The Impact of Psychological Disorder Representation and Diagnosis Source on Symptom Perception, Help- Seeking Intentions, Social Connection on Social Media

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ABSTRACT

Title: The Impact of Psychological Disorder Representation and Diagnosis Source on Symptom Perception, Help-Seeking Intentions, Social Connection on Social Media

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Social media, and in particular TikTok, are becoming increasingly powerful and influential, with an increase in mental health-related content generated by expert and non-expert users. This study focuses on how the representation of a psychological disorder (as a health condition or illness) and the explicit source of the diagnosis (self-diagnosis and professional diagnosis) influence users' perceptions and behaviour. Seven dependent variables were measured: perceived severity of symptoms, perceived negative impact of symptoms in daily life, perceived stability of symptoms, intention to seek help (professional and non-professional), proximity to the influencer, perception of the disorder as a social condition and identification with symptoms. To answer the research question, a survey was conducted. The results show that the representation and source of the diagnosis influence the perception of symptom severity and the intention to seek help. Furthermore, when the disorder is represented as a health condition, the attribution of the diagnosis influences the perception of the disorder as a social condition and the stability of the symptoms.

Keywords: Social media, Mental health, Psychological disorder, Self-diagnosis, Tik Tok

SUMÁRIO

Título: O impacto da representação da perturbação psicológica e da fonte de diagnóstico na perceção dos sintomas, nas intenções de procura de ajuda e na ligação social nas redes sociais

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As redes sociais, e em particular o TikTok, estão a tornar-se cada vez mais poderosas e influentes, com um aumento do conteúdo relacionado com a saúde mental gerado por utilizadores especializados e não especializados. Este estudo centra-se na forma como a representação de uma perturbação psicológica (como uma condição de saúde ou doença) e a fonte explícita do diagnóstico (autodiagnóstico e diagnóstico profissional) influenciam as percepções e o comportamento dos utilizadores. Foram medidas sete variáveis dependentes: perceção da gravidade dos sintomas, perceção do impacto negativo dos sintomas na vida quotidiana, perceção da estabilidade dos sintomas, intenção de procurar ajuda (profissional e não profissional), proximidade do influenciador, perceção da perturbação como uma condição social e identificação com os sintomas. Para responder à questão de investigação, foi realizado um inquérito. Os resultados mostram que a representação e a fonte do diagnóstico influenciam a perceção da gravidade dos sintomas e a intenção de procurar ajuda. Além disso, quando o transtorno é representado como uma condição de saúde, a atribuição do diagnóstico influencia a perceção do transtorno como uma condição social e a estabilidade dos sintomas.

Palavras-chave: Redes sociais, Saúde mental, Perturbação psicológica, Auto-diagnóstico, Tik Tok

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1. Introduction

TikTok is a social networking app with 1.7 billion users who can share videos freely. In recent years, one of the topics that has gained most popularity on the platform is mental health. You can find a huge amount of content dealing with topics such as anxiety, depression, ADHD and other disorders (Foster, A.& Ellis, N., 2024). The biggest risk is that these videos can be made either by professionals in the field or by ordinary people who have no expertise or knowledge and who can simply list symptoms in a very general and superficial way. This inevitably has a significant impact on the mass audience, with potentially significant consequences. For example, it can lead to misinformation about symptoms and disorders, their generalization or romanticization, and, even more concerning, self-diagnosis, which is the danger of believing one has a condition that they do not actually have. In this study we will analyse whether the way in which a psychological distress is portrayed in the videos, e.g. whether the disorder is described as an illness, as in the case of depression, or as a health condition, such as ADHD, and whether the attribution of the diagnosis is specified, i.e. whether it is a diagnosis made by a professional or a self-diagnosis based on personal knowledge, influences the perception of the symptoms described. Furthermore, we will examine if these factors contribute to an emotional connection with the author of the video, particularly in relation to the degree of 'romanticisation' with which the experience is narrated, and whether they ultimately increase the viewers' intention to seek help. Previous research has already shown that the way an illness or disorder is portrayed on social media has a strong impact on perception by influencing not only users' opinions, but also their behaviour. In this study, we aim to investigate how much users' perceptions actually change depending on the presentation and type of narrative used for psychological distress and transparency with respect to diagnosis.

In total, this dissertation consists of eight chapters.

This dissertation begins with the introduction that takes a broad perspective on the topic, followed by the literature review, where information and theories are presented regarding the phenomenon of the influence of social media videos, in particular on TikTok, on the perception of mental health-related symptoms and user behaviour.

The methodology part is divided into four sections: participants, design, materials (including independent variables; dependent variables; control questions; manipulation controls; demographic data) and procedure. Next, we present the results of all relevant information gathered from the survey that address our research question, accompanied by a list of figures and tables supporting our findings. Finally, we proceed with the discussion, in which we offer a summary of the results and

several theoretical and practical recommendations, comparing our results with those of the works in the literature review. To conclude, we present limitations, conclusions, and the bibliography.

2. Literature Review

Social media represent web and mobile platforms that allow individuals to connect with others within a virtual network, such as Facebook, Twitter, Instagram or TikTok. These platforms allow people to share, co-create or exchange different types of digital content, including information, messages, images and videos. In recent years, they have emerged as prominent elements in the field of mental health (Ahmed et al., 2019). Analysing their impact is fundamental to understanding how these tools can contribute to distorting reality. The hashtag #mentalhealth on TikTok has amassed over 17 billion views, highlighting how social media offers the general public instant access to a wide range of content, including psychoeducation, mental health advice, and personal testimonials related to psychological conditions (Corzine & Roy, 2024). However, the sheer size of the content available inevitably has drawbacks. The main risk is misinformation and the way conditions are presented, which can be especially harmful when it comes to mental illness. Researchers analyzed the most viewed videos on TikTok related to ADHD, finding that about half of them contained misleading information. The misinformation contained, according to studies, could contribute to increased health-related anxiety. In addition, viral trends on TikTok, 'echo chambers' in social media (situations in which users primarily interact with content that confirms their pre-existing ideas or beliefs, without being exposed to conflicting views) and the romanticization of mental health symptoms are all factors that further increase this problem. (Yeung et al., 2022). Videos on Tik Tok regarding autism, for example, culminated in nearly 200 million views, and despite being intended to inform and educate the public about aspects of this disorder, they presented information that was mostly (about 73%) inaccurate or generalized (Aragon-Guevara et al., 2023).

In addition, seven different databases were searched (including Ovid MEDLINE (via Ovid), PsycINFO (via Ovid), CINAHL (via EBSCO), SCOPUS and the ProQuest Public Health, Psychology and Computer Science databases) using keywords related to social media, mental health and other aspects of representation such as trivialization or stigma (Tudehope et al., 2024) and from this it emerged that since on social media anyone can freely express their thoughts and opinions, public narratives can be created that have a significant impact, with the risk of spreading negative

messages, for example the association of mental disorders with dangerous behaviors, character weaknesses or, the description of general symptoms that can be misunderstood and confused.

This is further proof that the information on social media lacks quality control, is not monitored, and can be done by anyone, regardless of preparation.

2.1 Symptoms perception and Intention to seek help

The way a disease is portrayed has an impact on public perception and influences the behavior of individuals. Mental illnesses and people with these illnesses are often stigmatised and presented as unpredictable and threatening, which can generate prejudice and fear. (Wahl OF Media Madness, 1995; Fernando, 2011) By using exaggerated and humorous images to portray people with psychiatric disorders, the media also contribute to the stigma of mental illness by spreading false information. (Wahl OF Media Madness, 1995). The general public has unfortunately often believed that people with psychiatric disorders are dangerous and uncontrollable and should be feared and avoided, because they are often portrayed as violent and guilty of their condition (Granello DH, Pauley PS., 2000). In particular there are two theories of mass communication (the cultivation theory and the social learning theory) that explain how the media influence and perpetuate these stereotypes. The first suggests that those who spend more time 'living' in the virtual world may perceive 'the real world' based on the images to the principles and representations portrayed on the small screen. (Gerbner G. et al.,2002). The second proposes that learning is achieved not only through direct experience, but also through observation. People acquire knowledge about behaviour from the media that teach or reinforce social conventions about how to treat people with psychiatric disorders. (Bandura A. et al.,1992).

Similarly, trivialising conditions such as attention deficit hyperactivity disorder (ADHD) may reduce the perception of severity (Robinson, P. et al.,2019) and may influence individuals' behaviour regarding intentions to seek help. In fact, people tend to be less inclined to seek support if they perceive that the represented condition is subject to stigma or romanticisation (Gulliver A. et al., 2012; Yap MBH et al,2013). Trivialisation, therefore, reduces the severity of a disease by making it perceived as easier to acquire, deal with or treat.

Moreover, the minimisation of conditions leads to a perception of greater stability, as symptoms are seen as traits, part of the person. This approach reflects a fixed mentality, according to which symptoms are immutable because they represent a permanent and intrinsic trait in the person and consequently the motivation to seek treatments and solutions is also reduced. (Dweck, 1996, Dweck

& Elliott, 1983). Recent research has also demonstrated that the introduction of diagnoses into everyday speech without explanation can lead to trivialization. For instance, using phrases like "I am obsessive-compulsive about tidying up my room" to characterize basic personal preferences regarding the arrangement of objects is an example of how the term "OCD" (obsessive-compulsive disorder) is misused, which devalues and minimizes the experience of those who actually have this illness. (Pavelko R. & Myrick JG, 2016).

Therefore, given the enormous volume of often inaccurate information and the fact that it is also presented by inexperienced people, we hypothesise that depending on how a condition is represented, it may influence the perception of symptoms. In particular, the representation of mental illness through a professional diagnosis could lead to a greater perception of the severity of symptoms and a more negative impact on daily life, compared to a less medical mind representation, such as one based on self-diagnosis. This could also increase the intention to seek professional help.

Conversely, we hypothesise that oversimplification of illnesses and self-diagnosis lead to a perception of greater symptom stability, thus reducing the intention to seek professional help.

