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Adolescents' self-diagnosis of mental disorders: A qualitative study of psychiatrists' perspectives

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Research Article

Keywords: Self-diagnosis, psychiatrists, adolescents, CAMHS

Posted Date: November 3rd, 2026

DOI: https://doi.org/10.21203/rs.3.rs-11567335/v1

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Additional Declarations: No competing interests reported.

Abstract

Background

The phenomenon of self-diagnosis with mental disorders among adolescents has gained increasing attention. While previous studies have explored adolescent and clinician perspectives on self-diagnosis, little is known about how psychiatrists specifically experience and interpret these encounters. Given psychiatrists' central role in formal diagnosis and treatment, their perspectives offer unique insight into how self-diagnosis is approached within clinical settings.

Methods

In this study, N = 16 UK-based psychiatrists who work with adolescents aged 10–24 participated in one-to-one semi-structured interviews. Psychiatrists were asked about their experiences and attitudes towards self-diagnosis of mental disorders.

Results

Using reflexive thematic analysis, we developed five themes: (1) *Self-diagnosis is shaped by peers both online and offline;* (2) *The drive for a diagnosis often comes from the parent, not the adolescent;* (3) *Self-diagnosis has personal and social benefits*; (4) *Self-diagnosis is problematic when it becomes inflexible*; and (5) *Disagreement about self-diagnosis can be a threat to the therapeutic relationship*.

Conclusions

These findings offer new insights into how psychiatrists experience and respond to adolescent self-diagnosis. While clinicians recognised the potential value of self-diagnosis, they also raised concerns around inflexibility and relational tensions. This study extends existing work by foregrounding psychiatrists' voices, offering a clinical lens on the relational and developmental dynamics of self-diagnosis. The findings underscore the need for nuanced clinical guidance on how to manage adolescent self-diagnosis, in a way that respects young people's agency, recognises psychiatrists' expertise and fosters collaborative clinical relationships.

Introduction

Self-diagnosis refers to labelling oneself as having a mental disorder without receiving a formal diagnosis from a healthcare professional (Tse & Haslam, 2024). Although self-diagnosis is not new, its prevalence has expanded in the digital age. Online forums, social media and mental health awareness campaigns have normalised diagnostic language, democratised expert knowledge, and made clinical terms part of everyday vocabulary. As a result, discourse about the impact of self-diagnosis has grown

across media, clinical, and research domains (Padhi, 2024; Caron, 2022; Davey, 2023). The increase in self-diagnosis offers opportunities for personal insight, social support and early help-seeking, but also raises concerns about the reliability of self-assessment, the medicalisation of normal emotional states, and the influence of misinformation.

Recent research has begun to elucidate the underlying factors driving the rise in adolescent self-diagnosis. First, there has been an increase in mental health difficulties in this age group (Benton et al., 2021; Newlove-Delgado, 2022). Second, long NHS waiting lists and overwhelmed services make formal diagnosis difficult to access, meaning self-diagnosis is often seen as the only option (Underhill & Foulkes, 2023). Third, public awareness surrounding mental health problems has transformed, through government and charity campaigns, social media content and school-based initiatives (Bolinski et al., 2020; Draganidis et al., 2024; Henderson & Thornicroft, 2009; Orben, 2020; Werner-Seidler et al., 2021). Social media is particularly significant because it can disseminate high volumes of detailed, personally relevant mental health information to individuals, with algorithms and infinite scroll features leading young people down “narrow and repetitive rabbit-hole pathways” that reinforce specific content.

Increased mental health awareness, and any resulting self-diagnosis, is a double-edged sword (Foulkes & Andrews, 2023). On the one hand, increased awareness and self-diagnosis can help genuine symptom recognition, encourage self-help, and facilitate access to treatment (Jutel, 2009; Mirea et al., 2021; Sikorski et al., 2023). It can also validate distress and allow individuals to connect with others who share similar experiences, fostering belonging (Jones et al., 2015). On the other hand, there is concern that mental health awareness can contribute to over-pathologisation, leading people to inaccurately self-diagnose, i.e. to interpret typical emotional difficulties as clinical symptoms (Foulkes & Andrews, 2023; Monteith et al., 2023). There is now experimental evidence that mental health awareness materials can induce anxiety and increase inaccurate self-diagnosis (Sandra et al., 2025). The risk of inaccuracy is a particular concern on social media, given mental health information online is often wrong (Fitzpatrick et al., 2025; Schiros et al., 2025; Starvaggi et al., 2024). Inaccurate content on social media may lead young people to interpret traits and symptoms incorrectly (Monteith et al., 2023). Taking all this together, it has been theorised that mental health awareness might make people better at recognising the presence of mental disorders but worse at recognising their absence (Haslam & Tse, 2025).

It is particularly important, for several reasons, to understand self-diagnosis in adolescence (10 to 24 years; Sawyer et al., 2018). Adolescence is a critical period of identity formation, during which individuals are particularly attentive to language and frameworks that help them understand and communicate who they are (Acheson & Papadima, 2023). It is well-established that both professional diagnoses and self-diagnoses can offer these insights to young people (Fletcher-Watson, 2024; O’Connor et al., 2018; Underhill & Foulkes, 2025). It is also a key period of social development, in which ly increasing important and influential in young people’s lives (Laursen & Veenstra, 2021). This is relevant to self-diagnosis, because shared labels and identities can help adolescents make sense of their experiences and reduce isolation (Acheson & Papadima, 2023). Longitudinal evidence demonstrates that adolescents who communicate with peers who self-label are more likely to adopt similar mental health labels themselves

(Varela, 2025). Lastly, adolescence is well established as a period of risk for developing mental health problems. Given the combination of these internal and external factors, it is unsurprising that self-diagnosis is increasing among adolescents today.

What remains unclear is how the rise in self-diagnosis is impacting clinical interactions. A recent pilot study of 57 young people entering treatment for mood and anxiety disorders found that 71.4% (40/57) had self-diagnosed before their first appointment, and that the value they ascribed to the diagnosis was associated with viewing mental health content online (Armstrong et al., 2025). It is reasonable to expect that a pre-existing self-diagnosis would affect the resulting interaction: clinicians must explore young people's symptoms while developing appropriate formulations and, where possible, arrive at a definitive diagnosis. An ethnographic study of two UK psychiatric clinics found that patients arriving with self-diagnoses can lead to a 'negotiation' between patient and doctor around proposed diagnosis, creating tension between competing forms of expertise (Lane, 2020). Other evidence suggests self-diagnosis can benefit clinical interactions: a mixed-methods systematic review found that patients who arrived with internet-driven self-diagnoses were better prepared for the appointment, asking more focused questions and communicating their concerns more clearly (Farnood et al., 2020). Patients reported more positive experiences when clinicians acknowledged and discussed the information the patients had found online (Farnood et al., 2020). Conversely, dismissive or contradictory responses could undermine rapport. However, because this review included both physical and mental health settings, its relevance to adolescent psychiatry remains uncertain.

Our previous study interviewed mental health professionals about their experiences and attitudes towards self-diagnosis among adolescents (Cunningham-Rowe & Foulkes, 2025). The sample included a range of professionals including clinical psychologists, psychotherapists, and counsellors. Contrary to our expectations, we found that these clinicians generally did not consider self-diagnosis inherently problematic and sometimes viewed it as useful therapeutic material. Participants reported that self-diagnosis could provide a useful starting point for understanding adolescents' difficulties and their own interpretations of these experiences (Cunningham-Rowe & Foulkes, 2025). However, participants also reported concerns when a diagnosis became inflexible or central to the young person's identity, potentially functioning as a self-fulfilling prophecy and interfering with therapeutic engagement (Cunningham-Rowe & Foulkes, 2025).

