

Identifying pathology and pathologising identity. The role of self-diagnosis in philosophy of psychiatry

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Abstract: This paper is concerned with *psychiatric self-diagnosis*^{**}, a topic that has been overlooked in academic literature (except for a few studies mostly based on autistic communities and individuals), while being increasingly discussed in the context of activism. Since awareness about mental health has been increasing in the past decades, and autism is one of the most targeted conditions in the social and philosophical literature concerning psychiatry, self-diagnosis has become a topic worthy of academic discussion. I will introduce the topic and review some of the limited literature that explicitly targets it (§§ 1-2). I will then proceed to highlight the key features of self-diagnosis that emerge in the context of autism (§ 3). Then, I will explore the connections with its official counterpart – that is, professional diagnosis – and with broader discussions in the field of philosophy of psychiatry (§ 4). The goal of this kind of exploration is to gather the reasons that make self-diagnosis a relevant topic to be inquired (both theoretically and practically) and to showcase a list of issues that could direct further research on it. My final claim will be that self-diagnosis can have significant socio-political consequences, and therefore an understanding informed by social models (§ 5).

Keywords: self-diagnosis, autism, neurodiversity paradigm, psychiatric diagnosis, philosophy of psychiatry

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^{**} When I first wrote this paper, the literature on psychiatric self-diagnosis was extremely limited: some of the crucial works I considered in the final version were either unpublished or not easy to access. I made an effort to integrate the most recent papers, but as a testimony of the timeliness of the topic and the growing need for its academic discussion, literature on self-diagnosis keeps being published, found and reviewed: that is why I could not provide an analysis of some of these contributions as I did for other works on the topic. I cannot say I am unhappy with having proof that the growing interest towards psychiatric self-diagnosis – that I anticipated and hoped for – is becoming a reality: however, since the goal of this paper is not to provide exhaustive literature on the topic, sometimes I had to refer the reader to more complete reviews.

1. Introduction

Psychiatric self-diagnosis is a scarcely explored subject in academic research, with few relevant exceptions in the context of autism (ASD)¹. Even though the main concern of the present paper will not be refining definitions, we can preliminarily say that psychiatric self-diagnosis is a process (or a journey) of autonomous investigation of a person's own experiences, that leads them to self-identify in a psychiatric category. Moreover, self-diagnostic experiences are intuitively – and usually defined in literature – as not requiring to be confirmed by so-called *official diagnosis* (i.e., professional psychiatric diagnosis conferred by a medical expert in a clinical setting). This is a non-refined definition, that will serve the aims of the present paper and is provided mainly to distinguish the professional (or official) diagnosis from the subject-matter. Hence, for now, I will rely on the intuitive meaning of “self-diagnosis” and on what has been used as a definition in the literature on the topic. So far, the main concerns about definition focused on what I will call the epistemic or moral features of diagnosis (Fellowes, 2024), or have been limited to the comparison with the official “counterpart”, i.e. psychiatric diagnosis obtained in a clinical setting (Lewis, 2016a; Sarrett, 2016; Overton *et al.*, 2023). Given that these worries about self-diagnosis seem to be shared by those who are variously concerned with it, I am for now settling with this preliminary distinction: as mentioned above, in the literature that I will be considering, self-diagnosis is usually contrasted with professional diagnosis, both from the point of view of psychiatric patients that are professionally diagnosed and who are skeptical about self-diagnosed individuals (Sarrett 2016), as well as from the more general standpoint of risks and acceptance of the practice (Fellowes 2023a, Marocchini 2024).

The reason behind the resolution to study this particular topic comes from both its supposed conceptual relevance as a theoretical object, as well as its seemingly growing employment as a practice among people who are canonically regarded as “non-experts” but can count on what is called “expertise-by-experience”. Since self-diagnosis stands at the crossroads of theoretical and scientific inquiry and reclaiming practices, it can be employed as a starting point for the investigation of conceptual problems and social consequences of both biomedical research and clinical practice. My goal will be to provide an overview of the potential issues that self-diagnosis poses to

¹ Throughout the paper, when I mention a specific psychiatric condition, I will refer to the current classification of the DSM-5-tr, the *Diagnostic and Statistical Manual of Mental Disorders* (APA, 2022); I will use autism and ASD (Autism Spectrum Disorder) interchangeably. As it should become clearer throughout the paper, my position is sceptical about some theoretical and clinical features of the DSM, but it is useful to provide the shared language for everyone dealing with the psychiatric field.

psychiatry, in order to better understand what theoretical, clinical and social aspects of such field it tackles.

To do so I will provide a brief review of the limited academic literature on the topic, which, as we will see, is mainly connected to neurodivergence and autism (§ 2). This will bring me to consider some of the reasons why self-diagnostic practices spread particularly within these psychiatric identities and categories (§ 3): hence, I will outline some elements that might have been crucial in fostering self-diagnostic practices in neurodivergent people, and that might be relevant for future studies on self-diagnosis. Once I have sketched the most comprehensive account of self-diagnosis I can provide on this basis, I will move on to a more general framing of it within the field of philosophy of psychiatry (§§ 4-5), by connecting self-diagnosis to some more general and notorious ontological, epistemological, ethical and political problems of psychiatry. What I hope to do is not to provide clear-cut definitions, nor criteria to carry out self-diagnostic practices: rather, my main goal will be to elucidate issues that might guide future research on the topic, as well as to assess its potential social relevance.

