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Countering essentialism in psychiatric narratives

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ABSTRACT

The practice of self-diagnosing, amplified by the spread of psychiatric knowledge through social media, has grown rapidly. Yet, the motivations behind this trend, and, critically, its psychological repercussions remain poorly understood. Self-ascribing a psychiatric label always occurs within a broader narrative context, with narratives serving as essential interpretive tools for understanding oneself and others.In this paper, we identify four principal motivators for people pursuing self-diagnosis, pertaining to 1. waiting time and cost of mental health resources, 2. recognition, 3. identity formation, and 4. destigmatization. We compare these motivators against the backdrops of psychiatric narratives, including DSM-based (operationalism), bio-medical, and Neurodiversity narratives, to evaluate the psychological implications of self-ascriptions. We show that while self-ascription aligns with many motivations, it also carries the risk of essentialism across all analyzed narratives, which can over-simplify and sometimes misrepresent people's attempts to find meaning through psychiatric labels. Essentialism makes narratives less comprehensive, responsive, and resourceful.We contend that self-ascriptions are not inherently problematic; instead, they show the need for greater focus and understanding in psychiatric practices and the importance of incorporating people's experiences and perspectives in clinical settings. However, both the narratives and the social climate from which they emerge may need adjustments to make self-ascriptions meaningful, comprehensive, and resourceful tools.

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1. Introduction

Self-ascription of psychiatric labels and concepts has become common in western societies, leading to widespread use of psychiatric categories to refer to oneself. This includes self-diagnosing, such as ascribing the label "autistic" or "ADHD" (Attention Deficit/Hyperactivity Disorder) to oneself or

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identifying with having a Post-Traumatic Stress Disorder (PTSD). Regardless of whether these are further confirmed by an official diagnosis, their use persists outside of clinical settings. It also includes applying psychiatric characteristics to oneself, as when one considers being "depressed", addicted to a substance or habit, or having lived a traumatic experience. Labels and concepts of psychiatry have become meaningful within people's life context and are sometimes taken up as central components of one's identity.[1] Online discourses on mental health, including psychiatric terms and their manifestations, have increased massively over the last years on platforms such as *TikTok* and *Instagram* (Giedinghagen, 2023; Milton et al., 2023), causing these discourses, terms and categories to seep into the popular vernacular and contributing to their dissemination among lay people.

The phenomenon of self-ascription is evident in the increase of online discussions linking behaviors, lifestyles, feelings and supporting tips to psychiatric categories, and in the dissemination of information about these categories through social media, blogs, and websites (Cuthbertson, 2022; Gallagher, 2021) as well as through the development and accelerated dissemination of psychotherapy chatbots and AI tools for mental health (Sierra & Ruiz, 2022; Ş. Tekin, 2021).

Self-ascriptions of psychiatric labels can be characterized through their fast and widespread disseminations, reaching far more people than most official diagnostic pathways. Furthermore, self-ascriptions can be made on the basis of very few manifestations or symptoms and completely outside of a person's life context, and studies have shown that online health information is often considered trustworthy by the simple fact that it is online, especially by adolescents, and even more when that information is in line with one's identity (Freeman et al., 2023). However, the way social media depict manifestations of psychiatric categories is generally not monitored by professionals (Pretorius et al., 2022).

All this has created a gap between online communities and clinical settings, i.e., a polarization between lay people who share ideas about psychiatry through the virtual world and clinicians and researchers on mental health. A new area of research has been growing about the consequences of this new phenomenon of self-ascriptions (David & Deeley, 2024; Fellowes, 2023).

Some research about the consequences of receiving a psychiatric label also mentions self-diagnoses (Fletcher-Watson, 2024). Some have pointed to structural consequences and disadvantages that can come with self-diagnosing: David and Deeley (2024) mention the reinforcement of in-group and out-group dynamics; the shift toward milder ends of the spectrum, which can leave people thinking a condition is more manageable than it is; and the risk of misdiagnosing and

thereby missing out on another underlying condition, which might require attention. Fellowes (2023) made a similar point by arguing that within the dynamics of self-diagnosing, misdiagnosing can become a problem, as people do not necessarily consider a range of diagnoses and often only consider diagnoses that get the most attention (e.g., on social media), which have greater public awareness and are less stigmatized. However, people may not get the accommodations that are most appropriate for them. Fellowes (2023) argues further that inaccurate self-diagnosis can alter the strength of social resources available for different diagnoses, reinforcing the public focus on conditions that already get a lot of attention, while leaving others in the background. Although researchers have started to consider advantages and drawbacks of self-ascriptions, this research is still at its infancy, and it considers structural rather than psychological consequences.

In this paper, our goal is to assess the psychological impacts of self-ascriptions by comparing them against the goals and motivations of those who self-ascribe.

We argue that self-ascriptions respond to these personal projects but also run some risk of essentialism. The risk of self-ascriptions leading to essentializing one's identity becomes especially prominent since psychiatric labels are signifiers embedded into broader discourses and systems of knowledge. These systems of knowledge give the psychiatric labels their meaning in the first place and determine *how* a person makes use of a given label. We refer to the systems of knowledge surrounding a psychiatric category as "narratives". It is not just a label that a person takes on when they self-ascribe, but an entire narrative (Ş. Tekin, 2011). We propose that rather than legitimizing a decrease in using psychiatric labels outside of clinical settings, the risk of essentialism through self-ascriptions calls for a refinement of psychiatric narratives that include the experiences of patients and people with lived experience.

In the first part of this paper, we describe the phenomenon of self-ascription by applying it to existing analyses of *concept expansions* in psychiatry. We show that this phenomenon is the result of unmet needs in the psychiatric world, which has created a gap between lay people and psychiatry. In the second section, we consider three narratives of psychiatry — behavioral, theoretical, and political – which are often associated with the process of self-ascriptions. We show how these narratives all help to respond to some of the motivations behind this new social phenomenon while reinforcing the risk of essentialism. In the last part of the paper, we propose some starting points for empirical and theoretical research aimed at reducing the risk of essentialism.

1.1. Self-ascriptions of psychiatric labels

1.1.1. Motivations behind self-ascriptions

The normative aspect of self-ascriptions of psychiatric labels has been debated both among professionals and within psychiatric communities (Hens et al., 2019) dividing those who believe that diagnoses require a professional evaluation from those who value self-diagnoses. Given the increasing practice of self-ascription, we believe that morally condemning it runs the risk of increasing the existing gap between online users and clinicians or researchers on mental health. It is even more the case if these practices respond to some needs that motivate self-ascriptions in the first place. We rather take this practice as a starting point to understand the motivations of those who self-ascribe.

