

The Impact of Professional and Self-Diagnosis on GAD Symptoms

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There has been a striking diagnostic inflation during the past 30 years. As fear of diagnostic labels and anticipation of stigma are common barriers to mental health service utilization, understanding the psychological consequences of labeling is critical for public health in this era of increased diagnoses. Yet, clinicians and researchers have paid relatively little attention to the consequences a diagnostic label has on psychological well-being. At the same time, there has been a notable increase in the prevalence of Generalized Anxiety Disorder (GAD) over the past decade, drawing greater public and research interest on the topic. This growing prevalence raises important questions about the impact of a GAD diagnosis, as being diagnosed with a Diagnostic and Statistical Manual of Mental Disorders (DSM-5) disorder can trigger fear and worry core symptoms of GAD in patients. This study examined an association between having a diagnosis and GAD symptom frequency, as measured by GAD-7, a seven-item scale that assesses the frequency of GAD symptoms over the past two weeks. This study also explored whether the type of diagnosis professional or self-diagnosis differed in its effects. Participants were divided into four groups based on the presence or absence of a diagnosis: Group 1 (with a professional diagnosis and no self-diagnosis), Group 2 (with both a professional diagnosis and a self-diagnosis), Group 3 (with neither a professional diagnosis nor a self-diagnosis), and Group 4 (with a self-diagnosis but no professional diagnosis). Their GAD symptom frequency was measured by GAD-7 and a one-way ANOVA and pairwise comparisons using the Tukey method were conducted to analyze the data. Participants with both a professional diagnosis and a self-diagnosis exhibited the highest GAD scores, while those with neither a professional diagnosis nor a self-diagnosis exhibited the lowest GAD scores. This result suggests an association between the presence of a diagnosis and the higher GAD symptom frequency as measured by GAD-7. Interestingly, no significant differences were found between participants with only a professional diagnosis and those with only a self-diagnosis. Still, the suggested link between the presence of a diagnosis and the higher GAD symptom frequency opens the door for future research to further examine causal relationships through longitudinal studies.

Keywords: Generalized Anxiety Disorder (GAD), diagnosis, labeling theory, stigma

Introduction

Generalized Anxiety Disorder (GAD) is a mental health condition marked by excessive and unrealistic worry about everyday things, producing fear and a constant feeling of being overwhelmed (Munir & Takov, 2022)¹. An individual is diagnosed with GAD if excessive anxiety and worry occur more days than not for at least 6 months, about a number of events or activities (DSM-5). Recently, there has been a notable increase in the prevalence of GAD. Global rates of anxiety and depression surged by 25% during the first year of the COVID-19 pandemic (WHO, 2022)², while the number of individuals affected by anxiety disorders rose by over 55% from 1990 to 2019 (Javaid et al., 2023)³. Historically, GAD was often overlooked due to unclear diagnostic criteria and indistinct symptom profiles (Newman et al., 2013)⁴. Whether GAD merits its own diagnostic category was questioned as its core features, worry and anxiety, are common to many emotional disorders (Newman et al., 2013)⁴. However, GAD is now widely recognized as a legitimate and

stand-alone medical disorder. This shift in recognition arose from the growing prevalence of GAD, along with an increasing emphasis on transdiagnostic processes and emotional dysregulation (Newman & Przeworski, 2018)⁵. Public interest in GAD has grown significantly with increased studies focusing on the topic (Newman & Przeworski, 2018)⁵, and research publications on GAD have increased in number since 2006 (Asmundson & Asmundson, 2018)⁶. Despite the increased recognition, GAD remains less studied compared to other anxiety disorders, such as panic disorder, agoraphobia, posttraumatic stress disorder, and obsessive-compulsive disorder (Dugas, 2000)⁷. Also, it is still often the least successfully treated among anxiety disorders (Newman et al., 2013)⁴. Given that relatively little attention has been paid to the consequences of a diagnostic label on psychological well-being (Sims et al., 2021)⁸, both the psychological consequences of a diagnosis and GAD are under-researched, leaving the relationship between a diagnosis and GAD symptom frequency underexplored. This gap is particularly significant, as receiving a diagnosis can evoke emotional responses fear and

worry that closely align with core symptoms of GAD (Lebel et al., 2020)⁹.