2.2 Romanticisation of symptoms

As already mentioned, many of the videos on TikTok, in which influencers and creators deal with topics such as ADHD, autism or similar conditions, have increased considerably in recent years and often oversimplify the disorder, romanticising and glorifying the diagnosis. (Foster, A., & Ellis, N., 2024). This phenomenon leads, in some cases, to users desiring such conditions and identifying with the symptoms. Users, in fact, recognising themselves in the symptoms described in the videos, end up believing they are suffering from a psychological condition, even when this is not the case. In recent years, with the spread of social media, this behaviour has increased dramatically, particularly in online communities dedicated to mental health. For example, symptoms such as fatigue and worry can be mistaken for a serious illness, for example as a psychological disorder, instead of more mundane conditions, such as a sleep disorder (Moulder, 2023). In addition, there is a tendency to normalise disorders and present their symptoms as romanticised or attractive, with the result that users feel closer to creators who have gone through similar experiences, fostering the development of communities in which experiences are exchanged and integrated into social identities. (Foster, A., & Ellis, N., 2024)

In fact, users are offered an algorithmically derived ‘For You’ page, where videos are shown that users are most likely to interact with, based on previous activity, such as likes or comments, and intangible factors such as attitudes, affections and beliefs (Avella H., 2023; Gallagher L., 2021) Individuals attribute to the content displayed by the algorithm, which appears to be highly personalised, a mind-reading or ‘diagnostic’ capability and the ‘For You’ page is perceived as being a projection of their subconscious identity and beliefs, regardless of whether they had this self-perception previously. (Corzine & Roy, 2024). This phenomenon occurs because the precision with which content is selected according to individual characteristics allows for the cultivation of communities based on personalised experiences, fostering meaningful connections. As a result, users become convinced that each element on their ‘For You’ page is closely connected to them personally (Avella H., 2023). Through this cyclical scheme of mutual reinforcement, a phenomenon called the "feedback effect of human categories" is initiated, whereby identity becomes increasingly linked to diagnosis. (Hacking, I., 1995). The main consequence is that the content and the individual support each other symbiotically through continuous interactions. A community of people who share similar interests, such as mental health, is therefore created and, consequently, the viewer tends to identify and feel more understood by these people because favoring peer support through shared experiences contributes to the formation of the identity deriving from the various community groups. (Giles DC., 2006). In fact, users perceive Tik Tok videos as reliable and often create emotional bonds with influencers and perceive disorders as part of their social identity and this is particularly relevant for scenarios that adopt a less medical mind.

The theory of social identity could explain why this phenomenon occurs. According to this theory, identity is constructed through membership in social groups through self-categorization and social comparison (Hogg & Abrams, 1988). Adolescents who relate to TikTok content can therefore classify themselves as belonging to the appropriate social group, comparing their actions, thoughts, and attitudes to what they observe (Stets & Burke, 2000). According to Ullah (1987), people who use a label linked to a social group are more likely to identify with and engage with that group's unique culture. Therefore, this theory may explain why group membership is attractive to teens on TikTok looking to discover their identity, and how the use of labels (Foster, A., & Ellis, N., 2024) which in the case of a psychological diagnosis can intensify this effect.

In addition, a person may be reluctant to take the risk of an experienced doctor refuting their self-diagnosis, because this could result in their expulsion from a social group that provides them with a sense of identity and belonging (Foster, A., & Ellis, N., 2024).

Therefore, we hypothesise that individuals exposed to influencer videos in which the disorder is presented as a less medical condition, accompanied by a self-diagnosis, develop a greater sense of connection and closeness with the influencer, incorporate the disorder more into their social identity, and are more likely to identify with the described symptoms, compared to a more serious and professional representation of the condition.

2.3 Hypothesis

Symptoms Perception

H: Representation of symptoms as a mental illness leads to a higher perceived severity of symptoms and higher perceived negative impact of symptoms, and lower symptoms stability than representation as a mental health condition.

H: Professional diagnosis leads to a greater perception of the severity of symptoms, greater perceived negative impact of symptoms, and lower symptoms stability than self-diagnosis.

Intention to seek help

H: Representation as a mental illness leads to higher intention to seek professional help and to lower intention to consider using online resources or self-assessment compared to representation as a mental health condition

H: Professional diagnosis leads to higher intention to seek professional help and to lower intention to consider using online resources or self-assessment compared to self-diagnosis

Symptoms romantization

H: Representation of symptoms as a mental health condition leads to higher perceived closeness to the influencer, to higher social identity, higher personal identification with symptoms compared to representation as mental illness.

H: Self-diagnosis leads to higher perceived closeness to the influencer, to higher social identity and leads to greater personal identification with symptoms compared to professional diagnosis.

3. Methodology

The next part illustrates the methodology adopted in the study, including the participants involved, the research design, the materials used and the procedure followed. This chapter aims to provide other researchers with a detailed overview of the study approach in order to facilitate replicability. The experimental investigation allowed for the collection of significant data, enabling the exploration of participants' decisions, actions and opinions after being subjected to different scenarios characterised by distinct mental stimuli.

3.1 Participants

The study's survey was distributed online, reaching 129 volunteer participants, mainly via social media and personal networks. The mean age of the participants was 27 years old (M = 27.52, SD = 10.65), with the youngest respondent being 16 and the oldest participant being 63. The sample included 78 individuals of the female gender (60.5%), 50 individuals of the male gender (38.8%) and 1 individual who preferred not to say their gender (1%). The majority of participants indicated Italian as their native language, with a total of 108 participants (83.7%); Other languages listed include English, with 8 participants (6.2%), followed by Arabic, Spanish, German, Hungarian, Malayalam, and Español, each with 1 participant (0.8%). Additionally, 4 participants (3.1%) listed Portuguese as their native language.

3.2 Research Design

The data collected to test the previous hypotheses were collected via an online survey that was created and published using the Qualtrics platform. The approximate compilation time was 2/3 minutes. The experiment involved a between-subjects design of 2 representations of psychological distress (health condition (ADHD), illness (depression)) x 2 attributions of the diagnosis.
The four experimental conditions were randomly assigned to the participants.

Details of the experimental manipulations are given below:

1) Mental health condition (ADHD) + professional diagnosis
2) Mental health condition (ADHD) + self-diagnosis
3) Mental illness (depression) + professional diagnosis
4) Mental illness (depression) + self-diagnosis

3.3 Materials

As a stimulus for this study, four different scenarios were created that were designed to simulate personal narratives shared by influencers on social media regarding life experiences and health conditions. All four conditions contained the same textual structure, but with different representations and attributions. In the representation of the psychological distress, to ensure that only the representation was manipulated (health condition vs illness), in both conditions the scenarios included the symptoms of ADHD and depression. This means that the scenarios were identical in the symptoms description changing only the diagnosis, either ADHD (health condition) or Depression (illness).

3.3.1 Independent Variables

Representation of psychological distress:

This variable has two conditions: health condition and illness.

The experimental condition “health condition” is represented through ADHD, described as a way of being that reflects social functions and regulates emotions. In the experimental condition in which symptoms are represented as an “illness”, distress is represented as a real mental illness, through depression, described as a disorder that affects mood and social interactions. Each scenario includes descriptive texts designed to represent different perceptions of psychological distress, with the aim of observing the impact of these representations on participants' reactions.

Attribution of the diagnosis:

This variable has two attributes: professional diagnosis and self-diagnosis.

In the first case, symptoms are attributed to a diagnosis provided by a doctor or specialist, while in the second case they are attributed to a diagnosis made directly by the influencer himself.

Each scenario includes descriptive texts designed to represent different attributions of the diagnosis, with the aim of observing the impact of these representations on the participants' reactions.

Example of a scenario representing psychological distress as a health condition and diagnosis diagnosed by a professional:

Influencer: "I had no idea I had ADHD until a specialist diagnosed me. He explained to me that ADHD has a big impact on my daily life. It is a health condition, it reflects my social functioning and how I regulate my emotions.

I often struggle to concentrate and sometimes forget important commitments. I feel disorganised and easily distracted, and other times I feel mentally exhausted and have difficulty finding motivation for the things I enjoy. I tend to isolate myself from others, feeling as if my mind is scattered among a thousand thoughts and as if I am stuck in a mental space where time seems not to flow. For a long time I felt alone, as if no one could really understand how I felt.
Only after I received the diagnosis from the specialist, I realise that this was all part of my condition, my way of being".

3.3.2 Dependent Variables

Subsequently, participants were instructed to evaluate a set of dependent variables, carefully selected to measure the constructs of interest in the study.
The variables were divided into three main categories: Symptoms perceptions (perceived Severity, Negative impact, Stability of Symptoms), Intention to seek help (professional and self -help), Symptoms romantization (perceived Closeness to the Influencer, Social Identity, Personal Identification with Symptoms).

Symptoms perceptions

This category assesses the perceived severity of symptoms by individuals, including how intense and problematic they consider them to be. It also analyses the negative impact these symptoms have on daily life, an aspect closely related to the perception of their severity. In addition, it explores how people interpret the stability and variability of symptoms, thus whether they perceive the symptoms as stable and almost traits of the person or changeable over time.

Perceived severity of symptoms: To measure the severity of symptoms, we asked participants to rate how severe they considered the symptoms described by the influencer (chaotic thoughts, disorganization, loss of interest, isolation) on a scale of 1 (not at all serious) to 7 (extremely severe).

Perceived impact of symptoms in daily life: To measure the perceived impact, we asked participants to rate how much they felt the symptoms described negatively affected their quality of life on a scale of 1 (no impact) to 7 (extremely negative impact).

Perceived stability of symptoms: To measure the perceived stability of symptoms, we asked participants to rate how much they felt the symptoms described could vary or change over time, on a scale from 1 (not at all stable) to 7 (extremely stable).

Intention to seek help

We wanted to explore the possible propensity to seek support, considering both the general intention to seek professional or self-help and the preferences regarding the different types of support available.

Intention to seek help: To measure, in particular, the type of support preferred, we asked the participants, via multiple choice question, to select which type of professional help they would be most inclined to look for among the following options: self-help apps, individual therapy, group therapy, online support groups, medication, or none of the above.

To measure the propensity to consult a professional, we asked participants to rate the extent to which they would consider consulting a professional to better understand their symptoms, on a scale of 1 (not at all) to 7 (extremely).