A key limitation of this study was that the sample did not include psychiatrists. The findings cannot necessarily be generalised to this group, who place greater reliance on diagnostic labels than other mental health professionals, in part because these labels influence prescribing decisions (Craddock & Mynors-Wallis, 2014). Psychiatry is a medical specialty in which diagnosis plays a central role, and psychiatrists may rely more heavily on structured diagnostic criteria such as the DSM-5 (Cruz et al., 2013). Psychiatrists' experiences of self-diagnosis may therefore differ, particularly when a young person's self-diagnosis conflicts with the psychiatrist's clinical assessment (Lane, 2020). Psychiatrists are therefore well positioned to provide insight into adolescent self-diagnosis because of their diagnostic expertise and experience with patients experiencing high levels of distress and disability.

Their perspectives can help clarify how self-diagnosis affects treatment engagement, the therapeutic relationship and ultimately clinical outcomes.

The current study therefore explores adolescent self-diagnosis of mental disorders through qualitative interviews with psychiatrists who have experience working with adolescents aged 10–24 years. One-to-one semi-structured interviews were conducted online to examine psychiatrists' perspectives on adolescent self-diagnosis, its implications and its challenges in clinical practice. Reflexive thematic analysis was used to address four research questions:

1. According to psychiatrists, how does self-diagnosis influence the therapeutic relationship and clinical outcomes?
2. What are psychiatrists' perceptions of the role of various information sources in adolescents' self-diagnosis of mental disorders?
3. If psychiatrists disagree with a self-diagnosis, how do they address this with the young person?
4. What do psychiatrists perceive to be the risks and benefits of self-diagnosis?

Method

Participants

N = 16 UK-based psychiatrists who work clinically with adolescents aged 10–24 were recruited (Sawyer et al., 2018). The sample consisted of n = 7 males and n = 9 females. They gave their age as between 25 and 34 years (n = 6), 35 and 44 years (n = 8) or 45 and 54 years (n = 2). They reported their ethnicity as white (n = 12), mixed (n = 1) or other (n = 3). Participants worked in England (south west: n = 3, south east: n = 5, north west: n = 3, London: n = 2) or Scotland (n = 3). Psychiatrists in the UK complete a medical degree, a two-year foundation programme, and at least six years of psychiatry specialty training (CT1–CT3 and ST4–ST6). With regard to seniority, n = 2 participants were still in training, and the remainder had varying lengths of ing experience (n = 9 had 1–4 years; n = 2 had 5–9 years; n = 1 had 10–15 years and n = 2 had over 15 years). All participants worked in the NHS; no participants worked privately. They worked clinically with patients aged 10–18 years (n = 11), patients aged 18–24 (n = 2) or both age groups (n = 3). Three additional psychiatrists completed the screening questionnaire but did not commit to taking part. Besides the requirement to be a UK-based psychiatrist who worked clinically with adolescents aged 10–24, either in child and adolescent (CAMHS) services (ages 10–17) and/or adult services (ages 18–24), no other inclusion/exclusion criteria were implemented.

Ethical Considerations

Ethical approval

was obtained from the divisional ethics board at the authors' institution, and informed consent was obtained from all participants. For anonymity, pseudonyms were used. Participants were given the choice of choosing their own pseudonym or letting the researchers randomly ascribe one (Lahman et al.,

2023). Participants were informed they could skip questions or withdraw at any time. A distress protocol allowed for breaks or stopping the interview if needed.

Sample size

Our sample size of N = 16 was based on our previous similar study with clinicians (Cunningham-Rowe & Foulkes, 2025) and the “information power” approach (Malterud et al., 2016). This approach proposes that the adequacy of a qualitative sample depends on the amount and relevance of information the sample provides in relation to the study aims, rather than on a predetermined numerical threshold (Malterud et al., 2016). Given our focused research questions and the specific expertise of our participant group, we considered a sample of 16 participants likely to provide sufficient information power while allowing for in-depth analysis. This sample size also corresponds to reflexive thematic analysis recommendations for focused interview studies, where the emphasis is on detailed interpretation rather than population representativeness (Braun & Clarke, 2013; Braun & Clarke, 2019). In this study, as with much qualitative research, the goal was not to generalise findings to a wider population, but to generate nuanced, in-depth insights into participants’ lived experiences from their clinical practice.

Recruitment

We employed purposive snowball sampling, advertising via the Department of Psychiatry at the authors’ institution, as well as the professional networks and social media networks of the authors. Interested participants completed a screening questionnaire consisting of 11 questions about their profession, years of experience, age group worked with, UK region, work setting, and how they learned about the study. Demographic questions covered gender, sexuality, age, and ethnicity, and whether their job is a psychiatrist with options for 'other' and 'prefer not to answer.' Based on this screening, those who worked as psychiatrists and worked with the appropriate age group of adolescents (between 10–24) were selected. To eliminate non-legitimate participants, work emails were required to confirm participants’ status as registered psychiatrists (Ridge et al., 2023).

Procedure

The first author conducted semi-structured one-on-one interviews with all participants, lasting around 45 minutes and conducted online on Microsoft Teams. The interviewer explained the study's purpose: to explore psychiatrists’ experiences with adolescent patients self-diagnosing with mental disorders. Self-diagnosis was defined as an individual identifying themselves with a mental disorder without a professional providing the diagnosis (Tse & Haslam, 2024). The interview included eight core questions, which were developed iteratively between both authors to ensure clarity, relevance and alignment with the research aims (Roberts, 2020; Table 1). The questions were supplemented with follow-up clarification questions to explore participant responses in more depth. Careful attention was given to

wording and structure to allow flexibility while aligning with the research aims (Brinkmann & Kvale, 2015; Kallio et al., 2016). We conducted interviews online to create a private and comfortable environment that encouraged participants to speak openly, while also offering flexibility and broader access regardless of location (DiCicco-Bloom & Crabtree, 2006; Janghorban, Roudsari, & Taghipour, 2014).

Table 1
Interview questions

Number	Interview Question
1	What is your experience of adolescents' self-diagnosis? Has this view changed in recent years of your practice? If so, can you say how?
2	What impact, if any, do you think the role of different information sources has in adolescent self-diagnoses?
3	What impact, if any, do you think the internet or social media has on self-diagnosis?
4	What impact, if any, do you think family has on shaping adolescents' self-diagnosis? If so, what does this typically look like?
5	What impact, if any, do you think peers have on adolescents' self-diagnosis? If so, what does this typically look like?
6	What do you think are the benefits and risks/harms of self-diagnosis?
7	Have you ever experienced situations where adolescents become resistant to contradictions of their self-diagnosis? How do you approach this?
8	Is there anything else that you want to say about self-diagnosis that we haven't covered?

Reflexivity and researcher positioning

The first author, who conducted the interviews and led the analysis, was a postgraduate psychology student. At the outset of the project, they had concerns about potential harms associated with self-diagnosis, including misdiagnosis and over-pathologisation. The senior author is an academic psychologist whose research examines mental health awareness and self-diagnosis, and they entered the analysis anticipating complexity in the potential benefits and harms of self-diagnosis. Both authors had exposure to academic, public and online discourse surrounding self-diagnosis, which informed their understanding of its potential risks and benefits. Neither researcher was a psychiatrist nor had any clinical training, positioning both as outsiders to psychiatric practice. As academics interviewing psychiatrists, the authors were conscious that participants occupied a position of greater clinical expertise, which may have shaped the interviews towards explanatory accounts in which participants positioned themselves as professional authorities.

The first author maintained a reflexive journal throughout data collection and analysis, documenting assumptions, reactions to participants' accounts, developing interpretations and analytical decisions

(see Supplementary Materials 1). The researchers also met regularly during analysis for crystallisation meetings, to discuss developing ideas, consider alternative interpretations and reflect on how their respective assumptions and positions were shaping engagement with the data (Tracy, 2010). These practices were used to facilitate reflexive engagement with researcher subjectivity, and to allow a deeper and more complex understanding of the data, rather than to establish a single objective or consensus interpretation (Tracy, 2010).