Labeling Theory and Stigma

A diagnostic label does offer various benefits, such as validation of health concerns, access to interventions, and increased support (Sims et al., 2021)⁸. It also helps healthcare professionals classify individuals for both treatment and research purposes (Garand et al., 2009)¹⁰. However, often less considered are the negative consequences of a diagnostic label (Sims et al., 2021)⁸. After being diagnosed with psychopathology, such as GAD, individuals often experience increased stigma and a sense of powerlessness (Eads et al., 2021)¹¹. Clinical diagnosis can exacerbate stigma through group labeling (Ben-Zeev et al., 2010)¹², reinforcing negative stereotypes and impacting individuals' self-perception. One way labeling evokes stigma is through stereotype awareness, which happens when labeled individuals become aware of the negative stereotypes associated with their diagnosis (Yang et al., 2015)¹³. This awareness can further lead individuals to internalize and agree with those negative stereotypes, resulting in a feeling of shame (Rüsch et al., 2014)¹⁴. Consequently, the stigma may cause social withdrawal, loss of confidence, and fear of discrimination (Harrison & Gill, 2009)¹⁵. Self-diagnosis may also contribute to this emotional burden as it involves a process of self-labeling, where individuals label themselves as having a mental disorder with and without professional confirmation (Fellowes, 2023)¹⁶. This process of self-labeling can make individuals more susceptible to the negative effects of internalized, anticipated, and experienced stigma (Fox & Earnshaw, 2022)¹⁷. As stigma often causes social withdrawal, loss of confidence, and fear of discrimination (Harrison & Gill, 2009)¹⁵, self-diagnosis itself may be associated with similar emotional and cognitive processes to a formal diagnosis. One study showed that adolescents who self-labeled reported higher self-stigma and depression (Moses, 2008)¹⁸, which further supports the idea that the process of self-labeling itself can be psychologically impactful. Furthermore, self-diagnosis involves the belief that one has a mental disorder even in the absence of a professionally assigned diagnosis (Fellowes, 2023)¹⁶, and this expectation of illness itself can exacerbate symptoms and disease progressions as well (Pagnini, 2019)¹⁹. The emotional burden of such labeling illustrates how being diagnosed with a Diagnostic and Statistical Manual of Mental Disorders (DSM-5) disorder can evoke fear and worry in patients (Lebel et al., 2020)⁹. Based on this understanding, it was hypothesized that participants with both a professional diagnosis and a self-diagnosis would exhibit the highest GAD-7 scores, while those with neither a professional diagnosis nor a self-diagnosis would exhibit the lowest GAD-7 scores (Hypothesis 1a and 1b).

Interestingly, healthcare professionals—perceived as experts

in society—can also play a crucial role in carrying out the external processes of labeling (Armstrong, 1994)²⁰. Patients trust healthcare professionals as the most reliable source of information, while viewing the internet as a complementary source of information alongside healthcare professionals (Farnood et al., 2020)²¹. As patients view healthcare professionals as accurate, they often directly accept their diagnosis without trying to prove them wrong (Farnood et al., 2020)²¹. Since stigma begins when the individuals identify themselves as having a mental health condition (Aakre et al., 2015)²², the legitimacy and authority of a professional diagnosis may play a key role in shaping how individuals come to identify themselves with the label and internalize it. This dynamic may explain why some patients intentionally choose not to pursue a professional diagnosis. Their reluctance to disclose their mental health conditions to healthcare professionals often arises from a fear of the potential consequences they might face (Dew et al., 2007)²³. Patients' apprehension about receiving their results reflects the anxiety surrounding a professional diagnosis and underscores a broader link between a professional diagnosis and a sense of fear among patients. Given that fear is one of the key symptoms of GAD, it was hypothesized that there would be a statistically significant difference between GAD-7 scores of participants with only a professional diagnosis and those with only a self-diagnosis and that participants with only a professional diagnosis would have higher GAD-7 scores compared to those with only a self-diagnosis (Hypothesis 2).