To measure propensity to use online resources, we asked participants to rate the extent to which they would consider using online resources or self-report tools to better understand their symptoms, on a scale of 1 (not at all) to 7 (extremely).

Romanticisation of symptoms

We wanted to examine how people interpret and give meaning to the described symptoms by measuring the degree of emotional involvement in the influencer and the narrative, considering the extent to which people identify with them on a social and personal level and how much the participants recognise the described symptoms in their personal experience.

Perceived closeness to the influencer: to measure emotional connection, we asked participants to rate how attuned they felt to the emotions expressed by the influencer on a scale of 1 (not at all) to 7 (extremely). To measure personal recognition in the influencer's story, we asked participants to rate how much they perceived the influencer's story as something they could relate to personally on a scale of 1 (not at all) to 7 (extremely).

Social identity: To measure social identity, we asked participants to rate the extent to which they considered ADHD or depression to be part of their identity on a scale of 1 (not at all) to 7 (extremely). To measure emotional connection with people who have the same difficulties, we asked participants to rate how emotionally connected they possibly felt with them on a scale of 1 (not at all) to 7 (extremely).

Identification with symptoms: To measure identification with symptoms, we asked participants to rate how often they had experienced similar symptoms in the past 10 days, on a scale of 1 (never) to 7 (many times a day).

3.3.3 Control variables

We also included follow-up questions to test participants' level of familiarity, experience, and knowledge about ADHD or depression, and their use of social media for mental health-related content. The intention was to collect data to contextualize participants' responses to the main variables and explain hypothetical individual variations. In fact, a basic understanding of the condition and symptoms, experience, and digital exposure can impact the interpretation of the answers.

Family History of ADHD/Depression: to measure how familiar the participants were with ADHD or depression, we asked them to rate how familiar they were with the condition on a scale of 1 (not at all familiar) to 7 (extremely familiar)

Personal Experience With ADHD/Depression: we asked, using the multiple choice option, to indicate to the participants their level of experience (no experience or direct or indirect experience) with the condition in order to calculate their personal experience.

Knowledge of the symptoms and characteristics of ADHD/Depression: to measure how well the participants were informed about the specific characteristics of the condition, we asked them to rate with a scale of 1 (not at all) to 7 (extremely) how well they knew the symptoms related to ADHD or Depression.

Use of social media: In order to measure how much participants use social media as a source of information for mental health-related content, we asked them to rate how often they use Tik Tok or Instagram to follow topics of this type on a scale of 1 (never) to 7 (very often)

3.3.4 Manipulation check

We also integrated manipulation questions to verify that the participants had indeed correctly understood the experimental manipulation and whether they had perceived the representation of

psychological distress (mental illness vs mental health condition) and the type of diagnosis (professional diagnosis vs self-diagnosis) described in the scenarios.

Control of the representation of each diagnosis: we asked the participants, through two answer options (health condition or disease), how the influencer had described the pathology, in order to understand and measure their perception of the representation.

Manipulation check of health representation: To check what specific disorder the participants had associated with the influencer, we asked, via multiple choice that included distractors, to identify her.

Manipulation check of attribution of diagnosis: To measure whether they understood the type of diagnosis, we asked participants to indicate how the influencer had been diagnosed with the condition, with multiple choice options that also included distractors.

3.3.5 Demographics

Finally, in order to give context to the data collected and describe the sample of the study, we included demographic questions.

Gender: we asked participants to select their gender via multiple choice which included inclusive categories.

Age: In order to collect the age of the participants, we asked them to enter it in an open field.

Primary language: To know the primary language, we asked to specify it in an open space.

3.4 Procedure

Initially, upon arrival, the participant was greeted by a welcome page. This page provided information on the general context of the study, which focused on the perception of psychological experiences and mental health. In addition, the anonymity of responses and data was guaranteed, and the estimated time for completion of the survey (approximately 2 minutes) was communicated.

Participants were randomly assigned to one of the four experimental conditions using the Qualtrics randomisation tool. To ensure a fair distribution, the randomisation process was monitored and adjusted periodically. Following the welcome page, participants read a scenario in which an influencer described his or her symptoms and psychological condition, with emphasis on the representation of the disorder and the type of diagnosis. Participants then answered questions on dependent variables such as Symptoms perception (perceived severity, perceived impact of symptoms in daily life, perceived stability of symptoms), Intention to seek help, Romanticisation of symptoms (perceived closeness to the influencer, social identity, identification with symptoms). Next, participants answered control questions to assess their familiarity and experience with the subject matter, as well as manipulation verification questions to ensure that they had correctly interpreted the proposed narrative. Finally, demographic data were collected, including age, gender and main language. These demographic data facilitate a comprehensive analysis of the study results, allowing for possible subgroup analyses or comparisons between different participant characteristics. At the end of the survey, participants were presented with a short debriefing message to thank them for their participation and explain the purpose of the research. The survey adhered to established research protocols and ethical guidelines to ensure participant confidentiality, informed consent and the overall integrity of the study.

4. Results

The following chapter presents the results of our analysis, conducted using the robust two-way ANOVA. When the results required further analysis of the data, independent sample t-tests were used to check for interaction trends.

4.1 Symptoms perceptions

Perceived Severity

An ANOVA 2 diagnosis attribution (doctor diagnosis vs. self-diagnosis) x 2 representation of the diagnosis (health condition vs. illness) was conducted to examine the effects on perceived severity.

The analysis revealed a significant main effect of attribution on perceived severity, *($F(1,125) = 4.55, p = .035$)*, with diagnosis by a doctor *($M_{doctor} = 4.93, SD_{doctor} = 1.13$)* leading to higher perceived severity compared to self-diagnosis *($M_{self} = 4.46\ SD_{self} = 1.32$).*

This confirms our initial hypothesis that diagnosis by a professional would have increased the perception of severity compared to self-diagnosis.

We also found a marginal main effect of representation ($F\ (1,125) = 3.012,\ p = .085$) on perceived severity, where the representation of health condition ($M_{hcond} = 4.47,\ SD_{hcond} = 1.28$) led to lower perceived severity compared to illness ($M_{ill} = 4.88,\ SD_{ill} = 1.19$). Although this effect did not reach statistical significance, the trend suggests a potential effect of the diagnosis representation on perceived severity.

The interaction between attribution and representation was not statistically significant $F\ (1,125) = .581,\ p = .447$).

However, follow-up independent samples t-tests were conducted to further explore the interaction. For the health condition representation, the independent t-test revealed a significant difference in perceived severity between doctor diagnosis and self-diagnosis ($t_{doctor} = 1.982,\ p = .026$). In contrast, for the illness representation condition, the independent t-test showed no significant difference ($t_{ill} = 1.003,\ p = .160$). See Table 1, for the means and standard deviations, and Figure 1.

These findings suggest that while the interaction was not significant in the ANOVA, the t-tests indicate a potential moderating effect of representation on the relationship between attribution and perceived severity.

Figures and tables

Representation	**Attribution**	***M***	***SD***
Health condition	Diagnosis	4.82	1.156
	Self-diagnosis	4.19	1.327
Illness	Diagnosis	5.03	1.11
	Self-diagnosis	4.74	1.263

Table 1 - Descriptive statistics for Severity

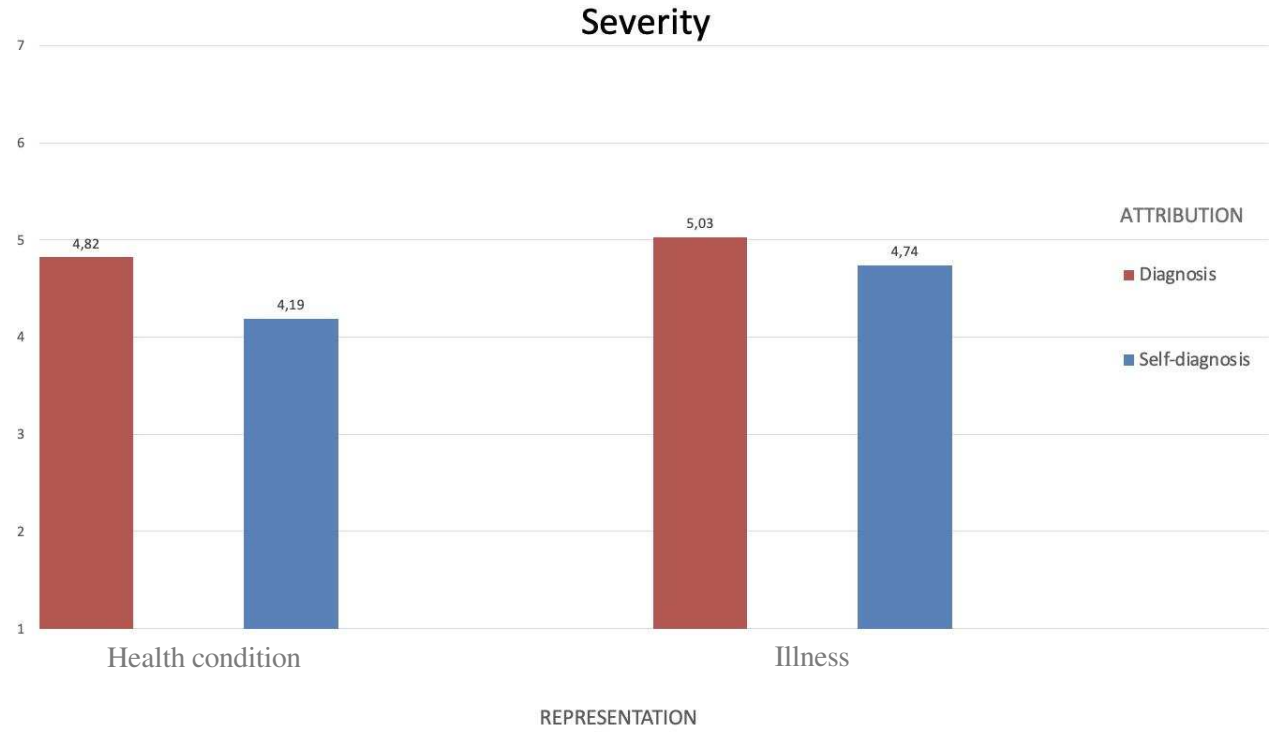

Figure 1- Severity

Perceived impact of symptoms in daily life

A two-way ANOVA was conducted to evaluate the effects of attribution (doctor diagnosis vs. self-diagnosis) and representation (health condition vs. illness) of psychological distress on the perceived impact of symptoms in daily life.