On the one hand, some of the practices of self-ascriptions have reflected a political search for more inclusion, acceptance, and decreasing stigma that surround mental illness (Gosselin, 2018), and for an alternative to the current medical system as standing in the way of these goals (Ş. Tekin, 2011). Although this paper focuses more on psychological factors, we do acknowledge that structural, societal, and political factors play a crucial role in people experiencing mental health related symptoms in the first place.

Most people who develop symptoms of *mental illness* seek mental health screenings online because the process of receiving an official diagnosis can be as long as a 10 year endeavor (Jacobson et al., 2022). Thus, waiting times and costs are likely to be important motivators for the search for psychotherapeutic support online. We consider them the first set of motivators for self-ascriptions. (1.) Recent research that focuses on the impacts of political movements in psychiatry and investigates how political vindications impact psychiatric classifications and practices leave aside the question of online sharing about mental health and its impact on people (Arnaud & Gagné-Julien, 2023; Dyck & Russell, 2020; Friesen et al., 2021).

Some researchers have identified psychological or personal reasons for self-ascriptions that can be grouped in three other sets of motivators: 2. an increase in recognition, credibility/legitimacy, and a validation of difficult experiences. This can also more broadly be described as attempts of increasing one's own self-understanding and consecutively solidifying an identity, which helps with credibility and the validation of difficult experience.[2] 3. A yearning for a sense of belonging and a connection to one's own identity (particularly in adolescence) (Acheson & Papadima, 2023), and 4. an increase of one's visibility against stigmatizing attitudes toward mental illness or toward the identification with a psychiatric label (Cuthbertson, 2022; Giles & Newbold, 2011; Lewis, 2016).

Recent research that focuses on the increase of mental health discussions on social media does not assess its impacts on people who self-ascribe (Gilmore et al., 2022; Ş. Tekin, 2021; Torous et al., 2021; Yeung et al., 2022).

The process of self-diagnosing, as well as the practice of online sharing and discussion unfolding around it, relies on the usage of psychiatric labels and categories. Some associations attached to psychiatric labels may be amended in the process of self-diagnosing and online sharing, (*e.g.*, autistic people have contested the alleged lack of empathy supposed to characterize them). Thus, labels and categories of psychiatry are both a starting point into the phenomenon we are describing but also subject to modification through this phenomenon. In the rest of this section, we describe the different types of interactions between people and psychiatric labels resulting from self-ascriptions through the analysis of concept dynamics described by philosophers and psychologists. We clarify their mutual impacts, and we call for bridging the gap between the field of psychiatry and people who self-ascribe.

1.1.2. Interactions between self-ascriptions and psychiatric labels: the growing gap between lay people and psychiatry

Self-ascriptions can come with various potential consequences at a structural level. Through self-ascriptions, psychiatric categories have been applied in increasingly broad and generalized ways (Giedinghagen, 2023), where often fewer manifestations are needed to reach a conclusion about a condition. This can be further facilitated by the absence of the consideration of someone's life circumstance and personal history. Self-ascription of psychiatric labels can lower the threshold or severity of symptoms connected to existing disorders. This phenomenon is called "vertical expansion" (N. Haslam, 2016) and is notably exemplified by the current discussions on ADHD via TikTok videos, which have been leading to a drastic increase in self-diagnoses (Gilmore et al., 2022). Some TikTok trends have virally conceptualized ADHD as object impermanence, i.e., the phenomenon where an object not currently perceived is forgotten (Chevalier, 2024). Researchers have suggested that half of these videos could be misleading, implying a dissemination of health misinformation (Yeung et al., 2022).

Generally, vertical expansions can lead to specific experiences, such as negative emotions, difficulties in social interactions, challenges in understanding different perspectives, and limited attention being framed as psychiatric categories, when they would otherwise be considered normal aspects of the human experience. On social media, the complexity of these experiences is overlooked. Thus, self-ascriptions entail the risk of false positive through misdiagnoses. This is noted by David and Deeley who indicate that self-ascription "is not a sufficient

basis for accessing the benefits which medical diagnosis allows; it may lead to misdiagnosis and misdirect the person from care that could help them." (p. 3).

As a result of these expansions, which are seen in online discourses and through the practice of self-labeling, definitions and labels can become more complex and convoluted. More experiences are being labeled as "pathological" and placed within the realm of psychiatry.[3] This describes what Weathers and Keane (2007) call "semantic dilution"; the meaning of PTSD, for example, becomes almost debased and trivialized through its semantic transformation, leading to conceptual confusion of the word use. In a recent paper, Tse and Haslam argue that psychiatric categories are more likely to be self-ascribed by people who conceptualize these categories more broadly, incorporating milder, diverse and atypical cases (Tse & Haslam, 2024). Drawing from a vast sample of participants completing various questionnaires, the authors show that people with more expansive concepts are more likely to self-diagnose, as they perceive a wider range of phenomena to represent a psychiatric category or have lower thresholds for identifying these categories. This suggests that vertical expansions, which broaden the meaning of these concepts, contribute to the phenomenon of self-ascription. This creates the following cycle: self-diagnoses broaden the meaning of psychiatric categories, which, once expanded, lead to more self-diagnoses. And because these terms are already the source of controversies within professional classifications (Bryant, 2019), their transformation leads to further disagreements in psychiatry and an increase in the gap between psychiatry and lay people.

Categories and labels have been said to interact with their referent through a "looping effect" (Hacking, 1995): people who identify with a label would (implicitly and automatically) shape their behaviors differently because of the identification; and these new ways of behaving would then interact and re-shape labels and categories themselves. It seems that this has been happening through self-ascriptions: young people who share their experiences with mental illness on TikTok by engaging in community-building trends heavily incorporate pop culture content (Schipper, 2022). In a recent study, philosopher Owen Chevalier interviews some of TikTok users with ADHD about the concept of object impermanence we mentioned (Chevalier, 2024). He concludes from his interviews: "the way the public engages with psychiatric content online takes the form of a looping effect. With the aid of an algorithm, like the one TikTok uses, someone's proposal for a new term or revision of a term is sent to people who may be interested. These other TikTok users then loop with the new/revised term by applying it to themselves and by offering further revisions. Given the simplicity with which users create and engage with content on the platform, this process is often unconscious".