Present Study

There has been a striking diagnostic inflation during the past 30 years (Batstra & Frances, 2012)²⁴. As fear of diagnostic labels and anticipation of stigma are common barriers to mental health service utilization (Moses, 2008)¹⁸, understanding the psychological consequences of labeling is critical for public health in this era of increased diagnoses. Yet, clinicians and researchers have paid relatively little attention to the consequences a diagnostic label has on psychological well-being (Sims et al., 2021)⁸. Furthermore, being diagnosed with a DSM-5 disorder can evoke fear and worry about illness in patients (Lebel et al., 2020)⁹. Given that these emotions are the key symptoms of GAD, the increased prevalence and interest in GAD naturally prompts discussion about the consequences of a diagnosis on individuals with GAD. This study aims to address this gap by exploring the psychological impact of professional and self-diagnosis (defined here as participants' identification of a probable diagnosis despite lacking formal diagnosis) on GAD-7 scores amongst individuals with and without diagnoses related to internalizing anxiety symptoms. The data come from a larger cross-sectional study on the impact of adverse childhood experiences and childhood socioeconomic status on the well-being of young adults. Specific data collection procedures were not accessible due to

current data protection policies, and a one-way ANOVA and pairwise comparisons using the Tukey method were used to analyze the data. It was hypothesized that participants with both a professional diagnosis and a self-diagnosis would have the highest GAD-7 scores and that those with neither a professional diagnosis nor a self-diagnosis would have the lowest GAD-7 scores (Hypothesis 1a and 1b). Further, it was hypothesized that there would be a statistically significant difference between GAD-7 scores of participants with only a professional diagnosis and those with only a self-diagnosis and that participants with only a professional diagnosis would have higher GAD-7 scores compared to those with only a self-diagnosis (Hypothesis 2).

Results

A one-way ANOVA was conducted to compare GAD scores among the four groups, examining the effects of professional and self-diagnosis (defined here as participants' identification of a probable diagnosis despite lacking formal diagnosis). Those four groups consisted of Group 1 (with a professional diagnosis and no self-diagnosis), Group 2 (with both a professional diagnosis and a self-diagnosis), Group 3 (with neither a professional diagnosis nor a self-diagnosis), and Group 4 (with a self-diagnosis but no professional diagnosis). The mean GAD scores for the groups were as follows: Group 1 ($M = 9.45$, $SE = 0.51$), Group 2 ($M = 11.32$, $SE = 0.41$), Group 3 ($M = 5.95$, $SE = 0.21$), and Group 4 ($M = 9.76$, $SE = 0.50$). A one-way ANOVA revealed a significant effect of professional and self-diagnosis on GAD scores, $F(3, 632) = 59.40$, $p < .001$, $\eta^2 = 0.22$. The large effect size suggests significant differences between the various groups. The group with both a professional diagnosis and a self-diagnosis had the highest GAD scores ($M = 11.32$, $SE = 0.41$), while the group with neither a professional diagnosis nor a self-diagnosis had the lowest GAD scores ($M = 5.95$, $SE = 0.21$).

Pairwise comparisons using the Tukey method revealed a significant difference between several groups: the group with a professional diagnosis and no self-diagnosis (group 1) and the group with both a professional diagnosis and a self-diagnosis (group 2), ($MD = -1.87$, $SE = 0.65$, $p < .05$); the group with a professional diagnosis and no self-diagnosis (group 1) and the group with neither a professional diagnosis nor a self-diagnosis (group 3), ($MD = 3.50$, $SE = 0.55$, $p < .001$); the group with both a professional diagnosis and a self-diagnosis (group 2) and the group with neither a professional diagnosis nor a self-diagnosis (group 3), ($MD = 5.37$, $SE = 0.46$, $p < .001$); and the group with neither a professional diagnosis nor a self-diagnosis (group 3) and the group with a self-diagnosis but no professional diagnosis (group 4), ($MD = -3.80$, $SE = 0.54$, $p < .001$). However, the comparison between a group with only a professional diagnosis (group 1) versus a group with only a self-diagnosis (group 4) revealed no significant difference in their GAD scores ($p = 0.97$).

Discussion

Our pairwise comparisons using the Tukey method revealed significant differences in GAD-7 scores among several groups. Both the group with only a self-diagnosis and the group with only a professional diagnosis had significantly higher GAD scores compared to the group with neither diagnosis, indicating an association between the presence of a diagnosis whether self or professional and the higher GAD symptom frequency as measured by GAD-7. No significant difference in GAD scores between the group with only a self-diagnosis and the group with only a professional diagnosis suggests that the type of diagnosis does not exhibit a significant association with more frequent GAD symptoms.

