7] and a radical approach to care that might better tackle the fundamental causes of distress.[8] Trying to help distressed people into work without offering them meaningful alternative frameworks and resources for understanding and tackling their suffering is unlikely to be successful.

In contrast with the explosion of recent discussion about overdiagnosis of mental health conditions, it's notable that there's been little public conversation about overdiagnosis of physical health conditions. Newspaper headlines, politicians, and government reports have said relatively little, for example, about the overdiagnosis recognised to be caused by breast cancer screening. Research shows that, for every woman whose life is saved through breast cancer screening, around three will have the condition overdiagnosed or have a breast cancer diagnosed that would never have progressed to cause harm or death.[9]

Breast cancer overdiagnosis disproportionately affects more affluent groups in our society who are more likely to respond to invitations for screening and testing.[10 11] In focusing particularly on the "overdiagnosis" of people who rely on the welfare state because they live in a state of significant distress, we risk stigmatising some of the poorest and most vulnerable people in the UK. What may get lost

in debates about the appropriate boundaries of diagnostic categories is what really matters: people are suffering, and they visit their GPs to ask for help. Our focus should be on how we can best respond with care.

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