2. *Framing self-diagnosis*

The review of the literature will be brief, since I was not able to find many academic papers that explicitly targeted self-diagnosis as their central topic: these can however be considered evidence of at least some interest towards the study of such practice². The growing concern that self-diagnosis is rising is also testified by the cursory mentions of self-diagnosis and closely related concepts in published works, for example:

For many reasons, self-identification or the attribution of a diagnostic label might be good enough (Gorman in Tremain, 2024: p. 427)

[N]ot to mention those with no official diagnosis at all (Chapman, 2023: p. 5)]

[T]he validity of those who identify as autistic without a medical diagnosis (Chapman, 2020: p. 810)

[People who] assumed autistic identities (Ryan in Davidson and Orsini, 2013: p. 203)

For example, thinking of oneself as ill versus divergent can alter one's self-conception, self-respect, self-acceptance (Hoffman in Tekin and Bluhm, 2019: p. 80)

² For a wider literature review, that includes also other kinds of mentions of self-diagnosis, see the one posted by Fellowes on his website: <https://www.samfellowes.com/self-diagnosis-literature-review/>.

Moreover, the inclusion of autistic and neurodivergent self-diagnosed subjects in both research studies and within communities can be considered as additional evidence for this growing attention on the topic³. Usually, some of the works that consider self-diagnostic practices are rightfully concerned with grasping their relevance for potential or actual psychiatric patients, as well as their consequences on the lives and experiences of such people. The theoretical effort of these studies is therefore directed to analyse self-diagnosis more as a practice than as a concept, and their interest towards clear definitions, epistemological investigation and ethical considerations is quite limited. Such studies can be considered exploratory field-studies, conducted via interview or questionnaire administered specifically to autistic people: this evidence might strengthen the claim that self-diagnostic practices primarily found their way into autistic communities. Lewis (2016a) explores the *prevalence and features* of self-diagnostic journeys among such population, uncovering five main themes that characterise them, ranging from individual reasons for resorting to self-diagnosis, to personal feelings towards the official “counterpart”.

Another crucial theme, as explored by Sarrett (2016), is the *acceptance* of self-diagnostic practices within autistic communities: this study was carried out on a population recruited in an online autism self-help group, and highlights how such practices are sometimes opposed not only by professionals, but also from clinically diagnosed autistic people. Overton *et al.* (2023) performed a scoping review on self-*identification* (which is usually characterised along the lines of the proposed preliminary definition of self-*diagnosis*). The review aimed at establishing the most studied dimensions and features of lived experiences that might lead to self-identification journeys in autistic individuals, and included also the above-mentioned field-studies on autism self-diagnosis. While being an exploratory study, it poses the interesting theoretical question (that goes understandably unexplored) of what are the terminological and conceptual differences between self-diagnosis and self-identification: my working hypotheses that I will try to motivate in the last sections is that self-*diagnosis* has a strong political and practical relevance (that self-*identification* might not have), since the need of reclaiming and re-appropriating the clinical diagnostic process has its roots also in the long history of psychiatric critique, and not only in the importance of the identity dimension for psychiatric patients⁴.

³ For example, the Italian activists’ group NeuroPeculiar, in its activities, does not require diagnoses nor certifications (see, for example, the following call for abstracts: <https://neuropeculiar.com/2024/04/16/call-for-autcamp-2024/>), as well as research group EuCap (in their project “AIRA”: <https://eucap.eu/aira/>) included in the survey both self-diagnosed and officially diagnosed subjects.

⁴ Given that I am not discussing self-identification in detail, nor aiming for a systematic re-

While having been the focus of some exploratory field-studies, psychiatric self-diagnosis seems to have also recently caught the attention of philosophers of psychiatry. Two relevant papers have been published by Fellowes, who focused on some aspects that might be crucial in refining our definition of self-diagnosis (Fellowes, 2024), as well as on the consequences of its practicing (Fellowes, 2023a). In the first paper, the main concern is to provide the arguments needed for assessing the *accuracy* of self-diagnosis, while the second paper is a discussion of its impact on the so-called “social resources”⁵ (i.e., sources of support and benefits, alternative to the institutional or medical ones that a self-diagnosed individual cannot access).

These are both timely discussions on an unexplored topic that can very easily stimulate further debate: however, it is beyond the scope of the present paper to provide a conclusive review of such works. Instead, I will briefly focus on Fellowes’ opening disclaimers to his 2024 paper, to make some considerations more relevant to the aims of this work. In the second section of his paper, Fellowes distinguishes between the above-mentioned accuracy, *reliability*, *validity* and *legitimacy*⁶: I suggest considering the latter a “moral” feature of self-diagnosis, while the other three I will call “epistemic”. In other words, all the above features raise very different questions on the relevance and importance that self-diagnosis can have in different contexts. This type of discussion shows in a pretty clear way what theoretical concerns usually surround self-diagnosis: seemingly, the goal is to *justify* the existence and practicing of self-diagnosis (i.e., if it is legitimate), or to *establish rigorous criteria* to perform it in the “right way” (i.e., if such practices possess the above-mentioned epistemic features). In contrast, what has still received little to no attention in philosophical studies are the reasons that are making self-diagnosis seemingly more practiced and studied than before, as well as its role in contemporary debates around psychiatry.