Moreover, new research has demonstrated a looping effect on depression and anxiety from young people who interact with psychiatric labels (Lindholm & Wickström, 2020).

They relate the stories and messages conveyed by pop culture to their own personal experiences with mental illness, and when they find these messages relatable, they integrate them into their own narratives as a way of expressing themselves (Schipper, 2022).

Thus, through self-diagnoses, labels expand, misdiagnosing becomes more common and looping effects take place, in which people come to identify with and act according to the label taken on. People who understand their emotional and psychological problems as psychiatric conditions tend to be less optimistic about their own recovery and more passive in acting on their difficulties (N. Haslam & Kvaale, 2015). Collectively held beliefs about certain conditions, including psychiatric labels and experiences, can act as self-fulfilling prophecies, where people consider what they perceive in others or what they feel and experience to fit prevailing labels and categories (Summerfield, 2001). However, the first part of the loop, the psychological rather than structural impact has not received much attention yet.

Furthermore, officially, the second part of the loop, the meanings of the labels themselves have barely changed: the recent revision of the DSM 5 only includes a few changes on disorders, even on those extensively discussed online and self-ascribed. Minor clarifications have been done to the characterization of autism, as well as PTSD, and nothing has changed on the one of ADHD (Moran, 2021; Rzepa et al., 2022). Researchers and clinicians rarely acknowledge expansions and modifications of labels in social media discussions. As a result, labels do not loop back in an "official" way. People who identify with these labels outside of a clinical context remain exempt from potential therapeutic care and remain isolated from psychiatric settings. The self-ascription phenomenon rather reveals the need for finding new ways of considering mental health and managing the professional-lay discursive relationship. Here is why.

2. Narratives underlying self-ascriptions

Psychiatric labels are used in association with various narratives. These narratives help people who take on or use psychiatric categories (through self-ascription of via a clinical process) and guide them in using the terms. They provide them with apparent explanations about a condition, and they can direct actions and expectations.

By "narratives," we mean theoretical approaches that provide an understanding of mental health in general and of psychiatric categories in particular. Contemporary psychiatry lies at the intersection of several

main narratives: 1. Operationalism, which defines psychiatric categories through specific diagnostic criteria (notably through the DSM); 2. the biomedical model, which considers mental disorders as brain-based dysfunctions; and 3. approaches such as the Neurodiversity movement, which prioritize social or personal interpretations of experiences, reflecting patients' current challenges, context of living, and potentially cultural and personal values in understanding psychiatric categories. All of these can be considered different narratives with their own methods of analysis, empirical and theoretical tools, goals, and values that motivate them.

We acknowledge that these categories could benefit from further refinement and subdivision, as they involve subtleties and complexities that go beyond these broad descriptions. But we think these frameworks constitute a useful generalization of views of mental health categories. Operationalism is "behavioral" in that it puts emphasis on checklists of manifestations rather than theories of mental health categories; the biomedical model claims to be "scientifically based", offering a theory of mental health and its deviations; and social or activists' narratives are political by adopting a critical perspective on the pathologizing and medicalizing psychiatric categories.[4] Below we consider them in turn and in relation to the practice of self-ascriptions.

It should first be noted that a narrative is usually not taken on actively and through deliberate decisions, but rather more implicitly and sometimes with little reflection. Narratives do not need to be true to accompany one's self-understanding. With the help of narratives, people make sense of their moods, behaviors, and relationships. Adopting a certain narrative means adopting a certain type of evaluation toward past life events, assessment of feelings and behaviors, and visions toward the future. Narratives are specifically helpful if they provide the person with comprehensiveness, responsiveness, and resourcefulness, referring respectively to meaningful and suitable interpretations of historical and psychological facts of the person, resonance to historical and psychological facts, and insights into action tendencies (Ş. Tekin, 2011). Thus, all three factors neatly feed into identity-making and into the desire for wellbeing.

We now evaluate how the potential and actual impacts of narratives correspond to the phenomenon we outlined, and hence, what feeds into the motivations of people to find labels and narratives that:

1. decrease waiting time and cost of therapeutic support, 2. increase recognition and validation of some difficult experiences and against indifference, 3. provide a sense of belonging and identity-making, 4. and increase one's visibility against stigmatizing attitudes toward mental illness or the identification with a psychiatric label. By looking at the three narratives, we explore whether what people aim for when they self-ascribe a psychiatric category is met.

2.1. Operationalism ("diagnosis by symptom-Checklist")

Operationalism generally is applied to concepts that cannot directly be measured, and therefore must be "measured" by proxy. In the DSM, while biological measurements of its categories do not exist, the DSM relies on its concepts (the psychiatric terms), by operationalizing them. DSM-categories are comprised of symptoms, representing observable behavioral criteria, thereby constituting a "symptom-based" approach (Mayes & Horwitz, 2005) and generally being used for diagnoses.

As pointed out by Ş. Tekin (2011), the DSM functions as a source of narrative and thereby affects people's sense-making of themselves and others, and social discourses at large. Crucially, diagnosis-by-symptom checklist can take place in a clinical setting, but may also take precedence in online settings, where "symptom-checklists" act as gatekeepers or gate-openers.

Andreasen (2007) points out that diagnosis by checklist has become part of our shared culture, mass-media, and the web. Cosgrove and Cosgrove (2011) further described diagnosis by checklist as a form of self-regulation and self-monitoring when making sense of emotions and behavior of self and others.

When people self-ascribe psychiatric labels through a DSM-type narratives (with the help of checklists, or reading the DSM itself), they can decrease the waiting time and cost of therapeutic support rapidly, due to the specificity of symptoms and the observability of behavioral criteria, thereby responding efficiently to the first set of motivators (reducing waiting time and cost). Due to the apparent discreteness around psychiatric categories, adopting a label through a checklist comes with an enhancement of validation and legitimization of experiences against potential indifference and minimization, which corresponds to the second set of motivators. For example, saying "I have ADHD", might lead to more recognition than saying "it is sometimes difficult to concentrate at school". Another example of this occurs when expressing sadness is dismissed while declaring one is depressed legitimizes one's experience. Self-ascription through operationalized criteria can also provide a sense of belonging through online communities; one can contribute to the discussions around the psychiatric categories by sharing their first-hand experiences and feelings, which are in turn validated by other users, recognizing these experiences and making sense of them through their own. This contributes to identity-making, offering a response to the third set of motivators. This is recognized by Fellowes (2023) who explains: "[a] self-diagnosing individual might be better able to establish whether they meet the official diagnostic criteria than a professional diagnostician is able to" (p.3) because of stereotypical examples used in the official criteria that can bias someone without

a relevant experience. Fellowes adds that in these cases: "the DSM or ICD is taken as providing the standard and the relevant question is whether the diagnostician or the self-diagnosing individual is more likely to accurately assess whether the individual meets the DSM or ICD diagnostic criteria". (p.3).