The analysis revealed no significant main effect of attribution *($F (1, 125) = .001, p = .974$),* indicating that the source of diagnosis (doctor vs. self-diagnosis) did not significantly affect the perceived impact of symptoms. Specifically, the mean for doctor diagnosis *($M_{doctor}=4.88, SD_{doctor}= 1.341$)* was not significantly different from the mean for self-diagnosis *($M_{self}=4.88, SD_{self}= 1.215$).* Similarly, no significant main effect of representation was found *($F (1, 125) =.119, p =.731$)* with the health condition group *($M_{hcond}=4.84, SD_{hcond}= 1.208$)* not significantly differing from the illness group *($M_{ill}=4.92, SD_{ill}= 1.335$)* in terms of perceived impact.

Additionally, the interaction effect was not significant *($F (1, 125)=0.04, p=.947$)* and we didn't run the independent t-test.

Perceived stability of symptoms

A two-way ANOVA was conducted to examine the effects of attribution (doctor diagnosis vs. self-diagnosis) and representation (health condition vs. illness) on perceived stability of symptoms.

The analysis revealed a significant main effect of attribution on perceived stability, *(F (1, 125) = 4.081, p = 0.046)* with diagnosis by a doctor *(M_{doctor}= 3.92, SD_{doctor}= 1.705)* leading to lower perceived stability compared to self-diagnosis *(M_{self}= 4.49, SD_{self}= 1.576).*
This is consistent with our initial assumption that a doctor's diagnosis leads to a lower perceived stability than self-diagnosis.
The main effect of representation was not significant, *(F (1, 125) = 1.298, p = 0.257)*: participants in the health condition group *(M_{hcond} =4.08, SD_{hcond}= 1.597)* did not significantly differ from those in the illness group *(M_{ill}= 4.37, SD_{ill}= 1.710)* in terms of perceived stability.
The interaction between attribution and representation was not statistically significant *(F (1, 125) =.421, p=.518).*
To further explore the potential interaction between attribution and representation, we conducted independent samples t-tests for each level of representation. In the health condition group, diagnosis by a doctor led to significantly lower perceived stability compared to self-diagnosis *(t_{hcond}=-1.967, p=0.27)*. In the illness group, no significant difference was found between doctor diagnosis and self-diagnosis *(t_{ill}=-935, p=.177)*. See Table 2 and Figure 2.

These results suggest that the effect of attribution on perceived stability is present only in the health condition group. Specifically, when symptoms are perceived as a health condition, self-diagnosis leads to greater perceived stability compared to a doctor's diagnosis. However, when symptoms are framed as an illness, the source of the diagnosis does not influence perceived stability.

Representation	**Attribution**	***M***	***SD***
Health condition	Diagnosis	3.64	1.592
	Self-diagnosis	4.42	1.538
Illness	Diagnosis	4.16	1.791
	Self-diagnosis	4.56	1.637

Table 2 -Descriptive statistics for Perceived stability of symptoms

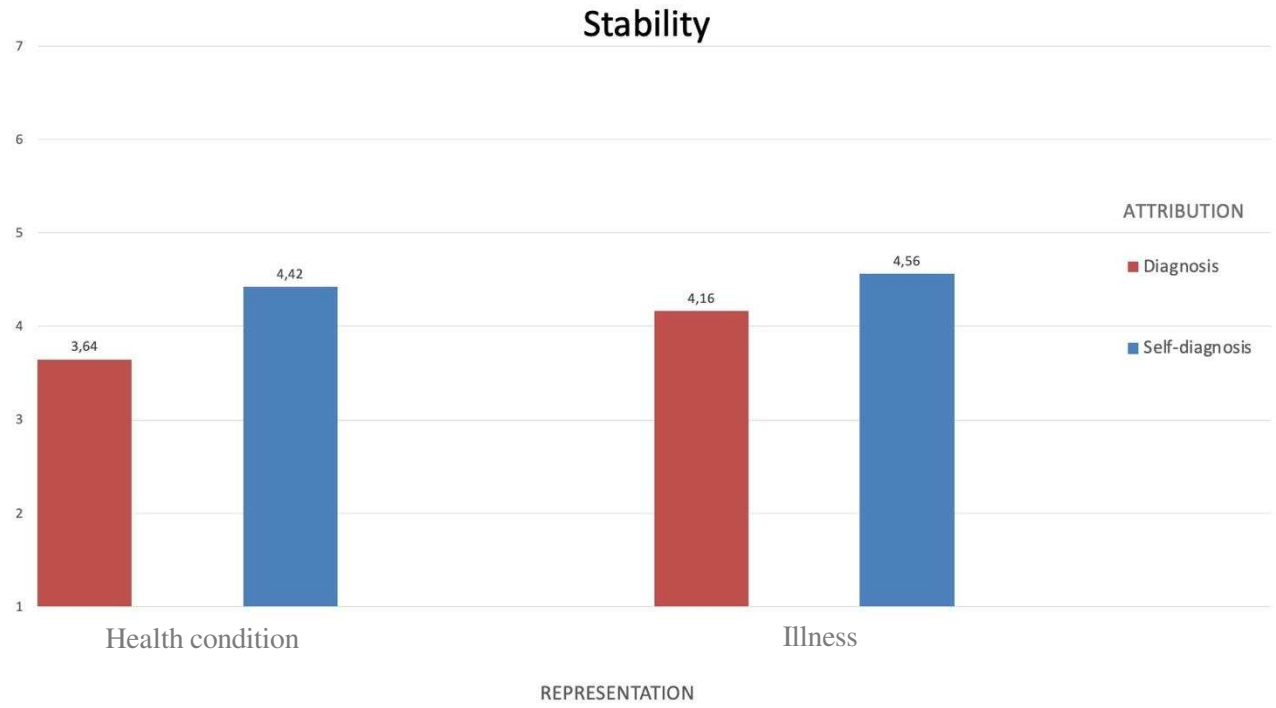

Figure 2- Stability

4.2 Intention to seek help

Intention to seek professional consultation

A two-way ANOVA was conducted to assess the impact of attribution (doctor diagnosis vs. self-diagnosis) and representation (health condition vs. illness) on participants' intention to seek professional consultation to better understand their symptoms.

The results indicated no significant main effect for attribution *(F (1, 125) = 2.233 p = .138)* indicating that diagnosis by a doctor *(M_{doctor}=5.08, SD_{doctor}= 1.735)* did not significantly differ in their intention to consult a professional compared to self-diagnosed *(M_{self}=4.61, SD_{self}= 1.713).* Also the main effect of representation was not significant *(F (1, 125) =1.156, p = .284*) showing that perceiving the symptoms as a health condition *(M_{hcond}=4.66, SD_{hcond}= 1.739)* was not statistically different from perceiving them as an illness *(M_{ill}=5.00, SD_{ill}= 1.723).*

Lastly, no interaction effect was observed between attribution and representation *(F (1, 125) =.014, p=.906).*

Intention to consider using online resources or self-assessment

A two-way ANOVA was conducted to examine the effects of attribution (doctor diagnosis vs. self-diagnosis) and representation (health condition vs. illness) on participants' intention to consider using online resources or self-assessment tools to understand their symptoms.
The results indicated no main effect of attribution *(F (1, 125) = .385 p = .536)* with diagnosis by a doctor *(M_{doctor}=3.46, SD_{doctor}= 1.735)* being not statistically different from self-diagnosis *(M_{self}=3.69, SD_{self}= 1.877).*
However, a significant main effect of representation emerged *(F (1, 125) =6.843, p = .010)* 22indicating that participants perceiving symptoms as a health condition *(M_{hcond}=4.00, SD_{hcond}= 1.860)* had a higher intention to use online resources compared to those perceiving their symptoms as an illness *(M_{ill}=3.17, SD_{ill}= 1.673).* This is in line with our initial hypothesis.
No significant interaction effect between attribution and representation was found *(F (1, 125) =.000, p=.988).*

4.3 Romanticisation of symptoms

Perceived closeness to the influencer

A two-way ANOVA was conducted to assess the impact of attribution (doctor diagnosis vs. self-diagnosis) and representation (health condition vs. illness) on perceived closeness to the influencer.The results showed that the main effect of attribution was not significant, *(F (1, 125) = 0.15, p = .904):* participants did not report a difference in perceived closeness whether the diagnosis was provided by a doctor *(M_{doctor}=3.46, SD_{doctor}= 1.595)* or through self-diagnosis *(M_{self}=3.49, SD_{self}= 1.605).* Also the main effect of representation was not significant *(F (1, 125) =.575, p= .450).*Perceived closeness did not differ between the health condition group *(M_{hcond}=3.36, SD_{hcond}= 1.648)* and the illness group *(M_{ill}=3.58, SD_{ill}= 1.544).*

Additionally, the interaction effect between attribution and representation was not significant, *(F (1, 125) =.199, p=.656).* Given the lack of interaction and tendency, no further independent t-tests were performed.

Social identity

A two-way ANOVA was conducted to examine the effects of attribution (doctor diagnosis vs. self-diagnosis) and representation (health condition vs. illness) on social identity, specifically how strongly individuals perceive ADHD or depression as part of their social identity.

The analysis revealed no significant main effect of attribution**,** *(F (1, 125) = .275, p = .601.)* indicating that the source of diagnosis (doctor vs. self-diagnosis) did not significantly influence the perception of the condition as part of one's social identity. Specifically, the mean for doctor diagnosis *(M_{doctor}= 2.59, SD_{doctor}= 1.416)* did not differ significantly from the mean for self-diagnosis *(M_{self}=2.73, SD_{self}= 1.541).*

Similarly, no significant main effect of representation was found *(F (1, 125) = .020, p = .888.)*: there was no significant difference in how the condition was perceived as part of social identity when it was framed as a health condition *(M_{hcond}= 2.70, SD_{hcond}= 1.487)* versus an illness condition *(M_{ill}=2.63, SD_{ill}= 1.485).*

Although the interaction between attribution and representation was not statistically significant, *(F (1, 125) = 1.776, p = .185)* follow-up independent t-tests revealed some tendencies . In the health condition, there was a tendency for self-diagnosis to influence social identity more than doctor diagnosis. *(t_{hcond}= -1.310, p=0.98).* In the illness condition, no significant difference was found between the two types of diagnosis *(t_{ill}= .573, p=.284).*

These results suggest that the attribution (source of diagnosis) may slightly affect the perception of the condition as part of one's social identity when the condition is considered a health condition, but not when it is framed as an illness. See Table 3 and Figure 3.