All the information gathered here on psychiatric self-diagnosis (both as a practice and as a concept) is quite heterogeneous and lacks a unifying framework: my belief is that, for a thorough theoretical analysis of it and related issues, we will have to consider different conceptual perspectives on mental illness, disability and diagnosis, to provide a more complete account of all the dimensions that were highlighted in this preliminary overview. It is important, at this point, to disclose the initial assumptions: even though I will

view of the appearances of the term, I refer the reader to Overton *et al.* (2023) for a more complete bibliography on it.

⁵ Similar concerns about the “risks” of self-diagnosing are expressed by Marocchini (2024).

⁶ My opinion is that each one of these terms would require further analyses that, once again, go beyond the aim of the present paper. Therefore, I will refer the reader to the author’s framing of the distinction.

try to incorporate and present all the sides of the debates relevant to self-diagnosis, I will be adopting the Social Model of Disability (Oliver, 1990) in its original formulation – as opposed to the (bio)medical one – and its recent integration in what has been called the Neurodiversity Paradigm (Chapman, 2023)⁷. Caniglia (2018) reports the “*psychomedical model*” as being the interpretative and clinical model underlying psychiatry (since it is no more just biomedical, but it combines cognitive psychology with the tendency towards biological reductionism of neurosciences): this approach is usually oriented towards cure and treatment.

The social framing of mental conditions, instead, has progressively incorporated suggestions that date back to constructivist theories and 1970s anti-psychiatry movements, and tends to be hostile to cure-oriented approaches. There are also intermediate stances between these two poles, such as the “biopsychosocial” model of health and disease (Engel, 1977): if applied to mental conditions, this framework lacks overtly anti-psychiatric elements but still integrates social and environmental aspects when accounting for them⁸.

My working hypothesis is that the practical need and theoretical relevance of psychiatric self-diagnosis would require to be understood within these debates at least for two main reasons. First of all, self-diagnosing with a psychiatric category calls into question many issues pertaining to the psychiatric field, as well as our understanding of the diagnostic classes as *disorders*, *illnesses*, *disabilities* or *differences*. The need to refer to the Social Model of Disability is elicited by its core stance that the disablement (i.e., experienced difficulties associated with bodily or mental conditions) is caused by the inability of societies to provide for different and heterogeneous needs, since they are built around the restrictive norms of able-bodiedness and able-mindedness. Secondly, as sketched above and as we will see in the next section of the paper, self-diagnostic practices have been studied within the boundaries of autistic

⁷ See Chapman (2023), and Chapman’s chapter in Tekin and Bluhm (2019), on the connection between the Social Model of Disability and Neurodiversity. My reference is the original Marxist framing of the Social Model, but we must mention that this model has been criticised during the past decades – especially for its account of the disability-impairment relationship, e.g. Shakespeare (2014). As I will mention later, this model has been applied to Neurodiversity by Chapman in a way that connects the structural ableism of our societies against different kinds of bodies and minds to the development of capitalism: Dwyer (2022) proposes an overview of different neurodiversity approaches that do not need this link to be necessarily drawn.

⁸ The biopsychosocial model is still a crucial reference for contemporary debates on health, disability and psychiatry – and it has been largely endorsed and criticised throughout the past decades: for example, the current definition of “health” provided by the World Health Organisation (<https://www.who.int/about/governance/constitution>) might be considered in line with this model. For some more recent comments on the biopsychosocial model see, for example, Bolton and Grant (2019), as well as the related book symposium: <https://eujap.uniri.hr/volume-17-no-2-special-issue-in-philosophy-of-medicine/>.

people's lived experience, and might require to be further analysed in how they manifest in autistic communities and movements. The individual and collective experiences of autistic people have been understood through the concept of Neurodiversity at least since the end of the 1990s⁹. Self-diagnosis, in particular, can tackle the epistemological issues that pertain to the debate around psychiatric diagnoses, as well as the sociopolitical implications that clinical practice has for the individuals and groups who deals with it. That is why we need to keep these frameworks in mind when we address self-diagnosis in the contexts where it allegedly emerged.

3. *Autism and neurodivergence(s) as case studies in the discourse on self-diagnosis*

In the first section I reviewed some of the literature that specifically deals with self-diagnosis as a topic of inquiry, and I summarised the main concerns and research questions that authors have followed in their works. What emerges from such studies is that self-diagnosis seems to be a widespread practice in autistic communities, and that these are the main contexts in which such practices have been studied. In this section, I will therefore try to piece together some of the main reasons why this is the case.