However, multiple drawbacks play out when using the DSM as a narrative tool. First, according to Cosgrove, using checklists represent a form of subjection into industry-supported conceptions of *normativity*. She explains in reference to the *Premenstrual* dysphoric disorder (*PMDD*) and *premenstrual* syndrome (*PMS*) that "PMS/PMDD discourse reinforces a rigid and stereotypical model of femininity by forcing women into constant self-surveillance" (Cosgrove & Cosgrove, 2011).

Insofar as it is impossible to be both "feminine" and irritable, labeling one's emotional distress and negative emotions as PMDD preserves the fantasy and fiction of idealized constructions of femininity. What is not made transparent is the possibility that instead of engaging in autonomous practices and exercising freedoms, women are being subjugated by industry-supported conceptions of normative femininity (PMDD) and heteronormativity (Hypoactive Sexual Desire Disorder)" (p. 10). Thus, rather than a straightforward example of autonomy and empowerment, by using DSM categories, people are constrained into constant self-surveillance and predefined borders of normativity. This rigidity and stereotypical thinking of "normal" functioning related to self and others are also reinforced by the pathologizing vocabulary used in the DSM and other checklists that consider "dysfunctions", "deficits", rather than differences and diversity. The fourth set of motivators behind self-ascriptions (i.e., 4. destigmatization) has therefore low chances to be met through a DSM-type narrative.

Secondly, even a reliable test can be invalid (N. Haslam, 2013). The formation process of DSM diagnoses is not purely scientifically driven but rather results from conventions and intersects with motives, political, economic, social, and especially pharmaceutical interests, and values (Ghaemi, 2009; Pickersgill, 2014). This interaction with various other interest groups makes it questionable to what extent DSM diagnosis and symptoms represent valid, scientifically proven (disease, biological, social, etc.) entities. Nevertheless, especially within DSM/operationalism based narratives, DSM categories are often given the appearance of scientific phenomena.

Some have argued that operationalism in psychiatry may oversimplify the complexities of mental disorders and may not capture the full range of symptoms and experiences of individuals with mental health conditions (Ghaemi, 2009; Pickersgill, 2014). It is easy to see how this can backfire on people who self-ascribe psychiatric labels. Indeed, as pointed out by Ş. Tekin (2011), the symptom-based approach that the DSM adheres to abstracts mental disorders away from the person by placing the experience into

a classificatory system of observable behaviors. Using DSM categories as narratives thus makes it non-responsive and non-comprehensive to the psychological and historical facts of a person's situated context and life. The non-comprehensiveness prevents the person from understanding their condition as the outcome of multiple factors, which is necessary in many contexts. For example, in cases of trauma, understanding the context of the trauma and its impact on the person's life can be crucial for effective treatment and healing (Banks, 2006).

Furthermore, in the case of symptoms that would fit the criteria for Major Depressive Disorder (MDD) in the DSM, without considering the person's unique context and life historical patterns, such as recent life stressors, cultural factors, and childhood experiences, the DSM diagnosis may not accurately capture the complexity of experiences or the factors contributing to symptoms (Kuwabara et al., 2007). Similarly, in cases where someone experienced childhood abuse or neglect and exhibit symptoms of borderline personality disorder such as emotional instability, impulsivity, and fear of abandonment, the context of the traumatic experience and personal history would be essential for accurate understanding and treatment (Ball & Links, 2009).

All these drawbacks could simply be the result of operationalism rather than specific to self-ascriptions. However, these components can be brought back to awareness through therapeutic accompaniment. Without them, the autobiographical narrative can lead to a fragmentary understanding of oneself under the guise of a sense-making tool. Using DSM categories or symptoms as a narrative outside of clinical settings or psychotherapy carries a higher risk of a limited understanding of the person's condition, thereby compromising sense-making around one's identity. This shows that it is the association between self-diagnosing and an operationalized narrative, rather than each taken separately, that leads to these drawbacks. In addition, aspects of one's identity might become "essentialized". Dar-Nimrod and Heine (2011) outline essentialist thinking as a cognitive bias characterized by five distinct features. Subscribing to an essentialist view on a phenomenon (*e.g.* a psychiatric category) entails viewing it as a.) immutable, stable, innate, and determined; b.) independent of the environment and the person's control; c.) having a specific etiology, meaning the assumption of a causal relationship between essence and characteristics; d.) homogeneous and discrete; e.) natural: perceived as having an elementary nature and thereby causes entities to be what they are.

When one self-identifies with a set of symptoms, the absence of links with one's own psychological and historical and situated self will likely lead a person to treat their condition as immutable. The DSM remains agnostic toward the etiology of its categories. The absence of explanations and theories of categories could leave people to believe that their conditions

are chronic and static, or in other words, immutable, stable, and determined. This constitutes the first set of criteria (a.) for an essentialized phenomenon. For example, someone who believes that they are depressed after having self-assessed the criteria for depression, outside of any clinical guidance, could easily believe that there is nothing to do about it and that the ascription of depression is the answer, i.e., the ultimate cause, meaning that nothing needs to be figured out further. Outside of (even hypothetical) explanations, their diagnosis could thus lead to an "out of control" feeling that their depression is static and that nothing in their environment can change this state of affair, which correspond to the second feature of essentialist thinking (b.).

This lack of pluralistic explanations and hypotheses for the understanding of psychiatric categories also implies a certain idea of homogeneity in the categories that can easily be endorsed by people who identify with these labels, believing they belong to a group of people who share similarities in behaviors and feelings. However, researchers recognize that the DSM falsely categorizes psychiatric categories as discrete entities that are in fact heterogeneous (Feczko et al., 2019). The use of operationalized tools alone can thus restrict to one an impression of discreteness and homogeneity about psychiatric categories. This makes this narrative meet the fourth criteria of essentialism (d.).