Analytical approach

Data from the interviews were analysed using reflexive thematic analysis (RTA; Braun & Clarke, 2006; Braun & Clarke, 2019). Analysis was predominantly inductive, with coding and theme development primarily guided by participants' accounts rather than an a priori coding framework. However, consistent with RTA, we recognise that analysis was inevitably informed by our existing knowledge, including the academic literature and public debate about self-diagnosis, and was thus partly deductive.

We adopted a critical realist approach, which assumes that while an external reality exists, such as the real-world practices of psychiatrists and the challenges they encounter, interpretation of this reality is always socially and culturally mediated (Fletcher, 2017). We therefore treated psychiatrists' accounts of adolescent self-diagnosis as grounded in real clinical encounters, while also recognising that these accounts, and our interpretation of them, are shaped by broader discourses, including institutional and professional norms, clinical training and public mental health narratives. This position enabled us to examine psychiatrists' reflections of adolescent self-diagnosis while recognising that their accounts were shaped by their prior clinical experiences and public and professional contexts.

Analysis was conducted following six steps from Braun & Clarke (2006, 2013). Analysis was performed in a flexible and iterative manner, moving back and forth between the different stages (Braun & Clarke, 2021). All coding was done in NVivo 15 (Lumivero, 2023). The first stage, *familiarisation*, involved listening to each interview recording in full, transcribing the data, and then reading the transcriptions several times. This was key for generating initial observations about patterns or ideas in the data set.

In the second stage, *initial coding*, initial codes were generated (Braun & Clarke, 2006). Both researchers independently coded one randomly chosen interview and met to discuss our approaches to the codes we had devised. This exercise was used to facilitate reflexive discussion and encourage the first author to consider alternative readings of the data, rather than to assess coding agreement or establish a consensus coding framework. The remaining transcripts were coded by the first author but were discussed in weekly crystallisation meetings to review research questions and findings (Tracy, 2010). This initial step produced 37 codes (see Supplementary Materials 2), and coding was then iterative, with some codes added, modified or collapsed as the first author progressed through the analysis.

In stage three, *initial themes* were generated using these codes (Braun & Clarke, 2006). After several rounds of refinement and reworking, seven candidate themes were identified at the end of this stage

(see Supplementary Materials 2). In stage four, *reviewing themes*, candidate themes were reviewed against the coded extracts and wider dataset and iteratively refined, combined or discarded according to their coherence and relevance to the research questions. This process resulted in five themes. In stage five, themes were *defined and named* by identifying the central organising concept or pattern of meaning represented by each theme. Clear and concise names were then chosen for each theme. Analysis continued during the final stage, *writing the report*, which involved a recursive process and multiple drafts to refine the analytic narrative (Byrne, 2022).

Results

The analysis produced five themes: (1) Self-diagnosis is shaped by peers both online and offline; (2) The drive for a diagnosis often comes from the parent not the adolescent; (3) Self-diagnosis has personal and social benefits; (4) Self-diagnosis is problematic when it becomes inflexible; and (5) Disagreement about self-diagnosis can threaten the therapeutic relationship (see Fig. 1). We describe each theme in detail below.

Theme 1: Self-diagnosis shaped by peers both online and offline

The first theme highlights how participants consistently described self-diagnosis as socially embedded – shaped by offline friendships, school environments and online communities. They reported that adolescent patients had often encountered diagnostic labels through friends with professionally-diagnosed or self-diagnosed conditions such as ADHD, autism, anxiety or depression. Participants suggested that adolescents observing others' experiences prompted some to compare these with their own, leading to self-reflection and, at times, self-diagnosis. Some described referral spikes in specific locations, and groups of young people expressing diagnostic interest after one student received a diagnosis and shared their experience:

"You end up with lots of referrals at the same time and often that relates to one person maybe being diagnosed...and then naturally, a lot of them will then talk about it with their friends" (Rohan)

Peer-to-peer transmission was viewed as both constructive and problematic. It could foster understanding, connection and self-validation, but could also encourage over-identification or pressure to adopt a label, with one psychiatrist describing patients who felt, "I need this diagnosis to affirm the fact that I am part of this group" (Freddy). They felt similarly ambivalent towards the role of the internet, particularly TikTok, Instagram and online forums, which were seen to amplify the social transmission of self-diagnosis through videos, influencers and psychiatric symptom lists. These spaces could also provide belonging, shared language and legitimacy when formal clinical validation was unavailable. One psychiatrist, adopting the perspective of a patient, captured this as follows:

“I've found my people, and I found a sense of identity. And I’ve found a way to understand my experiences” (Stevie)

However, psychiatrists also raised concerns about misinformation and algorithms reinforcing particular symptoms or identities. As Rohan noted, young people may not realise they are seeing “this tiny portion of very carefully curated internet to get their engagement”. At the same time, participants acknowledged that peer communities could provide valuable informal support to young people, reducing isolation by providing a kind of “informal peer support” (Helen). Overall, this theme indicates that peer and online influences meant self-diagnosis was rarely an isolated, individual process. These networks could provide validation, belonging and language for understanding distress, but could also shape expectations about diagnosis in ways that complicated later clinical assessment.

Theme 2: The drive for a diagnosis often comes from the parent not the adolescent

This theme captures how psychiatrists frequently described the desire for assessment as originating with parents rather than young people themselves. They reported that parental diagnosis-seeking resulted from a number of factors: advocacy to ensure their child received support, family history of a specific disorder, internet research, and educational pressures to confirm a diagnosis. One psychiatrist described families reasoning, for example, that “all of their cousins have got autism and ADHD... so they must do as well” (Freddy). Participants generally viewed parental concern as understandable, particularly when parents wanted timely support for their child:

“I don’t want to miss it. I want them to get support as soon as possible” (Stevie)

However, participants reported that parental certainty about a diagnosis could create tension when it conflicted with their clinical judgement or when obtaining a diagnosis became the primary goal. Institutional requirements, including access to Education, Health and Care Plans (EHCPs) and mental health services, were described as contributing to this pressure. Participants said that parent diagnosis-seeking was not only an expression of concern but could also reflect structural incentives to secure services:

“Parents know they won’t get support unless their child has a diagnosis” (Helen)

When parents strongly expected a particular diagnosis, disagreements could become difficult. One psychiatrist described a mother who was “absolutely furious” (Alice) and refused to allow an assessment to continue because she expected an ADHD diagnosis, which the psychiatrist did not endorse.

Participants also described cases in which they felt diagnosis-seeking appeared to be a useful means of attributing external difficulties to the young person. Identifying a diagnostic label seemed to serve a useful function of reducing parental blame. Parental shame or guilt could also contribute, with Emily describing a “shame drive” in which parents sought reassurance that difficulties were “not anything we’ve

done". Instead, with a diagnostic label, the parent hoped that the child's difficulty could be explained and resolved with external intervention:

"If there's a label… there's no blame for the parent" (Alice)

"Sometimes a label for a child can act as a scapegoat... It can risk ignoring the social problems and the relationship problems in the family unit" (Peter)

Overall, participants reported that parental involvement was often motivated by care and a desire for support, but could overshadow the young person's own understanding of their difficulties and narrow the clinical focus to a preferred diagnosis, which could mean missing important factors in the young person's and parent's life. Participants therefore described diagnosis-seeking as shaped not only by wider educational and mental health service structures but also by family beliefs and desires.

Theme 3: Self-diagnosis has personal and social benefits

This theme highlights that psychiatrists acknowledged many benefits of self-diagnosis for the individual adolescent, including self-understanding, coping, emotional regulation, belonging and greater engagement with services. Rather than simply adopting a label, they said, some young people used self-diagnosis as a framework for understanding their experiences and preparing for clinical conversations. Participants found that patients' pre-existing knowledge could improve the clinical interaction and their understanding of the patient:

"[self-diagnosed young people can be] really open with you and really share lots of different experiences about their internal world" (Stevie).

