

2023

Self-Diagnosis & Pathologizing Normality During the Information Age

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Self-Diagnosis & Pathologizing Normality During the Information Age

A Thesis

Presented to

The Faculty of the Department of Psychology

Murray State University

Murray, Kentucky

In Partial Fulfillment

of the Requirements for the Degree

of Master of Science in Clinical Psychology

by Chelsey Eaton

May 2023

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Acknowledgements

First and foremost, I would like to express my deepest appreciation to Dr. Laura Liljequist, my thesis chair and professor, for all of her patience, time, and expertise throughout this process. Her mentorship, wisdom, and humor were invaluable and made my graduate school experience one to remember. I would also like to thank the members of my thesis committee for their contributions: Dr. D. Gage Jordan, Dr. Sean Rife, and Dr. Nikki Gaylord. I would like to further acknowledge Dr. D. Gage Jordan for going beyond his required responsibilities by being empathetic and encouraging towards students. Thanks should also go to Dr. Michael Bordieri for instilling in me the confidence I needed to be successful and push myself beyond my comfort zone.

Words cannot express my gratitude to my husband, Joshua Eaton, for providing me with endless support and unconditional love throughout my master's program. His encouragement during the difficult times, understanding during the busy times, and thoughtfulness during the weary times have made all of the difference. None of this would have been possible without Josh and his constant love and support. I would also like to recognize our cocker spaniel, Zoey, who was right beside me throughout all of the late night studying and early morning rising. I am grateful to my family for always believing in me and cheering me on. Lastly, I would like to mention my cohort: Lainie Krumenacker, Jeremy Morgan, Connor Brown, Olivia Bowden, and Lindsey Hunter. I will always cherish our memories together as well as the uplifting nature of our cohort.

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Abstract

Self-diagnosis has become a concern for medical and mental health diagnoses. More people are engaging in self-diagnosis based on information that was obtained from the internet, including websites, social media platforms, and online forums. There are several reasons one may choose to self-diagnose. Some common reasons outlined in research are the desire to fit in with others who share similar characteristics and having a label to explain one's experiences. Past research has shown that people frequently search for mental health information online, but they may not understand or may misinterpret the information that is found. This study aimed to address one reason for the increase in self-diagnosis by examining the relationship between social media use and one's knowledge about a popular (autism spectrum disorder [ASD]) and less popular disorder (histrionic personality disorder [HPD]). Data from 47 participants at an undergraduate university were examined. Results indicated that there was a significant difference in the total knowledge about ASD and HPD as well as between incorrect items endorsed on the ASD DSM criteria subscale and ASD associated features subscale. Results also indicated that there were significant correlations between the following: total screentime and total incorrect items. There was not a significant difference between those who believed they have autism and those who did not believe they have autism on total autism knowledge. Additionally, there were not significant correlations on the following: total SMUIS score and total incorrect items, total SMUIS score and total ASD knowledge, and total screentime and total ASD knowledge.

Keywords: self-diagnosis, autism, social media, information seeking

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Self-Diagnosis & Pathologizing Normality During the Information Age

The popularization of the internet led to more and more information being accessible online at any time. In 2022, most people have access to a wealth of knowledge about any topic imaginable in a matter of seconds. This has led to an increase in people using the internet to seek out medical and mental health information (Alhousseini et al., 2020; White & Horvitz, 2009). The third most common reason people in the United States used the internet was to search for information related to health (Alhousseini et al., 2020). While searching for information online can be beneficial, it can also contribute to misinformation or misunderstanding. One example of this is when the information obtained uses technical jargon that is not easily understood by most people (Alhousseini et al., 2020). Most people do not know how to interpret clinical jargon or use the diagnostic criteria in the manner that it was intended to be used (American Psychiatric Association [APA], 2022; Epstein et al., 2013). The internet has also provided a space for people to connect on diverse topics through social media platforms, blogs, and online forums. (Giles & Newbold, 2011). This has contributed to an increase in people self-diagnosing based on information found online.

Generally, people do not understand the difference between normality and pathology, so they may link a normal experience with a clinical symptom (Wakefield, 2010). Searching online for information may lead them to attribute the “symptoms” to a particular disorder. Once these beliefs are in place, it can be hard to change them due to the labeling theory, confirmation bias, belief perseverance, and the illusory truth effect (Henderson et al., 2021, Link & Phelan, 1999; Mendel et al., 2011; Moses, 2009; Savion, 2009). Another reason for self-diagnosis may be that people want to be included in

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certain communities, like the ones on social media for particular disorders (Giles & Newbold, 2011). Some individuals may feel as if they need a diagnosis to connect with people on their shared experiences, which leads to the individuals seeking a specific diagnosis from mental health professionals. Although the widespread use of the internet has helped to decrease stigma regarding mental health disorders, it has also had some negative effects like spreading misinformation (Giles & Newbold, 2011).

Self-Diagnosis

With internet searches for medically related questions becoming more prevalent, people are beginning to self-diagnose for medical and mental health concerns. It has been noted that about 80-90% of people use the internet to find information related to healthcare, but 75% of those people do not examine the quality of their sources (Alhusseini et al., 2020; White & Horvitz, 2009). White and Horvitz (2009) conducted a study regarding medically related web searches with 515 participants recruited from Microsoft's employees at the Redmond, Washington campus. Within a month, participants reported executing five to ten online searches for medical information. People often search online using symptoms that are common or shared among various diagnoses, but the search results may indicate an uncommon diagnosis or a more serious diagnosis than a medical or mental health professional would have given (White & Horvitz, 2009). The results of an internet search usually do not indicate the base rates of disorders, which can lead some people to conclude that they have a diagnosis that is rare based on a few common symptoms that could be better explained by more prevalent or less severe diagnoses. Failing to consider the likelihood of having a disorder based on the

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base rates of that disorder may lead more people to decide that they could possibly have that disorder.