Representation	**Attribution**	***M***	***SD***
Health condition	Diagnosis	2.43	1.200
	Self-diagnosis	2.92	1.663
Illness	Diagnosis	2.74	1.591
	Self-diagnosis	2.53	1.398

Table 3-Descriptive statistics for Identity

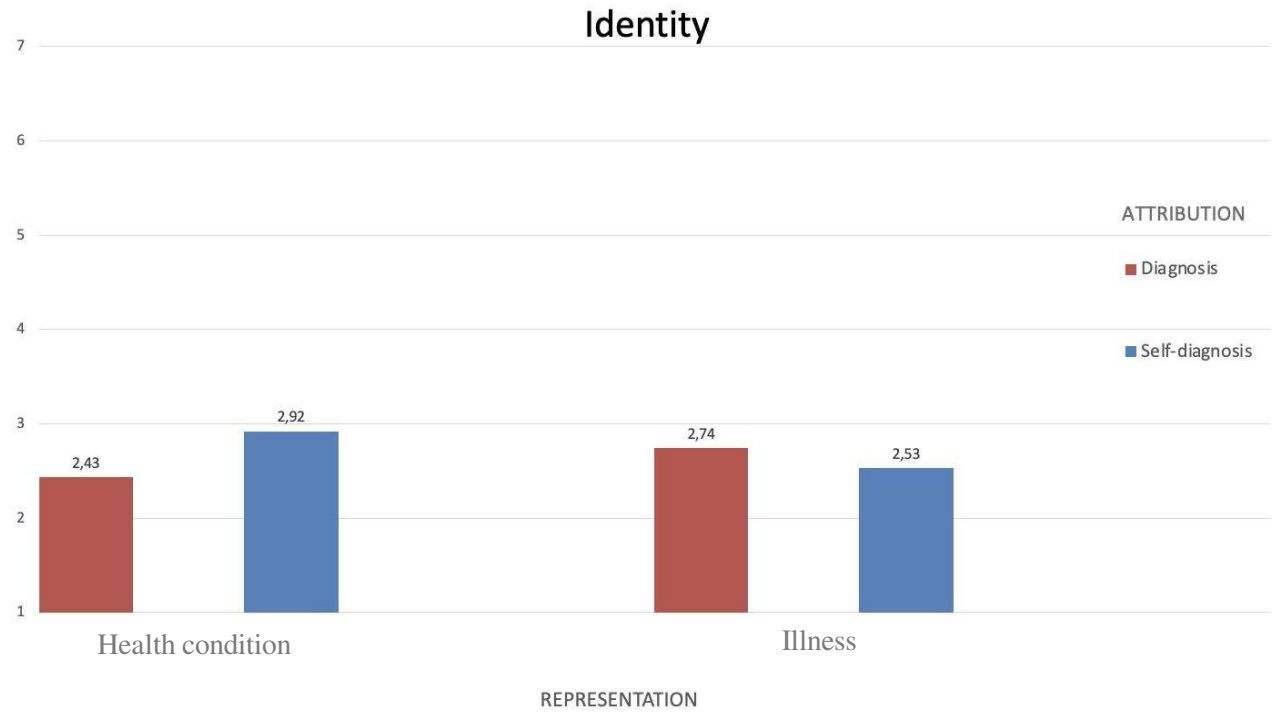

Figure 3- Social Identity

Identification with symptoms

A two-way ANOVA was conducted to examine the effects of attribution (doctor diagnosis vs. self-diagnosis) and representation (health condition vs. illness) on participants' identification with symptoms.

The results indicated no significant main effect for attribution *(F (1, 125) = .183, p = .670).*

There was no notable difference in identification between doctor diagnosis *(M_{doctor}=3.53, SD_{doctor}= 1.526)* and self-diagnosis *(M_{self}=3.66, SD_{self}= 1.570).*

Similarly, the main effect of representation did not reach significance *(F (1, 125) =.955, p. = .330).*

Participants in the health condition group *(M_{hcond}=3.74, SD_{hcond}= 1.551)* did not differ significantly from those in the illness group *(M_{ill}=3.46, SD_{ill}= 1.539).*

Since the results indicate that there is no tendency at all *(F (1, 125) =.221, p=.639),* we didn't run the independent t-tests.

4.4 Intention and type of support

We examined the frequency and percentage of the selected support options in the different experimental conditions to further explore participants' choices regarding professional support. Below, the Table 4 illustrates the frequencies and percentages for each type of professional support chosen in the four scenarios.

	Health condition/Diagnosis	*Health condition/Self-diagnosis*	*Illness/Diagnosis*	*Illness/Self-Diagnosis*
Type of professional support	**Freq./Percentage**	**Freq./Percentage**	**Freq./Percentage**	**Freq/Percentage**
Self-help app	5/17.9%	5/14.3%	2/6.5%	0
Individual therapy	18 /64,3%	20/57.1%	23/74.2%	27/84.4%
Group therapy	3/10.7%	6/17.1%	0	0
Online support groups	1/3.6%	2/5.7%	2/6.5%	3/9.4%
Medication	1/3.6%	2/5.7%	4/12.9%	2/6.3%
None of the above	0	0	0	0

Table 4– Type of professional support

5. Discussion

This chapter discusses the results in the light of the literature and the hypotheses previously presented.

The main purpose of this study was to investigate how the way psychological distress is portrayed on social media (whether as a health condition or illness) and the attribution of diagnosis (whether diagnosed by a professional or if self-diagnosed) influences individuals' perception, connection, and behavior.

5.1 Summary of results

5.1.1 Symptoms perception

As far as the perception of severity is concerned and focusing on the attribution variable, the results indicate that cases in which diagnoses are made by a doctor are associated with a greater perception of symptom severity than cases of self-diagnosis and this confirms what we had hypothesized. No significant main effect was found with regard to the representation of psychological distress.

However, there is a slight trend that psychological distress presented as a "disease" is associated with a perception of higher severity than that described as a "health condition" and this is in line with our initial hypothesis. Importantly, we found an interaction effect between the two variables diagnosis attribution and symptoms representation. In the condition of representation as a "health condition" a significant difference in the perception of severity was observed between professional diagnoses and self-diagnosis, with symptoms in professional diagnoses being perceived as more serious. On the contrary, for the representation as a "illness", no significant difference emerged between professional diagnosis and self-diagnosis. This suggests that the effect of attribution on perception of severity is more pronounced when the diagnosis is framed as a "health condition" rather than as a "illness".

Focusing on the variable related to the perceived impact of symptoms in daily life, the results indicate that neither the attribution of the diagnosis nor the representation of psychological distress exerts a relevant effect. The interaction effect between the two variables was also not significant, indicating that the combination of attribution and representation did not lead to significant variations. The data collected therefore do not support our initial hypothesis that representation as a mental illness would have led to a more negative perceived impact of symptoms than representation as a mental health condition and professional diagnosis would have brought a more negative perceived impact than self-diagnosis.

The results concerning the perceived stability of symptoms showed a significant main effect for the attribution of the diagnosis, whereby in cases where the diagnosis was made by a Doctor the perception of stability of symptoms was lower than in cases of self-diagnosis. This response pattern is consistent with our initial hypothesis that professional diagnosis should lead to lower perceived symptoms stability than to self-diagnosis. The representation of psychological distress did not have a significant effect on perceived stability. Interestingly, when the interaction between the two variables was decomposed, we found that the different types of symptoms representations (health condition vs. illness) appears to influence symptom stability. Particularly, stability is higher for self-diagnosis than medical diagnosis in the health condition group, but not in the illness group. Participants therefore tend to perceive symptoms as more enduring when framing them in the context of a health condition and self-diagnosis. This confirms our initial hypothesis that the representation as a mental illness would lead to a decreased perception of stability compared to the representation as a mental health condition.

5.1.2 Intention to seek help

As for the variable related to the intention to seek professional help, the results indicate that neither attribution (diagnosis by doctor vs. self-diagnosis) nor representation (health condition vs. disease) exert a significant effect. In addition, no significant interaction effect between the two variables was observed.

On the other hand, when examining the variable of intention to consider using online resources or self-report tools to understand one's symptoms, the results indicate that attribution of the diagnosis does not exert a significant effect. So, the attribution of diagnosis (self vs doctor) does not substantially affect the decision to use self-assessment tools. Instead, the representation has a significant effect because when psychological distress is described as a health condition, it is leads to higher intention to use self-report tools to better understand the symptoms.

5.1.3 Romanticization of symptoms

The data relating to the perception of conditions as part of social identity did not show significant effects either for the attribution of the diagnosis or for the representation of psychological distress and there does not seem to be an interaction between the two variables. However, there is an interesting trend in that when psychological distress is represented as a "health condition", self-diagnosis seems to lead to greater social identification than medical diagnosis. Attribution (source of diagnosis) may slightly influence the perception of the condition as part of one's social identity when the condition is considered a health condition, but not when it is framed as a disease. These data do not fully support the initial hypothesis that health conditions and self-diagnosis would lead to an increased likelihood of symptoms being incorporated into social identity, but the observed trends suggest that self-diagnosis may play a more important role in social identification than professional diagnosis.

As for the variable perceived closeness with the influencer, the analysis showed that there was no significant effect regarding the attribution of the diagnosis. Participants, in fact, reported no differences in the perception of closeness and connection with the influencer regardless of whether the diagnosis was provided by a doctor or resulted from a self-diagnosis. Similarly, the effect of the representation was not significant because the fact that the discomfort was described as a health condition or as a disease did not have an impact on the perception of closeness. The interaction between the two variables also showed no significant effects. In summary, this model contradicts our initial hypothesis that a health condition and self-diagnosis would lead to a greater connection and closeness than a disease representation and professional diagnosis.