Participants also described practical benefits. They reported how young people sometimes used information associated with a suspected diagnosis to develop coping strategies while waiting for assessment. Mehrdad gave the example of looking up ADHD-related organisational strategies, describing this as unlikely to be harmful and potentially useful while waiting for an assessment appointment. d acknowledge that self-diagnosis was a pragmatic response to long waiting lists and perceived barriers to formal assessment. Emily noted that when young people self-diagnosed and clinicians agreed there was sufficient evidence to support the diagnosis, the young person could "get support a lot quicker than they can through formal routes". Similarly, Jack described a young person who recognised her own difficulties and adapted "the way she approached the world", making her feel more comfortable and helping her cope with her symptoms.

Participants further highlighted the social benefits of diagnostic identification. For some young people, particularly those who identified with neurodivergent communities, diagnosis provided a sense of identity and belonging: "They may feel part of a community" (Helen). Others reported that they themselves found self-diagnosis beneficial, as it provided useful information for the assessment. Kate described young people arriving with a proposed self-diagnosis as "not unhelpful", because it gave clinicians a starting point for further exploration. Together, this theme indicates that participants did not

view self-diagnosis as inherently problematic. It could promote reflection, coping, validation and help-seeking for the individual, especially where formal pathways were slow or difficult to access, could enable them to access social and community support, and could provide useful information for the clinicians themselves.

Theme 4: Self-diagnosis is problematic when it becomes inflexible

This theme describes the specific circumstances under which self-diagnosis can become problematic. The main concern identified by psychiatrists was not self-diagnosis itself, but rigid attachment to a diagnostic label; concerns arose when the label became fixed or when identification narrowed the range of possible explanations. In these cases, participants said that a label could shift from a working hypothesis to a central component of the young person's identity, making it harder for them to consider alternative explanations or collaborate on treatment. Peter suggested that viewing experiences entirely through a mental health label could create "limits and reasons not to do things", and described some young people as becoming "so attached to the label that trying to prise them away from it is very difficult".

Long waits for assessment were viewed as making self-diagnoses more entrenched, because young people had sometimes spent years believing they had a particular diagnosis. Participants shared that, after such a long time, a label could become central to a young person's identity. Disagreement could therefore feel personally threatening to them, and challenging the diagnosis could feel like "attacking a bit of their identity" (Amy). Jack characterised this experience as "pulling out the rug" from beneath the young person because "their narrative had been taken away from them". Relatedly, Emma described situations in which improvement during treatment could become problematic for the young person's understanding of themselves, stating that such improvement raised the question for the participant of "Who are you?".

Participants also suggested that strong attachment to a diagnosis could reflect a young person's need for validation. A diagnostic label could provide evidence that distress was real and worthy of recognition, particularly for young people who felt dismissed elsewhere. Helen questioned whether disappointment at not receiving a diagnosis might reflect "not feeling validated or heard". For some, the label also offered a coherent explanation for distress and reduced uncertainty, even if it was clinically inaccurate.

Psychiatrists therefore distinguished between flexible self-identification and rigid over-identification. The former could support reflection and coping, while the latter could constrain self-concept, reduce openness to alternative formulations and interfere with treatment planning. Although such cases were not described as typical, they represented an important barrier to collaborative care.

Theme 5: Disagreement about self-diagnosis can be a threat to the therapeutic relationship

This theme captures how disagreement over diagnosis can lead to conflict and rupture in the therapeutic relationship. Participants said that, when they did not confirm the expected diagnosis, some young people became angry, disengaged or mistrustful. Rohan described young people effectively saying, “I’ve got this diagnosis and I want this treatment”, followed by, “Well, I’m not interested then” when clinicians disagreed. Jack similarly described a young person who became “really cross and left” after being told that borderline personality disorder was not the appropriate diagnosis for them. Such disagreements could disrupt care and, in some cases, lead to disengagement from services. Participants also described more concerning responses in which young people escalated harmful behaviours to demonstrate the legitimacy of their diagnosis:

“[Some young people] would escalate their behaviours, self-harm, risky situations in order to prove you wrong... to prove they do deserve this label” (Peter)

Separately, some participants highlighted that disagreement over diagnoses could arise because of the medicalisation of ordinary emotional and developmental experiences. Distress associated with breakups, loneliness or academic pressure could, in their view, be interpreted too readily as evidence of psychiatric disorder. Peter argued that “Life is hard and that’s OK”, and cautioned that applying a diagnostic label to such experiences could discourage young people from developing other ways of coping.

For clinicians, the challenge was to balance diagnostic responsibility with preservation of rapport. Emma noted that psychiatrists should be “really confident” in their belief before directly challenging a young person’s self-diagnosis. This was difficult for some participants, who shared that a confident self-diagnosis felt like a challenge to their professional identity. Emily described the difficulty of patients arriving believing they “know all the answers”, raising the question of “what have we got to offer?” when professional expertise appeared to be challenged. Amy described some young people as being willing to discount their professional opinion, choosing instead to self-diagnose or seek alternative routes when official diagnosis was not readily available. Despite these tensions, psychiatrists identified opportunities for constructive disagreement. Rather than directly rejecting a young person’s interpretation, some preferred to use it as a starting point for a shared formulation. Mehrdad described this as: “It wasn’t a contradiction... more like, ‘Let’s explore the roots of where this is coming from’”. This approach allowed clinicians to maintain diagnostic independence and authority while acknowledging the meaning attached to the young person’s self-diagnosis.

Overall, participants reported that disagreement about self-diagnosis could undermine trust, engagement and treatment when the label had become central to the young person’s identity or expectations of care. Participants nevertheless suggested that disagreement did not have to become confrontational. A collaborative approach that validates the young person’s experiences while helping them remain open to alternative formulations may help preserve the therapeutic alliance.

Taken together, the five themes show that psychiatrists view self-diagnosis as a complex and socially embedded phenomenon. Peer networks, online communities and family influences shape how young

people understand diagnostic labels, while self-diagnosis can provide validation, coping strategies, identity and access to support. However, participants felt that these benefits may become problematic for both the psychiatrist and the young person when a label becomes rigidly incorporated into the young person's identity, limiting their openness to alternative explanations. Disagreement can then threaten engagement and therapeutic relationships, particularly where young people experience rejection of a diagnosis as rejection of their identity and self-understanding. The findings therefore suggest that, when interacting with a young person who has self-diagnosed, they must carefully respond to the meaning, flexibility and expectations attached to this label.

Discussion

This study examined 16 psychiatrists' perspectives on self-diagnosis in adolescents. Using reflexive thematic analysis, five themes were generated: (1) Self-diagnosis is shaped by peers both online and offline; (2) The drive for a diagnosis often comes from the parent not the adolescent; (3) Self-diagnosis has personal and social benefits; (4) Self-diagnosis is problematic when it becomes inflexible; and (5) Disagreement about self-diagnosis can be a threat to the therapeutic relationship.

The findings of this study demonstrate that self-diagnosis is not an isolated or purely individual process but one shaped by a complex interplay of social, familial, and systemic factors. Peer networks, both online and offline, played a central role in exposing young people to diagnostic language and validating their self-identified labels, while parents were often key drivers of help-seeking, sometimes pursuing a diagnosis for access to support or as a way to make sense of their child's difficulties. Participants felt that, for many young people, self-diagnosis offered important personal and social benefits, including emotional validation, a sense of identity, and belonging within supportive communities. However, these same processes could also contribute to difficulties when diagnostic labels became rigidly held, shaping identity in limiting ways and, in some cases, escalating distress when challenged. In their clinical practice, psychiatrists described a nuanced balancing act: regardless of the diagnostic accuracy, clinicians stressed the importance of respecting the young person's narrative and using it as a starting point for collaborative exploration and care.