Laypersons may not understand the technical language used online, or they may misapply it (Alhusseini et al., 2020). Some clinical terms are also used commonly to mean something else. An example is the word “trigger,” meaning an individual is experiencing clinically significant distress, but some laypersons use trigger to refer to something unpleasant happening to them. Another example is “flashback,” meaning the individual re-experiences trauma, but some laypersons use flashback to describe a memory that comes up for them. This can lead people to make incorrect assumptions about what they have read or heard. Another concern related to internet searches is the possibility of incorrect information being presented. The internet allows people to find and share information on various platforms, which has some benefits, including social support (Alhusseini et al., 2020). However, platforms such as social media, online forums, and blog posts are not fact-checked to ensure information is accurate.

In a study conducted by Alhusseini and colleagues (2020), 67.5% of the 6,697 participants used electronic devices to find health-related information. They also found that participants with a mental health diagnosis, specifically anxiety or depression diagnoses, were more likely to look for health-related information online when compared to people without these diagnoses. Cyberchondria is a term that has been used to describe when someone searches a common term, and the internet results lead the individual to become unnecessarily concerned (White & Horvitz, 2009). White and Horvitz (2009) found that 50% of people searching for their symptoms online reported a reduction in their anxiety regarding their health, while 40% reported an increase in their anxiety. This

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could be related to a person's hypothesis about themselves prior to searching in combination with confirmation bias. Anxiety may decrease when someone finds supporting information for what they believe to be true, while others have an increase in anxiety when evidence does not support their beliefs. Giles and Newbold (2011) believed cyberchondria led to self-diagnosis. White and Horvitz (2009) found that participants who labeled themselves as hypochondriacs executed searches for health information at a rate that was five times the average of other participants.

Pathology Versus Normality

Wakefield (2010) discussed how distinguishing between normal distress and disordered distress is a problem when diagnosing someone. A symptom of a disorder can be a normal reaction for most people, but the circumstances, duration, and severity may lead to a diagnosis of a mental disorder. This can be problematic when someone is self-diagnosing because they can interpret their symptoms and report them on self-report measures without a regard for context, frequency, or intensity of their symptoms. People can also become confused about associated features compared to diagnostic symptoms and criteria. Associated features may be correlates of a diagnosis but do not appear as symptoms or diagnostic criteria of that diagnosis. Associated features and unrelated characteristics may be presented as indicative of a diagnosis on the internet and social media platforms. Being able to describe a single instance of one symptom compared to having multiple examples in different settings and points in time could be the difference between normal variation and a disorder. It is also possible to have all of the symptoms of a mental disorder without significant distress and accompanying impairment in academic,

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social, or occupational functioning, and therefore, not meet the criteria for a diagnosis (APA, 2022).

Epstein and colleagues (2013) discussed how people used to present to mental health facilities with a description of the problematic behaviors or symptoms experienced, but there has been a shift in the past fifty years to more and more individuals presenting with specific diagnoses in mind and using clinical terminology and jargon to describe their symptoms. This can be problematic because when individuals are using certain terms to describe themselves, they may begin to change their behaviors to match their descriptions. The idea that characterizing someone with a disorder causes the individual to begin to act in a manner similar to others characterized with that disorder was described by Hacking (1995) as a looping effect. This is based on the theory that language can have an effect on thoughts, feelings, and behaviors. This is also known as the labeling theory, which states the way individuals are described can influence their behavior, and they may act more like the label placed on them (Link & Phelan, 1999). Over time, individuals might take on this label as part of their identity and therefore alter pieces of themselves in the process. Following a diagnosis, clients may begin to think about stereotypes related to the label they were given, which could lead them to feel powerless and develop self-stigma (Moses, 2009). This can occur both when someone self-diagnoses or after a formal diagnosis.

Once people have a belief in mind, they are more likely to pay attention to information that supports their beliefs and ignore information that goes against their beliefs. This could mean trusting information from unreliable sources while disregarding information from reliable sources. This phenomenon is known as confirmation bias

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(Mendel et al., 2011; Savion, 2009). Through the use of the internet and social media, people can form a hypothesis about themselves (including a diagnosis that may or may not be applicable), find confirming evidence to support that hypothesis, label themselves as having a particular disorder, and start to take on that disorder as part of their identity. Belief perseverance can play a role as well where people hold their beliefs to be true despite evidence that goes against their beliefs (Savion, 2009). Individuals may be less likely to believe a mental health professional if the professional does not diagnose the disorder the individual believes he or she has.

Confirmation bias is something that could happen to anyone, including mental health professionals (Mendel et al., 2011). Professionals may make an initial hypothesis about a diagnosis for someone followed by focusing on evidence that supports their hypothesis and disregarding evidence that goes against it. Mendel et al. (2011) conducted a study made up of 75 medical students and 75 psychiatrists where participants were given an initial case description followed by the opportunity to gather more information, which included both confirming and disconfirming information. After reviewing all of the information, the preliminary diagnosis should have changed, but there were 58 participants that failed to change their initial diagnosis to the correct diagnosis. Mendel and colleagues (2011) also analyzed the manner in which participants sought information through a balanced search, disconfirmatory search, and a confirmatory search. Participants who conducted confirmatory searches were more likely to stick with their initial incorrect diagnosis when compared to participants who used a disconfirmatory or balanced search. This further supports the idea that it is harder to change someone's mind after they have found evidence that supports their ideas. Literature has acknowledged that

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mental health professionals are making these errors in diagnosing, despite having a sound grasp on the diagnostic criteria and knowledge of thorough evaluation processes. It is likely true that those who are not trained clinicians can also make these same mistakes when performing self-diagnoses, perhaps even to a greater extent.

The more confirming information one has, the more difficult it may be to dissuade that individual. This could be due to the illusory truth effect, which states that people believe something to be more truthful the more they hear it (Henderson et al., 2021). This occurs whether the original information is true or false. Time between the repetition of information seems to have a small effect, so one could hear the information minutes apart and still have this effect. Upon hearing repeated information, people are more likely to view the information as familiar, and therefore, view it as true.