However, it has been argued that the reliability of these tools can legitimate their relevance in clinical settings and practices, so that therapists share a common language despite their potentially divergent theoretical backgrounds (N. Haslam, 2013). And because people are diagnosed by professionals, the DSM is not the ultimate authority; it is rather a pragmatic tool for navigating the complexity of diagnoses. This shows that the risks of the operationalized narratives are increased with the phenomenon of self-diagnosing, as this practice bypasses the professional judgment of professionals. Without it, and with the checklists alone, there is often a systematic neglect of specific forms of experience (Kendler, 2005), or of other behaviors and reactions that can be conflated with a disorder, such as defense mechanisms. This not only leads to oversimplified concepts of mental disorders (Drożdżowicz, 2020), but also impoverishes our understanding of the categories (Parnas & Zahavi, n.d.), and essentializes their manifestations by giving them an "elementary" nature (the fifth criteria of essentialism (e.)). If a psychiatric label is taken as explanatory, it makes it appear as the cause of certain behaviors that it might be unrelated to. The categories themselves create an irreconcilability between the succinct criteria of nosologies and complex, rich experiences of people with a psychiatric diagnosis (Drożdżowicz, 2020), and ultimately essentialize one's identity through the internalizing of over-simplified self-concepts and narratives.

To sum up, the operationalism approach as a narrative can respond to the two first sets of motivators: decreasing waiting times and cost (1) and enhancing recognition and validation of experiences (2). However, it can also lead to essentialism, by giving the impression that psychiatric labels refer to entities that are a.) immutable, stable, and determined; b.) independent of the environment and the person's control; d.) homogeneous and discrete; and conflating other behaviors with manifestations of a mental disorder, thus making them e.) the outcome of a natural occurring process and viewing them as having an elementary nature. Contrary to the two last motivators, self-ascription through this narrative can thus provide an inaccurate sense of oneself and of one's own identity (against motivator 3) and increase stigmatizing attitudes toward mental illness (against 4). Therefore, the operationalization approach has contributed to a distorted understanding of "psychiatric" experiences, and it constitutes an insufficient narrative for self-ascriptions.

2.2. Biomedical model and biopsychosocial Model

Although the DSM does not explicitly commit to any theory about the underlying etiology of psychiatric categories, and therefore theoretically does not essentialize the origin of psychiatric categories, it is often implicitly associated with the assumption that these categories are concrete, categorical, biomedical entities with potentially identifiable underlying biological causes. In the defense of the medical model, Aftab (2024) points out that it is not the model itself, but the public understanding that essentializes it. That the DSM, ICD, etc, have not been designed to serve as a basis for a person's identity and self-understanding.

Along similar lines, the work of Ahn et al. (2006) has shown that laypeople tend to think of the categories as more "real" and essentialized than experts do.

The assumption that these categories are concrete, categorical, biomedical entities corresponds to the biomedical model, which constitutes a closely related narrative to operationalism (Salicru, 2020). In addition to most of the assumptions given about the operationalism approach, the biomedical model proposes specific, bio/-neurological etiologies to the psychiatric categories: the approach assumes a causal relationship between the DSM-symptoms and underlying neurological characteristics, such as aberrations in neurotransmitters or neural networks (e.g., Ayano et al., 2016). In recent attempts to finding recognition and visibility through social media, people who self-ascribe psychiatric categories are often adopting this model, as it gives an impression of scientificity, thereby providing more validations to people's feelings and experiences (this corresponds to the second motivator that we identified). As Cuthbertson (2022) explains, people "attempt to

make what is invisible, visible to others. In doing so, many suggest a particular involvement of the brain which reinforces a medical model of mental illness." (p. 100).

The biomedical narrative posits psychiatric categories as natural, biological phenomena, thus potentially reinforcing essentialist thinking. This narrative, alongside the criteria of essentialism identified through a DSM narrative, asserts that psychiatric categories are "natural" and possess a specific etiology, assuming a causal relationship between the manifestations of psychiatric categories and a presumed essence. However, the etiology of numerous psychiatric categories – including bipolar disorder and schizophrenia (Quintero et al., 2019), autism (Sauer et al., 2021), antisocial personality disorder (DeLisi et al., 2019), ADHD (Custodio et al., 2023), and mood disorders, such as anxiety and depression (Zhang et al., 2020) – remains either undetermined or inadequately explained, pointing toward explanatory pluralism as a more fitting approach. The frequent assumption of a biological foundation for these categories, rather than a comprehensive understanding, can lead to presuppositions about the inherent characteristics of individuals labeled accordingly. In instances of self-identification, when individuals perceive themselves as possessing an innate, immutable trait distinguishing them from others, this perception can foster internalized stigma (going against the motivator of decreasing stigma 4.). This contradicts the objective of reducing stigma and may hinder attempts to seek additional support or discover interventions that acknowledge the intricate and diverse aspects of the psychiatric category. Consequently, this undermines the efficiency of online support seeking, which contradicts the aim of obtaining rapid and cost-effective therapeutic assistance (criteria 1.).

This narrative further characterizes DSM psychiatric categories as detached from environmental or contextual influences. As pointed out by Ş. Tekin (2011), by assuming determined neurophysiological causes, this perspective is non-comprehensive in terms of a person's specific conditions and life context. It overlooks broader social environments and neglects both first-person and psychological viewpoints. The origins of some psychiatric diagnoses may be multifactorial and not readily measurable. Consequently, the biomedical narrative can be unhelpful, suggesting to those diagnosed that their experiences are merely the result of chemical imbalance, implying limited options beyond medication.By prioritizing single explanations over a pluralistic view, this narrative appears to offer greater reliability and suggests an appearance of enhanced credibility (Motivator 2), as it leaves no room for doubt in a biomedical approach. However, this perception can easily be accompanied by a sense of helplessness, attributed to an assumed but vague biological cause. All this neatly fits into essentialist thinking, limiting a person's sense-making and ability to accurately perceive themselves.

Some researchers have been urging a shift away from the "Disease Model" of mental health and toward a "Psychosocial Model" with new attempts at classifying psychiatric categories (Salicru, 2020). At the heart of the Psychosocial Model is the recognition that mental health and mental disorders are influenced by both psychological and social factors that cannot be reduced to the biological. This is commonly accepted in psychiatry, with many researchers subscribing to a "biopsychosocial model of health" (Bolton & Gillett, 2019).

Adopting a nuanced, pluralistic approach, the biopsychosocial model recognizes that mental illness is not only the result of biological factors, but that social context, cultural norms, and historical circumstances can also play a significant role. This perspective challenges the notion of mental illness as an inherent trait, and instead recognizes that the barriers to achieving desired abilities or functions are often a result of systematic and institutional obstacles, negative beliefs, or prejudices toward people with mental illness (Gosselin, 2018). This addresses the goal of increasing visibility to combat stigma (motivator 4). It suggests greater adaptability, countering the essentialist criteria of immutability (a.) and independence from environmental and personal influence (b.).