Many of the psychiatrists' observations align with existing work on self-diagnosis. For example, the notion that adolescents form communities around shared diagnostic identities echoes previous evidence that self-diagnosis is shaped by peers both online and offline (Giles & Newbold, 2011; Milton et al., 2023; Varela, 2025). This study also supports and extends previous findings examining clinicians' attitudes towards self-diagnosis, in which no psychiatrists were recruited (Cunningham-Rowe & Foulkes, 2025). Specifically, both the current study and the Cunningham-Rowe and Foulkes (2025) study found that self-diagnosed identities are not merely shaped by peer discourse but can become actively defended when clinicians question their accuracy, which can result in emotional and relational tensions (Cunningham-Rowe & Foulkes, 2025). Our study extends these findings by showing that psychiatrists, despite their different clinical roles and diagnostic authority, encounter similar difficulties around self-diagnosis. This suggests that conflict around self-diagnosis may be a consistent feature across different

therapeutic contexts, underscoring the need for clinicians to carefully navigate disagreement in a way that preserves trust and therapeutic engagement.

Our findings also resonate with literature on adolescent development, particularly the way diagnostic labels can become intertwined with identity during adolescence. Given adolescence is a critical period for identity formation, the defensive attachment to diagnostic labels may reflect a broader developmental need for self-understanding and belonging. This reflects the findings of Acheso3 and Papadima (2022), who argue that diagnostic labels often provide a scaffolding for self-understanding, particularly in adolescence, a time marked by uncertainty and identity negotiation. Psychiatrists in our study described cases where young people became strongly attached to a particular diagnosis, not merely as an explanation for distress, but as a core part of who they were. In such cases, challenging or reformulating the diagnosis was experienced as invalidating or even threatening, with potential consequences for therapeutic engagement. Our findings extend the work of Acheson and Papadima (2023) by offering psychiatrists' perspectives on this dynamic, illustrating how diagnostic identities are also actively negotiated and, at times, contested within psychiatric consultations. This adds to a growing body of literature suggesting that diagnoses can function as both explanatory tools and identity anchors during a formative developmental period (Corzine & Roy, 2024; Mogensen & Mason, 2015; O'Connor et al., 2018).

Our findings also emphasise the influential role of parents in shaping diagnostic narratives, with some initiating the assessment process, advocating for diagnoses, or relaying prior concerns based on their own observations. This is in line with a previous ethnographic study of U.S. parents navigating their children's mental health care, which found that parents often acted as reframers or gatekeepers of diagnostic information, sometimes withholding or reshaping clinical language when communicating with schools, family members or their children (Bringewatt, 2017). Just as parents in Bringewatt's study shaped how diagnoses were communicated and understood, psychiatrists in our sample observed that parents frequently played a central role in initiating or reinforcing specific diagnostic narratives. These narratives were often based on informal assessments (e.g., symptom checklists) or influenced by family history. This supports our finding that adolescents' self-understandings are not always self-driven but co-constructed with parental influence. Such early framing could limit space for clinical reformulation, particularly when families arrived with firmly held beliefs about the child's condition. Drawing from psychiatrists' insights, our study contributes to a relational view of diagnosis co-produced by familial expectations (DuPont-Reyes et al., 2024; Sayal, 2006; Sayal et al., 2010).

Participants also discussed the potential harms of self-diagnosis. Psychiatrists shared that over-identification with a disorder or becoming too attached to it could become a self-fulfilling prophecy, as has been discussed extensively in previous qualitative and theoretical papers (O'Connor et al., 2018; Underhill & Foulkes, 2025; Yanos et al., 2010). This is consistent with emerging experimental evidence showing that self-labelling is associated with unhelpful emotional and behavioural responses. For instance, cross-sectional studies have found that identifying oneself as depressed was linked to reduced perceived control and greater use of maladaptive emotion regulation strategies (Ahuvia et al., 2024) and

stronger identification with anxiety was associated with increased avoidance behaviours (Ahuvia et al., 2025). Our findings suggest that psychiatrists have similar concerns. Although clinicians in our study noted that rigid identification with self-diagnosis was relatively uncommon, they described a small subset of cases where this hindered therapeutic progress. This aligns with similar reports from non-psychiatrist clinicians (Cunningham-Rowe & Foulkes, 2025). Future research is needed to systematically assess the prevalence of this phenomenon and also examine its potential long-term effects.

Several limitations of our study should be noted. First, our sample skewed toward early-career psychiatrists, which may be partly attributable to our recruitment strategy via social media platforms that may have attracted younger clinicians. This may have introduced a generational bias in the data. Younger psychiatrists might be more familiar with or open to digital mental health content and evolving diagnostic practices, potentially shaping more accepting or nuanced views of self-diagnosis compared to their more senior counterparts. Second, few participants had five or more years of post-training experience, which may have limited the insights available from those with longer-term clinical experience. Third, all participants were employed within the UK's National Health Service (NHS), and their perspectives were likely shaped at least in part by the values, limitations, and structures of this institutional context. Including psychiatrists from private practice or academic settings in future work could enrich the range of viewpoints. Future research should also focus more explicitly on neurodivergent conditions, given the prominence of neurodivergent self-identification among young people, which was also evident in our study (Kroll et al., 2024; Overton et al., 2024). A final limitation is the use of r sampling though existing networks. Some of the participants may have been indirectly influenced by the second author's academic work, which focuses on the consequences of mental health awareness and interventions, including the rise of self-diagnosis. Given that participants were partly recruited via the researcher's professional social media channels, it is possible that some were already familiar with this area of research. This prior exposure may have shaped their views on self-diagnosis.

As a qualitative study, our research does not provide information about the prevalence of self-diagnosis or adolescents' experiences at a population level. Future research could also build on our qualitative findings by exploring self-diagnosis quantitatively. Large-scale surveys could examine the prevalence of self-diagnosis and its relationship with associated phenomena such as peer influence, social media use and parental help-seeking. Longitudinal studies could investigate whether rigid attachment to self-diagnosis predicts poorer clinical engagement, treatment adherence, or mental health outcomes, and whether factors such as social validation moderate these relationships.

Our findings have important implications for clinical practice and future research. The strong emotional and relational dynamics surrounding self-diagnosis suggest a need for evidence-based guidelines on how clinicians can approach self-diagnosis in a way that balances clinical accuracy with validation of young people's lived experiences. Training on how to collaboratively explore self-diagnosis, rather than dismissing it, may help protect the therapeutic alliance and prevent disengagement or risk behaviours.

In conclusion, this study provides a novel investigation of psychiatrists' perspectives on and experiences of self-diagnosis in adolescents. The findings suggest that psychiatrists largely view self-diagnosis as an understandable attempt by young people to make sense of their difficulties, shaped by access to social media, and attitudes of family and peers. Psychiatrists described how, when approached collaboratively, self-diagnosis could serve as a useful entry point into meaningful therapeutic conversations, and could support self-reflection and adaptive coping. However, they also cautioned that when a self-diagnosed label becomes central to a young person's identity, it can complicate diagnostic assessment and strain the therapeutic relationship. The study underscores the need for clinical approaches that acknowledge and validate the young person's self-understanding while maintaining clinical accuracy and broadening the young person's perspective on their symptoms. Developing clear guidance and training on how to navigate self-diagnosis in clinical settings could help clinicians respond in ways that are compassionate, clinically accurate and therapeutically effective.

Declarations

Ethics approval and consent to participate

Ethical approval was obtained from the divisional ethics board at the authors' institution, and informed consent was obtained from all participants.

Consent for publication

Participants provided informed consent for the use of anonymised quotations in this manuscript.

Competing interests

The authors declare no competing interests.

Funding

The first author received funding from the University of Oxford's Department of Experimental Psychology to complete this study. The second author holds a Prudence Trust research fellowship.