Spreading Misinformation

People have contributed to online forums where they share their own or others' experiences with an online community (Giles & Newbold, 2011). People in these online communities often respond to each other's posts with suggestions for diagnoses that might fit based on the experiences that were described. They offer medical advice that may or may not be consistent with the advice of a mental health professional. When symptoms and experiences overlap with users who have and post about a diagnosis, one may begin to label themselves as having the same diagnosis, despite having never been assessed by a mental health professional. Members of these online communities might feel as if they need a diagnosis or label to be a part of that specific community (Giles & Newbold, 2011).

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Giles and Newbold (2011) conducted a study using compiled data that was previously collected from user led mental health forums online. They focused on the following three themes: online informal diagnoses, relationship between official diagnosis and identity, and community members informally diagnosing other people in their life. In the data, users who posted in a thread began with a short background of what they were experiencing, and other users commented advice or attempted to explain the symptoms and experiences with an informal diagnosis. An example of online community members providing each other with an informal diagnosis is when someone who commented told another user that they had bipolar disorder and had not been diagnosed yet. Giles and Newbold (2011) described problematic uses of these forums when people were assigning diagnostic labels to others in their life. For example, users try to explain why a relative has a mental health diagnosis based on the information the user has read online rather than the relative being diagnosed by a mental health professional.

Misinformation about diagnosis is also spreading from self-help websites or online providers. These websites and providers have a list of symptoms or a test that may lead individuals to believe they meet criteria for a mental health diagnosis. Oftentimes, these “tests” assess for symptoms or signs of a disorder, but the tests do not provide the reader with information he or she can interpret (The Autism Service, 2020). Some tests may provide results saying one has characteristics of a disorder and should seek further assessment and a formal diagnosis while other tests may tell someone they have a high likelihood of having a disorder when they may not meet diagnostic criteria in a formal assessment. Some “tests” have not been proven to be reliable and valid while others are written by non-professionals. Some of the tests available online are able to identify

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characteristics of a disorder, but the tests and quizzes alone are not enough to warrant a diagnosis. The Autism Service (2020) also discussed how these tests could increase a user's anxiety based on the results they receive, and this could lead individuals to expect similar results in a professional setting. Overall, regardless of online "test" results, mental health professionals still need to perform a diagnostic assessment to determine if someone meets the criteria for a diagnosis. Consumers may not be aware of this process to be formally diagnosed or may not feel as if they need to be assessed by a mental health professional after receiving their online test results.

Repercussions of Reducing Stigma

Stigma can be presented as public stigma or self-stigma, and it occurs after someone has been labeled with a mental illness (Corrigan et al., 2010). Public stigma includes discrimination, prejudice, and stereotypes. Corrigan and colleagues (2010) stated the first step of stigma is being labeled with a mental disorder. The label serves as a heuristic to quickly access stereotypes about the group of individuals with that specific disorder. Blaming the individual who has the disorder, believing these individuals are incompetent, and assuming these individuals are dangerous are the three most common stereotypes. Discrimination is when these stereotypes lead to a reduction in quality of life because someone with a mental illness is unable to obtain housing or employment, has fewer opportunities for education and insurance benefits, and fails to make meaningful relationships with other. Prejudice can show up in the emotions people in the community have towards someone with a mental illness.

Self-stigma can occur when someone who has a mental illness internalizes the stereotypes commonly held in society, leading to a decrease in self-efficacy and self-

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esteem. This has negative effects like difficulty finding employment and living independently. For these reasons, some people do not seek mental health services because they are afraid of being labeled with a diagnosis (Corrigan et al., 2010).

While reducing stigma related to mental health is generally acknowledged to be a good thing, there may be some negative effects to reducing stigma as well. People are more likely to talk about mental health with each other and on social media platforms when stigma is not a barrier, which may lead to the spread of misinformation. For example, sometimes people attribute quirky or idiosyncratic personality traits to their diagnosis, but they share that information on social media as if it is a criterion for the diagnosis. An example of this is users on social media have stated that they enjoy eating food with a tiny spoon or teaspoon instead of a standard sized dinner spoon, and then they have linked this to autism spectrum disorder for unknown reasons. This led to other social media users sharing this information as factual, which contributed to some people believing they may have autism since they also enjoy eating with tiny spoons. A search of “autism tiny spoon” results in many TikTok videos spreading this information. Another outcome of stigma reduction is that people are celebrating when they are diagnosed with a mental health disorder. It is cool and trendy to be considered “neurodivergent.”

Social media has amplified this because more and more people are sharing their experiences and diagnoses with not just friends and family but the whole world. TikTok is a social media platform that is popular right now with various creators discussing mental health from different viewpoints. This could look like anything from anecdotal experiences presented as factual truth to licensed mental health professionals sharing diagnostic criteria.

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ASD and HPD were chosen to be included in this study based on the much greater usage of hashtags for ASD than HPD. In addition, there is a lower base rate for HPD than ASD, so the average person is likely much less familiar with HPD than ASD. On TikTok, there were 13.9 billion views on videos using “#autism”, 7.3 billion views on videos using #autismproblems, and 77.5 million views on videos using “#autismlife,” based on a search of number of views on November 9, 2022. Conversely, there were only 13.3 million views on videos using “#histrionic” and 22.4 million views on videos using “histrionicpersonalitydisorder.” On Facebook, there were 3.2 million people posting with #autism and 1,000 posting with #histrionic. This suggests that posts about autism spectrum disorder (ASD) are being made and viewed much more frequently than posts about histrionic personality disorder (HPD) based on this data, especially presently. These two disorders were chosen for the current study due to the difference in posts and views for each of the disorders.

Clients are presenting to mental health facilities seeking specific diagnoses. Some clients even say they do not want to be considered “neurotypical,” which is the norm for most people who do not have a mental disorder. Some individuals desire to be labeled as “neurodivergent,” as evidenced by the amount of engagement with social media posts using these hashtags. On TikTok, there were 5.2 billion views on videos using “#neurodivergent.” On Facebook, there were 41,000 people posting with #neurodivergent on November 9, 2022.

