About the Increase in Mental Disorder Diagnoses Among the Young

Available data reveal a 28% surge in the diagnosis of mental disorders among young people in the U.S. since 2018, with diagnoses involving two or more conditions rising 48%. Evernorth Res Inst

The surge in mental disorder diagnoses is striking. Some have dubbed it an "epidemic." Youngsters are being assigned not just one, but multiple labels over time. Some professionals argue that higher diagnosis rates are due to greater awareness, improved practices, and reduced stigma. Research points to a range of interacting factors, including school pressures, social media related problems, cultural and identity pressures, the pandemic aftermath, and economic considerations – including provider incentives (Pierce, Bai, Taxiarchi, et al., 2025).

In recent years, the surge has centered around several high profile diagnoses (e.g., Attention-Deficit/Hyperactivity Disorder – ADHD, Learning Disorder – LD, Oppositional Defiant Disorder – ODD). While some youngsters are diagnosed with a single label (e.g.,ADHD), others are seen as having comorbidity and assigned two labels (e.g., ADHD and LD). Over time, a sequence of several diagnostic labels may be assigned an individual.

Children in foster care and other high-stress environments are especially prone to accumulating numerous labels.

For decades, the proliferation and use of mental disorder labels has sparked debate over whether the benefits of such diagnoses are greater than the harm generated through mislabeling, stigma, diagnostic inflation, and other negative outcomes (Adelman & Taylor, 2020). Of particular concern is that diagnostic errors generally misguide interventions.

Because the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) is the primary guide for professional diagnoses in the U.S., it has been a constant focus of those concerned with the rate at which diagnoses are increasing. It is noteworthy that the classification system is under continuous revision (currently in its 5th edition).

Criticism of the Diagnostic and Statistical Manual

Among the many concerns related to DSM's are that it

- over-medicalizes normal behavior by relying too heavily on static, symptom-based categories that don't reflect the fluid dimensional nature of many mental health concerns
- doesn't translate well across cultures or account for socioeconomic and personal contexts that affect mental health
- lacks sufficient biological or empirical grounding and prioritizes agreement among clinicians (reliability) over valid representation of disorders

Individuals are assigned labels that follow them throughout their lives, even when symptoms wane or go away

These deficiencies are all seen as contributing to the increasing number of individuals being diagnosed and misdiagnosed.

---

*The material in this document builds on work done byYiwen Xu(Wendy) as a participant with the national Center for MH in Schools & Student/Learning Supports at UCLA in 2025

The center is co-directed by Howard Adelman and Linda Taylor and operates under the auspices of the School Mental Health Project, Dept. of Psychology, UCLA.Website: **https://smhp.psych.ucla.edu**

How concerns related to diagnosing youngsters are addressed currently

A diagnosis can open doors to resources, specialized instruction, and treatment that may greatly benefit a child and family. For example, an appropriate diagnosis might qualify a student for an individualized education plan or insurance-covered therapy.

However, labels also can be stigmatizing, potentially changing how peers and adults view an individual. For a diagnosed youngster, a label might provide some degree of relief (giving a name to their struggles) or cause distress if they feel "defined" by it. Diagnoses are meant to be tools for helping, but they also can tag a child with a permanent identity.

Critics argue that the DSM manual tends to reduce complex individuals to a set of symptoms, potentially affecting self-perception and social treatment

Beyond improving the DSM, constant efforts are in play to improve diagnostic practices for mental health disorders. All are intended to generate practices that help more than they harm. To those ends:

- Professional guidelines emphasize comprehensive evaluation – including medical, psychological, and environmental assessments. Those making diagnoses are encouraged to make contextually informed assessments, rule out other explanations (such as situational stress and trauma), and consider neurodevelopmental differences, as well as motivational and developmental states of being. They also are encouraged to use multi-informant assessments (e.g., from parents, teachers).
- As an alternative to immediately diagnosing a very young child with a controversial disorder, some professionals have adopted a sequential strategy. They initially use broad descriptive diagnoses and then monitor to assess how symptoms and ongoing development unfold during intervention (see Appendix).

Rather than symptoms of pathology, some behaviors may be adaptive responses to environmental challenges.

- Our Center has developed a sequential and hierarchical approach that starts by assessing responses to escalating levels of intervention. A diagnostic label is assigned only after problems are unresponsive to all but specialized treatment (Adelman & Taylor, 2020). This approach can help distinguish between transient developmental challenges and persistent impairments and suggest root causes for symptoms.
- Rather than a formal diagnosis, reports often offer detailed descriptions using non-stigmatizing language. For example, a clinician might explain that a child has a traumatic history, attention weaknesses and mood regulation difficulties in specific circumstances, and discuss how these fit into a holistic intervention plan. This is consistent with the call for a shift to a recovery-based approach that emphasizes a shift from labeling to personal growth and resilience to empower individuals to manage their mental health effectively.