Author Contribution

SS and LF jointly conceptualised and designed the study. SS conducted participant recruitment, data collection and analysis, with supervision and input from LF throughout the research process. SS drafted the initial manuscript, and LF provided input and revisions. Both authors contributed to the interpretation of the findings, reviewed and approved the final manuscript.

Acknowledgements

The authors would like to thank all the psychiatrists who generously gave their time to participate in this study and share their experiences and perspectives.

Data Availability

The interview data are not publicly available due to the risk of identifying participants and the need to protect participant confidentiality.

References

1. Acheson R, Papadima M. The search for identity: Working therapeutically with adolescents in crisis. J Child Psychother. 2023;49(1):95–119. https://doi.org/10.1080/0075417X.2022.2160478.
2. Ahuvia IL, Eberle JW, Schleider JL, Teachman BA. Anxiety identity centrality is associated with avoidant coping in anxious adults. J Soc Clin Psychol. 2025;44(1):60–74. https://doi.org/10.1521/jscp.2025.44.1.003.
3. Ahuvia IL, Schleider JL, Kneeland ET, Moser JS, Schroder HS. Depression self-labeling in U.S. college students: Associations with perceived control and coping strategies. J Affect Disord. 2024;351:202–10. https://doi.org/10.1016/j.jad.2024.01.229.
4. Aragon-Guevara D, Castle G, Sheridan E, Vivanti G. The reach and accuracy of information on autism on TikTok. J Autism Dev Disord. 2025;55(6):1953–8. https://doi.org/10.1007/s10803-023-06084-6.
5. Armstrong S, Osuch E, Wammes M, Chevalier O, Kieffer S, Meddaoui M, Rice L. Self-diagnosis in the age of social media: A pilot study of youth entering mental health treatment for mood and anxiety disorders. Acta Psychol. 2025;256:105015.
6. Benton TD, Boyd RC, Njoroge WFM. Addressing the global crisis of child and adolescent mental health. JAMA Pediatr. 2021;175(11):1108. https://doi.org/10.1001/jamapediatrics.2021.2479.
7. Bolinski F, Boumparis N, Kleiboer A, Cuijpers P, Ebert DD, Riper H. The effect of e-mental health interventions on academic performance in university and college students: A meta-analysis of randomized controlled trials. Internet Interventions. 2020;20:100321. https://doi.org/10.1016/j.invent.2020.100321.
8. Braun V, Clarke V. Successful qualitative research: A practical guide for beginners. First published). SAGE; 2013.
9. Braun V, Clarke V. Reflecting on reflexive thematic analysis. Qualitative Res Sport Exerc Health. 2019;11(4):589–97. https://doi.org/10.1080/2159676X.2019.1628806.
10. Braun V, Clarke V. One size fits all? What counts as quality practice in (Reflexive) thematic analysis? Qualitative Res Psychol. 2021;18(3):328–52. https://doi.org/10.1080/14780887.2020.1769238.

11. Bringewatt EH. Delivering diagnoses: Parents as translators and withholders of children's mental health diagnoses. J Child Fam stud. 2017;26(7):1958–69. https://doi.org/10.1007/s10826-017-0709-5.
12. Brinkmann S, Kvale S. (2015). *InterViews: Learning the craft of qualitative research interviewing* (Third edition). Sage.
13. Byrne D. A worked example of Braun and Clarke's approach to reflexive thematic analysis. Qual Quant. 2022;56(3):1391–412. https://doi.org/10.1007/s11135-021-01182-y.
14. Caron C. (2022, October 29). Teens Turn to TikTok in Search of a Mental Health Diagnosis. New York Times. https://www.nytimes.com/2022/10/29/well/mind/tiktok-mental-illness-diagnosis.html
15. Chan D, Sireling L. I want to be bipolar'… a new phenomenon. Psychiatrist. 2010;34(3):103–5. https://doi.org/10.1192/pb.bp.108.022129.
16. Craddock N, Mynors-Wallis L. Psychiatric diagnosis: Impersonal, imperfect and important. Br J Psychiatry. 2014;204(2):93–5. https://doi.org/10.1192/bjp.bp.113.133090.
17. Corzine A, Roy A. Inside the black mirror: Current perspectives on the role of social media in mental illness self-diagnosis. Discover Psychol. 2024;4(1):40. https://doi.org/10.1007/s44202-024-00152-3.
18. Cruz M, Roter DL, Cruz RF, Wieland M, Larson S, Cooper LA, Pincus HA. Appointment length, psychiatrists' communication behaviors, and medication management appointment adherence. Psychiatric Serv. 2013;64(9):886–92. https://doi.org/10.1176/appi.ps.201200416.
19. Cunningham-Rowe K, Foulkes L. (2025). *Adolescents' self-diagnosis of mental disorders: A qualitative study of clinicians' perspectives*. https://doi.org/10.31234/osf.io/bh7v8_v1
20. Davey M. (2023, January 8). 'Urgent need' to understand link between teens self-diagnosing disorders and social media use, experts say. *The Guardian*. https://www.theguardian.com/australia-news/2023/jan/09/urgent-need-to-understand-link-between-teens-self-diagnosing-disorders-and-social-media-use-experts-say
21. DiCicco-Bloom B, Crabtree BF. The qualitative research interview. Med Educ. 2006;40(4):314–21. https://doi.org/10.1111/j.1365-2929.2006.02418.x.
22. DuPont-Reyes MJ, Villatoro AP, Phelan JC, Painter K, Link BG. Familial transmission of mental health help-seeking: Does it run in the family? SSM - Popul Health. 2024;27:101695. https://doi.org/10.1016/j.ssmph.2024.101695.
23. Draganidis A, Fernando AN, West ML, Sharp G. Social media delivered mental health campaigns and public service announcements: A systematic literature review of public engagement and help-seeking behaviours. Soc Sci Med. 2024;359:117231. https://doi.org/10.1016/j.socscimed.2024.117231.
24. Farnood A, Johnston B, Mair FS. A mixed methods systematic review of the effects of patient online self-diagnosing in the 'smart-phone society' on the healthcare professional-patient relationship and medical authority. BMC Med Inf Decis Mak. 2020;20(1):253. https://doi.org/10.1186/s12911-020-01243-6.

25. Fellowes S. Self-diagnosis in psychiatry and the distribution of social resources. Royal Inst Philos Supplement. 2023;94:55–76. https://doi.org/10.1017/S1358246123000218.
26. Fitzpatrick M, Moore AS, Kichuk SA, Pittenger C, Zaboski BA. #OCD: A Content Analysis of Obsessive-Compulsive Disorder Stereotype Amplification and Misinformation on TikTok. Cyberpsychology Behav Social Netw. 2025;28(9):607–15. https://doi.org/10.1177/21522715251370135.
27. Foulkes L, Andrews JL. Are mental health awareness efforts contributing to the rise in reported mental health problems? A call to test the prevalence inflation hypothesis. New Ideas Psychol. 2023;69:101010. https://doi.org/10.1016/j.newideapsych.2023.101010.
28. Fletcher-Watson S. What's in a name? The costs and benefits of a formal autism diagnosis. Autism. 2024;28(2):257–62. https://doi.org/10.1177/13623613231213300.
29. Franssen G. The celebritization of self-care: The celebrity health narrative of Demi Lovato and the sickscape of mental illness. Eur J Cult Stud. 2020;23(1):89–111. https://doi.org/10.1177/1367549419861636.
30. Galdas P. Revisiting bias in qualitative research: Reflections on its relationship with funding and impact. Int J Qualitative Methods. 2017;16(1):1609406917748992. https://doi.org/10.1177/1609406917748992.
31. Giles DC, Newbold J. Self- and other-diagnosis in user-led mental health online communities. Qual Health Res. 2011;21(3):419–28. https://doi.org/10.1177/1049732310381388.
32. Gilmore R, Beezhold J, Selwyn V, Howard R, Bartolome I, Henderson N. Is TikTok increasing the number of self-diagnoses of ADHD in young people? Eur Psychiatry. 2022;65(S1):S571–571. https://doi.org/10.1192/j.eurpsy.2022.1463.
33. Hall R, Keenan R. (2025, May 31). More than half of top 100 mental health TikToks contain misinformation, study finds. *The Guardian*. https://www.theguardian.com/society/2025/may/31/more-than-half-of-top-100-mental-health-tiktoks-contain-misinformation-study-finds
34. Hasan F, Foster MM, Cho H. Normalizing anxiety on social media increases self-diagnosis of anxiety: The mediating effect of identification (but not stigma). J Health Communication. 2023;28(9):563–72. https://doi.org/10.1080/10810730.2023.2235563.
35. Haslam N, Tse JS. Public awareness of mental illness: Mental health literacy or concept creep? Australasian Psychiatry. 2025;33(1):18–20.
36. Henderson C, Thornicroft G. Stigma and discrimination in mental illness: Time to Change. Lancet. 2009;373(9679):1928–30. https://doi.org/10.1016/S0140-6736(09)61046-1.
37. Howard J. Negotiating an exit: Existential, interactional, and cultural obstacles to disorder disidentification. Social Psychol Q. 2008;71(2):177–92. https://doi.org/10.1177/019027250807100206.
38. Issaka B, Aidoo EAK, Wood SF, Mohammed F. Anxiety is not cute analysis of twitter users' discourses on romanticizing mental illness. BMC Psychiatry. 2024;24(1):221.