I found little to no literature that concerns self-diagnosing and self-identifying with other mental conditions¹⁰, but from anecdotal evidence it seems at least possible, especially within the Neurodiversity Paradigm and movements: neurodivergent activism, for example, seems to be focused also on ADHD (Attention Deficit and Hyperactivity Disorder), another condition that is classified as a “neurodevelopmental disorder” in the DSM, and that is often associated with autism, both clinically and politically. While Neurodiversity aims to be an all-encompassing approach to mental conditions, there might be some discrepancies in what neurodivergence/neurodiversity mean for different authors¹¹. Even though the main references will be from literature on autism, I therefore hope that further developments in the field of Neurodiversity Studies will make my considerations progressively generalisable.

⁹ See, for instance, Singer (1998) in Valtellina (2020). Such concept has been modelled around the concept of “biodiversity” and highlights *differences* in a positive sense. In contrast, the medical model is centred on the concept of the condition as *illness, disorder or dysfunction*.

¹⁰ As mentioned in fn. 3, I refer the reader to this review <https://www.samfellowes.com/self-diagnosis-literature-review/>, for more literature on psychiatric self-diagnosis.

¹¹ Since this is not the place to explore such terminological issues, I will use “neurodiversity” as a term that characterises *a diverse group of people*, as well as to refer to specific theoretical approaches. Meanwhile, “neurodivergent” and “neurodivergence” will be used to talk about particular individuals and conditions.

Neurodevelopmental disorders are usually diagnosed during childhood, therefore self-diagnostic journeys are typically elicited in adults who may have gone “undiagnosed” for a long time and are in search for self-understanding or support. This is explored in two papers on adult autism by Lewis (2016b and 2017) that include self-diagnosis as a part of these late-diagnosed adults’ experiences. Therefore, I will now expand on three domains that emerge from general literature on autism and from the studies on adult autism diagnosis: i.e., sociocultural and demographic factors, psychological features, and the practice of “camouflaging”. These can be understood as reasons that could bring about a lack of professional diagnoses or issues with clinical practices, as well as the subsequent emergence of self-diagnostic practices.

First, I consider the sociocultural and demographic factors that can play a role in preventing some groups of individuals from getting professionally diagnosed, due to current understanding of autism (and other specific psychiatric conditions) or to difficulties in accessing healthcare services. The previously mentioned studies highlight how economic and demographic factors play a fundamental role in determining lack of diagnosis, or in the cases of “misdiagnosis”, which can both lead to self-diagnostic experiences and/or professional diagnosis in adulthood. The works on the historical development of autism¹² show that its diagnostic criteria – modelled on white, Western, male children – prevented many people who fell outside these demographics from getting professionally diagnosed. Moreover, socioeconomic factors play a similar role of exclusion, since psychiatric and mental health services are often expensive, and their availability and acceptance can be culturally-dependent: therefore, sociocultural norms and socioeconomic status can prevent people from learning about their conditions and being diagnosed for a long time. Both the changes in diagnostic criteria for autism (alongside their wider application), and the need for better mental health services and policies have been politically advocated by autistic activists and neurodiversity movements¹³. The achieved results and further requests cannot be separated from the above-mentioned barriers in getting institutional support via professional diagnosis (Lewis, 2017): self-diagnostic experiences could have found space within autistic communities and self-help groups to bypass loopholes in healthcare systems and mental health support.

Secondly, we must take into account psychological reasons that might make it difficult for people to get assessed in the first place, and negative

¹² See, for example, Hacking (2008), parts IV and V, Eyal (2013), Hollin (2014), and Valtellina (2016). Drawing from this works, I will further elaborate on how such factors impact not only clinical practice, but also the theoretical construction of psychiatric knowledge.

¹³ On the political advocacy and social movements for autism, see Fein and Rios (2018), part I, Davidson and Orsini (2013), parts II-III.

experiences with the clinical domain that can push people to revert to self-diagnosis. Drawing from the studies on autistic self-diagnosis mentioned in the first section, we can say that there are also psychological dimensions that self-diagnostic journeys can accommodate for: Lewis (2016a), for example, outlines the needs for self-understanding and for sense of belonging, which strongly connect with a positive outlook on autism, as well as the formation of a strong autistic identity. There are also negative psychological features, such as the emerging of self-doubt when self-diagnosis is not confirmed by professional validation: this could also relate to the level of acceptance within autistic communities (Sarrett, 2016) or the degree to which a self-diagnostic hypothesis is taken seriously by mental health professionals. Negative opinions on diagnostic practices can have an experiential source: self-diagnosis can be therefore elicited by unsatisfactory experiences with clinical evaluations, as well as by failures in the therapeutic alliance between medical professionals and patients (Overton *et al.*, 2023). Once again, these problematic relations with psychiatry can result in a history of misdiagnoses, in the person going undiagnosed for a long time, or in a refusal to undergo further assessments or treatments: therefore, people might revert to self-diagnosis to have their needs met.