Purpose of This Study

Past literature has focused on how the proliferation of information online has led to self-diagnosing behaviors in online communities (Alhousseini et al., 2020; Epstein et

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al., 2013; Giles & Newbold, 2011; White & Horvitz, 2009). It also discusses how labeling, confirmation bias, belief perseverance, and the illusory truth effect can affect the way one interprets information they are presented with (Henderson et al., 2021, Link & Phelan, 1999; Mendel et al., 2011; Moses, 2009; Savion, 2009). The present study aimed to expand on how individuals attend to and evaluate the information and accuracy of information that they take in from various sources.

The purpose of the current study was to examine the role social media use plays in the information college students have about mental health disorders by comparing scores on symptom quizzes of a disorder that was popular online (ASD) and a disorder that was less popular online (HPD) using both diagnostic criteria and associated features of the disorders shared on social media platforms. Participants were given a knowledge quiz containing both true symptoms (DSM criteria) and false symptoms (associated features) and asked to identify which were accurate symptoms of the disorder. They were also asked about their use of social media to examine exposure to misinformation. Additionally, the present study sought to examine how one's own belief that they have a disorder (ASD) could affect the amount of correct and incorrect information one knew about the subject by running an exploratory analysis comparing those who believe they had ASD compared to those who did not believe they had ASD.

Hypotheses

1) Based on the findings that there were more views on videos pertaining to ASD than HPD, it was hypothesized that participants would have higher total scores on the knowledge quiz for the popular disorder, autism spectrum disorder (ASD), than the less popular disorder, histrionic personality disorder (HPD).

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2) Since there were false symptoms or associated features shared as symptoms on social media, it was hypothesized that participants would endorse more incorrect items on the associated features subscale than the DSM criteria subscale for the ASD quiz.

3) It was also hypothesized that participants with more social media use would have more incorrect items on the knowledge quiz for each disorder, for the same reason as indicated in Hypothesis #2.

4) Because information about ASD is spread on social media, it was hypothesized that participants with more social media use would have higher total scores on the ASD knowledge quiz.

Research Question: An exploratory analysis examined if there is a relationship between believing one has ASD and one's total score on the ASD knowledge quiz.

Methods

Participants

Participants were undergraduate students at a regional university. There were a total of 48 participants; however, one participant was excluded due to not being 18 years or older, so there were 47 participants in the final sample (see frequencies of demographic variables in Table 1). Participants were between 18 and 45 years old ($M = 20.15$, $SD = 4.61$). Three participants were psychology majors (6%) while 44 participants had a major other than psychology (94%). Thirty participants had an active Facebook account (65%), and 29 participants had an active TikTok account (63%).

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Table 1
Sample Demographics and Characteristics

Variable	Total N	Percentage
Gender		
Male	11	23.40%
Female	34	72.34%
Non-binary	1	2.13%
Genderqueer	1	2.13%
Year in College		
Freshman	29	61.70%
Sophomore	10	21.28%
Junior	8	17.02%
Race		
Asian	6	12.77%
Black/African American	6	12.77%
Hawaiian/Other Pacific Islander	1	2.13%
White	34	72.34%
Diagnosed with		
ADHD	6	12.77%
Anxiety Disorder	8	17.02%
Depression Disorder	8	17.02%
Other	10	21.28%
None	15	31.91%
Believe They Have Autism		
Yes	33	73%
No	12	27%
Believe They Have ADHD		
Yes	20	43%
No	26	57%

Materials

Knowledge Quizzes – The two knowledge quizzes consisted of DSM-5-TR criteria as well as associated features of the diagnoses collected from social media. The knowledge quiz for ASD has 9 DSM criteria items and 9 associated feature items while the knowledge quiz for HPD has 11 DSM criteria items and 11 associated feature items.

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For the ASD knowledge quiz, a DSM criterion item is “difficulty maintaining eye contact” while an associated feature item is “prefer using small utensils.” For the HPD knowledge quiz, a DSM criterion item is “easily influenced by others” while an associated feature item is “quickly bored by sex.”

This measure was created by the researcher to assess participants’ current knowledge about autism spectrum disorder (see Appendix B) and histrionic personality disorder (see Appendix C). Fellow graduate students and clinical faculty members served as “expert judges” while people with little to no psychology knowledge served as “non-experts” to validate the knowledge quizzes before administering the quizzes to participants. There were six experts and six non-experts in the initial validation of the quizzes. The validation process began with 27 ASD items and 28 HPD items, but any item that had less than 80% correct classification in the expert group was removed from the final quiz, resulting in 18 items on the ASD knowledge quiz and 22 items on the HPD knowledge quiz.

For the expert group, the average number of correct items for ASD was 17.33 (calculated as endorsing DSM criteria and not endorsing associated features), and the average number of incorrect items was .67 (calculated as endorsing associated features and not endorsing DSM criteria). In comparison, the non-expert group had an average number of 12 correct items and 6 incorrect items. For the expert group, the average number of correct items for HPD was 20.83, and the average for incorrect items was 1.17. In comparison, the non-expert group had an average number of 13 correct items and 9 incorrect items.

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Participants checked either “yes” or “no” for each item with yes indicating that the item was a DSM criterion and no indicating that the item was an associated feature or not a DSM criterion. Correct items were the total number of “yes” on DSM criteria and “no” on associated features. Incorrect items were the total number of “no” on DSM criteria and “yes” on associated features. For example, a yes on “difficulty maintaining eye contact” and a no on “prefer using small utensils” would both be correct, but a no on “difficulty maintaining eye contact” and a yes on “prefer using small utensils” would both be incorrect. Incorrect items were subtracted from the total correct items to get a total knowledge score with higher scores indicating more correct knowledge about the disorder. For example, if someone got 11 items correct and 7 items incorrect on the autism knowledge quiz, the total knowledge score would be 4. In other words, a correct item was scored +1, and an incorrect item was scored -1. Total knowledge score for the ASD quiz was a scale from -9 to 9 while the total knowledge score for the HPD quiz was a scale from -11 to 11. A higher score indicated more knowledge. Additionally, the knowledge quizzes included two subscales: DSM criteria and associated features. Each subscale was summed separately.