https://doi.org/10.1186/s12888-024-05663-w.

39. Jamieson MK, Govaart GH, Pownall M. Reflexivity in quantitative research: A rationale and beginner's guide. Soc Pers Psychol Compass. 2023;17(4):e12735. https://doi.org/10.1111/spc3.12735.
40. Janghorban R, Roudsari RL, Taghipour A. Skype interviewing: The new generation of online synchronous interview in qualitative research. Int J Qualitative Stud Health Well-Being. 2014;9(1):24152. https://doi.org/10.3402/qhw.v9.24152.
41. Jones JL, Gallus KL, Viering KL, Oseland LM. Are you by chance on the spectrum?' Adolescents with autism spectrum disorder making sense of their diagnoses. Disabil Soc. 2015;30(10):1490–504. https://doi.org/10.1080/09687599.2015.1108902.
42. Jutel A. Sociology of diagnosis: A preliminary review. Sociol Health Illn. 2009;31(2):278–99. https://doi.org/10.1111/j.1467-9566.2008.01152.x.
43. Jutel A, Nettleton S. Towards a sociology of diagnosis: Reflections and opportunities. Soc Sci Med. 2011;73(6):793–800. https://doi.org/10.1016/j.socscimed.2011.07.014.
44. Kallio H, Pietilä A, Johnson M, Kangasniemi M. Systematic methodological review: Developing a framework for a qualitative semi-structured interview guide. J Adv Nurs. 2016;72(12):2954–65. https://doi.org/10.1111/jan.13031.
45. Kroll E, Lederman M, Kohlmeier J, Kumar K, Ballard J, Zant I, Fenkel C. The positive impact of identity-affirming mental health treatment for neurodivergent individuals. Front Psychol. 2024;15:1403129. https://doi.org/10.3389/fpsyg.2024.1403129.
46. Lahman MKE, Thomas R, Teman ED. A good name: Pseudonyms in research. Qualitative Inq. 2023;29(6):678–85. https://doi.org/10.1177/10778004221134088.
47. Lane R. Expanding boundaries in psychiatry: Uncertainty in the context of diagnosis-seeking and negotiation. Sociol Health Illn. 2020;42(S1):69–83. https://doi.org/10.1111/1467-9566.13044.
48. Laursen B, Veenstra R. Toward understanding the functions of peer influence: A summary and synthesis of recent empirical research. J Res Adolescence. 2021;31(4):889–907. https://doi.org/10.1111/jora.12606.
49. Lumivero. (2023). *NVivo (Version 15)*.
50. Malterud K, Siersma VD, Guassora AD. Sample size in qualitative interview studies: Guided by information power. Qual Health Res. 2016;26(13):1753–60. https://doi.org/10.1177/1049732315617444.
51. Milton A, Ajmani L, DeVito MA, Chancellor S. (2023). I see me here: Mental health content, community, and algorithmic curation on TikTok. *Proceedings of the 2023 CHI Conference on Human Factors in Computing Systems*, 1–17. https://doi.org/10.1145/3544548.3581489
52. Mirea D-M, Martin-Key NA, Barton-Owen G, Olmert T, Cooper JD, Han SYS, Farrag LP, Bell E, Friend LV, Eljasz P, Cowell D, Tomasik J, Bahn S. Impact of a web-based psychiatric assessment on the mental health and well-being of individuals presenting with depressive symptoms: Longitudinal observational study. JMIR Mental Health. 2021;8(2):e23813. https://doi.org/10.2196/23813.

53. Monteith S, Glenn T, Geddes JR, Whybrow PC, Achtyes ED, Bauer M. Implications of online self-diagnosis in psychiatry. Pharmacopsychiatry. 2024;57(02):45–52. https://doi.org/10.1055/a-2268-5441.
54. Mogensen L, Mason J. The meaning of a label for teenagers negotiating identity: Experiences with autism spectrum disorder. Sociol Health Illn. 2015;37(2):255–69. https://doi.org/10.1111/1467-9566.12208.
55. Morgan H. (2024). Using triangulation and crystallization to make qualitative studies trustworthy and rigorous. *The Qualitative Report*. https://doi.org/10.46743/2160-3715/2024.6071
56. O'Connor C, Kadianaki I, Maunder K, McNicholas F. How does psychiatric diagnosis affect young people's self-concept and social identity? A systematic review and synthesis of the qualitative literature. Soc Sci Med. 2018;212:94–119. https://doi.org/10.1016/j.socscimed.2018.07.011.
57. Olmos-Vega FM, Stalmeijer RE, Varpio L, Kahlke R. A practical guide to reflexivity in qualitative research: AMEE Guide 149. Med Teach. 2023;45(3):241–51. https://doi.org/10.1080/0142159X.2022.2057287.
58. Orben A. Teenagers, screens and social media: A narrative review of reviews and key studies. Soc Psychiatry Psychiatr Epidemiol. 2020;55(4):407–14. https://doi.org/10.1007/s00127-019-01825-4.
59. Overton GL, Marsà-Sambola F, Martin R, Cavenagh P. Understanding the self-identification of autism in adults: A scoping review. Rev J Autism Dev Disorders. 2024;11(4):682–702. https://doi.org/10.1007/s40489-023-00361-x.
60. Padhi A. (2024, April 14). Diagnosing yourself with a mental health issue may bring comfort, but it can be dangerous. *The Guardian*. https://www.theguardian.com/commentisfree/2024/apr/15/diagnosing-yourself-with-a-mental-health-issue-may-bring-comfort-but-it-can-be-dangerous
61. Palaganas E, Sanchez M, Molintas MV, Caricativo R. Reflexivity in qualitative research: A journey of learning. Qualitative Rep. 2017. https://doi.org/10.46743/2160-3715/2017.2552.
62. Ridge D, Bullock L, Causer H, Fisher T, Hider S, Kingstone T, Gray L, Riley R, Smyth N, Silverwood V, Spiers J, Southam J. Imposter participants' in online qualitative research, a new and increasing threat to data integrity? Health Expect. 2023;26(3):941–4. https://doi.org/10.1111/hex.13724.
63. Rutter LA, Howard J, Lakhan P, Valdez D, Bollen J, Lorenzo-Luaces L. I haven't been diagnosed, but i should be—insight into self-diagnoses of common mental health disorders: Cross-sectional study. JMIR Formative Res. 2023;7:e39206. https://doi.org/10.2196/39206.
64. Sandra DA, Segal Z, Majoo S, Sistanis A, Burke MJ, Inzlicht M. Inform and do no harm: Nocebo education reduces false self-diagnosis caused by mental health awareness. Psychol Med. 2025;55:e330.
65. Sayal K. Annotation: Pathways to care for children with mental health problems. J Child Psychol Psychiatry. 2006;47(7):649–59. https://doi.org/10.1111/j.1469-7610.2005.01543.x.
66. Sayal K, Tischler V, Coope C, Robotham S, Ashworth M, Day C, Tylee A, Simonoff E. Parental help-seeking in primary care for child and adolescent mental health concerns: Qualitative study. Br J

Psychiatry. 2010;197(6):476–81. https://doi.org/10.1192/bjp.bp.110.081448.