Examining personal identification with symptoms, the results showed no significant effects either for the attribution of the diagnosis or for the representation of psychological distress. In addition, no interaction effect between these two variables was found. Our initial hypothesis was that the level of identification with symptoms would be higher in self-diagnosis cases and when the diagnosis was represented as a "health condition" but the data obtained did not support this prediction.

5.2 Theoretical implications

5.2.1 Symptoms perception

With regard to the stability of symptoms, the results showed that when a health condition is described through self-diagnosis, this leads to a perception of greater stability than a medical diagnosis. In other words, when the condition is represented in non-medical mindset, individuals tend to perceive the symptoms as more stable and lasting. This result is in line with the earlier theory developed by Dweck and her colleagues, according to which there are two main mindsets that profoundly influence individuals' approach to challenges and learning: the fixed and growth mindset. (Dweck, 1996; Dweck & Elliott, 1983). This theory directly connects to our findings: when people see their symptoms as fixed and as an intrinsic part of their personality ("my way of functioning"), they may be less inclined to seek professional help. The portrayal of symptoms through self-diagnosis leads to less motivation to seek help to deal with them because they are seen as traits of the person and this interpretation is in line with existing literature that emphasises how rigid mindsets can hinder the search for solutions for change.

The results on the intention to seek help are congruent with those on the stability of symptoms because in the case of health condition the intention to seek professional help did not emerge but possibly to seek self-help solutions. This confirms that a fixed mindset hinders the intention to seek help. These results contribute to the literature by showing how the perception of stability is also linked to the decision to seek help and opens the way for future studies and research on the role of cultural perceptions.

5.2.2 Intention to seek help

Studies such as that of Bohon et al. (2016) have shown that positive attitudes towards care and greater perceived behavioural control directly predict greater intention to seek mental health services.

The existing literature offers a theory that could explain the increase in favourable attitudes towards the general intention to seek help: Ajzen's (1991) theory of planned behaviour, which illustrates how individual perceptions influence the intention to act in a particular way through three main factors. The first is attitudes towards behaviour, which includes all beliefs about whether a particular behaviour will lead to specific desired outcomes, as well as evaluations of these outcomes (Hayden, 2017).
The second relates to subjective norms, which include all beliefs about what people near or dear to us expect of that behaviour (Brooks et al., 2017). Finally, perceived control refers to the set of evaluations regarding the resources needed, the skills possessed and any environmental obstacles to implementing a specific behaviour (Koka & Hagger, 2017).
Our results, on the one hand, are in line with the literature, because participants who perceived the disorder as a health condition were more likely to seek self-help solutions. This could reflect a positive attitude towards the idea of coping independently, a belief in greater control over coping skills. However, our study did not directly measure attitudes, social norms or perceived control and therefore future studies could incorporate these measures.

5.2.3 Romanticisation of symptoms

With regard to the romanticisation of symptoms, we analysed the extent to which users perceived the disorder as part of their social identity, the connection to the influencer and the identification with the symptoms. The results show that, when the disorder is represented as a health condition, self-diagnosis can lead to an increased perception of the discomfort as part of one's social status. However, no significant effects were found for the other two variables analysed. The literature offers sociological and psychological theories that helps to explain why users tend to perceive disorders as part of their social condition or identify more with the symptoms described in videos produced by non-professionals.

Indeed, a micro-theoretical perspective in sociology that could explain this phenomenon is symbolic interactionism, which focuses on how individuals attribute meaning to things based on everyday interactions (Carter & Fuller, 2016). Scholar Thoits (1985) applied this approach to self-labelling processes in the context of mental health. According to the author, people tend to self-label and self-diagnose when they feel they cannot manage their needs on their own and feel they are failing. At that point, they start to see themselves as others see them and identify with that label. However, with Tik Tok and social media, this process works in reverse: young people might start exploring identities and roles through diagnoses and labels first online from a wider community, also thanks

to the guaranteed anonymity, and then discuss them with those closest to them. (Keipi & Oksanen, 2014; Foster, A., & Ellis, N.,2024).

Another theory called ‘optimal distinctiveness theory’ proposed by Brewer (1991) aims to justify the apparent contradiction whereby, in addition to wanting to belong to a social group, people want to present themselves as unique and distinctive individuals. In this context, identification with a mental disorder diagnosis could satisfy this balance: differentiating oneself from the ‘neurotypical’ norm and, at the same time, identifying oneself with a ‘neurodivergent’ minority. Tik tok could facilitate this process because it offers a space to share personal experiences and recognition both as part of a group and as a unique individual (Foster, A., & Ellis, N., 2024).

The results that emerged are therefore consistent and can be explained by these theories because they suggest that the attribution of a disorder to a health condition can contribute to it being perceived as part of identity and social status.

5.3 Practical implications

From a practical perspective, with the increasing popularity of social media and influencers, it will be important to understand the effects of how psychological disorders are portrayed online.
The results suggest that a doctor's diagnosis leads to a greater perception of severity than self-diagnosis. However, the perception of negative impact in daily life does not seem to be influenced by either symptoms being characterized as a health condition (e.g., ADHD) or as an illness (e.g., depression). In order to strengthen the perception of the severity of symptoms and raise awareness of their negative impact when it comes to illness, it would be necessary to improve communication on social media and promote more information. It is important to make people understand that mental illness, even if it is an ‘invisible’ disease, entails significant consequences, such as the need to go to therapy, take medication or undertake a course of a specific treatment. Raising awareness of these issues could help reduce stigma and foster a more aware and informed approach to mental health.

The results showed that the source of the diagnosis can influence how much a person perceives the disorder as part of their condition, especially when the disorder is considered a health condition and not a disease; in fact, when an influencer talks about their symptoms in a personal and less medical way, the individual tends to perceive the disorder as part of themselves. From a practical point of view, this suggests that influencers, if they are not self-diagnosed, should not deal with mental

health issues in a superficial way. Instead, if they are professionally diagnosed, they should explain their symptoms and experience in a professional manner, perhaps accompanied by psychologists or experts in the field, always reminding users of the importance of avoiding self-diagnosis.

In fact, according to McCashin and Murphy (2023), a more proactive way to address this issue might be to increase the amount of accurate content. The two academics note that professional TikTok content producers are few and frequently do not utilize the app's features, which lowers the possibility that their videos will be seen. (Foster, A., & Ellis, N., 2024) while those of incompetent influencers but with perhaps thousands of followers are successful.
Indeed, Tik Tok has the potential to be a public health tool, provided that professionals create quality content on their own or precisely by collaborating with existing creators. (Chochol, M.D. et al., 2023)
Therefore, in order to increase the quantity and quality of information related to mental health, it would be useful for educational psychologists, associations of ADHD or depression and other highly disseminated illnesses and health conditions , such as anxiety and OCD to engage on Tik Tok by creating content. (Foster, A., & Ellis, N., 2024).

Finally, neither depression nor ADHD, nor the attribution of the diagnosis seem to significantly influence the intention to seek professional help. However, when ADHD is adequately represented, a higher intention to use online or self-help resources is observed. This could be due to the fact that a strong bias towards seeking professional help persists, prompting people to prefer easily accessible content. For this reason, it would be fundamental to promote more social media campaigns that raise awareness of the importance of therapy, rather than spreading videos in which incompetent individuals self-diagnose without any basis. Influencers could, for example, make videos in which they talk about their therapy experience without referring to specific diagnoses or disorders. In fact, longitudinal studies suggest that mental health literacy can be significantly improved through public social campaigns, and that greater awareness of antidepressants could promote their more widespread use (Jorm AF. Et al.,2009).

6. Limitations and future research

This study has limitations that may inspire future research projects.
A first significant limitation concerns the use of two different diseases, treating ADHD as a ‘health condition’. This choice may not have been clear to the participants and may have introduced bias and noise into the results. To avoid this issue in future studies, one could consider using only one

disease, manipulating its representation: in one condition describe it as a ‘disease’ and in another as a ‘health condition’. Another option would be to modify the symptoms associated with the disease. In our study, the symptoms were not changed in order to keep the representation constant; however, this choice may have generated confusion, compromising the measurement of the variable ‘symptom identification’, which did not produce significant results.

The variable negative impact of symptoms in daily life also did not yield a significant result, probably due to the sample size which may not have been large enough to detect particular effects. In terms of materials, it will be necessary, in future studies, to accentuate the differences between the representations in the experimental conditions to a greater extent, to make them more evident and perceptible for the participants.

Another limitation concerns the presentation of the influencer used in the scenarios. The lack of details about her life may have made her less ‘human’ and less engaging. In the future, it would be useful to enrich the character with a more in-depth backstory or to add pictures, to increase its impact and identification by the participants.

Finally, the participants might not read the proposed scenarios carefully, not focusing on the source of the diagnosis or the differences between the experimental conditions, so future studies could work on this fundamental aspect by introducing more engaging formats or clearer language

7. Conclusion

In conclusion, this study investigates how social media and in particular influencers influence users in areas related to mental health. In particular, whether the way a disorder is presented and whether it is certified or not influence perceptions and behaviour the most. The results of some variables generated significant results: the representation of the disorder and specifying the attribution of the diagnosis influence the perceived severity of the symptoms, the source of the diagnosis influences how much an individual perceives the disorder as part of his or her social status, attribution influences the perceived stability of the symptoms and finally, representation influences the intention to seek non-professional help.

The study has some limitations such as the small sample size and potential bias and confusion generated by the scenarios. To improve validity, future research could adopt larger samples and use more defined variables.

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APPENDIX

Appendix 1- Survey scenarios

BLOCK 1

*Influencer: "I had no idea I had **ADHD** until **a specialist diagnosed me.** He explained to me that **ADHD** has a big impact on my daily life. It is a **health condition**, it reflects my social functioning and how I regulate my emotions.*

I often struggle to concentrate and sometimes forget important commitments. I feel disorganised and easily distracted, and other times I feel mentally exhausted and have difficulty finding motivation for the things I enjoy. I tend to isolate myself from others, feeling as if my mind is scattered among a thousand thoughts and as if I am stuck in a mental space where time seems not to flow. For a long time I felt alone, as if no one could really understand how I felt.