However, it has been recognized that even when clinicians adopt the biopsychosocial model, and particularly with autistic people, "the emphasis is placed on the 'bio' aspect, and when examined closely it is a medical model view that is actually being used" (Hartman et al., 2023, p. 51). Moreover, researchers have recognized that despite viewing disorders as less "internal", the biopsychosocial model still considers psychiatric categories as essentialist categories (Zachar & Kendler, 2007), persisting beyond one's actions and behaviors. Thus, this model might not enhance the sense of control for people who self-ascribe these labels. Simply knowing that one's environment and history are also parts of oneself does not inherently provide control over one's life or environment. Even with the desire to regain control, the systemic and social nature of harm allows little room for action. Criteria a.) and b.) of essentialism could still be met through biopsychosocial narratives. Regarding the other criteria, these models suggest an etiological pathway between people's biology and environment and their behaviors, addressing criterion c.); and while this pathway depends on external rather than internal causes, it still views psychiatric categories as d.) homogeneous and discrete, because they are related to biological mechanisms.

Finally, these models do not aim to de-pathologize; they shift the cause and location of mental illness from the individual to the environment, but still view psychiatric categories as dysfunctions and pathologies. While the biopsychosocial model may emphasize the importance of understanding the social and cultural factors contributing to mental illness, this may not be sufficient to overcome the stigma and internalized beliefs individuals hold

about their own mental health, nor does it necessarily increase visibility against stigmatizing attitudes toward psychiatric categories. The risk of stigmatized attitudes and discrimination persists.

2.3. Neurodiversity (ND)

The last narrative that we want to consider is the Neurodiversity movement, which emerged as a response to the biomedical model and is rooted in the social model of disability. It critiques the biomedical approach by emphasizing cultural, historical, and systemic influences on disability, including mental illness (Shakespeare, 2016). Highlighting that disability is not merely a biological issue but also a product of societal barriers and prejudices, the ND narrative shifts the focus from inherent dysfunction to the impact of environmental factors on individuals with psychiatric labels, offering an alternative to pathologization (Oliver, 1983). When applied to self-ascriptions, the neurodiversity movement supports the quick access to resources, for example through what David and Deeley (2024) have noticed as an "admittance to the peer support of a community" (p. 3) (motivator 1.), and enhances the recognition and validation of challenging experiences, counteracting indifference (motivator 2.).

Unlike the biomedical and biopsychosocial narratives that are propagated from the top down by scientific research, the DSM task force, and healthcare professionals, the Neurodiversity movement emerges from the bottom-up, addressing epistemic injustice, and gaining momentum through social media. It fosters a deeper self-understanding by integrating personal experiences with social contexts, which increases credibility and visibility against the stigma of mental illness. These correspond to the two last motivators for self-ascriptions (3. and 4.). However, self-ascriptions within the ND framework can still fall into the trap of essentialism. We now explain why, focusing more specifically on the case of autism.

ND centers on psychiatric labels and categories like autism and ADHD, perceived as neurological differences entwined with societal oppression rather than diseases (Bovell, 2015; Chown, 2020). The ND movement takes a clear stance against the disease assumption inherent in operationalism and the biomedical model of psychiatric categories. Its advocates challenge the medical deficit model and its negative trajectory (Chapman, 2021). Specifically, in autism, where self-advocates significantly contribute to ND, the effort to find causes and treatments, alongside the view of autism as a pathology, disorder, or disease, is broadly contested (Bovell, 2015; Chown, 2020). There is also a critique of the lack of ethical justification for the seeking cure and prevention (Bovell, 2015). Instead, the *suffering* that autistic people may experience is attributed to environmental factors rather than autism itself. By prioritizing

neurological differences over the disease model, ND posits that such differences are inherently compatible with a fulfilling life and well-being (Chapman & Carel, 2022). The absence of a narrative that supports a fulfilling life may leave autistic people epistemically adrift, unable to fully comprehend and navigate their experiences (Chapman & Carel, 2022), which highlights the importance of suitable narratives. The transition from viewing conditions as disorders to recognizing them as part of neurodiversity aligns with the social or relational model of disability, which attributes disablement and distress to social exclusion, oppression, and marginalization (R. Chapman, 2019). According to these views, disablement is socially caused, so raising awareness to deconstruct stigma is the first step toward better inclusion and well-being of people who identify with a psychiatric label.

ND activists identify as belonging to a minority neurocognitive group, focusing on neurodivergence as an aspect of identity rather than a matter of capabilities being either enhanced or reduced (Chapman, 2021). This perspective challenges the "neuronormative" belief that deviating from the brain's typical functioning is unfavorable (Catala et al., 2021). Viewing psychiatric labels as expressions of diversity, not disease, benefits well-being, and identity development, reduces uncertainty, and fosters a collective identity. This approach addresses the third motivator by enhancing a sense of belonging and self-connection (3). This is an advantage for many people engaging in self-ascriptions and identifying with the categories since it has the potential to decrease stigma and eliminate the need for treatment and cure. It achieves this by considering the status of being neurotypical as just having "the sort of psychological profile that is already served (more or less) well by one's environment, and there is no reason to see such a profile as inherently healthier, rather than just more convenient under the current circumstances" (Tabb, 2021, p. 5). In association to an adherence of a ND narrative, self-ascription could enhance the goals of social justice promoted by the movement. In fact, in an editorial on the consequences of receiving a diagnostic of autism, Fletcher-Watson (2024) notes that "[s]elf-identification offers advantages in that it could constitute a key step toward autistic (and also more generally neurodivergent) liberation, by transferring power into the hands of autistic people themselves" (p.259). Thus, ND directly addresses the fourth motivator by increasing visibility and countering stigmatizing attitudes and discrimination (4).

While the neurodiversity paradigm emphasizes diversity, it highlights that the diversity itself is of a neuro-cognitive and neuro-biological kind (Singer, 1999). Thus, ND is still built on the assumption that there is an underlying difference between groups who are neurodivergent against a "normality", and that this difference is biologically based. This is the explicit position of some of ND proponents who claim: "the neurodiversity

movement's framework conceptualizes autism itself as purely biological, as opposed to resulting from dynamic genetic-environmental interplay (. . .) or at least in part from toxins in the physical environment" (Kapp, 2020, p. 8). These claims map back onto a unified explanation and etiology, although it is more a biological/neurological explanation, rather than one in terms of disease. If ND is sometimes attached to a biomedical narrative, it is more often associated with a biopsychosocial narrative (Doyle, 2020; Hartman et al., 2023; Whelpley et al., 2023), because of its adoption of a theoretical framework that stressed that neurodiversity corresponds to different brain wirings.