67. Sawyer SM, Azzopardi PS, Wickremarathne D, Patton GC. The age of adolescence. Lancet Child Adolesc Health. 2018;2(3):223–8. https://doi.org/10.1016/S2352-4642(18)30022-1.
68. Schiros A, Bowman N, Antshel K. Misinformation mayhem: The effects of TikTok content on ADHD knowledge, stigma, and treatment-seeking intentions. Eur Child Adolesc Psychiatry. 2025;34(11):3521–33. https://doi.org/10.1007/s00787-025-02769-8.
69. Scheff TJ. The labelling theory of mental illness. Am Sociol Rev. 1974;39(3):444. https://doi.org/10.2307/2094300.
70. Sikorski F, Löwe B, Kohlmann S. How adults with suspected depressive disorder experience online depression screening: A qualitative interview study. Internet Interventions. 2023;34:100685. https://doi.org/10.1016/j.invent.2023.100685.
71. Starvaggi I, Dierckman C, Lorenzo-Luaces L. Mental health misinformation on social media: Review and future directions. Curr Opin Psychol. 2024;56:101738. https://doi.org/10.1016/j.copsyc.2023.101738.
72. Tracy SJ. Qualitative quality: Eight big-tent criteria for excellent qualitative research. Qualitative Inq. 2010;16(10):837–51. https://doi.org/10.1177/1077800410383121.
73. Trefflich F, Kalckreuth S, Mergl R, Rummel-Kluge C. Psychiatric patients internet use corresponds to the internet use of the general public. Psychiatry Res. 2015;226(1):136–41. https://doi.org/10.1016/j.psychres.2014.12.037.
74. Tse JSY, Haslam N. Broad concepts of mental disorder predict self-diagnosis. SSM - Mental Health. 2024;6:100326. https://doi.org/10.1016/j.ssmmh.2024.100326.
75. Underhill R, Foulkes L. Self-diagnosis of mental disorders: A qualitative study of attitudes on reddit. Qual Health Res. 2025;35(7):779–92. https://doi.org/10.1177/10497323241288785.
76. Vaismoradi M, Turunen H, Bondas T. Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. Nurs Health Sci. 2013;15(3):398–405. https://doi.org/10.1111/nhs.12048.
77. Varela G. Undiagnosed: Relational characteristics of mental health pre-diagnostic self-labeling. Soc Sci Med. 2025;369:117725. https://doi.org/10.1016/j.socscimed.2025.117725.
78. Werner-Seidler A, Spanos S, Calear AL, Perry Y, Torok M, O'Dea B, Christensen H, Newby JM. School-based depression and anxiety prevention programs: An updated systematic review and meta-analysis. Clin Psychol Rev. 2021;89:102079. https://doi.org/10.1016/j.cpr.2021.102079.
79. Wright A, Jorm AF, Harris MG, McGorry PD. What's in a name? Is accurate recognition and labelling of mental disorders by young people associated with better help-seeking and treatment preferences? Soc Psychiatry Psychiatr Epidemiol. 2007;42(3):244–50. https://doi.org/10.1007/s00127-006-0156-x.
80. Yanos PT, Roe D, Lysaker PH. The impact of illness identity on recovery from severe mental illness. Am J Psychiatric Rehabilitation. 2010;13(2):73–93. https://doi.org/10.1080/15487761003756860.

81. Yeung A, Ng E, Abi-Jaoude E. TikTok and attention-deficit/hyperactivity disorder: A cross-sectional study of social media content quality. Can J Psychiatry. 2022;67(12):899–906. https://doi.org/10.1177/07067437221082854.

Figures

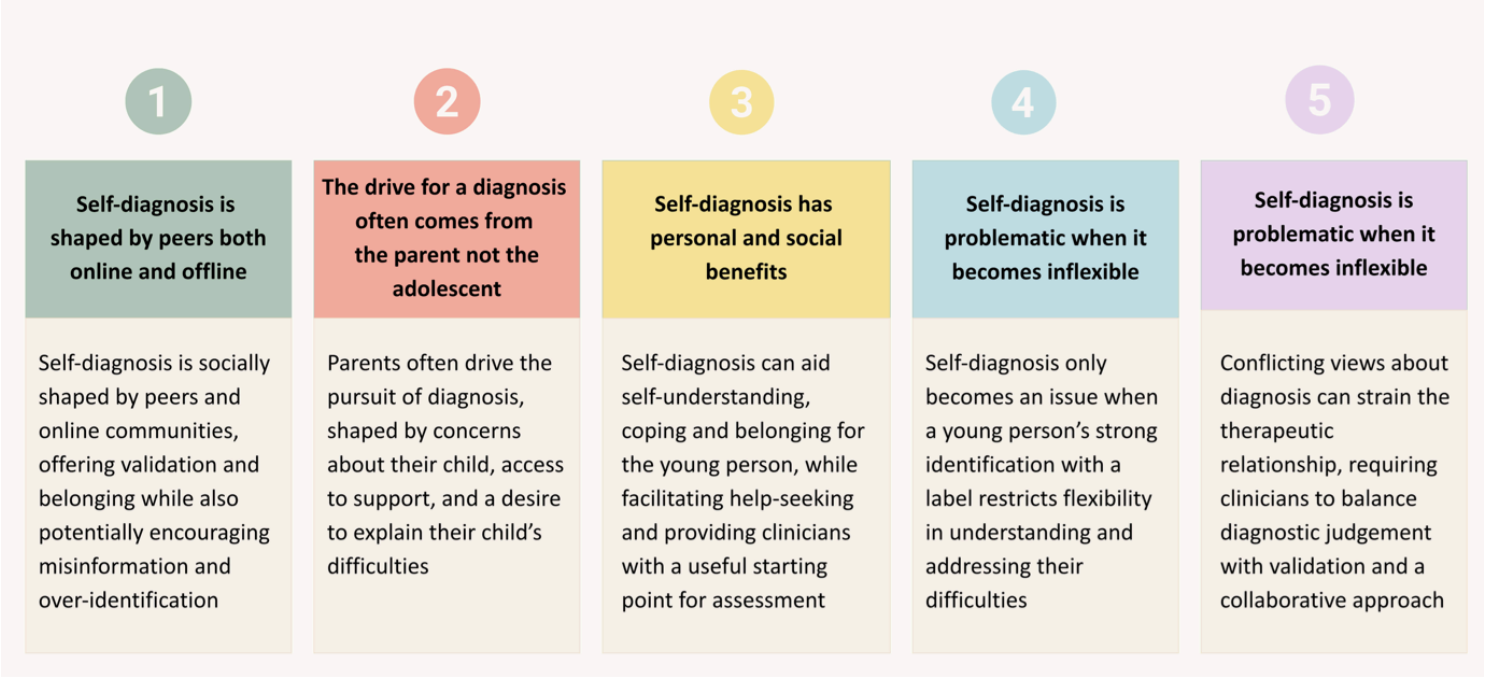


Figure 1

Overview of the five themes identified in the analysis

Supplementary Files

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- Supplementarymaterials2Initialcodingandthematicmap.docx