Lastly, we have to tackle the issue of “masking” (more generally referred to as “camouflaging”)¹⁴, a practice that mostly undiagnosed autistic people use to be more socially accepted. By camouflaging we refer to the set of behaviours that neurodivergent people carry out – knowingly or not – in order to suppress, hide, or compensate for behavioural proclivities that do not align with social norms and demands. The common notion is that the “camouflaging” effect is obtained via compensation, assimilation, or masking. Such practices could play a central yet unexplored role in the discourse on self-diagnosis, for two main reasons. First, camouflaging is usually very common in late-diagnosed (or undiagnosed) individuals, who had to live most of their lives without accommodations and support: this can cause the emergence of diagnostic “comorbidities”, that can contribute to the worsening of one’s overall mental health, while concurrently making professional diagnosis more difficult and complex. Second, as implied by the very term (especially for the practice of masking), the fact that these behaviours tend to disguise (i.e., *mask*) neurodivergent characteristics makes it harder for a “high-masking person” to seek professional help, and can increase the risk of being misdiagnosed or invalidated. Self-diagnosis can be therefore used as a tool to find answers and to accommodate unmet needs.

¹⁴ For popular literature on the topic see <https://embrace-autism.com/> and Price (2022). On autistic “camouflaging”, “masking” and “passing” see, for example: Livingston, Shah and Happé (2019), for the empirical side, as well as Pearson and Rose (2021) and Petrolini, Rodríguez-Armentariz, Vicente (2023) for more theoretical analyses.

All of the mentioned demographic, sociocultural and psychological factors, as well as the neurodivergent-specific practice of masking, can be considered as reasons for negative outcomes of clinical assessments and doctor-patient relationships, as well as for the enforcement of barriers that might prevent people from accessing mental healthcare and psychiatric services: this can lead, as explained throughout the section, to people reverting to self-diagnosis as a way of overcoming the risk of being misdiagnosed or undiagnosed, and the lack of institutional support.

4. *Psychiatric self-diagnosis as a central theme in philosophy of psychiatry*

I believe that treating psychiatric self-diagnosis as an autonomous research topic would require an analysis of the relationship with its official counterpart. I tried to outline this need in the context of autism and neurodivergence through the literature review provided in section 2. In section 3 I recalled sociocultural and demographic factors, psychological features and the practice of neurodivergent “masking”, as reasons that could prevent people from getting officially diagnosed and make them resort to self-diagnostic practices. Therefore, I think that the next appropriate step is to examine what we can assume to be a problematic relationship between the two kinds of diagnosis within the theoretical framework of more general issues of the psychiatric field.

This analysis calls into question the concepts of mental disorders, illnesses, etc., alongside the notorious debates around the theoretical framework of psychiatry and its practical applications. When we consider “official diagnosis”, we are usually concerned with single classes of diagnostic *criteria* and the *categories* individuated by them, as well as the *process* of applying both to patients. Because of this – and due to the above-mentioned material and experiential conditions that lead autistic people to resort to self-diagnostic and self-help tools – there is the need to explore the conceptual and practical problems of the complex relationship between official and self-diagnosis.

To start untangling the intricacies of this relation, I am now presenting, without aiming for completeness, some of the main issues that psychiatric self-diagnosis shares with its official counterpart. This brief overview must be understood as a non-exhaustive list of suggestions and possible directions that future studies on this topic might take.

4.1. *Ontological issues and human kinds*

The first class of philosophical concerns that self-diagnosis calls into question is ontological. There is an ongoing debate around what mental conditions *are* and we might as well say that it constitutes one of the main concerns in philosophy of psychiatry¹⁵. This question takes at least two different forms, both of which are potentially relevant to the discourse on self-diagnosis.

- (1) Given that psychiatry is a medical discipline and profession, that often operates through biomedical and pharmaceutical interventions, can we consider mental conditions to be *pathologies*, in the same sense as medical illnesses? And if not, do they still retain the negative meaning that the terms usually used to indicate them (such as disorder, dysfunction, deficiency, etc.) have?
- (2) Are mental conditions *real*, in at least some sense?¹⁶ Technically speaking, do psychiatric conditions (and the corresponding DSM classes) refer to ontologically independent objects (natural kinds) or are they socio-cultural constructions (artificial kinds)? And if they are artificial, does it mean they are not real in any sense?

My aim is not trying to provide an answer to these open issues. Yet, this topic of inquiry calls into question these same problems: whatever we believe about the ontological status of *psychiatric conditions*, we will have to compromise at some point and settle to use at least some of the *psychiatric lexicon* and theoretical framework (even if just for purposes of critique). Therefore, to some extent, we will manipulate the psychiatric conditions as *diagnostic classes* (as I have done throughout this paper and is frequently done in literature¹⁷). Self-diagnosis is usually manipulated in the same way¹⁸: moreover, the issue of what mental conditions and diagnoses are raises the question of why they are subject to formal approval from the professional diagnostician.

We should therefore consider the consequences that ontological assumptions have on both diagnosis and self-diagnosis, since the way we conceptualise mental conditions impacts directly on how they are approached both by clinicians and patients.

¹⁵ See, for a variety of approaches to this question, for example: Szasz (1960), Hacking (1998), Hoffman in Tekin and Bluhm (2019), Tsou (2021), and Wilkinson (2023), chapters 2 and 3.