The Presence of a Diagnosis and Higher GAD-7 scores

To compare the results with our original hypotheses, hypotheses 1a and 1b—asserting that individuals with both a professional diagnosis and a self-diagnosis would exhibit the highest GAD-7 scores and that individuals with neither a professional diagnosis nor a self-diagnosis would exhibit the lowest GAD-7 scores—were supported by our findings. The group with both a professional diagnosis and a self-diagnosis (group 2) had the highest GAD-7 scores, while the group with neither a professional diagnosis nor a self-diagnosis (group 3) had the lowest GAD-7 scores. Our findings suggest an association between the presence of a diagnosis and the higher GAD symptom frequency as measured by GAD-7, which is likely because diagnosis carries stigma. This stigma may result in individuals' loss of confidence and fear of discrimination (Harrison & Gill, 2009)¹⁵, and indeed, can evoke fear and worry as well, which are the key symptoms of GAD (Lebel et al., 2020)⁹.

Differences due to the Type of Diagnosis

Meanwhile, hypothesis 2 was not supported. The comparison between the group with only a professional diagnosis versus the group with only a self-diagnosis revealed no significant difference in their GAD-7 scores ($p = 0.97$). This result indicates that those with a self-diagnosis do not report lower GAD symptom frequency than those with a professional diagnosis. One possible explanation for this finding is individuals' increased access to online health-related information due to the expansion of the internet and social media (Monteith et al., 2024)²⁵. Online self-diagnosis can exacerbate individuals' anxiety, particularly for those who do not have much medical knowledge (Guo et al., 2020)²⁶, as it may lead individuals to be exposed to unfiltered and inaccurate information on social media (Monteith et al., 2024)²⁵. It is also important to note that the consequences of diagnostic labels can vary between individuals, influenced by internal factors, such as age, sex, culture, and medical history, as well as external factors, such as service availability and country

of residence (Sims et al., 2021). Additionally, one study suggests that younger individuals are more inclined to engage in self-diagnosis (Tse & Haslam, 2024)²⁷. Given that the participants in this study ranged from 18 to 25 years old, this youthful demographic may be important to consider when understanding the complexity and impact of self-diagnosis.

Implications and Recommendations

In the study, GAD-7 scores did not significantly differ between individuals with only a self-diagnosis and those with only a professional diagnosis. Since receiving a professional diagnosis is the most accurate way to evaluate a condition and receive treatment, clinicians should actively educate patients about the potential risks of self-diagnosis, while patients should be discouraged from relying solely on self-diagnosis without professional input. Moreover, as the psychological impact of receiving a diagnostic label has not been studied in depth (Sims et al., 2021)⁸, further research is needed to explore the consequences of labeling. Future studies should address the limitations of this study by adopting experimental designs that allow causal inferences. Ultimately, this study lays the groundwork for future investigations into clinical and psychological implications of both self and professional diagnosis.

Limitations and Future Directions

While our findings are significant, it is essential to acknowledge the limitations of the study. GAD scores were calculated based on self-reported measures, which may introduce bias. Some participants might have reported their symptoms in a way that they think is more socially acceptable while others might have reported their symptoms in an exaggerated way either, unintentionally or for various personal reasons. Moreover, as pairwise comparisons can only infer significant mean differences but not causal relationships, our findings can only imply an association between the presence of a diagnosis and GAD symptoms, rather than a definitive cause-and-effect link. Additionally, it is worth noting that some individuals reported choosing not to pursue a professional diagnosis due to apprehension about receiving the results, while others avoided a diagnosis due to the associated cost or concerns about their family knowing. These factors could further complicate the relationship between diagnosis type and GAD symptoms. Future longitudinal research will be needed to explore the causal relationship between each type of diagnosis and its impact on GAD symptoms.

Conclusion

This study investigated the impact of professional and self-diagnosis amongst individuals with and without diagnoses related to internalizing anxiety symptoms. While this construct

has remained largely unexplored, our findings suggest an association between the presence of a diagnosis and the higher GAD symptom frequency as measured by GAD-7. Interestingly, the type of diagnosis whether professional or self-diagnosis did not result in significantly different GAD symptoms. This research is among the first to establish a link between the presence of a diagnosis and its impact on GAD symptoms, and the identified association opens the door for future research to build upon this foundation and to further examine causal relationships through longitudinal studies.