A child's development is a moving target, so after a label is assigned, good practice calls for periodic reevaluations

While efforts are being made to ensure diagnoses are valid and helpful, there remains a need to remain vigilant and counter diagnostic inflation and the downsides of labeling. Flexibility and willingness to refine diagnostic approaches is essential, as is sensitivity in how diagnoses are communicated and used.

Concluding Comments

Diagnostic labeling is essential to organizing and mobilizing research and practice. At the same time, mislabeling can lead to unnecessary treatment and poor use of sparse resources. And as with all diagnostic activity, labels can generate life shaping negative personal and social consequences. Moreover, current trends risk medicalizing everyday struggles and diverting attention from those with severe needs.

Few stakeholders doubt that increases in mental disorder diagnoses are partially due to growing awareness, acceptance, and improved professional practices. At the same time, the increases bring overdiagnosis and a growing number of misdiagnoses. And as someone sagely noted: *Being misdiagnosed is like being given the wrong map in a storm – not only are you still lost, but now others expect you to find your way.*

Exhibit

Good Practices for Countering Inappropriate Diagnoses

A synthesis of good diagnositc practice related to behavior, emotional, and learning problems is seen as involving the following continuous improvement efforts.

Assuming that a valid differential diagnosis has been made, it will be used for a variety of purposes. At the core, it is a guide for intervention.

Use Labels Thoughtfully	In using and communicating about a given diagnosis, clarity is essential about what the label means and doesn't mean. Emphasis should be placed on the individual's strengths and assets not just deficits. Stress that the label is not meant to define the individual. This can help prevent the label from becoming a self-fulfilling prophecy or a source of inappropriate expectations.
Improve Practices and Training	Diagnosticians must be familiar with the latest research, assessment processes, and criteria for differential diagnoses. Steps must be taken to avoid cultural bias in assessment tools and interpretation. This calls for continuing professional education. Current trends call for multi-source, multi-method, and sequential assessments, including response to intervention strategies. A reciprocal determinist approach can help look for environmental as opposed to internal disorders.Regularly updated diagnostic guidelines can aid practitioners in deciding when a diagnosis is warranted versus when to take a watchful waiting approach.
Monitor Intervention & Reevaluate Diagnoses	Multi-source, multi-method assessments of progress and problems during corrective interventions can provide crucial context and other related information about behavior across settings and over time. Such data are used to validate or to consider reevaluating a diagnosis.

Appendix

Labeling Problems: The Example of Pediatric Bipolar Disorder

Diagnostic classification systems are essential tools in the pursuit of good practice, policy, research, and training, At the same time, there is a constant need to address problems associated with some labels.

In the 1990s and 2000s, the surge in *pediatric bipolar* diagnoses taught the field a hard lesson about the importance of diagnostic precision and humility. Bipolar disorder was historically understood as an adult illness, rarely identified in young children. However, beginning around the mid-1990s, clinicians in the U.S. began diagnosing bipolar disorder in children at unprecedented rates.

Studies found a forty-fold (4,000%) increase in the diagnosis of bipolar disorder among youth between the mid-1990s and early 2000s (Moreno et al., 2007). By the mid-2000s, bipolar disorder had become one of the most common psychiatric diagnoses for pre-adolescent children in inpatient settings. This surge prompted concern that typical childhood temper outbursts and irritability were being pathologized as pediatric bipolar disorder. Many experts argued that the "epidemic" was driven less by a true prevalence increase and more by diagnostic trends and misidentifications. They pointed out that children labeled as bipolar often did not fit the classic criteria of the illness. For example, instead of discrete manic episodes, many had chronic irritability or explosive anger as their primary symptom. Such observations led to questions about diagnostic accuracy and whether other problems were being overlooked in the rush to apply the bipolar label.

As a corrective measure, rather than immediately labeling a very young child with bipolar disorder, some pediatric psychiatrists adopted a more conservative approach – initially using broad descriptive diagnoses to reduce the risk of misdiagnosis by allowing for support and monitoring as the child's symptoms and development unfold. Early on, they used "Mood Disorder, Not Otherwise Specified;" in 2013, “Disruptive Mood Dysregulation Disorder” (DMDD) was added to DSM as a diagnosis for children who exhibit persistent severe irritability and frequent temper outbursts (American Psychiatric Association, 2013). The goal of DMDD was to curb potential overdiagnosis of pediatric bipolar by providing an alternative label for volatile mood behavior in childhood with a diagnosis that does not carry the implications of a lifelong bipolar illness. Following the introduction of DMDD, the rate of new bipolar disorder diagnoses in children.

This example highlights that the field can learn and adapt when a diagnosis is being overused or misused. The conversation sparked by the pediatric bipolar diagnosis boom has added to ongoing efforts for more careful labeling practices.