¹⁶ See Chapman (2020) on the reality of autism, and also Fellowes in Tekin and Bluhm (2019) or Amoretti in Guerini and Marraffa (2019).

¹⁷ The example of autism is paradigmatic here, because even its most radical critiques have inevitably to draw from scientific literature on the topic, or use the psychiatric theoretical framework to formulate questions and reconstruct the evolution of diagnostic criteria: see fn. 12, and also Chapman (2020).

¹⁸ See a rigorous exposition of this in Fellowes (2024).

We can refer to the concept of “kinds of people” (Hacking, 2007), more popularly known as “human kinds”, to better understand these implications. Hacking defines psychiatric conditions as “kinds of people”, which are both the science-specific labels (i.e., psychiatric *categories*) and the classes of individuals characterised by them. The individuals thus classified share some common features, and their identity and experience of that particular kind of person depend on the interaction of the psychiatric knowledge (that produces the class) with them. Moreover, their groups are also characterised by the ability to *interact* with (and eventually modify) the scientific field and the classification itself (Hacking, 2008)¹⁹. We can say that both people with an official psychiatric diagnosis and self-diagnosed individuals are therefore subjected to these interactive processes, that Hacking called *looping effects*. As testified by the studies presented in the first section, self-diagnosis (similarly to professional diagnosis) deeply impacts the life of the person, leading them to rethink their experiences of suffering (and eventual discrimination associated with their condition). Interestingly, it may find space and acceptance within disability and mental health self-help groups and movements: this can lead (as it happened for movements of professionally diagnosed people) to renegotiation of the meaning and redefinition of the limits of the imposed classification.

The consequences of the mentioned looping effects and the material conditions that bring about self-diagnostic journeys, then, might compel us to a weaker psychiatric ontology that borders on eliminativism and anti-psychiatry. As I shall see later, the radically social interpretations of mental conditions (that we could use to frame the relevance of self-diagnosis) are more concerned with structural changes for collective liberation from oppressive norms and systemic failures in providing care (Chapman, 2023), rather than alleviating individual suffering by reforming psychiatry from the inside or by analytically refining its definitions and assumptions.

4.2. *Epistemological issues*

In the last paragraph, I concluded that experiences with official diagnoses and self-diagnostic journeys might require a social framing of the ontological status of mental conditions, in order to be understood in all of their sociopolitical

¹⁹ Hacking’s solution is not unanimously considered conclusive for settling the debate on natural and artificial kinds in psychiatry: the author himself reviewed his position throughout the years, especially concerning the terminological choice between “human kinds” and “kinds of people” (Hacking, 2007). For critiques of the concept as decisive in this debate see, for example, Cooper (2004), Tsou in Tekin and Bluhm (2019) and Chapman (2020). Nonetheless Hacking’s “human kinds” have been exceptionally popular, and his general interpretative framework is still a respected and valued position in the literature.

implications. We argue that this is the case because otherwise we might overlook or underestimate the structural and systemic reasons that bring about problems in diagnostic assessments, mistrust in clinical settings and failures in the therapeutic alliance, that usually push people towards self-diagnostic practices.

Self-diagnosis can thus be considered a form of reclaiming the clinical practice of evaluation and application of classes and criteria, as well as a stepping stone for rethinking psychiatry as a whole. I have now to compare self-diagnosis and its official counterpart under the other epistemological assumptions of the psychiatric theoretical system. Up to this point, we considered both of them to be category-dependent: we have not considered the possibility of self-diagnosing or being diagnosed with the general concept of being “mentally unwell” (or ill, or disordered, etc.), but only with a specific category that is usually found within the DSM or other medical classifications. The consequences of the ontological presuppositions reflect on psychiatric nosology, which does not need radically social interpretations of mental conditions to be criticised. However, changes in diagnostic categories (and their defining criteria) are deeply connected to how we define mental conditions, and therefore to how we understand such changes²⁰.

The instability of psychiatric classifications, paradigmatically framed in the history of DSM²¹, can be explained under different understandings of what psychiatric conditions and categories are, and this might impact directly on how we conceptualise self-diagnosis. But if clinicians can be mistaken, and even the classification itself is unstable, diagnosis and self-diagnosis might have similar features and be framed under the same interpretative model (that does not require more than practical grounds for discriminating between them). By this, I do not mean that there are no differences between the two practices, nor that clinicians and classifications are “more wrong” than their unofficial counterparts. Rather, I argue that we can understand both diagnosis and self-diagnosis under the same paradigm, regardless of which one we choose: this is mainly because they both usually refer to the same psychiatric knowledge and diagnostic classes, but also because they are both influenced by the same fac-

²⁰ On the link between ontological positions and psychiatric classifications see also the articles of Kosko, or Zachar, both in Tekin and Bluhm (2019).