Social Media Use Integration Scale (SMUIS; Jenkins-Guarnieri et al., 2013) -

This scale uses ten items to measure the following related to social media: social habits, emotional attachment, and use (see Appendix D). This scale was chosen because it gets at participants’ emotional connection to the social media platform and has items in relation to others. Items were answered on a six-point Likert scale with one being strongly disagree and six being strongly agree. An example item is “Facebook plays an important role in my social relationships.” Since the authors of the scale allow researchers to

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modify the social media platforms used in the items, the current study included Facebook and TikTok (see Appendix A). Scores were summed for Facebook and TikTok separately. The scores for Facebook and TikTok were also summed to create a total SMUIS score. The SMUIS was found to be reliable ($\alpha = .92$) (Jenkins-Guarnieri et al., 2013). There are two subscales: Social Integration and Emotional Connection ($\alpha = .89$) and Integration into Social Routines ($\alpha = .83$). This measure has been found to have convergent validity with the Facebook Use Intensity Scale. It was also found to have discriminant validity using the Big Five Inventory.

Design and Procedure

Participants were recruited from undergraduate courses at a regional public university including undergraduate students. Participants took the survey in person to minimize the risk of distractions as well as to prevent access to the internet. The researcher provided participants with a copy of informed consent and explained confidentiality. Participants completed the knowledge quizzes followed by the SMUIS. Participants took the knowledge quiz for both grouping conditions in a counterbalanced order, so there was an equal amount of people receiving the ASD and HPD condition first. Then, participants completed demographic questions, such as age, sex, and academic classification. After all data were collected, the researcher debriefed participants by explaining the purpose of the study.

Results

A repeated measures ANOVA indicated there was a significant difference between total scores on the ASD knowledge quiz and the HPD knowledge quiz, $F(1,46) = 11.45$, $p = .001$, $\eta^2_p = .20$, 95% CI [1.31, 5.16]. Participants had a higher score on the

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ASD knowledge quiz ($M = 2.62$, $SD = 5.40$) than the HPD knowledge quiz ($M = -.62$, $SD = 4.98$; for means and standard deviations of major study variables, see Table 2).

Table 2*Means and Standard Deviations of Major Study Variables*

Variable	M	SD
ASD Total Score	2.62	5.40
HPD Total Score	-0.62	4.98
ASD DSM Criteria Subscale	3.17	2.26
ASD Associated Features Subscale	4.47	2.35
ASD Total for those who believe they have ASD	2.64	5.63
ASD Total for those who believe they don't have ASD	3.00	5.29
Total SMUIS	47.98	17.81
Total Screentime	82.00	109.07
Total Number of Incorrect Items	18.94	4.05

Assumptions of normality were met using the Shapiro-Wilk test of normality, which applies for all subsequent analyses. A dependent samples t-test was performed to test for differences between participants' endorsement of incorrect items on the ASD associated features subscale and the ASD DSM criteria subscale. A significant difference was found, $t(46) = -2.39$, $p = .021$, $d = 3.73$, 95% CI [-2.39, -.20]. Participants endorsed more incorrect items on the ASD associated features subscale ($M = 4.47$, $SD = 2.35$) than on the ASD DSM criteria subscale ($M = 3.17$, $SD = 2.26$).

Total screentime (Facebook screentime and TikTok screentime summed) and the total SMUIS score (Facebook SMUIS and TikTok SMUIS scores summed) were examined in relation to social media use. Since normality was not violated, a Pearson's correlation was conducted to determine if there was a relationship between social media

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screening time and number of total incorrect items on both knowledge quizzes. Participants with missing screening time data were excluded from this analysis, leaving a usable sample size of 39. A significant correlation was found, $r = .47, p = .003$ (see Table 3 for correlations). Since the assumption of normality was met, a Pearson's correlation was performed to determine if there was a relationship between total SMUIS score and total incorrect items on both knowledge quizzes. A significant correlation was not found, $r = .24, p = .100$.

Table 3
Correlations for Study Variables

Variable	n	M	SD	1	2	3	4
1. Total Screentime	39	82.00	109.07	–			
2. Total SMUIS	47	47.98	17.81	.55**	–		
3. Total Number of Incorrect Items	47	18.94	4.05	.47**	.24	–	
4. ASD Total Score	47	2.62	5.40	-.28*	-.10	-.80**	–

* $p < .05$ ** $p < .01$

Since normality was not violated, a Pearson's correlation was conducted to test for a relationship between total SMUIS score and total ASD knowledge score. This analysis was also performed with the total screening time and the total SMUIS score to see if there was a relationship with social media use. A significant correlation was not found, $r = -.10, p = .517$. Since normality was not violated, a Pearson's correlation was conducted to test for a relationship between total social media screening time and total ASD knowledge score. A significant correlation was not found, $r = -.28, p = .080$.

Since the assumptions of normality and homogeneity of variance were met, an independent samples t-test was conducted. There was not a significant difference between those who believed they had autism ($N = 12, M = 2.64, SD = 5.63$) and those who did not

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believe they have autism ($N = 33$, $M = 3.00$, $SD = 5.29$) on the total score on the ASD knowledge quiz, $t(43) = -.19$, $p = .847$.

Discussion

Internet use and social media platforms have been connected to mental health knowledge during previous research (Alhousseini et al., 2020; Epstein et al., 2013; Giles & Newbold, 2011; White & Horvitz, 2009). Further, there has been an increase in self-diagnosis in mental health facilities as well as online platforms (Giles & Newbold, 2011; Wakefield, 2010; White & Horvitz, 2009). The aim of this study was to address a possible reason for an increase in self-diagnosis. The current study looked at the relationship between social media and knowledge about ASD and HPD specifically, based on their differing levels of popularity described earlier in this paper. The results of this study supported the notion that social media use can influence knowledge about mental health disorders, but more research is needed to further address this.