The assumption that diversity is neurologically driven taps into essentialist thinking it assumes stable, fixed, and discrete entities through distinct neurocognitive types (criteria a.). Moreover, the emphasis on neurological differences as explanation highlights the assumption of an independence of these categories from the environment and a persons' control (criteria b.), assuming specific etiologies (criteria c.) that are of a natural kind (criteria e.). Essentialist assumptions are sometimes even directly endorsed by people in the ND movement. In fact, Kourti (2021) writes: "autism indeed has an essential nature, even if it cannot be epistemologically accessed, measured, and analysed" (p.9). These assumptions are also inherently implied by conceptualizations as distinct neurocognitive types.

Finally, it has been recognized by ND activists that the need for constant therapeutic care of some autistic people should be attributed to the presence of additional conditions that exist alongside of, but are not inherent to, autism (R. Chapman, 2019, p. 380). Therefore, the homogeneity and discreteness (criteria b. of essentialism) are not dismantled by proponents of ND.

The emphasis on neurological difference might risk undermining an appreciation of the circumstances: historical, personal, and societal as well as socioeconomic facts. Thus, ND might prove non-comprehensive with respect to these factors, thereby impacting the sense-making of a person, going against the third motivator of self-ascriptions. In short, it facilitates a fragmented and context-deprived understanding of oneself or others.

By highlighting the neurocognitive aspect as the *essence* of differences, similar to other narratives, ND thinking might discourage people from taking action, assuming responsibility, or changing behaviors if they attribute their behaviors, emotions and ways of relating to the world to naturally specific brain wiring. This is well illustrated by the TikTok trend we mentioned on object permanence and ADHD which has led many people including those diagnosed with ADHD and those who self-diagnosed after watching these videos, to identify with this trait. Viewing oneself through this lens can simplify the understanding that ADHD inhibits engaging in serious relationships, especially if the potential partner is not continuously

present to be seen and remembered. Considering this as a consequence of distinct brain wiring, self-identification is likely to encourage essentialist thinking about oneself.

By promoting diversity, community, and identity, against the backdrop of supposed neurotypical health, the ND narrative offers a framework that addresses all motivators for self-ascriptions. However, the ND narrative still delineates between what is considered typical and what is considered deviant, risking a slide into essentialism characterized by inaccurate and overly simplified self-descriptions. This risk is particularly relevant in self-ascriptions because online discourse about psychiatric categories may be inaccurate. Self-ascriptions of psychiatric labels in association with ND thinking mirrors several aspects of essentialist thought. The advantage of the ND narrative over the other narratives is that it can also increase one's credibility and visibility against stigmatizing attitudes toward disabilities or toward the identification with a psychiatric label (4.). However, it does not fully address the risk of essentialism.

3. Toward lived-experience narratives of psychiatry

Across the previous sections, we have argued that the usage of a diagnostic label in self-ascriptions processes always comes embedded in a narrative and that these narratives run the risk of essentialism when people self-ascribe psychiatric categories.

To mitigate this risk, the narratives used by people who chose to self-ascribe a psychiatric label should aim at avoiding both essentialism and an adherence to a stereotypical sense of normativity. The ND movement already does the latter.

In this last section, we propose a few steps that could be taken in the pursuit of reducing the risks of essentialism mentioned here, foremost among them being the risk of adopting a context-deprived understanding of oneself. We do not call for radically new narratives because we think the narrative of the ND movement has helped people to respond to the goals underlying self-ascriptions. However, we think that an explicit aim at avoiding essentialism could foster the dialogue between laypeople who self-ascribe psychiatric labels and psychiatric discourses in clinical and most research settings, bridging the growing divide between them and allowing a more inclusive and constructive understanding of mental health and disability.

Exploring the outlined phenomenon empirically helps illustrate what we have so far outlined on a more theoretical level. A first step would be to assess the extent to which people already break off from the definitions and symptom checklists when they are ascribing psychiatric labels to themselves, and thus, to identify the types of narratives that people

who self-ascribe a psychiatric label typically adopt. This could be done by testing whether some looping effects have taken place within online discourses, and more specifically, what associations people attach to labels such as "neurodiverse", "autistic", "ADHD", etc. By contrasting attributes attached to labels in online communities to the manifestations described in the DSM, we suspect that studies would show that the meaning of these labels have progressively deviated from the DSM-descriptions, proving the existence of the second half of the looping effects within online-discourses. This would mean that people initially use DSM categories to claim their identity as a neurominority, but then disagree with some characterizations of the DSM (for example pathological or deficit-based descriptions), and with some implications of the associated biomedical model, and start adhering to social or political narratives.

Practically, associations with a label could be tested with an implicit or *semantic association test* (*e.g.* the Harvard Implicit Association Test). Association tests are used in psychology to study some semantic connections that underlie the meaning attached to what people are asked to associate, even when these connections are implicit. These tests are particularly suitable for assessing what meanings people attach to their self-concepts (Schnabel et al., 2008). For example, a subject can be told to state the first word that comes to mind in response to a stated word, concept, or other stimulus. In "controlled association," a relation may be prescribed between the stimulus and the response (e.g., the subject may be asked to give opposites). Though more complex analyses may be used for special purposes, the reaction time for each response and the words the subject gives constitute the data provided by the test.

To show which narrative people follow when they self-ascribe a psychiatric label, people could be asked to ascribe attributes to the psychiatric label that they identify with or to an association pair between that label and terms particularly associated with a specific narrative, such as "ADHD and pathology" "ADHD and pride", or "ADHD and lack of attention", etc. These ascriptions would then be analyzed using a semantic analysis framework to derive overarching themes, which could then be mapped onto the motivations for self-ascriptions and the narratives that are used. The associations (i.e., the themes) could also be compared with the DSM checklist to determine overlaps and deviances. If associations connected to a label have changed and significantly deviate from the DSM-checklist, we would have an example of a looping effect where the meaning of the diagnostic label itself does seem to change. Assessing what people associate with a label, it might also become apparent what narratives they adhere to (biological, ND, etc.), or whether they are building their own narratives around a psychiatric category.