²¹ Since I cannot provide here an exhaustive historical analysis for all diagnostic classes, see (beyond autism) the following examples: Hacking (2008) wrote also about the “epidemic” of Multiple Personality Disorder in the 80s (a category that has been removed and can currently be diagnosed as Dissociative Identity Disorder). Narcissistic Personality Disorder and personality disorders underwent similar processes of re-systemisation, that brought up two different models for this diagnostic class (Lalumera in Guerini and Marraffa, 2019). Attention Deficit and Hyperactivity Disorder was first defined as a hyperactivity issue, then (when the inattentive symptoms were privileged) Attention Deficit Disorder diagnosis replaced almost completely the first ones; lastly, both types of symptoms were taken into account, resulting in the category we currently know (Caniglia, 2018).

tors (as the ones outlined in section 3) and subjected to the same looping effects (as explained in paragraph 4.1).

Given the great synchronic and diachronic variety of diagnostic classes and criteria, we have to face three crucial elements when comparing official diagnoses with self-diagnostic journeys:

- (1) public awareness of some psychiatric diagnoses varies greatly in different times and contexts (Fellowes, 2024): information, sources and knowledge available for potential patients to learn about their experiences (and eventually self-diagnose) is bounded to this difference in “popularisation”, that characterizes also the frequency with which some conditions are officially diagnosed;
- (2) the qualitative difference between criteria for different conditions causes people with more stigmatising diagnoses²² to be considered less reliable and trustworthy in their testimony, both in clinical settings and in self-diagnostic experiences;
- (3) the issue of testimony can be generalised to all psychiatric patients and so-called Madpeople²³: the class of people with mental conditions are usually considered to be more questionable than “normal” population, therefore they need the supervision and validation of experts.

4.3. *Sociopolitical and ethical implications.*

While these epistemological concerns are internal to the discipline of psychiatry, they have some crucial and direct implications on the experiential domains connected to it (and therefore on its sociopolitical and ethical dimensions). The three elements that close the last paragraph refer to *epistemic injustice* in psychiatry²⁴, as well as to the issue of psychiatric *expertise*, versus the so-called “expertise-by-experience”²⁵. We need to shift from their above-mentioned epistemological features to their practical, ethical and political relevance, in order to better understand what they mean for self-diagnosis. These kinds of injustice, suffered by psychiatric patients and self-diagnosed individuals, have their roots in the epistemic value granted by clinicians to their reported experiences, and in the epistemological status of *pathology*, or *illness*, that mental conditions retain: their consequences, however, go beyond this

²² See, for example, Palmer (2000) on delusions, Klein, Fairweather and Lawn (2022) on Borderline Personality Disorder, and Lalumera in Guerini and Marraffa (2019) on Narcissistic Personality Disorder.

²³ In the sense used by Jeppsson in Tremain (2024).

²⁴ See, for example: Chricton, Carel and Kidd (2017), Kidd, Spencer and Carel (2023), Catala in Tremain (2024).

²⁵ See, for example: Bueter (2021), Dings and Tekin (2022), Fellowes (2023b).

theoretical domain. Injustice experienced in clinical settings can lead to self-diagnostic journeys, in the same way they have led to activism in social movements. The concurrent perception of epistemological instability and socially constructed nature of psychiatric classifications tend to reinforce the theoretical basis for reclaiming practices and advocacy for radical changes, of which self-diagnosis can be considered an instance. Furthermore, self-diagnosed people whose autonomous evaluations are understated due to a “lack of expertise” (both by people close to them and by the professionals they eventually turn to) might be subjected to similar types of injustice, in relation not only to the dismissal of their general knowledge and experience of their conditions: most importantly, this kind of invalidation is specifically directed towards (and sometimes partially produces) their difficulties and disablement. Self-diagnostic practices become then a fundamental tool for reclaiming *expertise on one’s own personal suffering*, that the diagnostic criterion of “clinically significant impairment” (APA, 2022) for mental conditions fully poses in the hands of the professional figure.

These sociopolitical implications could call for more critical and radically transformative approaches not only to psychiatry but to society overall, as the ones implied in the Social Model of Disability and the Neurodiversity Paradigm. A great part of the suffering and disablement experienced by people who are inscribed (by themselves or others) in psychiatric categories is understood not only as a product of a passive societal inability to provide for heterogenous needs, but as an active mechanism of oppression and social control²⁶. These struggles and difficulties do not come from personal and intrinsic deficits: rather, they are a consequence of the processes of *pathologisation* of behaviours – that societies need to enforce to better manage their members. This process can be broken down into two steps: identification of the difference as an undesirable trait, and its subsequent medicalisation (e.g., Conrad, 2005). Hacking (2008) argues that this process serves the above-mentioned administrative goals and calls for divergent individuals to be (re-)normalised. What psychiatric self-diagnostic journeys and experiences address, then, is not the individual will of being accommodated to better fit into the restrictive norms of an ableist society (i.e., normalisation): we can argue that self-diagnosis, alongside “traditional” forms of reclaiming and advocacy, calls for systemic changes and drastic transformations of the structures that create and preserve physical and mental disablement. In the

²⁶ Fundamental conceptual instruments for this analysis were provided by Foucault in the 60s and variously developed from then on: this is not the place to properly address the crucial contributions of Foucault to the presented debates, therefore I will refer the reader to a summary of Foucaultian terminology found in Havi and Mosko in Tekin and Bluhm (2019). For a recent integration of Foucaultian insights in philosophy of disability, consider for example the work of Shelley Tremain (e.g., 2017).

following section I will provide one last argument concerning the relationship between normalisation and pathologisation, to back up the latter claim and provide conclusive remarks.