*Only after I received the **diagnosis from the specialist**, I realise that this was all part of my **condition, my way of being**".*

BLOCK 2

*Influencer: "I had no idea I had **ADHD** until I started noticing certain patterns in my behavior and eventually **diagnosed myself.** I found out that **ADHD** could be a **health condition** that has a big impact on my daily life, influencing my social interactions and how I regulate my emotions.*

I often struggle to concentrate and sometimes forget important commitments. I feel disorganised and easily distracted, and other times I feel mentally exhausted and have difficulty finding motivation for the things I enjoy. I tend to isolate myself from others, feeling as if my mind is scattered among a thousand thoughts and as if I am stuck in a mental space where time seems not to flow. For a long time I felt alone, as if no one could really understand how I felt.

*Only through **self-reflection** and observing these recurring behaviors I come to believe that this could be part of a larger **condition, my way of being**".*

BLOCK 3

*Influencer: "I had no idea I had **depression** until **a specialist diagnosed me.** He explained to me that **depression** has a big impact on my daily life. It is a **mental illness**, affecting not only my mood but also my social interactions and the way I manage my emotions.*

I often struggle to concentrate and sometimes forget important commitments. I feel disorganised and easily distracted, and other times I feel mentally exhausted and have difficulty finding motivation for the things I enjoy. I tend to isolate myself from others, feeling as if my mind is scattered among a thousand thoughts and as if I am stuck in a mental space where time seems not to flow. For a long time I felt alone, as if no one could really understand how I felt.

*Only after I received the **diagnosis from the specialist**, I realise that this was all part of my **illness, a problem I have**".*

BLOCK 4

*Influencer: "I had no idea I had **depression** until I started noticing certain patterns in my behavior and eventually **diagnosed myself.** I found out that **depression** could be a **mental illness,** affecting not only my mood but also my social interactions and the way I manage my emotions.*

I often struggle to concentrate and sometimes forget important commitments. I feel disorganised and easily distracted, and other times I feel mentally exhausted and have difficulty finding motivation for the things I enjoy. I tend to isolate myself from others, feeling as if my mind is scattered among a thousand thoughts and as if I am stuck in a mental space where time seems not to flow. For a long time I felt alone, as if no one could really understand how I felt.

*Only through **self-reflection** and observing these recurring behaviors, I realise that this was all part of my **illness, a problem I have".***

Appendix 2 – Tables for the means and standard deviations and Figures of the others dependent variables

Perceived impact of symptoms in daily life

Representation	Attribution	*M*	*SD*
Health condition	Diagnosis	4.84	1.169
	Self-diagnosis	4.84	1.255
Illness	Diagnosis	4.91	1.499
	Self-diagnosis	4.93	1.189

Table 5- Descriptive statistics for perceived Impact of symptoms in daily life

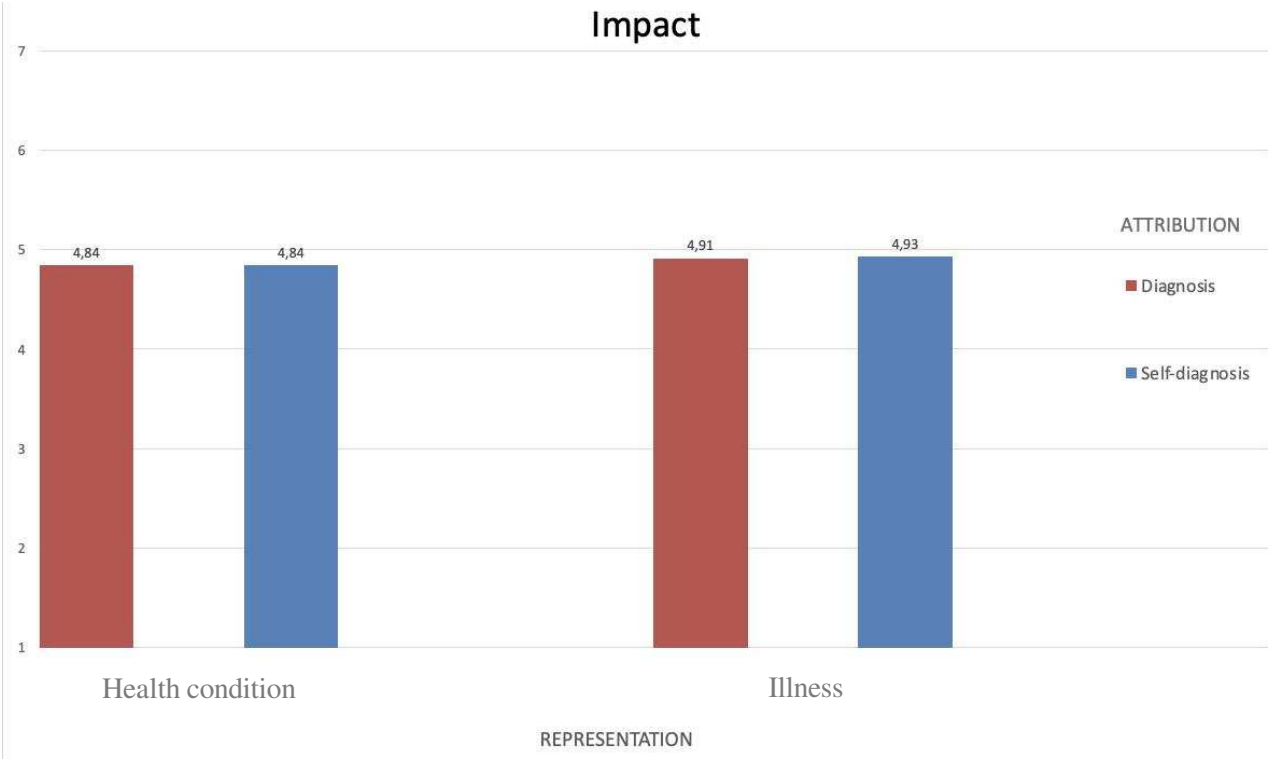

Figure 4- Perceived impact of symptoms in daily life

Intention to seek professional help

Representation	Attribution	*M*	*SD*
Health condition	Diagnosis	4.89	1.685
	Self-diagnosis	4.47	1.781
Illness	Diagnosis	5.26	1.788
	Self-diagnosis	4.76	1.653

Table 6- Descriptive statistics for Intention to seek professional help

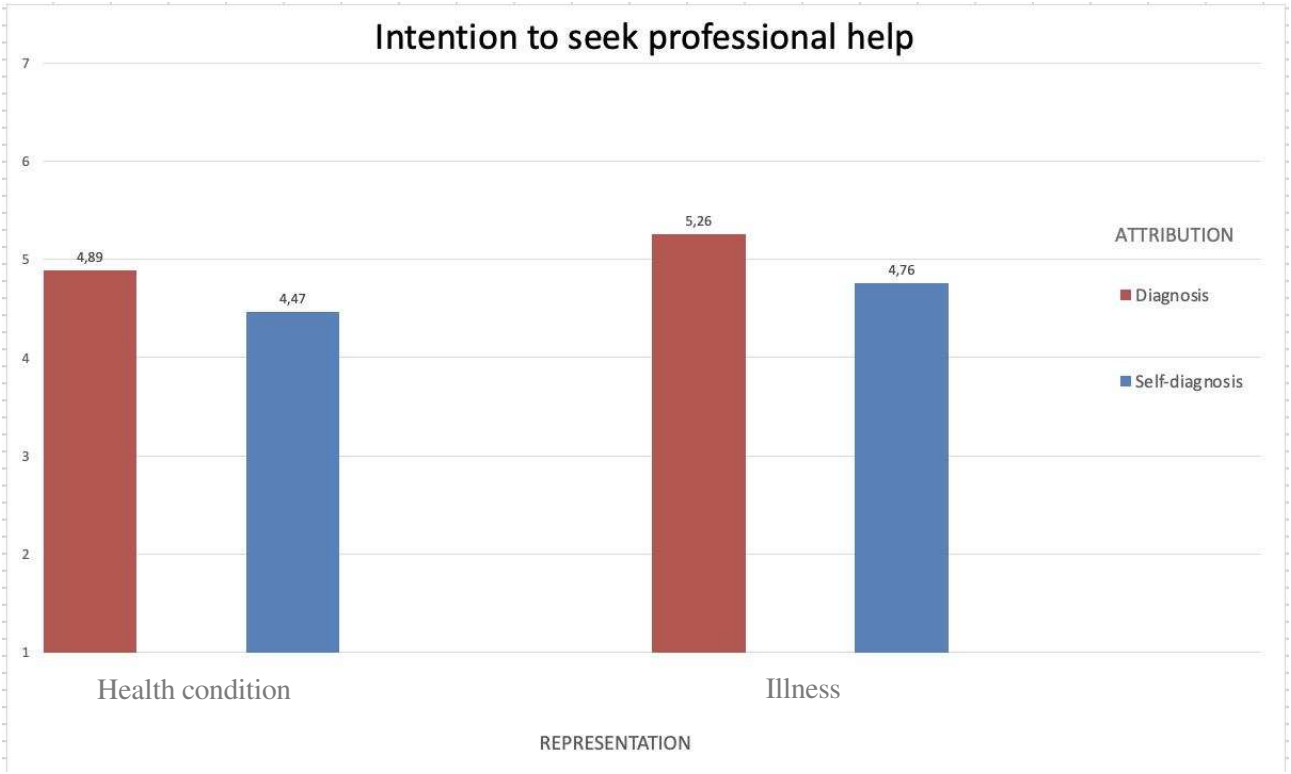

Figure 5- Intention to seek professional help

Intention to seek self help

Representation	Attribution	*M*	*SD*
Health condition	Diagnosis	3.89	1.792
	Self-diagnosis	4.08	1.933
Illness	Diagnosis	3.06	1.611
	Self-diagnosis	3.26	1.746