References and Resources Used in Preparing this Information Resource

Adelman, H.S., & Taylor, L. (2017). *Addressing barriers to learning: In the classroom and schoolwide.* Center for MH in Schools & Student/Learning Supports at UCLA. **https://smhp.psych.ucla.edu/pdfdocs/barriersbook.pdf**

Adelman, H.S., & Taylor, L. (2020). *Embedding Mental Health as Schools Change.* Center for MH in Schools & Student/Learning Supports at UCLA. **https://smhp.psych.ucla.edu/pdfdocs/mh20a.pdf**

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: APA Press.

Brotman, M.A., Kircanski, K., & Leibenluft, E. (2017). Irritability in children and adolescents. *Annual Review of Clinical Psychology, 13*, 317-341. **https://doi.org/10.1146/annurev-clinpsy-032816-044941**

Carlson, G.A. (1998). Mania and ADHD: Comorbidity or confusion. *Journal of Affective Disorders, 51*, 177-187. **https://doi.org/10.1016/S0165-0327(98)00179-7**

Chase, D., Harvey, P.D., & Pogge, D.L. (2020). Disruptive mood dysregulation disorder (DMDD) in psychiatric inpatient child admissions: Prevalence among consecutive admissions and in children receiving NOS diagnoses. *Neurology, Psychiatry and Brain Research, 38*, 102-106. **https://doi.org/10.1016/j.npbr.2020.11.001**

Evernorth Research Institute (2024). *For a healthy workforce, curbing the youth mental health crisis is imperative.* Author. **https://www.evernorth.com/youth-mental-health-research-may-2024**

Goldstein, B.I., & Birmaher, B. (2012). Prevalence, clinical presentation and differential diagnosis of pediatric bipolar disorder. *Israel Journal of Psychiatry and Related Sciences, 49*, 3-14. PMID: 22524987 **https://pmc.ncbi.nlm.nih.gov/articles/PMC5027964/**

Hatchett, G.T. (2022). Treatment planning strategies for youth with disruptive mood dysregulation disorder. *The Professional Counselor, 12,* 37-54. **https://doi.org/10.15241/gth.12.1.37**

Keramatian, K., & Morton, E. (2023). Barriers to timely identification of bipolar disorder in youth: A model informed by the situational analysis framework. *Frontiers in Child and Adolescent Psychiatry, 3*, 1186722. **https://doi.org/10.3389/frcha.2023.1186722**

Leibenluft, E., Charney, D.S., Towbin, K.E., Bhangoo, R.K., & Pine, D.S. (2003). Defining clinical phenotypes of juvenile mania. *American Journal of Psychiatry, 160,* 430-437. **https://doi.org/10.1176/appi.ajp.160.3.430**

Meng, Y., Liu, D., & Acevedo, B. (2023). Trends in diagnosis of bipolar and disruptive mood dysregulation disorders among youth (2013-2022). *Journal of Affective Disorders, 320*, 92-99. **https://pubmed.ncbi.nlm.nih.gov/32056757/**

Moreno, C., Laje, G., Blanco, C., Jiang, H., Schmidt, A.B., & Olfson, M. (2007). National trends in the outpatient diagnosis and treatment of bipolar disorder in youth. *Archives of General Psychiatry, 64*, 1032-1039. **https://doi.org/10.1001/archpsyc.64.9.1032**

Parry, P.I., & Levin, E.C. (2012). Pediatric bipolar disorder in an era of "mindless psychiatry": Restoring context and developmental focus. *Journal of Trauma & Dissociation, 13,* 51-68. **https://doi.org/10.1080/15299732.2012.642762**

Pierce, M., Bai, Y., Taxiarchi, V., et al., (2025). *Understanding drivers of recent trends in young people's mental health.* Youth Futures Foundation. **https://youthfuturesfoundation.org/wp-content/uploads/2025/07/Understanding-drivers-of-recent-trends-in-young-peoples-mental-health-July-2025-final.pdf**

Psychreg News Team (2025). *Calls grow to overhaul mental health diagnosis framework*. Online. **https://www.psychreg.org/calls-grow-overhaul-mental-health-diagnosis-framework/**

Ruscio, J. (2015). Labeling theory. In R. L. Cautin & S. O. Lilienfeld (Eds.), *The Encyclopedia of Clinical Psychology* (pp. 1-6). Hoboken, NJ: Wiley. **https://doi.org/10.1002/9781118625392.wbecp452**

Stringaris, A., Vidal-Ribas, P., Brotman, M. ., & Leibenluft, E. (2018). Practitioner review: Definition, recognition, and treatment challenges of irritability in young people. *Journal of Child Psychology and Psychiatry, 59,* 721-739. **https://doi.org/10.1111/jcpp.12823**