It was hypothesized that participants would have higher total scores on the knowledge quiz for the popular disorder (ASD) than the less popular disorder (HPD). There was a difference between scores on the ASD knowledge quiz and the HPD knowledge quiz. This result supports the notion that more people are familiar with the symptoms of ASD when compared to HPD. This is also shown in the difference in views on social media posts, with more people viewing posts about autism spectrum disorder than histrionic personality disorder. However, participants still did not know a lot about either disorder, as evidenced by low total score performance on both knowledge quizzes. Further, at least five participants asked the researcher what histrionic personality disorder was. This, along with the much greater number of social media views of ASD than HPD,

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indicated that HPD is a less popular and less known disorder than ASD. Although this supports the assumption that participants would not know about HPD, it could have also created a floor effect. Since most participants did not know about HPD, it was more likely there would be a greater difference between HPD and ASD knowledge. It is unclear whether there are more posts about autism because people have more knowledge or if there is more knowledge about autism because of the more frequent posts, however.

It was also hypothesized that participants would endorse more incorrect items on the associated features subscale than the DSM criteria subscale for the ASD quiz. There was a significant difference between the ASD DSM criteria subscale and ASD associated features subscale for incorrect items endorsed by participants, with participants endorsing more incorrect items on the ASD associated features subscale. This result suggests that more people believed an associated feature of ASD was a symptom of ASD than failed to identify DSM criteria. This information supports the idea that people are more likely to identify associated features of ASD as symptoms. This could support the previous research stating that people utilize the internet and social media to seek information about mental health disorders, of course, this presumes the information that participants endorsed was information they found online (Alhousseini et al., 2020; Giles & Newbold, 2011; White & Horvitz, 2009). Based on an informal review of social media posts about ASD, the associated features of autism are discussed heavily online and presented as if they are actual diagnostic symptoms. Since participants were reporting that these associated features are symptoms, it could be the case that this information was learned from social media. Additionally, these associated features are not discussed with

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diagnostic symptoms in mental health settings or from other reputable sources; therefore, it is possible this information was obtained from social media or un reputable sources.

The idea that participants with more social media use would have more incorrect items on the knowledge quiz for each disorder was examined. The current study found a significant correlation between total number of incorrect items on the ASD and HPD knowledge quizzes and total social media screentime. This result indicates that social media may play a role in the spreading of misinformation on DSM criteria and associated features of ASD and HPD. In other words, people are learning that symptoms and associated features are both real criteria for diagnoses of ASD and HPD rather than learning that associated features are not diagnostic criteria. This connects to previous literature regarding the spread of misinformation online as well as the lack of assessment of source trustworthiness (Giles & Newbold, 2011; White & Horvitz, 2009).

It was hypothesized that participants with more social media use would have higher total scores on the ASD knowledge quiz. There was not a significant relationship found between total screentime for Facebook and TikTok and total score on the ASD knowledge quiz. This could happen because participants are spending their time on social media viewing content that is not related to autism. If the participants did view content about autism, the information could have been incorrect or included the associated features, which would lead to a lower total score on the ASD knowledge quiz.

It was examined if there was a relationship between believing one has ASD and one's total score on the ASD knowledge quiz, but there was not a significant difference between those who believe they have ASD and those who did not believe they have ASD on knowledge about the disorder. This could be due to various reasons. Someone could

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have been told they have traits of autism, which led them to believe they might have autism; however, they may not have searched for any information about autism.

Alternatively, some participants who do not believe they have autism may have researched the symptoms of autism. This could be because they know someone else that has been diagnosed with autism, or they could simply be curious. Their scores would indicate more knowledge about autism, even though they do not believe they themselves have it. Overall, simply believing one has a disorder does not mean they have more knowledge about that disorder.

Overall, these results suggest that social media can influence one's knowledge about mental health disorders, with more influence on mental health disorders that are more popular on social media, such as ASD. However, these scores, on average, still suggest poor knowledge of these disorders as compared to the expert judges during the validation of the knowledge quizzes.

Limitations

One limitation is the relatively small sample size. This means these results may not generalize to other samples or could have been skewed more easily. In addition, there were a few outliers in the data that could have skewed the results. For example, one participant reported a TikTok screentime of 562 minutes. The participants with the next highest TikTok screentimes were 300 minutes and 251 minutes, so 562 minutes was quite a bit greater.

The reporting of screentime was another limitation of this study. Screentime measurement and presentation varied by device. Some participants' screentime statistics on their phone had an average daily use based on screentime data from previous weeks

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while others' screentime statistics only included time spent on social media during that day. Further, some participants did not read the instructions to show the researcher the screentime statistics screen, so they filled in that information on their own. Therefore, the screentime analyses are likely not the most representative of participants' actual screentime use. This means the researcher did not know if participants were using a daily average based on previous weeks or their use for the day they took part in the study. The inconsistent metric affects reliability and validity of this variable (screentime) as well as all of the results linked to it. If a participant was reporting the day's use, the time of day could have also affected these results because participants taking the survey at 10 a.m. compared to 3 p.m. likely had different amounts of opportunity to be on Facebook and TikTok. Additionally, time spent on social media does not indicate the amount of information one has seen on social media about ASD or HPD. The SMUIS and total screentime is not equivalent to information one has learned from social media about mental health. Someone could spend hours on TikTok and never see a video about ASD while others could spend 20 minutes on TikTok and see several videos. Since all of the participants were college students, these results may not be generalizable to other populations. Further, social media screentime may be higher in this population than other populations as well.

Lastly, there are several variables that could have influenced these results. Some possible influences are mental health information seeking, knowing someone with ASD or HPD, and the use of other social media platforms. Mental health information seeking could influence the knowledge one has about various mental health disorders and could

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be completely unrelated to one's social media use. There is a lack of prior research on this topic as well as research on TikTok use.