5. *Normalisation and pathologisation*

The argument for the radically political role of self-diagnosis, draws on the sociopolitical implication I sketched in the last paragraph and calls for a brief expansion on the relationship between normalisation and pathologisation. As I hoped to have made clear throughout the paper, in order to have a *medical* model of physical and mental disablement, we need to frame the deviations from the socioculturally constructed norms as undesirable conditions or traits, that are both reified and individualised. As the Social Model of Disability claims, this allows the creation of a “surplus class” that consumes medical and psychiatric services to be re-normalised, while simultaneously being excluded from the workforce and from major aspects of social life (Oliver, 1990). This economic framework can be applied to the increase in pathologisation of behaviours: as argued by Chapman (2023) in their characterisation of the Neurodiversity Paradigm, the shift towards more cognitive and emotional kinds of labour, and the subsequent production of new and more restrictive norms, allowed more people to enter the domain of psychiatric management and created growing mental and neurodivergent disablement. Self-advocacy and reclaiming practices, however, progressively changed the common representation of mental conditions: stigma and discrimination were partially alleviated; rights, accommodations and better services were obtained. This however produced another important effect that we can also call “normalisation” in a different sense, i.e. making progressively more common and available the psychiatric and neuroscientific language²⁷, as well as their tools and concepts. Both official diagnoses and self-diagnostic journeys can be considered interpretative (Fellowes, 2024) and sense-making (Ryan in Davidson and Orsini, 2013) practices: in the first case, however, this hermeneutical job is done mainly by professionals that pursue administrative aims. When this is done by the self-diagnosing individual, who operates through the tools of psychiatry, an open issue emerges: their lived experiences of suffering and struggling to conform to social norms are *justified* by the pathologisation of their own behaviours, which they inscribe in the medical-psychiatric theoretical system, through the use of its language and conceptual tools. At the same time, however, self-diagnosing individuals *reject* this interpretative

²⁷ On the “cerebralisation” of mental conditions (especially autism), see Ortega in Davidson and Orsini (2013).

model: by reclaiming expertise, they use the medical language to make sense of their lives, but in the re-appropriation of their central and active role in the diagnostic process they might actually radically criticise the disciplines they draw from. My claim is that this seemingly contradictory nature of self-diagnoses, which can be potentially puzzling for scholars, has great practical value and political potential that are strengthened (rather than weakened) by this ambiguity: it can be used to both temporarily accommodate unmet needs, as well as to advocate and bring about the above-mentioned structural changes. This claim, albeit strong and thoroughly discussed, must be considered my opinion and cannot be a conclusive argument: that is why I have to frame the ambiguity of self-diagnosis as an open issue.

6. *Conclusion and limitations*

What I tried to do in this paper is to provide an overview of psychiatric self-diagnosis as an object of philosophical inquiry. I drew on the limited literature on the topic to determine what we currently know about it (§§ 2 and 3) – then tried to frame it within popular debates in the field of philosophy of psychiatry (§§ 4 and 5).

In the second section, I provided an overview of the main studies that directly address self-diagnosis as their topic: I considered both explorative field studies that provided the social and experiential dimensions of self-diagnosis as a practice, as well as two crucial theoretical contributions that can further philosophical research on it. In the third section, I presented three dimensions of specifically neurodivergent and autistic experiences (demographic and sociocultural factors, psychological features and the practice of camouflaging), that emerge as reasons for failures of institutional support and skepticism towards clinical practices, that might push people to revert to self-diagnostic journeys. In the fourth section, I proceeded with an analysis of some crucial elements, (ontological issues, epistemological considerations, and sociopolitical and ethical implications) of the debates in philosophy of psychiatry, to frame self-diagnosis as a topic worthy of philosophical inquiry within this field. In the last section, I concluded that self-diagnosis calls for psychiatric conditions to be understood through the Social Model of Disability and the Neurodiversity Paradigm, since it theoretically and practically elicits structural problems of ableist oppression in Psychiatry as a discipline, and in societies more broadly.

As for other limitations and further research suggestions, I list some open challenges that – for reasons of space and complexity – cannot be exhaustively presented and dealt with here. First of all, there is the need of more explorative field-studies on self-diagnostic experiences and practices (especially, for mental conditions other

than autism). Second, we need to seriously consider the risks of over-diagnosing – especially, of over-diagnosing certain conditions at the expense of under-diagnosing others: this issue is discussed in Fellowes (2023a), seemingly under the assumption that psychiatric conditions are *real* and that self-diagnoses must be *accurate*, in at least some sense. I was not able to properly discuss it within the Social model in the present work, but I believe that it would be an important integration to the matter. Thirdly, we need to mention the epistemic and ethical difficulty of establishing clear boundaries and features for defining self-diagnosis, without the risk of collapsing into its official counterpart, under at least some respect.

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