In addressing the challenge of essentialism, some scholars and psychiatrists urge people not to throw the baby out with the bathwater, advising instead to differentiate between essentialist perspectives and medical practices. Psychiatrist Awais Aftab indicates: "The 'medical model' is conflated with the idea that all medical conditions are discrete biological disease entities, an assumption that isn't even true for much of general medicine, let alone psychiatry. (. . .) [T]he manner in which we as a society organize and reimburse healthcare makes it impossible for clinicians to do anything about the context of a person's life other than acknowledge its relevance" (Aftab, 2024). According to him, the limitations of clinicians are political, not theoretical. Clinicians recognize the heterogeneity of clients and service users' perspectives. On the contrary, Aftab explains that many service users essentialize themselves. We think that recognizing nuances and complexity in these debates instead of trying to identify a guilty party is a first step toward reconciliations between psychiatric framework and people who look for responses.

As a second step toward avoiding essentialism, and related to the first one, we believe that the foundations for a deeper understanding of psychiatric frameworks necessitate pluralists' perspectives of psychiatric categories. These allow a multiplicity of interpretations that diminish the risk of essentializing a category. These perspective are being developed by people with lived-experiences, such as the advocate of ND and other activist movements – notably people who proudly identify as Mad (Beresford & Russo, 2021; Soros, 2021), who now add their voices to the medical perspectives, and from scholars who embrace the vindications of these movements to integrate them to the conceptualization of psychiatric categories (Garson, 2022; Rosqvist et al., 2020). New models are also emerging through the work of researchers who highlight the importance of lived experiences, such as phenomenological accounts of psychopathology (Drożdżowicz, 2020; Ritunnano et al., 2021), as well as the integration of first-person perspectives in research, as seen in research testimonies (Hull et al., 2017) or participatory research in psychiatry (Friesen et al., 2021; Ş. Tekin, 2022). By considering the experiences of patients and people with lived experience in addition to operationalized definitions, the heterogeneity of manifestations inherent to psychiatric categories will be revealed. This approach will make the narratives less rigid, providing people with a more accurate representation of what it is like to be autistic, schizophrenic, to have an addiction, or an attention deficit, encompassing all the complexity these categories entail.

4. Conclusion

Concepts, labels, and the narratives surrounding them should be helpful, resourceful, and responsive to a person's history, personality, culture, and

circumstances. This is not just a normative proposition; it is crucial to ensure these elements align closely with the lived experiences and identities of people.

On one hand, developing these narratives must be informed by insights from people who identify with specific labels and narratives. On the other hand, certain aspects of narratives, especially those appealing to essentialism (whether genetic or biological), along with stereotypical descriptions and perspectives on normality, require careful avoidance to prevent reductive and potentially harmful conceptualizations. Whether through refining existing narratives (such as Neurodiversity, Mad Pride, etc.) or developing new ones, adhering to this principle is essential to understand the diversity of mental states and identities accurately.

To achieve this, the role of essentialism in narratives needs to be better understood, as it seems to fulfill a need, acting like a motivator for seeking validation and being taken more seriously. This need often arises from a social context where expressing an emotion – sadness for example – is undervalued and easily dismissed compared to declaring one has a mental health problem, e.g., is depressed. Therefore, we advocate for cultivating a social climate where psychiatric labels coexist with other expressions of human experience, including moods. Most importantly, a climate where any experience – whether psychiatric, neurodiverse, emotional, or of any other kind – is taken seriously and is being validated. This could diminish the tendency to essentialize experiences and might lead to a broader phenomenological description of experiences, becoming more responsive, comprehensive, and resourceful. Another important way to mitigate the process of self-diagnosis, as well as to deal with and incorporate an "official diagnosis" into one's identity, is through greater societal awareness of the conceptual issues surrounding diagnostic labels and the narratives in which these labels are embedded.

In fact, it is sometimes assumed that some psychiatric narratives, such as a "conservative reading" of the medical model, directly come with an essentialist assumption about the "causes" of psychiatric categories. However, most narratives, including the DSM do not make an etiological claim about underlying neurological/biological causes. It is instead the public discourse that asserts essentialists claims onto these narratives, rather than the narratives themselves, as Aftab explains about the DSM (Aftab, 2024).

Generally, narratives that tend to be more essentializing have a tendency to focus on isolated factors, such as neurological aspects or specific life experiences like trauma, rather than to consider a wide range of underlying mechanisms (biological, societal, developmental, economic). This narrower focus can make the narratives less comprehensive and less resourceful.Essentializing is thus not inherently about

biology or genetics but rather about concentrating on a single factor and treating it as the only "resource" and "explanation". Therefore, the wider the focus, the more nuanced the understanding, the fewer the limitations and the less essentializing the narrative. In line with this argument, some narratives have features that make the risk of essentialization greater, as they highlight specific factors, e.g., neurological features.

In line with this, and irrespectively of the specific narrative that frames the label, a label – or a single term – that describes a complex and multifaceted set of experiences is inherently reductionist and limiting. Focusing on the experiences themselves, rather than on the overarching "tag", is inherently less essentializing and, therefore, more comprehensive, resourceful, and responsive. From a standpoint that highlights lived experience, when focusing on lived experience, special emphasis should be placed on the experiences themselves, rather than on the use of labels.

Ultimately, change may not only lay at the individual level in finding narratives but also at a broader societal level, involving us all. Granting more credibility, validity and recognition to multifaceted experiences, regardless of a clinical label, taking people's concerns seriously, and prioritizing inclusion and diversity at the societal level might encourage a shift in the overall attitude and understanding of oneself and others.

Notes

1. We are excluding from this analysis the casual or permissive use of some psychiatric concepts to explain isolated behaviors (such as using the word "OCD" to describe one's habit of tidying up, or the concept of "PTSD" to describe one's reaction to a surprising situation).
2. An increase in self-understanding and understanding by others has been highlighted as a benefit (David & Deeley, 2024; Fletcher-Watson, 2024). However, it has not been explored in detail how self-diagnosing facilitates changes in self-understanding, or whether these changes bring benefits or harm.
3. The increased awareness and recognition of mental illness may have contributed to the increase in diagnoses and to these expansions as well (Foulkes & Andrews, 2023).
4. Note that we are not claiming that the biomedical model is proving the scientificity of psychiatric categories. Neither are we considering activism as nonscientific. This debate, while important in the contemporary literature of mental disorders, lies beyond the scope of this paper.

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