Future Research

Future research could use an experimental design to see if watching TikTok videos influences the information someone knows about a disorder. Pre-video and post-video knowledge should be assessed. One experimental group could be given videos that are factual and include factual symptoms while the second experimental group could be given videos that are nonfactual or include associated features of a disorder. An additional experimental group could receive a mix of both factual and nonfactual videos. The control group could receive videos of anything that is not related to the disorder (e.g., dogs playing, cooking, crafting). Additional measures could be included to assess how often someone seeks mental health information online as well as someone's perceived trustworthiness of online information. Future studies could ask participants to evaluate sources for credibility. It could be helpful to find out if there is a relationship between information sought and knowledge about a disorder. Other sources of information could be included, such as informative websites.

Future research could also examine screentime by using a weekly average to get a better idea of the amount of screentime one is engaging in. It is possible that more screentime occurs on a specific day or towards the end of the week, so a weekly average could help account for the variance in day-to-day screentime. Additionally, since everyone's "for you" page is curated to their previous interactions on the app, future research should ask participants if they have seen videos about mental health on TikTok as well as if they have sought mental health information from any online resources or

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social media platforms. It would be beneficial to ask know if they have sought information about mental health disorders, how frequently they search for mental health information, and the credibility or how much they believe the information they have found. Additional questions could be asked to assess if participants have come across information related to the disorder that knowledge is being assessed for (Have you watched a video on TikTok where someone described the symptoms of ASD? Have you searched for information related to ASD? If so, where did you look for this information?). Finally, future studies could analyze age effects by comparing different age groups as well as comparing the different social media applications used by each age group. The current study did not have enough diversity in age to analyze these effects.

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Appendix A

Informed Consent

Project Title: Self-Diagnosis & Pathologizing Normality During the Information Age

Principal Investigator: Chelsey Eaton

Faculty Mentor: Dr. Laura Liljequist, Dept. of Psychology, Murray State University, Murray, KY 42071, (270) 809-2990.

You are being invited to participate in a research study conducted through Murray State University. You must be at least 18 years of age to participate. The investigator will explain to you in detail the purpose of the project, the procedures to be used, and the potential benefits and possible risks of participation. You may ask him/her any questions you have to help you understand the project. A basic explanation of the project is written below. Please read this explanation and discuss with the investigator any questions you may have. You will be given a copy of this form to keep.

Nature and Purpose of the Project: The purpose of this study is to learn more about the role social media plays in the information people consume.

Explanation of Procedures: Your participation in this study will require you to complete an anonymous survey in person that will measure social media use and attachment and knowledge about autism spectrum disorder and histrionic personality disorder. Your total participation should take no longer than 20 minutes.

Discomforts and Risks: There are no more than minimal risks expected in this study. Please remember that your participation is voluntary, and you can refuse to answer any questions.

Benefits: There are no direct individual benefits to you beyond the opportunity to learn first-hand what it is like to participate in a research study and to learn about some of the methods involved in psychological research. A general benefit is that you will add to our knowledge of the research subject.

Confidentiality: Your responses and participation in all tasks will be completely anonymous; they will only be numerically coded and not recorded in any way that can be identified with you. Dr. Liljequist will keep all information related to this study secure for at least three years after completion of this study, after which all such documents will be destroyed.

Refusal/Withdrawal: Your participation in this study should be completely voluntary. Your refusal to participate will involve no penalty. In addition, you have the right to withdraw at any time during the study without penalty or prejudice from the researchers.

I acknowledge that the risks, benefits involved and the need for the research have been fully explained to me, and I have been informed that I may withdraw from participation at any time without prejudice or penalty. The investigator has offered to answer any inquiries that I may make concerning the procedures to be followed or my rights as a participant. The investigator has answered to my satisfaction any questions that I had. I voluntarily consent to participate in this research project.

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Appendix B

Autism Spectrum Disorder Knowledge Quiz

If you think the item is a symptom of autism spectrum disorder, place a checkmark in the yes box. If you think the item is not a symptom of autism spectrum disorder, place a checkmark in the no box.

Item	Yes	No
1. Insistence on sameness		
2. Spend time with animals rather than people		
3. Difficulty maintaining eye contact		
4. Holding arms in a t-rex position		
5. Think in pictures		
6. Don't like mixing foods		
7. Collecting items		
8. Difficulty maintaining relationships		
9. Restricted interests		
10. Absence of interest in peers		
11. Lining up toys or flipping objects		
12. Making lists		
13. Lack of facial expressions		
14. Twirling hair		
15. Perfectionism		
16. Difficulty with back-and-forth conversation		
17. Prefer using small utensils		
18. Indifference to pain		

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Appendix C

Histrionic Personality Disorder Knowledge Quiz

If you think the item is a symptom of histrionic personality disorder, place a checkmark in the yes box. If you think the item is not a symptom of histrionic personality disorder, place a checkmark in the no box.

Item	Yes	No
1. Attention seeking		
2. Uncomfortable when one is not the center of attention		
3. Inappropriate interactions with others		
4. Exaggerated expression of emotion		
5. Spontaneous		
6. Sexually seductive		
7. High energy		
8. Distorted self-image		
9. Excessive emotionality		
10. Unstable sense of self		
11. Excessive interest in oneself		
12. Easily influenced by others		
13. Believes relationships with others are more intimate than they are		
14. Quickly bored by sex		
15. Dramatic speech style using extremes like “best” and “worst”		
16. Charming		
17. Attempt to attract attention using physical appearance		
18. Shallow expression of emotion		
19. Need reassurance from others		
20. Speak over other people		
21. Sensitive to criticism		
22. Selfish		

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Appendix D

Social Media Use Integration Scale

Do you have an active Facebook account? Yes No

Do you have an active TikTok account? Yes No

Please circle the number that best corresponds to how much you agree or disagree with the following statements.