Table 7- Descriptive statistics for intention to seek self help

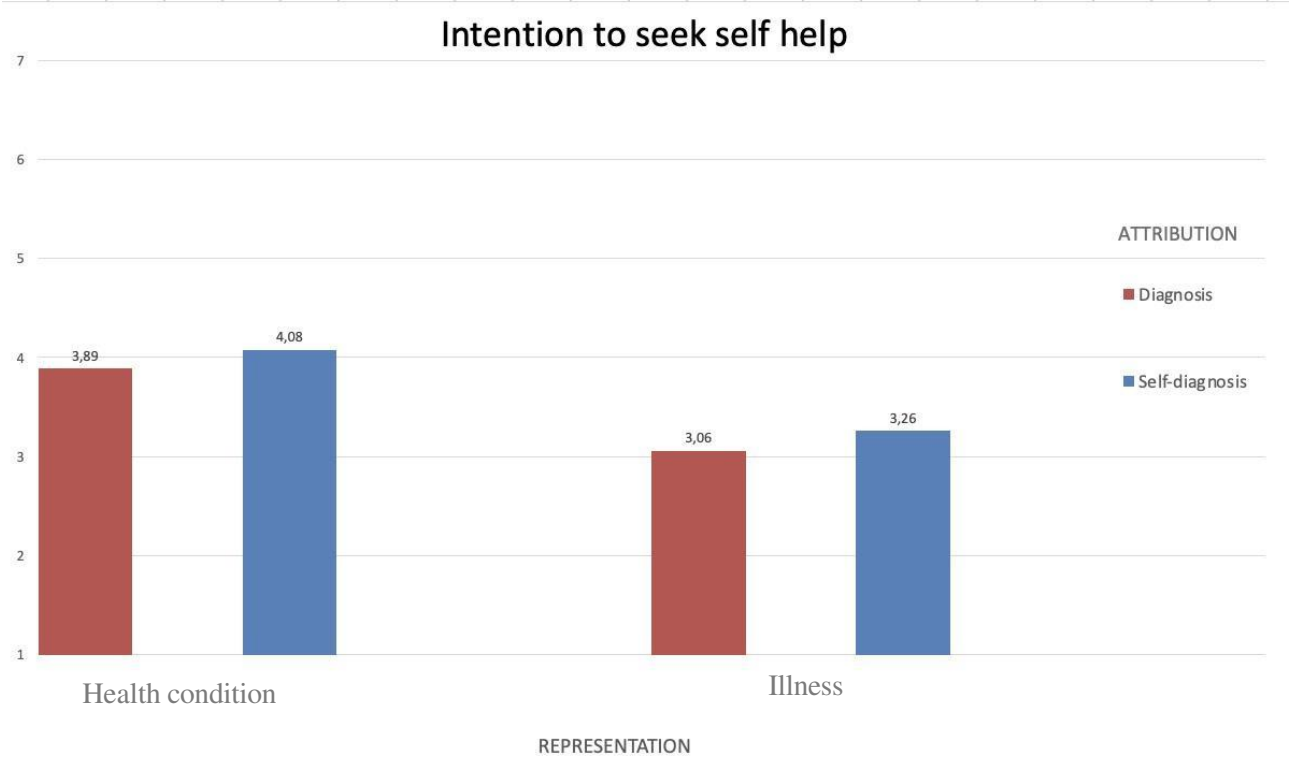

Figure 6- Intention to seek self help

Closeness

Representation	Attribution	*M*	*SD*
Health condition	Diagnosis	3.41	1.565
	Self-diagnosis	3.32	1.732

Illness	Diagnosis	3.50	1.646
	Self-diagnosis	3.66	1.465

Table 8- Descriptive statistics for closeness with the influencer

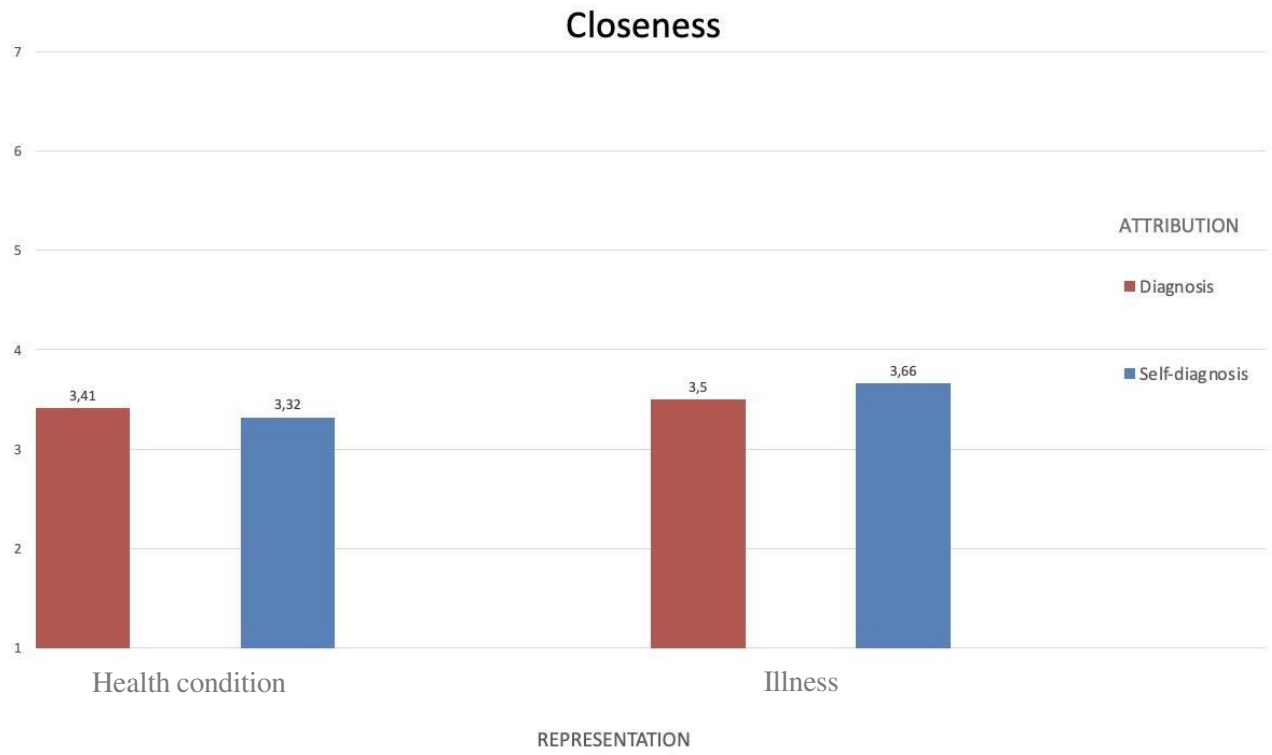

Figure 7- Closeness with the influencer

Identification

Representation	**Attribution**	***M***	***SD***
Health condition	Diagnosis	3.60	1.450
	Self-diagnosis	3.85	1.637
Illness	Diagnosis	3.46	1.613
	Self-diagnosis	3.45	1.494

Table 9- Descriptive statistics for Identification

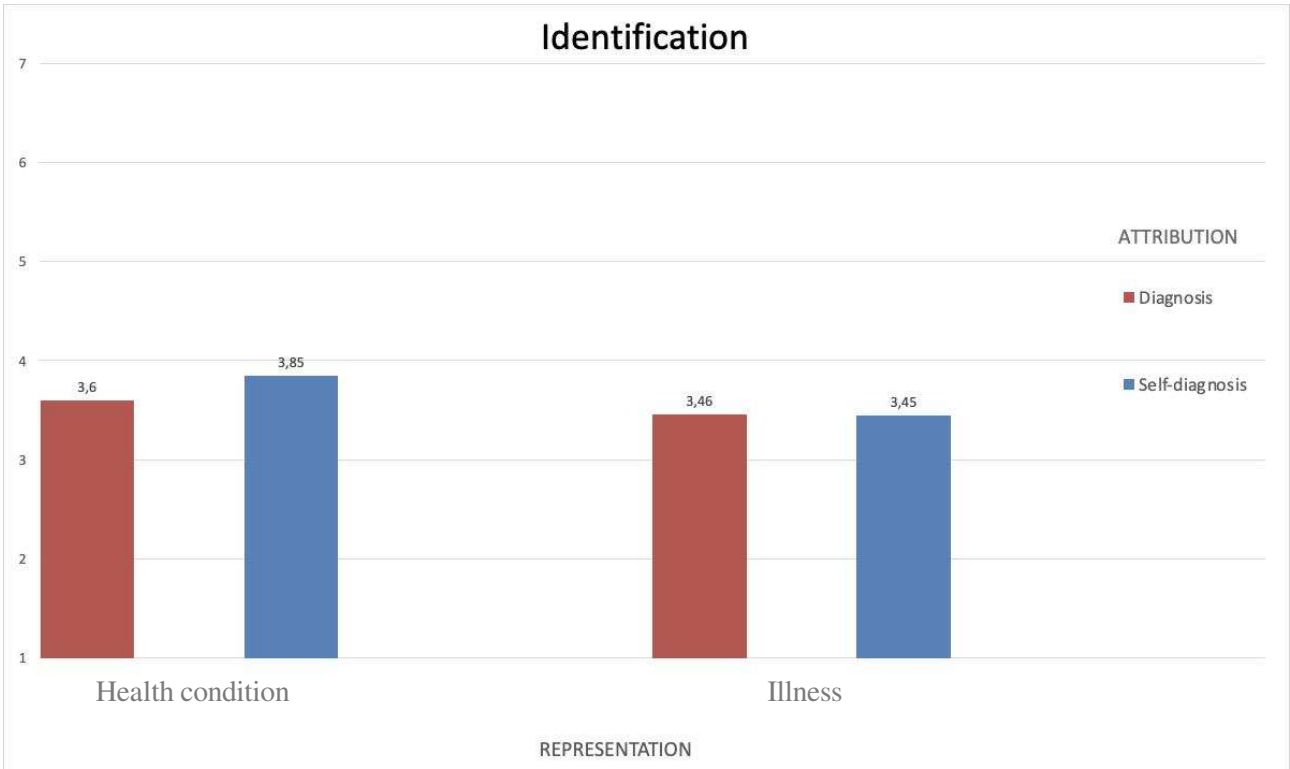

Figure 8- Identification