Methods

Data Source

The data were collected by Schmidt (2024)²⁸ to examine the impact of adverse childhood experiences and childhood socioeconomic status on the well-being of young adults. This paper specifically used the part where participants' Generalized Anxiety Disorder (GAD) symptoms and whether they had a professional diagnosis, a self-diagnosis, both, or neither, during the ages of 18 to 25 were assessed. Due to current data protection policies, specific data collection procedures were not accessible. Protocols were also restricted, and the limited demographic information provided in the dataset is reported here. There were 1,304 participants in total, and after excluding 668 participants who were outside the scope of the study, demographics for the remaining 636 participants were analyzed. The average age of participants was 22.8 years ($SD = 1.8$). In terms of gender, 315 participants identified as male, 292 as female, 12 as transgender female, 10 as transgender male, and 7 as gender variant/non-conforming. In terms of race, 466 participants identified as White, 66 as multiracial, 39 as Hispanic, 28 as Black, 28 as Native American/ Pacific Islander, and 9 as Asian.

Data Analysis

Participants were divided into four groups: Group 1 included individuals with a professional diagnosis and no self-diagnosis ($n = 66$); Group 2 included those with both a professional diagnosis and a self-diagnosis ($n = 103$); Group 3 included those with neither a professional diagnosis nor a self-diagnosis ($n = 397$); and Group 4 included those with a self-diagnosis but no professional diagnosis ($n = 70$). Additionally, 668 participants were not included in the analysis as they had symptoms that fell outside the scope of the study. While they had either a professional diagnosis or a self-diagnosis, their symptoms were not internalizing but rather externalizing symptoms, developmental disorders, or eating disorders. A one-way ANOVA and pairwise comparisons using the Tukey method were conducted to analyze the data.

Measures

GAD was measured by its symptom frequency using the GAD-7 (Spitzer et al., 2006)²⁹. The GAD-7 is a seven-item scale developed to assess symptom severity of Generalized Anxiety Disorder (GAD), and its reliability and validity as a measure of anxiety in the general population is proved (Löwe et al., 2008)³⁰. Items were rated on a four-point Likert scale with the anchors of nearly every day, more than half the days, several days, and not at all, which were respectively scored to 3, 2, 1, and 0. Example items from the scale include “Over the last two weeks, how often have you been bothered by the following problems? Feeling nervous, anxious, or on edge.” and “Over the last two weeks, how often have you been bothered by the following problems? Not being able to stop or control worrying.” A Generalized Anxiety Disorder (GAD) sum score was calculated by adding the scores across all seven items. A higher score was associated with more frequent anxiety symptoms; scores of 5, 10, and 15 were taken as the cut-off points for mild, moderate, and severe anxiety, and a score of 10 was the threshold for GAD diagnosis (Spitzer et al., 2006)²⁹.

The presence of a professional diagnosis was assessed based on Q 52 of the raw data (“Between the ages of 18-25, were you diagnosed by a medical professional with a mental health disorder?”) followed by Q 53 (“If Yes, which category would that diagnosis fall under?”) Self-diagnosis was a single item, self-reported data, where the participants actively labeled themselves. The presence of a self-diagnosis was assessed based on Q 54 of the raw data (“Between the ages of 18-25, did you or do you have an undiagnosed mental health disorder?”) followed by Q 55 (“If Yes, which category would that diagnosis fall under?”) Again, even if participants responded “Yes” to either Q 52 or Q 54, if their answers to Q 53 or Q 55 were not internalizing symptoms, but rather externalizing symptoms, developmental disorders, or eating disorders, those participants were excluded from the study.

In addition, it is important to note that the term “self-diagnosis” is used throughout this paper to refer to participants’ identification of a probable diagnosis despite lacking a formal diagnostic process. Diagnosis reflects the process of classifying an individual as having, or not having, a particular condition (Eyben & Moncrieffe, 2007)³¹. Given that participants who reported an undiagnosed mental health disorder were asked to identify the category their symptoms fell under, this process of classifying themselves under a particular diagnosis was referred to as a “self-diagnosis.” While this may not constitute a formal diagnostic process, the term ‘self-diagnosis’ is used throughout the paper to reflect participants’ self-recognition of symptoms and their identification of a probable diagnosis.

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