	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
1. I get upset when I can't log on to Facebook.	1	2	3	4	5	6
2. I prefer to communicate with others mainly through Facebook.	1	2	3	4	5	6
3. Facebook plays an important role in my social relationships.	1	2	3	4	5	6
4. I would like it if everyone used Facebook to communicate.	1	2	3	4	5	6
5. I feel disconnected from friends when I have not logged into Facebook.	1	2	3	4	5	6
6. I would be disappointed if I could not use Facebook at all.	1	2	3	4	5	6
7. Using Facebook is part of my everyday routine.	1	2	3	4	5	6
8. I enjoy checking my Facebook account.	1	2	3	4	5	6
9. I don't like to use Facebook.	1	2	3	4	5	6

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	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
10. I respond to content that others share using Facebook.	1	2	3	4	5	6
11. I get upset when I can't log on to TikTok.	1	2	3	4	5	6
12. I prefer to communicate with others mainly through TikTok.	1	2	3	4	5	6
13. Tiktok plays an important role in my social relationships.	1	2	3	4	5	6
14. I would like it if everyone used TikTok to communicate.	1	2	3	4	5	6
15. I feel disconnected from friends when I have not logged into TikTok.	1	2	3	4	5	6
16. I would be disappointed if I could not use TikTok at all.	1	2	3	4	5	6
17. Using TikTok is part of my everyday routine.	1	2	3	4	5	6
18. I enjoy checking my TikTok account.	1	2	3	4	5	6
19. I don't like to use TikTok.	1	2	3	4	5	6
20. I respond to content that others share using TikTok.	1	2	3	4	5	6

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Appendix E

Demographics

Age: _____

Major: _____

Gender: _____

Year in college (circle one): Freshman Sophomore Junior Senior

Race (circle one):

- American Indian or Alaskan Native Asian Black or African American
- Native Hawaiian or Other Pacific Islander White

Ethnicity (circle one):

- Hispanic or Latino or Spanish Origin Not Hispanic or Latino or Spanish Origin

How many courses in psychology have you taken? _____ courses

Have you ever been in therapy? Yes No

Have you ever been diagnosed with a psychological disorder? Yes No

If so, what disorder have you been diagnosed with? _____

Do you currently or have you ever believed you may have autism? Yes No

Do you currently or have you ever believed you may have ADHD? Yes No

Please pull up your screen time statistics in your phone's settings to show the examiner.

TikTok _____

Facebook _____

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Appendix F

IRB Approval Letter

**Institutional Review Board**

328 Wells Hall
Murray, KY 42071-3318
270-809-2916 • msu.irb@murraystate.edu

TO: Laura Liljequist, Psychology

FROM: Jonathan Baskin, IRB Coordinator *JB*

DATE: 1/11/2023

RE: Human Subjects Protocol I.D. – IRB # 23-097

The IRB has completed its review of your student's Level 1 protocol entitled *Self-Diagnosis & Pathologizing Normality During the Information Age*. After review and consideration, the IRB has determined that the research, as described in the protocol form, will be conducted in compliance with Murray State University guidelines for the protection of human participants.

The forms and materials that have been approved for use in this research study are attached to the email containing this letter. These are the forms and materials that must be presented to the subjects. Use of any process or forms other than those approved by the IRB will be considered misconduct in research as stated in the MSU IRB Procedures and Guidelines section 20.3.

Your stated data collection period is from 1/17/2023 to 5/1/2023.

If data collection extends beyond this period, please submit an Amendment to an Approved Protocol form detailing the new data collection period and the reason for the change.

This Level 1 approval is valid until 1/10/2024.

If data collection and analysis extends beyond this date, the research project must be reviewed as a continuation project by the IRB prior to the end of the approval period, 1/10/2024. You must reapply for IRB approval by submitting a Project Update and Closure form (available at murraystate.edu/irb). You must allow ample time for IRB processing and decision prior to your expiration date, or your research must stop until such time that IRB approval is received. If the research project is completed by the end of the approval period, then a Project Update and Closure form must be submitted for IRB review so that your protocol may be closed. It is your responsibility to submit the appropriate paperwork in a timely manner.

The protocol is approved. You may begin data collection now.

**Opportunity
afforded**

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Appendix G

IRB Amendment Approval Letter

**Institutional Review Board**

328 Wells Hall
Murray, KY 42071-3318
270-809-2916 • msu.irb@murraystate.edu

TO: Laura Liljequist
Psychology

FROM: Institutional Review Board
Jonathan Baskin, IRB Coordinator 

DATE: 1/25/2023

RE: Amendment to Human Subjects Protocol I.D. – IRB # 23-097

The IRB has completed its review of the amendment submitted for your student's Level 1 protocol entitled *Self-Diagnosis & Pathologizing Normality During the Information Age*. After review and consideration, the IRB has determined that the changes, as described in the amendment application, will be conducted in compliance with Murray State University guidelines for the protection of human participants.

The updated forms and materials that have been approved for use in this research study are attached to the email containing this letter. These are the forms and materials that must be presented to the subjects. It is your responsibility to ensure that only the updated materials are used from this point forward. Use of any process or forms other than those approved by the IRB will be considered misconduct in research as stated in the MSU IRB Procedures and Guidelines section 20.3.

This amended Level 1 protocol is valid until 1/10/2024.

If data collection and analysis extends beyond this time period, the research project must be reviewed as a continuation project by the IRB prior to the end of the approval period, 1/10/2024. You must reapply for IRB approval by submitting a Project Update and Closure form (available at murraystate.edu/irb). You must allow ample time for IRB processing and decision prior to your expiration date, or your research must stop until such time that IRB approval is received. If the research project is completed by the end of the approval period, then a Project Update and Closure form must be submitted for IRB review so that your protocol may be closed. It is your responsibility to submit the appropriate paperwork in a timely manner.

You may begin data collection using the approved changes.

**Opportunity
afforded**

murraystate.edu